SPMI PROGRAM CUTS: STATEWIDE FISCAL IMPACT WHITE PAPER — IDAHO 2025

Idaho is eliminating every evidence-based program for its highest-acuity psychiatric populations. These cuts will not save money — they will destabilize six distinct populations and shift $150–$180M in new costs to Idaho's hospitals, counties, EMS systems, and child-welfare programs

Prepared for Idaho Policymakers and Community Stakeholders
by the Idaho Association of Community Providers (IACP)
and the Idaho ACT Coalition (IAC)

ABSTRACT

Idaho is preparing to eliminate or defund the core high-acuity behavioral health programs that stabilize individuals with Serious and Persistent Mental Illness (SPMI)—ACT, HART, Peer Support, ESMI/CSC, half-day PHP—and to weaken IOP by reducing reimbursement. These programs serve **mutually exclusive populations**, each representing a distinct and non-overlapping tier of psychiatric risk. Decades of research show that these cohorts deteriorate rapidly in the absence of the intensive, bundled, team-based models that these programs require [1–31].

Idaho proposes replacing these evidence-based models with standard outpatient codes (therapy, case management, CBRS, crisis, medication visits) that cannot fund the high-frequency, multidisciplinary, in-community or in-facility interventions required for ACT, HART, or CSC fidelity [1–12,13–17,24–31]. This change is not a "reimbursement shift"—it is the **functional elimination** of every intensive psychiatric program in the state.

Using Idaho-specific cost inputs (hospital, ER, EMS, jail, homelessness, Medicaid rates) and conservative adjustments detailed in the **Fiscal Methodology & Calculation Appendix**, this report finds that the cuts will shift:

≈ $150 million to $180 million per year

in downstream costs to hospitals, law enforcement, counties, crisis centers, Medicaid, disability systems, and child welfare.

This estimate excludes ADA/Olmstead liability, catastrophic events, long-term disability, uncompensated-care spikes, and workforce outmigration, meaning true long-run costs are significantly higher.

STATEWIDE COST STACK SUMMARY

Program	Population	Immediate 12-Month Cost Impact	Sources
ACT	400	$35M–$40M	Tables 3–10; [1–12]
HART	352	$53M–$60M	Tables 3–10; [13–17]
Peer Support	4,500	$45M–$50M	Tables 4–10; [18–23]
ESMI/CSC	100	$7M–$9M	Tables 3–10; [24–31]
PHP (Half-Day)*	70	$3M–$4.5M	Tables 3–10; [45–65]
IOP (10% Cut)*	70	$2M–$2.8M	Tables 8–10; [45–65]
TOTAL (CONSERVATIVE)		≈ $150M–$180M annually	
MIDPOINT		≈ $165M	

MAJOR SYSTEM COST SHIFTS RESULTING FROM ELIMINATION OF IDAHO'S SPMI PROGRAMS

System / Sector	Description of Impact	Projected Annual Cost Shift (Conservative Estimate)
Hospitals & Emergency Departments	Increased psychiatric admissions, ER boarding, extended observation stays, medical complications from untreated SPMI, and higher uncompensated-care burden on hospital systems.	$70–$85 million
Jails & Criminal Justice System	Increased arrests, jail bed-days, psychiatric supervision in detention, court and arraignment volume, public defender workload, and sheriff transport associated with destabilized SPMI populations.	$28–$38 million
City & County Government Operations	Increased police call volume, welfare checks, ER-wait overtime, Fire/EMS non-transport calls, crisis-center drop-offs, county behavioral-health workload, guardianship petitions, and civil-commitment activity.	$30–$40 million
Child-Welfare / CPS System	Increased CPS investigations, foster-care placements, case management hours, family-reunification services, and court involvement resulting from psychiatric destabilization among SPMI parents.	$12–$18 million

Notes:

• Populations are mutually exclusive by Idaho Medicaid rule and SAMHSA/NIMH fidelity standards.

• Values exclude ADA/Olmstead liability, DOJ enforcement costs, workforce flight, ICU stays, and catastrophic events.

*No Published Data Available for Population size, so estimate of 10 patients per region per program.

Disclaimer

This report is a policy analysis prepared for informational and decision-support purposes. It synthesizes publicly available research, Idaho-specific data, and conservative fiscal modeling assumptions. It is ***not intended as legal, actuarial, or accounting advice****, and no portion of this report should be interpreted as a substitute for independent legal or financial analysis. Policymakers and agencies should consult their own legal counsel and financial professionals when evaluating statutory, regulatory, or fiscal implications.*

TABLE OF CONTENTS

- **Narrative Overview**
- **Why ACT Cannot Operate Under Outpatient Codes**
- **ACT Technical Modeling**
- **ACT Cost Shift**
- **ACT Funding Structure**

- **High Acuity Residential Treatment (HART)**
  - **Narrative Overview**
  - **What Actually Changes**
  - **Why HART Cannot Be Replaced by Outpatient Codes**
  - **Systemic Consequences**
  - **HART Updated Technical Modeling**
- **Peer Support**
  - **Narrative Overview**
  - **Why Peer Support Is Irreplaceable**
  - **Why It Cannot Be Replaced by Outpatient Codes**
  - **Peer Technical Modeling**
- **Early Serious Mental Illness / Coordinated Specialty Care (ESMI/CSC)**
  - **Narrative Overview**
  - **Why CSC Cannot Function Under Outpatient Codes**
  - **ESMI Technical Modeling**
  - **Downstream Cost Shift**
  - **Funding Structure**
- **Partial Hospitalization (PHP – Half Day)**
  - **Narrative Overview**
  - **What PHP Is**
  - **What Happens When PHP Is Removed**
  - **PHP Technical Modeling**

GLOSSARY OF TERMS (Alphabetical Order)

ACT — Assertive Community Treatment

A 24/7 multidisciplinary, outreach-based treatment team for the highest-acuity adults with schizophrenia, mania, and psychosis. Provides medication support, crisis response, and continuous community stabilization. Cannot operate under outpatient billing.

ADA — Americans with Disabilities Act (Title II)

Federal law requiring states to provide services in the most integrated setting appropriate. Eliminating ACT, HART, and ESMI removes all integrated-setting alternatives for people with SMI.

ALF — Assisted Living Facility

Residential setting providing basic supervision and ADLs. Not clinically staffed. HART homes become standard ALFs when the HART clinical rate ends.

CBRS — Community-Based Rehabilitation Services

Skills-training sessions for lower-acuity individuals. Not evidence-based for ACT/HART/ESMI-level clients and cannot replace intensive treatment models.

CM — Case Management

Brokered referral and coordination service with large caseloads. Not intensive, not clinical, and not appropriate for high-acuity SPMI populations.

CPS — Child Protection Services

Idaho's child-welfare system. Removals and case costs increase when parents with untreated SMI experience relapse, homelessness, or crisis.

CSC — Coordinated Specialty Care

See: ESMI.
Evidence-based early-psychosis treatment model including psychiatry, therapy, SEE, family psychoeducation, and team-based care.

ΔRate (Delta Rate)

The percentage increase in hospitalization, ER use, jail contact, homelessness, or crisis utilization caused by eliminating an evidence-based program. Derived from peer-reviewed outcome research.

Disengagement

Loss of treatment participation, typically caused by symptom relapse, medication lapses, or the absence of Peer Support/ACT. Leads directly to crisis-level events.

DOJ — U.S. Department of Justice

Federal agency enforcing ADA/Olmstead. Requires states to maintain ACT, crisis services, supported housing, CSC, and diversion programs to prevent institutionalization.

ER Boarding

Holding individuals in emergency rooms for 24–72+ hours due to lack of psychiatric beds or community alternatives. A major ADA/Olmstead violation factor.

ESMI — Early Serious Mental Illness

Evidence-based team model for youth experiencing first-episode psychosis. Prevents progression into lifelong disability and chronic schizophrenia.

FEP — First-Episode Psychosis

The first appearance of hallucinations, delusions, or disorganized psychosis. A psychiatric emergency requiring CSC/ESMI-level treatment.

FMAP — Federal Medical Assistance Percentage

The federal share of Medicaid funding (Idaho ≈ 70%). When ACT, HART, and ESMI are eliminated, Idaho loses substantial federal match.

HART — High Acuity Residential Treatment

Idaho's only subacute psychiatric residential program. Provides 24/7 supervision, milieu therapy, medication oversight, and crisis stabilization. Eliminated when the clinical rate is removed.

High-Acuity Population

Individuals whose psychiatric symptoms are severe (e.g., schizophrenia, mania, violent psychosis) and who cannot be stabilized by outpatient therapy.

Integrated Setting

A non-institutional community environment where individuals live or receive services without segregation. ACT, HART, and CSC are integrated settings; ERs, jails, and shelters are not.

Institutionalization

Placement in segregated or restrictive environments such as psychiatric hospitals, ER boarding, jails, nursing homes, or shelters. Preventable under ADA/Olmstead.

IOP — Intensive Outpatient Program

Multi-hour, multi-day stabilization for moderate-to-high acuity individuals. Reimbursement cuts weaken fidelity and capacity.

Outpatient Substitution

The limited replacement of intensive programs with therapy, CM, CBRS, crisis codes, or med-management. Replaces only 10–15% of lost intensity and cannot prevent destabilization.

Peer Support

Evidence-based, lived-experience behavioral-health engagement provided in the community. Prevents relapse, hospitalization, homelessness, and justice involvement.

PHP — Partial Hospitalization Program (Half-Day)

Structured 3–4 hour psychiatric treatment for post-hospital individuals who are too unstable for outpatient care. Eliminating it creates a post-acute stabilization gap.

SPMI — Serious and Persistent Mental Illness

Severe disorders such as schizophrenia, bipolar I with psychosis, delusional disorder, or chronic psychosis requiring intensive stabilization.

INTRODUCTION & SUMMARY OF FINDINGS

Idaho is eliminating every evidence-based program for its highest-acuity psychiatric populations. These cuts will not save money — they will destabilize six distinct populations and shift $150–$180M in new costs to Idaho's hospitals, counties, EMS systems, and child-welfare programs Idaho is eliminating or degrading every high-acuity behavioral-health program that stabilizes individuals with the most severe psychiatric disorders: ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and fully funded IOP. These programs prevent the highest-risk adults and youth from deteriorating into hospitalization, homelessness, incarceration, involuntary commitments, violent crises, suicide attempts, and medical destabilization [1–31].

These services **do not overlap**:

- ACT clients cannot be in HART or ESMI.
- HART residents cannot be enrolled in ACT, PHP, or IOP.
- ESMI clients are age-restricted and distinct from all other cohorts.
- PHP and IOP serve separate step-down populations.
- Peer Support serves individuals who are not eligible for ACT/HART/ESMI.

This means the consequences of eliminating these programs **accumulate across cohorts**.

What Idaho Is Doing: Eliminating Bundled, Evidence-Based Models

Idaho is eliminating the bundled funding structures that make ACT, HART, and ESMI/CSC possible and replacing them with a fee-for-service, billable-hour reimbursement model**.** Under the new system, providers may bill only standard outpatient CPT codes (therapy, case management, CBRS, crisis, and medication visits). These codes were designed for clinic-based, appointment-driven outpatient treatment—not for high-acuity, team-based, community-delivered stabilization.

Every one of Idaho's intensive programs exists *because* outpatient billing cannot fund their staffing patterns, their frequency, or their 24/7 crisis capabilities.

This change is not a realignment or redesign. It **eliminates Idaho's evidence-based high-acuity models and replaces them with services that are fundamentally not appropriate for these populations.** Fee-for-service codes pay only for discrete, scheduled encounters. They do *not* reimburse the core elements of ACT, HART, or CSC fidelity, including:

- shared caseloads and multidisciplinary team meetings
- daily or near-daily contact
- in-home/in-community fieldwork

- 24/7 crisis availability
- milieu-based residential stabilization
- rapid clinical response and medication adjustment
- environmental or safety interventions
- Supported Employment/Education (ESMI)
- integrated peer involvement

These models were never intended to operate on a billable-hour structure; nationally, intensive services are understood to require bundled, per-diem, or programmatic funding because the clinical work occurs outside of billable encounters.

Peer Support (PSS) is not being restructured—it is being eliminated outright. Idaho has stated that PSS billing codes will simply no longer be reimbursed, ending the service with no substitute, despite Peer Support being:

- a Medicaid-funded evidence-based practice,
- a DOJ-required integration support, and
- a core component of ACT, HART, CSC, crisis systems, and diversion programs.

By replacing ACT, HART, ESMI/CSC, PHP, IOP, and Peer Support with outpatient billing codes never designed for high-acuity care, Idaho is not shifting reimbursement policy. Idaho is dismantling its entire intensive-treatment infrastructure and replacing it with service types that cannot—by design—perform the clinical functions those programs were created to deliver.

Why These Programs Matter

ACT reduces hospitalization 50–80% [1–3,7,8], ER use 45–60% [2,4,8], homelessness 30–40% [5–8], and justice involvement 40–60% [9–12].

HART-type supportive housing reduces ER visits, jail days, homelessness, and medical crises [13–17].

Peer Support reduces readmissions, improves engagement, and lowers ER and crisis use [18–23].

ESMI/CSC reduces hospitalization, suicide attempts, and long-term disability [24–31].

Half-day PHP and IOP reduce hospitalization and crisis use 60–80% compared to standard outpatient care [45–65].

What Happens When These Programs Go Away

When ACT, HART, Peer Support, ESMI, and PHP disappear, Idaho does not get a smaller system.
It gets **no system** at all.

High-acuity individuals shift into:

- Emergency rooms
- Inpatient psychiatric units
- Jail cells
- Homeless encampments
- Police custody
- Ems transport systems
- Child-welfare investigations
- Medical-surgical floors
- Long-term disability enrollment

These systems are not designed to stabilize severe mental illness.

Fiscal Summary of Findings (Conservative Scenario)

(See Calculation Appendix, Tables 3–11.)

Even after major downward adjustments to hospitalization, ER, crisis, jail, homelessness, and child-welfare multipliers, Idaho incurs:

≈ $150 million to $180 million per year

(Midpoint ≈ $165 million)

This excludes:

- ADA/Olmstead liability
- DOJ enforcement
- Catastrophic public events
- Workforce depletion
- Long-term disability costs

Actual long-run exposure is higher.

System Collapse Pathways: How Each Eliminated Program Converts Into Higher-Cost Systems

When Idaho removes ACT, HART, ESMI/CSC, Peer Support, half-day PHP, and full-fidelity IOP, each population does not shift into a lower-cost alternative.
They shift directly into the highest-cost public systems.

Below is the predictable transition pathway documented across national literature:

1. ACT → ER → Inpatient → Jail/Homelessness
When ACT disappears, the most psychiatrically unstable adults lose 24/7 stabilization, leading directly to ER crises, involuntary admissions, and police contact.

2. HART → ER → Inpatient → Crisis Homes → Homelessness/Jail
When the HART clinical rate is removed, ALF residents remain in place but lose all stabilization capacity. Crises escalate into EMS calls, ER boarding, and inpatient admissions.

3. Peer Support → Disengagement → Relapse → ER/Inpatient → CPS/Jail
Peer removal causes disengagement within days or weeks. Relapse converts into emergency care, suicide attempts, overdose, homelessness, and justice involvement.

4. ESMI/CSC → Rapid Relapse → ER → Inpatient → Chronic Schizophrenia & Disability
CSC prevents disability. Removing it accelerates conversion into chronic schizophrenia, permanently increasing Medicaid and social-service costs.

5. Half-Day PHP → Readmission Loop → ER → Inpatient → Loss of Housing/Work
PHP exists to break the "post-discharge readmission cycle." Without it, patients fall directly back into ERs and hospitals.

6. IOP (Cut 10%) → Relapse → ER → Hospital → Crisis-Cycle
Reduced IOP intensity decreases protective capacity, increasing relapse and hospitalization.

Summary:

Each program removed creates its own destabilization pathway. Because the populations do not overlap, the cost impacts accumulate, not offset.

KEY FINDINGS FOR LEGISLATORS

1. Idaho is eliminating every high-acuity psychiatric program simultaneously.

ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and fully funded IOP will no longer exist in functional form under outpatient billing.

2. These programs serve mutually exclusive populations.

No one in ACT is in HART.
No one in HART is in PHP or IOP.
No one in ESMI can join ACT.
Peer clients do not qualify for any other program.
Six independent populations collapse.

3. Outpatient therapy cannot replace these programs.

Outpatient billing cannot fund:

- 24/7 care
- multiple daily contacts
- team meetings
- SEE (ESMI)
- crisis stabilization
- milieu interventions
- in-home/in-facility care

4. Direct annual cost shift: $150M–$180M (conservative).

This includes ER, hospital, EMS, justice, homelessness, workforce, and child-welfare impacts.

5. Idaho loses $40M–$45M in federal match.

The burden shifts to the General Fund and counties.

6. Idaho becomes non-compliant with ADA & Olmstead.

Eliminating all intensive community programs leaves no "most integrated setting," triggering DOJ enforcement.

7. Consequences appear within weeks:

- ER boarding surge
- police & EMS overload
- homeless encampment expansion
- youth psychiatric crises at schools
- inpatient overflow
- CPS involvement spikes

8. This model is conservative.

It excludes ICU stays, police overtime, crisis-center overtime, catastrophic events, long-term disability, and uncompensated care.

Bottom Line:

The cuts do not save money. They shift far larger costs to Idaho taxpayers, counties, hospitals, law enforcement, and schools — and expose Idaho to significant federal liability.

Loss of Federal Funds

The ACT, HART, ESMI, and Peer Support bundles include significant federal matching dollars. Eliminating bundled models eliminates ≈**$40–$45 million in federal participation**, shifting the burden to Idaho taxpayers.

Community Safety Impacts

Psychotic deterioration, mania, delusions, and disorganized behavior become:

- ER emergencies
- Law-enforcement crises
- Involuntary commitments
- Public-safety threats
- Violent or suicidal episodes

These patterns are extensively documented in ACT, HART, and CSC literature [1–31, 66–70].

Child-Welfare Impacts

Parents losing stabilization experience higher CPS investigations and removals. Conservatively:

≈ $8 million to $16 million annually
(See Calculation Appendix, Table 9.)

ADA/Olmstead Exposure

Eliminating all high-acuity community programs removes Idaho's ability to provide services in the "most integrated setting," directly violating ADA Title II and *Olmstead*. DOJ's 2025 findings already place Idaho under scrutiny.

ASSUMPTIONS USED THROUGHOUT THIS REPORT
To ensure the statewide fiscal estimate is conservative and withstands legislative, budget, and legal scrutiny, the following assumptions were used:
• All unit costs are Idaho-specific and use the lowest credible values (hospital, ER, jail, EMS, shelter).
• All program effects use conservative "delta" rates derived from the lowest effect sizes in the published literature.
• All populations (ACT, HART, Peer, ESMI/CSC, PHP, IOP) are mutually exclusive per Idaho Medicaid program rules and SAMHSA fidelity requirements.
• All cost estimates avoid double-counting by using either composite categories (HART) or downward adjustments.

• Outpatient substitution costs are included, but outpatient services are assumed to replace only 10–15% of lost intensity.
• Child-welfare impacts use Idaho's lower CPS cost range and downward-adjusted removal estimates.
• All downstream estimates (hospital, justice, EMS, homelessness, CPS) exclude overtime, ICU, catastrophic events, and uncompensated care.
• All "high-end" cost values in this report reflect the mid-range of published national or state data—not the maximums.

These assumptions purposely understate fiscal impact; actual long-run costs will be higher.

WHAT THIS MODEL DOES NOT COUNT

To avoid overstating fiscal impact, the following cost categories were deliberately excluded from all calculations:

- ER boarding beyond 24–72 hours
- ICU medical admissions due to psychiatric destabilization
- Police overtime, backfill, or tactical response costs
- Jail suicide-watch staffing and medical monitoring
- Homeless encampment policing, cleanup, or fire/EMS calls
- Uncompensated-care admissions in hospitals and ERs
- Out-of-pocket family expenditures
- Workforce loss beyond the first-year wage/ripple/tax impact
- Decades-long Medicaid/SSDI disability costs
- Litigation, oversight, and compliance expenditures under ADA/Olmstead

These exclusions mean the total statewide impact presented here (≈$150M–$180M) is a minimum estimate. Actual fiscal exposure will be significantly higher.

METHODOLOGY STATEMENT

This fiscal and systems impact model was developed using Idaho-specific cost inputs, peer-reviewed research, and federally recognized program standards. The purpose of the model is to provide a conservative, legally defensible estimate of the annual statewide cost impact resulting

from the elimination or degradation of Idaho's intensive SPMI programs (ACT, HART, Peer Support, ESMI/CSC, PHP, and IOP).

1. Evidence Base & Standards

All program impact estimates are based on:

- National randomized controlled trials (RCTs),
- Longitudinal cohort studies,
- Systematic reviews and meta-analyses,
- SAMHSA and NIMH Evidence-Based Practice guidelines,
- DOJ/ADA/Olmstead enforcement documents,
- Idaho Medicaid rates, unit costs, and operational rules.

Program definitions and fidelity requirements were taken directly from federally recognized ACT, CSC, supportive housing, and crisis-service standards to ensure modeling aligns with what these programs actually deliver in Idaho.

2. Idaho-Specific Unit Costs

All cost inputs—hospital, ER, EMS, jail, shelter, outpatient, workforce, and CPS—use **Idaho-specific unit values**, not national averages.
Where Idaho ranges exist, the **lowest credible value** was selected.
Where national values exceed Idaho's, Idaho's lower figures were used to avoid overstating impact.

3. Delta (ΔRate) Logic

The model quantifies only the *increase* in downstream utilization caused by program removal using ΔRate logic, which isolates attributable impact.
Each ΔRate was chosen from the **lowest effect-size range** found in peer-reviewed research.
Many ΔRates were then reduced further to ensure conservative estimates.

4. Mutual Exclusivity

Fiscal modeling strictly follows Idaho Medicaid rules, SAMHSA fidelity standards, and residential licensing criteria that make ACT, HART, ESMI/CSC, PHP, IOP, and Peer Support **mutually exclusive population groups**.
This prevents double-counting and ensures each program's cost impact is additive, not overlapping.

5. Outpatient Substitution

Outpatient therapy, case management, CM, CBRS, and crisis codes replace only **10–15%** of the lost intensity from ACT/HART/ESMI/Peer/PHP, based on national literature and Idaho utilization patterns.
Substitution costs are included, but substitution impact is not credited because the evidence shows it cannot prevent deterioration.

6. Downward Bias & Conservative Assumptions

This model intentionally **understates** statewide fiscal impact. To maintain conservative bias, the model:

- Uses Idaho's lowest cost values for all categories,
- Excludes police overtime, medical clearance, ICU-level care, homelessness encampment costs, and uncompensated care,
- Excludes multi-agency response costs and crisis center overtime,
- Reduces hospitalization, homelessness, and justice multipliers below values found in the literature,
- Understates child-welfare removal estimates relative to national evidence,
- Compresses HART crisis impacts into a single line to avoid double-counting.

7. Data Integrity & Transparency

All formulas, ΔRates, population estimates, and cost components are documented in the Fiscal Methodology & Calculation Appendix (Tables 3–11).
Every assumption is explicitly stated to allow audit, replication, or challenge.

8. Purpose & Scope

This model is not designed to estimate:

- Catastrophic events,
- Long-term disability trajectories,
- Workforce flight over multiple years,
- ADA/Olmstead litigation costs,
- Uncompensated hospital surges.

Those categories represent additional fiscal risk not included in the $150M–$180M estimate.

9. Conclusion

This is a **minimalist, conservative, Idaho-specific** fiscal estimate.
Every assumption, cost input, and effect size was selected to avoid overstating the statewide impact.
Given the conservative methodology used, actual long-run costs are expected to exceed the modeled range.

SECTION I — PROGRAM NARRATIVES & TECHNICAL ANALYSIS

Idaho is dismantling every evidence-based, high-acuity behavioral health program that stabilizes its most psychiatrically vulnerable residents. These include Assertive Community Treatment (ACT), High Acuity Residential Treatment (HART), Peer Support, Early Serious Mental Illness programs (ESMI/CSC), half-day Partial Hospitalization (PHP), and reimbursement-intact but fidelity-impaired Intensive Outpatient Programs (IOP).

These programs are **mutually exclusive by rule** — individuals eligible for ACT are not in HART; ESMI clients are not ACT clients; HART residents cannot be enrolled in PHP or IOP; Peer Support serves a distinct non-ACT/non-HART population; PHP and IOP serve transitional but separate cohorts.

Because the populations do not overlap, their destabilization is **additive**, not duplicative.

The following sections integrate **summaries, citations, and expanded explanations** of what the cuts change, why unbundling destroys the models, and what system-wide impacts follow.

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1. ASSERTIVE COMMUNITY TREATMENT (ACT)

ACT — Narrative Overview

ACT stabilizes Idaho's 400 highest-acuity adults with schizophrenia, mania, and psychosis. Without ACT's 24/7 community-based team, these individuals deteriorate rapidly into ERs, hospitals, jails, homelessness, and violent crises.

Assertive Community Treatment (ACT) is Idaho's only evidence-based, federally recognized, high-intensity community-based model for adults with the most severe and persistent mental illnesses — including schizophrenia, treatment-resistant psychosis, severe bipolar disorder with mania, delusional disorder, co-occurring SMI/SUD, and individuals who repeatedly destabilize

despite traditional outpatient treatment [1–12]. See Appendix 12, 13. These individuals represent Idaho's **highest-acuity cohort**, and ACT exists specifically because this population cannot be safely or sustainably treated through office-based services. Their symptoms impair insight, judgment, executive function, medication adherence, and their ability to seek help during relapse. ACT was created to reach people **who outpatient care cannot reach**.

ACT is a **24/7 multidisciplinary team** that delivers intensive treatment directly in the environments where psychiatric instability occurs. ACT staff intervene:

- In clients' homes,
- In shelters or encampments,
- In motels,
- On the street,
- After ed discharge,
- During police encounters,
- And in imminent crisis episodes that would otherwise result in hospitalization or jail.

This is not outpatient care. ACT delivers continuous, in-community clinical engagement, following clients into the most destabilizing contexts to prevent crises from escalating. Research shows ACT reliably reduces:

- Psychiatric hospitalization by **50–80%** [1–3,7,8],
- ER utilization by **45–60%** [2,4,8],
- Homelessness by **30–40%** [5–8],
- Arrests and jail days by **40–60%** [9–12],
- Medical hospitalization by **20–40%** through integrated medical-psychiatric support [4–8].

ACT's value is preventive: most ACT services occur **before** symptoms become visible to hospitals, police, or families.

Why ACT Cannot Operate Under Outpatient Codes (and Why Unbundling Eliminates the Program)

ACT's effectiveness depends on its **bundled**, **team-based**, **high-frequency**, **community-delivered** structure. Nearly all ACT services are *not* billable under therapy, CBRS, case management, crisis-hour, or med-management codes. These codes only reimburse for isolated, appointment-based visits, not for:

- Multiple weekly contacts (3–7+),
- In-community fieldwork,
- Daily medication monitoring,
- Team meetings and shared caseloads,
- 24/7 crisis availability,

- Co-staffed interventions,
- Rapid relapse detection,
- Continuous engagement with individuals who refuse office-based care,
- Transport, outreach, or follow-up outside the clinic.

Outpatient billing **removes the funding mechanism that makes ACT possible.** Once team-based staffing, high-frequency intervention, and 24/7 availability become unfunded, the model collapses into the same low-intensity outpatient services that failed this population before they were admitted to ACT [1–12].

SAMHSA is explicit:

"A program without multidisciplinary teams, shared caseloads, in-vivo services, and 24/7 capacity is not ACT."

Thus Idaho is not "changing ACT billing."
Idaho is **eliminating ACT**, removing the only community-based intervention proven to stabilize its highest-risk psychiatric population. See Appendix 12, 13.

ACT — Technical Modeling

Transfer costs to other programs and entities

(See Calculation Appendix: Tables 3–10)

Service	Calculation	Impact
Medicaid Services Eliminated		$12.23M in annual ACT bundled funding.
Hospitalizations	400 clients × 0.35–0.40 additional admissions/year	= 140–160 added admissions
	× 5 days × $1,100/day	= **$750k–$900k** [39–44].
ER Utilization	~220 additional ER visits × $2,400	= **$400k–$475k** [39–44].

Justice-System	Increased arrests, jail days, and court involvement	= **$700k–$850k** [9–12].
Homelessness & EMS	19 clients × $8,000 shelter cost + EMS	= **$225k–$275k** [5–8].
Medical Destabilization	$3.4M baseline × 25%	= **$650k–$750k** [4–8].
Outpatient Substitution	120 clients × $29,121	= **$3.49M** (state share ≈ $1.05M).
Workforce Loss		≈ $1.1M (wages); ≈ $1.3M ripple; ≈ $70k tax impact.
Child-Welfare	20–30 additional removals* × $130k–$160k	= **$4M–$6M** [66–70].
Total Transferred Cost from ACT Elimination		**≈ $35M–$40M per year**

*This reflects Idaho CPS's own documented removal rate for SMI parents (≈8× baseline), adjusted downward to 20–30 removals using conservative estimates.

ACT Cost-Shift to Idaho After Program Elimination

Eliminating ACT creates a large downstream cost shift for Idaho because the program serves a mixed population of Medicaid and non-Medicaid clients. When ACT disappears, increases in hospitalization, jail use, homelessness, ER utilization, crisis encounters, and child-welfare involvement translate directly into State liability. Based on Idaho's current client mix and evidence-based cost impacts, the annual State cost shift from eliminating ACT is estimated at **approximately $36 million per year**.

ACT Funding Structure and State Fiscal Exposure

ACT services are funded through a combination of Medicaid and State-only dollars. About **60% of ACT participants are Medicaid beneficiaries**, funded at a **70/30 FMAP split**, while the remaining **40% are not Medicaid-eligible** and therefore receive **no federal match**.

From the program's **$12.23 million** annual operating cost:

- **$7.34 million** represents Medicaid ACT services, with Idaho responsible for 30% of that amount.
- **$4.89 million** represents ACT services for non-Medicaid clients, which Idaho funds entirely.

Because Idaho pays both the State share of Medicaid services and the full cost of services for non-Medicaid participants, the State's fiscal responsibility is substantially larger than it would be

in a purely Medicaid-funded program. When ACT ends, the downstream costs associated with both groups—hospitalization, incarceration, crisis cycles, homelessness, and child welfare—fall directly on Idaho's general fund and local governments.

These program and population dynamics combined drive an estimated **$36 million annual cost burden** to the State following ACT elimination.

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2. HIGH ACUITY RESIDENTIAL TREATMENT (HART)

HART

HART provides Idaho's only subacute psychiatric residential stabilization for 352 adults who cannot live safely in the community. Removing the HART clinical rate eliminates 24/7 supervision, crisis stabilization, medication oversight, and all therapeutic structure, causing predictable ER, hospitalization, and justice-system surges.

Idaho currently has two tiers of assisted living facilities (ALFs) serving individuals with serious mental illness:

1. Lower-Tier ALFs (≈7)

These facilities provide basic residential supervision—meals, ADLs, medication reminders, safety monitoring—and contract externally with outpatient behavioral health providers for therapy, case management, CBRS, crisis visits, and medication management. They have always operated under fee-for-service outpatient billing and do not provide on-site psychiatric stabilization.

2. True HART Homes (≈10)

These facilities provide all ALF services *plus* a bundled, in-house clinical program funded through the $171.49/day HART clinical rate. This rate supports:

- 24/7 clinical and behavioral staffing
- Overnight supervision
- Continuous milieu therapy
- Daily psychiatric integration and nursing oversight
- Multiple daily interventions
- Real-time crisis de-escalation
- Medication monitoring and adherence support
- Environmental safety controls and high-acuity stabilization

These elements make HART Idaho's only subacute psychiatric residential level of care, serving individuals too unstable for outpatient treatment but not requiring hospitalization. All HART Home participants are Medicaid beneficiaries, and HART is financed entirely through Medicaid with federal matching; there is no separate general-fund-only HART population.

Research on high-acuity residential and supportive housing consistently shows these models reduce hospitalizations, homelessness, criminal justice involvement, and medical destabilization [13–17].

What Actually Changes Under the New Policy

Residents will not move.
They remain in their current ALFs—including current HART Homes.

What ends is the treatment layer.

Beginning under the new model:

- The HART clinical program disappears entirely
- The $171.49/day treatment rate ends
- Only residential supervision remains
- Each home must rely on external outpatient providers for treatment
- Only outpatient-billable services can be delivered
- Peer support disappears entirely, as it is not realistically deliverable under outpatient billing within ALFs
- Milieu therapy, 24/7 clinical supervision, and crisis stabilization stop completely

This means:

Every HART Home becomes functionally identical to a lower-tier ALF.
The only surviving services are those that can be billed outpatient—and these cannot replicate the HART model.

Why HART Cannot Be Replaced With Outpatient Codes

HART Requires In-House Services That Outpatient Billing Cannot Cover

HART's bundled clinical rate funds:

- High 24/7 staffing ratios
- Overnight clinical supervision
- Continuous milieu therapy
- Multiple daily contacts

- On-the-spot crisis de-escalation
- Psychiatric and nursing oversight
- Environmental and safety management
- Integrated team meetings and care coordination

Outpatient billing cannot pay for:

- Overnight staffing
- Milieu-based interventions
- Multiple daily behavioral contacts
- In-facility crisis stabilization
- Environmental safety management
- Embedded nursing oversight
- In-house peer services

This is why lower-tier ALFs can function under outpatient contracting—they serve lower-acuity residents with limited treatment needs.

True HART residents cannot be stabilized this way.

The state's change is not a "reimbursement shift."
It is the removal of Idaho's only subacute psychiatric residential program and conversion of all homes into basic residential facilities with episodic outpatient visits. See Appendix 12,13.

Systemic Consequences of Ending HART Treatment

The cessation of bundled funding within the HART program introduces a significant fiscal and operational challenge for providers, critically jeopardizing services deemed **unbillable** under the new structure.

1. Fiscal and Operational Strain

The elimination of the comprehensive day-rate structure necessitates that providers absorb the full cost of essential, non-reimbursable support services. Specifically, when a support worker accompanies a member to a medical appointment, the service provided is frequently rendered unbillable, creating an unfunded mandate on the provider. This systemic lack of reimbursement imposes substantial and unsustainable financial pressure, particularly upon smaller organizations dedicated to this specialized care.

2. Diminished Continuity of Care for the SPMI Population

For individuals diagnosed with Severe and Persistent Mental Illness (SPMI), the accompaniment and advocacy of a dedicated support worker during medical encounters is not merely beneficial—it is often **clinically essential**.

- **Crucial Advocacy:** Due to the nature of their condition, members with SPMI frequently struggle to articulate the full scope of their symptoms, medical history, or psychosocial needs. The support worker serves as a vital advocate and interpreter, ensuring accurate diagnostic information is conveyed and understood by the treating physician.
- **Systemic Information Gap:** Without the support worker's presence, the HART residential facility receives an incomplete or inaccurate record of the patient's medical issues, the resulting treatment plan, and discharge instructions. This information deficit severely impedes the home's ability to ensure **continuity of care**, which is paramount for successfully managing the complex and often co-occurring medical conditions inherent to the SPMI population.

Once HART clinical services stop:

1. Outpatient billing increases (but cannot replace HART)

External behavioral health providers will bill for therapy, CM, CBRS, crisis, and medication management.
But these services:

- Cannot deliver 24/7 stabilization
- Cannot perform milieu interventions
- Cannot prevent in-home crises
- Cannot meet the psychiatric acuity that HART managed
  Outpatient codes replace only a small fraction of the lost clinical work.

2. Peer services disappear entirely

HART peers were funded under the bundled rate.
Outpatient peers cannot staff ALFs at the frequency required for this population.

3. Increased crisis response and ER utilization

Without 24/7 in-home de-escalation:

- Crises escalate
- 911 calls increase
- Mobile crisis responses increase
- ED boarding increases
  Estimated cost shift: $5M–$8M.

4. Increased psychiatric hospitalizations

Without milieu, monitoring, medication support, or embedded crisis stabilization, admissions rise by an estimated 30–80% (based on national research).
Estimated cost shift: $6M–$10M.

5. Workforce loss and economic ripple

HART clinical staff positions (≈$12–$13M) disappear.
Associated ripple and tax impacts add another $16M–$17M.

HART — Updated Technical Modeling

Transfer costs to other programs and entities

(See Calculation Appendix: Tables 3–10)

Service	Impact
A. Clinical Medicaid Funding Eliminated	≈ $23.1M per year (Bundled clinical rate removed for all true HART homes)
B. Outpatient Substitution (increased but insufficient)	≈ $2.2M–$3.0M (represents outpatient billable hours replacing a portion of former HART work)
C. Loss of Peer Services	≈ $2.0M–$2.6M equivalent system impact (peer support is no longer deliverable inside ALFs at required frequency)
D. ER / Crisis / Law Enforcement Cost Shift	≈ $5.0M–$8.0M
E. Inpatient Psychiatric Hospitalization Increase	≈ $6.0M–$10.0M
F. Workforce & Economic Impact	
• **Ripple effect:**	≈ $15M–$16M
• **Direct wages lost:**	≈ $12M–$13M
• **Tax loss:**	≈ $750k–$850k
Total Transferred Cost from HART Elimination	≈ $53M – $60M per year

The HART composite includes all ER, crisis, EMS, inpatient, justice, and medical-destabilization costs together to avoid double-counting. These categories cannot be separated without overstating totals. The composite value intentionally compresses ER, hospitalization, EMS, crisis, and justice-system costs to prevent double-counting across categories.

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3. PEER SUPPORT

Peer Support — Narrative Overview

Peer Support is Idaho's largest statewide engagement layer, preventing relapse for more than 4,500 moderate-to-high acuity adults. Removing peers causes immediate disengagement from treatment, rapid psychiatric deterioration, higher ER use, and increased homelessness, justice-system contact, and CPS involvement.

Peer Support is Idaho's largest, most flexible, and most scalable behavioral-health engagement workforce. Unlike traditional clinicians—who generally rely on scheduled, office-based encounters—Certified Peer Support Specialists work in the field, in homes, shelters, encampments, libraries, motels, crisis centers, and jails. Peers specialize in reaching individuals who are **not yet willing, not yet ready, or not yet able** to engage with clinical providers. This is precisely the population at highest risk for psychiatric relapse, homelessness, incarceration, and repeated hospitalization.

Peers interrupt the progression toward crisis by providing **immediate, relationship-based engagement**—a uniquely effective service for people with severe mental illness who are distrustful of clinical systems, fearful after prior trauma, ambivalent about treatment, or experiencing early deterioration that they cannot cognitively recognize. Peer Support acts as a stabilizing "front door" that keeps people connected to care long before their symptoms escalate into emergencies.

Across multiple studies [18–23], Peer Support is consistently associated with:

• Lower psychiatric readmission rates

By maintaining contact after discharge, peers ensure people restart medications, attend follow-up appointments, and identify warning signs early. This prevents the "48–72 hour destabilization window" that often leads to rapid rehospitalization.

• Reduced ER use and fewer crisis episodes

Peers help individuals resolve symptoms at home or in the community, preventing escalation into ER boarding or involuntary holds.

• Lower suicidality and self-harm risk

Peers recognize subtle signs of withdrawal, hopelessness, shame, or isolation that often precede suicidal crises and intervene with lived-experience-based strategies that providers cannot replicate.

• Improved engagement and treatment retention

Peers rebuild trust with individuals who have dropped out of therapy, stopped medications, or avoided formal systems due to fear, trauma, or stigma.

• Reduced homelessness and housing instability

Peer engagement increases adherence to housing rules, improves landlord communication, reduces behavioral incidents, and helps people stay connected with community supports.

• Reduced justice-system involvement

Because peers recognize early agitation, paranoia, or behavioral dysregulation, they intervene before police become involved—directly reducing arrests, jail bookings, and jail-based mental-health crises.

Why Peer Support Is Irreplaceable for Idaho's SPMI Population

Peer Support is not simply a "nice to have" add-on. For many Idahoans with SPMI, peers are **the only contact they maintain** with the behavioral-health system. Peers build trust through shared lived experience, which creates a therapeutic pathway that traditional clinicians cannot access.

When Peer Support is removed:

1. Engagement collapses immediately

Individuals who relied on peers for re-engagement stop attending appointments, miss medications, and withdraw from services—triggering predictable psychiatric deterioration.

2. Crises emerge earlier and faster

Without peer check-ins, early warning signs go unnoticed—sleep loss, paranoia, agitation, missed meds, increased substance use, or social withdrawal.

3. Emergency systems absorb the fallout

Police, EMS, crisis centers, and ERs must take on all functions previously prevented by Peer Support.

4. Hospitalizations increase

Without peers to support post-discharge stabilization, relapse occurs rapidly and often catastrophically.

5. Justice-system involvement increases

More individuals enter jail for behaviors tied directly to untreated symptoms, homelessness, or public-space crises.

Why Peer Support Cannot Be Replaced by Outpatient Codes

Peer Support is not interchangeable with therapy, case management, or CBRS. Outpatient services:

- occur in offices,
- require scheduled appointments,
- lack mobility,
- have strict billable-activity definitions,
- cannot maintain daily, rapport-based engagement.

Peer Support happens **whenever and wherever deterioration begins**—including evenings, weekends, shelters, encampments, and unstructured community settings. This responsiveness cannot be duplicated by any existing outpatient code set.

Removing Peer Support eliminates Idaho's largest evidence-based prevention layer, creating immediate increases in ER use, psychiatric admissions, homelessness, suicidality, and jail contact—outcomes repeatedly documented in the national literature [18–23].

Peer Support — Technical Modeling

Transfer costs to other programs and entities

(See Calculation Appendix: Tables 4–10)

Service	**Impact**
Medicaid Funding Removed	≈ $28M
Hospital/ER Impact	≈ **$4.5M–$5.5M**
Justice/Crisis/EMS	≈ **$4M–$5M**
Outpatient Substitution	≈ **$1.2M–$1.4M**
Workforce/Economic Loss	450 FTE
Wages	$18M–$20M
Ripple	$23M–$25M
Tax	$1.2M–$1.4M
Child-Welfare (12–20 removals*)	≈ **$1.5M–$3M** [66–70]

Total Transferred Cost from Peer Elimination	**≈ $45M–$50M per year**

***This reflects Idaho CPS's own documented removal rate for SMI parents (≈8× baseline), adjusted downward to 20–30 removals using conservative estimates.**

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4. EARLY SERIOUS MENTAL ILLNESS / CSC (ESMI/CSC)

ESMI/CSC is Idaho's only evidence-based early-psychosis program. Eliminating CSC forces young people with first-episode psychosis into rapid relapse, hospitalization, disability, suicidality, and long-term schizophrenia, producing lifelong Medicaid and social-service costs.

Early Serious Mental Illness (ESMI), known nationally as **Coordinated Specialty Care (CSC)**, is Idaho's **only evidence-based program** for individuals experiencing **first-episode psychosis (FEP)**—one of the most dangerous and costly psychiatric events a young adult can face. The stakes are uniquely high: the first 6–24 months after the onset of psychosis determine long-term trajectory, functioning, and disability risk for the next **40–50 years**.

A robust body of research, including NIMH-funded RAISE studies, demonstrates that CSC reduces or prevents:

- **Hospitalization and ER utilization** through early detection, rapid response, and consistent follow-up [24–31].
- **Suicide attempts and suicide deaths**, which sharply spike in the first year following onset [14,24].
- **Progression to chronic, treatment-refractory schizophrenia**, including long-term cognitive decline [19,24–31].
- **Lifelong disability, unemployment, and SSI/SSDI dependence** by preserving functioning early [24–31].
- **Homelessness, criminal-legal involvement, and repeat crisis episodes** by stabilizing symptoms during the most volatile period [25–31].

Why CSC Works:
CSC is not a therapy; it is a *team-delivered* treatment model grounded in intensive, coordinated, multidisciplinary care. Standard outpatient therapy is not capable of producing these outcomes. CSC requires:

- A **multidisciplinary, integrated specialty team** (psychiatry, therapy, employment/education, case management).
- **Supported Employment & Education (SEE)** — a non-negotiable, evidence-based component.
- **CBT for psychosis** delivered at high frequency by trained clinicians.
- **Family psychoeducation and crisis support** to prevent relapse.
- **Psychiatric services integrated with the team**, not siloed appointments.
- **Frequent community-based and out-of-office contact**, especially during relapse risk periods.
- **Weekly team coordination meetings** to maintain fidelity and rapid response.

No research supports CSC delivered in a traditional outpatient billing environment.

Why ESMI/CSC Cannot Function Under Outpatient Codes (Improved Explanation)

CSC's effectiveness—and its entire evidence base—depends on *bundled, team-driven service delivery* that cannot be replicated under fee-for-service outpatient codes. Under the state's unbundling model:

1. SEE (Supported Employment/Education) becomes non-billable.

SEE is a required core component of CSC. Idaho has **no outpatient code that pays for SEE**, and CSC cannot be operated ethically or legally without it.

2. Family psychoeducation becomes non-billable or severely underbilled.

CSC requires **structured, multi-session** family interventions. Outpatient billing only reimburses **brief individual therapy codes**, which do not cover required curriculum, duration, or multi-family formats.

3. Team meetings and clinical coordination become entirely non-billable.

CSC fidelity requires:

- Weekly multidisciplinary team meetings,
- Psychiatric-therapeutic coordination,
- Shared treatment planning,
- Rapid response to symptom changes.

Under outpatient codes, **none** of this is reimbursable. Teams cannot operate without it.

4. Community-based service delivery is not reimbursable at the frequency CSC requires.

CSC clinicians meet clients:

- At home,
- On campus/worksites,
- During crises,
- After ER discharge,
- Wherever symptoms destabilize.

Outpatient therapy codes **cannot bill** for most community-based encounters, and clinicians cannot bill travel time or crisis coordination.

5. Psychiatry cannot integrate with the team under siloed, code-based billing.

CSC psychiatrists must:

- Attend team meetings,
- Coordinate medication changes with SEE and therapy staff,
- Participate in relapse-prevention planning,
- Provide rapid-access adjustments.

Fee-for-service psychiatry codes **only pay for brief medication appointments**, eliminating the integrated structure that produces CSC outcomes.

6. Required fidelity expectations become impossible to meet.

The CSC model, SAMHSA guidance, NIMH RAISE protocols, and international guidelines all stress that **CSC is not deliverable under standard outpatient billing** because the structure itself is the intervention.

Removing the bundled rate **dismantles every critical component**, leaving only fragmented outpatient services that fail to prevent psychosis progression and re-hospitalization.

Bottom Line

ESMI/CSC is not an outpatient program.
It is a **specialized evidence-based team intervention** delivered through a bundled structure.

Unbundling does not merely "shift reimbursement."
It eliminates Idaho's only early-psychosis program and removes the state from national standards of care (SAMHSA, NIMH, RAISE), guaranteeing:

- Higher hospitalization rates,
- Higher ER volume,
- Increased suicide risk,
- Rapid conversion to chronic psychotic disorders,
- Higher Medicaid and state-funded disability costs,

- Increased homelessness and arrest,
- Loss of federal matching opportunities,
- A twenty-to forty-year cost liability.

ESMI — Technical Modeling

Transfer costs to other programs and entities

(See Calculation Appendix: Tables 3–10)

Service	Impact
Medicaid Funding Eliminated	$2.09M
Hospital/ER	$600k–$720k
Justice	$40k–$60k
Homelessness/EMS	$120k–$150k
Medical Destabilization	$150k–$180k
Outpatient Substitution	$1.0M–$1.3M
Workforce Loss	$2.5M–$3M
Child-Welfare	$200k–$300k
Total Transferred Costs from ESMI Elimination	**≈ $7M–$9M per year**

The $7–$9 million represents the immediate 12-month transfer cost across hospitals, EMS, justice, outpatient systems, and workforce impacts. When long-term disability progression, suicide-related expenditures, chronic-care utilization, and multi-system downstream effects are included, the total State and local cost shift rises to approximately **$14.1 million annually**

ESMI/CSC Downstream Cost-Shift After Program Elimination

Ending Idaho's Early Serious Mental Illness / Coordinated Specialty Care (ESMI/CSC) program creates a substantial downstream cost shift because the program serves a mixed population of Medicaid and non-Medicaid clients. When CSC is removed, rates of psychiatric hospitalization, ER utilization, suicidality, relapse, loss of functioning, and long-term disability increase—impacts that fall directly on the State. Based on Idaho's current client mix and evidence-based cost data, the annual State cost shift from eliminating CSC is estimated at **approximately $14.1 million per year**.

.

ESMI/CSC Funding Structure and State Fiscal Exposure

Idaho's CSC program is funded through a blend of Medicaid and State-only dollars. Roughly **75% of CSC participants are Medicaid beneficiaries**, funded at a **70/30 FMAP split**, while about **25% are not Medicaid-eligible** and therefore receive **no federal match**.

From the program's **$6 million** total annual cost:

- **$4.5 million** relates to Medicaid-enrolled CSC clients, with Idaho responsible for 30% of that amount.
- **$1.5 million** covers CSC services for non-Medicaid clients, which Idaho pays in full.

Because the State must cover both the Medicaid share and the full cost of all non-Medicaid participants, Idaho's effective financial exposure is substantial. When CSC ends, the downstream costs for both groups—hospitalizations, crisis events, disability progression, and long-term social-service utilization—shift directly to State and local systems.

These dynamics produce an estimated **$14.1 million annual cost burden** to Idaho following elimination of the CSC program.

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5. PARTIAL HOSPITALIZATION (PHP – Half-Day Only)

Half-day PHP stabilizes 70 post-hospital individuals who are too fragile for outpatient care. Removing half-day PHP creates a "post-discharge cliff," driving immediate increases in suicide attempts, ER presentations, readmissions, and disability risk.

Partial Hospitalization Programs (PHP) are a **structured, multi-hour, multi-day psychiatric treatment level** designed specifically for individuals who are **too unstable for standard outpatient therapy** but **not sick enough**—or no longer sick enough—to require inpatient hospitalization. PHPs are the stabilizing "bridge" between acute hospitalization and the lower-intensity world of outpatient/IOP care. Without this bridge, individuals often fall directly from inpatient discharge into a level of care that cannot meet their clinical needs, which is why PHP programs have been shown to significantly reduce preventable readmissions, ER boarding, suicidality, and housing loss.

What PHP Is: A Hospital-Equivalent Treatment Day Delivered in the Community
Half-day PHP provides patients with **3–4 hours of clinically coordinated psychiatric care**, delivered multiple days per week. Treatment is structured, measurable, and team-based. A typical PHP treatment day includes:

• Psychiatric evaluation and medication adjustment
• Daily symptom monitoring

• Risk assessment (suicide, self-harm, relapse)
• Group therapy targeting stabilization needs
• Skills training (CBT-based, DBT modules, relapse-prevention)
• Case management & discharge planning
• Family engagement when indicated
• Coordination with outpatient providers

PHP clinicians meet daily to review patient progress and adjust treatment plans in real time. Patients receive the **frequency, duration, and structure** necessary to stabilize symptoms that cannot be managed in weekly therapy sessions. PHPs also closely monitor emerging risks—allowing early intervention before crises escalate.

What PHP Does: The "Safety Net" After Hospital Discharge

For individuals recently hospitalized or in crisis, PHP serves as the **critical post-acute stabilization period**. Research shows that the first **10–45 days** after psychiatric discharge carry the highest risk for:

• Suicide attempts and self-harm
• Medication non-adherence
• Severe relapse
• Functional deterioration (sleep, eating, cognition)
• Return to ER or inpatient psychiatric units
• Loss of housing due to symptomatic instability

Half-day PHP catches these individuals at the exact moment they are too fragile for IOP or outpatient therapy. The program delivers the level of supervision, treatment frequency, and clinical intensity needed while still allowing patients to sleep at home and maintain connection with their environments.

Why PHP is Distinct From Other Levels of Care

Most people who step down from psychiatric hospitalization **cannot** transition directly to IOP or weekly outpatient therapy. PHP exists because:

1. Outpatient therapy is not enough

Standard outpatient care offers 45–60 minutes **per week**, with no daily monitoring, no team-based review, and no structured safety planning.

2. IOP is not enough for post-acute patients

IOP provides **group-based therapy** several times a week, but does **not** provide:

• Daily psychiatric monitoring
• Frequent medication adjustments
• Acute risk management
• Near-daily symptom checks
• Coordinated team reviews

Patients leaving inpatient care often require exactly these functions.

3. PHP is the only level designed to prevent post-acute collapse

PHP fills the medical necessity gap between hospitalization and IOP/outpatient therapy. Without PHP, individuals fall into a dangerous "treatment intensity void" where relapse is common and early warning signs go unaddressed.

What Happens When Half-Day PHP Is Removed

Half-day PHP is a **core stabilization layer**. Eliminating it triggers predictable outcomes:

1. Increased hospital readmissions

Studies show PHP reduces inpatient readmissions **60–80%** when available [47, 54, 58].

2. Increased ER psychiatric boarding

Without structured post-acute monitoring, mild symptom changes escalate until emergency care is required.

3. Increased suicide attempts

PHP provides the exact kind of daily suicide-risk monitoring that prevents attempts [57, 64].

4. Earlier relapse into homelessness

Individuals with unstable housing or insufficient supports face functional collapse when symptoms worsen even slightly during post-acute periods.

5. Loss of treatment engagement

Patients leaving inpatient settings often cannot transition safely into low-intensity outpatient care; without PHP, many disengage entirely.

6. Higher long-term disability

PHP reduces the risk of long-term functional decline that drives people onto SSDI/Medicaid disability rolls [53].

Why Half-Day PHP Matters Even if Full-Day PHP Remains

Full-day PHP serves the **highest-acuity post-inpatient** patients.

Half-day PHP serves the **next step-down stage**, treating patients who are:

• out of immediate danger, but
• not yet stable enough for IOP/outpatient care.

Removing half-day PHP creates a **discharge cliff**:

In Idaho, at any time, ~70 individuals occupy this "middle" post-acute zone. Without half-day PHP, they fall directly to lower levels of care that cannot meet their clinical needs. The result is predictable:

ER → Hospital → discharge → NO half-day PHP → relapse → ER → Hospital

This is the exact cycle PHP was created to break.

PHP — Technical Modeling

Transfer costs to other programs and entities

(See Calculation Appendix: Tables 3–10)

Service	Impact
Hospitalization	$275k–$350k
ER	$180k–$230k
Justice	$200k–$280k
Homelessness/EMS	$150k–$200k
Outpatient Substitution	$500k–$750k
Workforce/Economic	$1.2M–$1.6M wages + $1.5M–$1.8M ripple
Child-Welfare	$200k–$350k
Total Transferred Costs from Half Day Elimination	**≈ $3.0M–$4.5M per year**

Note on population size:

Idaho lacks a fully centralized PHP census, so the modeling uses a conservative low-end estimate of ≈70 active half-day PHP participants statewide at any time. Providers report higher volumes, but this lower estimate was selected to avoid overstating fiscal impact.

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6. INTENSIVE OUTPATIENT (IOP – 10% Reimbursement Cut)

IOP — Narrative Overview

Intensive Outpatient Programs (IOP) provide multi-hour, multi-day stabilization for adults with moderate to high psychiatric acuity. These programs function as a critical step between routine outpatient therapy and inpatient care, offering structured group treatment, medication support, crisis monitoring, and behavioral interventions that significantly reduce emergency-department utilization and prevent hospital admissions.

The statewide reimbursement reduction to IOP does not eliminate the service, but it directly diminishes its effectiveness. Lower reimbursement leads to:

- Reduced clinical hours per participant
- Higher staffing ratios
- Fewer group sessions and specialty tracks
- Lower program fidelity to evidence-based IOP models
- Reduced overall capacity and access

More than two decades of research demonstrates that adequately funded IOP reduces psychiatric hospitalization, suicidality, and acute crisis-system use by providing consistent, intensive stabilization across the week [45–65]. When reimbursement declines, programs must shorten sessions, reduce clinician coverage, limit medication-management availability, and cap enrollment — all of which weaken IOP's preventive impact.

As treatment intensity drops, individuals who would have stabilized in IOP instead progress to higher-acuity crises, creating predictable surges in ER boarding, jail holds, and involuntary hospitalization. In addition, reduced IOP capacity increases pressure on already strained community-based services, leaving moderate-acuity adults with no viable alternative to inpatient care.

In rural regions with limited psychiatric bed availability, even small reductions in IOP efficacy can quickly cascade into overcrowded emergency departments, rising uncompensated-care costs, and lengthened wait times for acute psychiatric placement. In short, although IOP technically remains available statewide, reduced reimbursement reduces treatment intensity to a level that compromises clinical outcomes and predictably increases downstream public costs.

IOP — Technical Modeling

Transfer costs to other programs and entities

(See Calculation Appendix: Tables 8–10)

Category	Impact
Reimbursement Loss	$1.2M–$1.5M
Workforce/Economic Loss	$350k–$600k (wages)
	$450k–$750k (ripple)
Child-Welfare	≈ $130k–$160k
Total Transferred Costs from IOP Funding Cut	**≈ $2.0M–$2.8M per year**

Note on population size:

Because Idaho does not publish a statewide IOP census, this model uses a conservative low-end estimate of ≈70 active IOP participants statewide. This figure is deliberately understated to ensure the fiscal model remains conservative.

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7. Combined Summary: Why Unbundling Eliminates ACT, HART, and ESMI

ACT, HART, ESMI, Peer Support, PHP, and IOP serve completely distinct, mutually exclusive high-acuity populations. Eliminating all programs simultaneously causes six separate destabilization events that accumulate into statewide system failure.

Unbundling does not "change reimbursement."
It eliminates the programs.

ACT, HART, and ESMI depend on bundled funding to support:

- Multidisciplinary teams,
- High-contact intensity,
- 24/7 availability,
- Team meetings,
- SEE services (ESMI),
- In-community or in-facility care,
- Continuous monitoring,
- Crisis intervention,
- Medication supervision,
- Milieu-based interventions (hart).

Outpatient codes cannot fund these features.
Once removed, the programs **no longer meet SAMHSA, NIMH, or CMS criteria**, and therefore no longer exist as evidence-based models [1–31].

Elimination of these programs destabilizes a combined **5,400+ Idahoans**, each in a distinct and mutually exclusive cohort.

SECTION II — SYSTEM COLLAPSE ANALYSIS

Idaho is not removing one component of the behavioral-health system. It is removing **every high-acuity stabilization program simultaneously**, across **mutually exclusive** clinical populations who cannot be absorbed by outpatient therapy, crisis lines, or case management.

When ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and full-fidelity IOP disappear, every stabilizing mechanism preventing hospitalization, homelessness, incarceration, school and workplace disruption, emergency medical decline, and family collapse disappears with them.

The following analysis integrates extensive evidence [1–31, 45–70], Idaho-specific system data [39–44], and the detailed modeling in the **Fiscal Methodology & Calculation Appendix (Tables 1–11).**
All estimates are conservative.

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1. Removal of Every High-Acuity Service

Each high-acuity program Idaho is eliminating serves a **different, non-overlapping population** by rule:

- **ACT** (400 adults): highest acuity, severe psychosis, mania, disorganization [1–12]
- **HART** (352 residents): unsafe for community placement, require 24/7 monitoring [13–17]
- **Peer Support** (~4,500 people): moderate-severe risk of relapse, disengagement, suicide [18–23]
- **ESMI/CSC** (≈100 youth): first-episode psychosis—critical early intervention [24–31]
- **PHP (half-day)** (~70 people): post-discharge step-down group [45–65]
- **IOP** (~70 people): multi-hour stabilization; weakened by 10% cut [45–65]

These populations **do not overlap**, and once stabilization disappears, each group destabilizes along its characteristic trajectory.

Loss of ACT →

- Loss of psychiatric monitoring

- Loss of crisis interruption
- Rapid relapse into psychosis
- Hospitalization, jail cycling, homelessness [1–12]

Loss of HART →

- Loss of subacute residential stabilization
- Unsafe discharges
- Homelessness, police contact, psychiatric ER boarding [13–17]

Loss of Peer Support →

- Loss of engagement layer
- Dropout from treatment
- Increased relapse, crises, ER use [18–23]

Loss of ESMI/CSC →

- Loss of early psychosis intervention
- Transition to chronic schizophrenia
- Lifetime disability risk increases [24–31]

Loss of half-day PHP →

- Step-down instability
- ER and hospital readmissions [45–65]

Weakened IOP →

- Reduced stabilization intensity
- Loss of relapse-prevention capacity [45–65]

The result is a statewide collapse of all high-acuity psychiatric stabilization.

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2. Impact on Hospitals & Emergency Departments

Hospital systems experience the **most immediate and measurable** impact from the elimination of high-acuity programs. Stabilization gaps across ACT, HART, ESMI, Peer, and PHP cohorts produce sharp increases in:

A. Psychiatric ER Presentations

ACT, HART, Peer Support, ESMI, and PHP all significantly reduce ER psychiatric use [1–12, 13–31, 45–65]. Removing all five simultaneously increases:

- Psychosis-driven ER visits
- Manic/agitated episodes requiring sedation
- Suicidal episodes requiring holds
- Aggressive or disorganized behavior in waiting rooms
- Multiple ER returns within the same week

Even after conservative adjustments (see Appendix Tables 3–5):

Total added ER impact: ≈ $3.5M–$5M per year
Across ACT, HART, Peer, ESMI, PHP combined.

B. Psychiatric Boarding Explodes

Without ACT, HART, and ESMI, ERs lose:

- Rapid psychiatric diversion
- Community crisis response
- Supported discharge pathways
- Any community destination for unstable patients

This leads to:

- 24–72 hour psychiatric boarding
- Use of hallways, alcoves, and general medical beds
- Crisis-level security staffing
- Delays in medical-surgical care due to bed block

C. Inpatient Psychiatric Overload

Research indicates ACT, CSC, and supportive housing reduce inpatient use dramatically [1–12, 24–31].
Their elimination:

- Increases involuntary admissions
- Lengthens LOS due to lack of discharge destinations
- Increases readmissions
- Forces admission of individuals formerly stabilized in ACT or HART
- Results in inadequate beds for lower-acuity patients

Conservative combined impact:

≈ $10M–$12M per year
(ER + inpatient increases)

(Full math in Appendix Tables 3–6.)

D. Medical Floor & ICU Impacts

Psychiatric deterioration worsens:

- Diabetes control
- Cardiovascular issues
- Infection rates
- Seizure disorders
- Accidental injuries
- Dehydration and malnutrition

ACT specifically reduces these medical events [4–8]. With ACT gone:

- More SMI patients land on medical floors
- Increased ICU use for metabolic crises and overdoses
- Higher total medical utilization [4–8]

---

3. Impact on Jails, Police, and Courts

The justice system becomes the **default containment system** when high-acuity behavioral-health programs disappear. [Steadman et al., 2009; DOJ Findings in GA/DE/NH, citations 34–36]

A. Jail Psychiatric Populations Increase

Without ACT, HART, or Peer Support, individuals enter jail for:

- Disorderly conduct
- Trespass
- Public disorganization
- Substance use escalation
- Missed court dates
- Behavioral disturbances in public

These are **treatment failures**, not criminal-intent cases.

ACT/FACT studies show 40–60% reductions in jail days [9–12]. Removing ACT produces the opposite:

ACT alone → ~$700k–$850k in added jail/court/police costs
(HART, Peer, ESMI, PHP add more; see Appendix Table 4.)

B. Police & EMS Become Psychiatric Responders

With ACT, HART, and ESMI removed, police are dispatched for:

- Psychotic or manic episodes
- Public disorganization
- Suicidal or violent behavior
- Welfare checks that escalate
- Repeated calls involving the same person

Peer removal multiplies this effect [18–23].

C. Court, Probate, and Civil Commitment Caseloads Rise

- More psychiatric holds
- More competency evaluations
- More guardianship petitions
- More probation violations due to instability
- More civil commitment hearings

Justice-system total across programs:

≈ $4M–$5.2M per year
(Conservative; see Appendix Tables 4 & 11.)

---

4. Impact on Crisis Centers, EMS & Emergency Transport

A. Crisis Centers Overrun

Without ACT, HART, ESMI, PHP, or full-fidelity IOP:

- More individuals present in active psychosis
- More require medical clearance
- More require extended stays due to lack of follow-up resources

- Discharges become circular: crisis → ER → crisis → jail

B. EMS Transport Volume Surges

EMS is heavily impacted by:

- Psychosis-related crises
- Self-harm attempts
- Mania-induced injuries
- Overdoses linked to psychiatric instability
- Exposure-related injuries among homeless individuals formerly stabilized by HART/ACT
- Deteriorating early-psychosis youth

Conservative EMS impact:

$3.5M–$5M annually across all cohorts
(See Appendix Table 5.)

C. Co-Response with Law Enforcement Increases

EMS + police joint responses grow due to:

- Agitation
- Delusional violence
- High-risk behaviors in public
- Inability to safely de-escalate without ACT/HART/ESMI presence

These events increase officer injury risk, EMS burnout, and public-safety exposure.

---

5. Impact on Schools

Schools serve as early-warning systems for deteriorating adolescents and young adults. Eliminating ESMI/CSC removes Idaho's only early psychosis intervention [24–31].

Consequences include:

- More behavioral crises on school grounds
- Heightened suicidality and self-harm
- Emergency evaluations initiated by administrators
- Increased reliance on school resource officers

- More psychiatric EMT transport
- School removal, suspension, and dropout
- Severe long-term educational disruption

Schools are **not** clinical environments; yet without ESMI, they become the de facto first responders for early psychosis.

---

6. Impact on Families & Communities

Families experience:

- Frightening, unpredictable psychiatric episodes
- Domestic violence tied to relapse [66–70]
- Financial instability due to caregiving demands
- Missed work and job loss
- Caregiver burnout and trauma
- Inability to keep loved ones safe
- Acute hospitalizations or jail involvement
- Sudden CPS investigations

Communities experience:

- increased visible psychosis
- increased homelessness
- behavioral crises in public spaces
- encampments with medically unstable individuals
- overdoses, public disorganization, and police incidents
- strain on shelters, libraries, parks, and businesses

Peer Support, ACT, HART, and ESMI were the mechanisms preventing these outcomes [1–31, 18–23].

---

7. Catastrophic Public-Safety Risk

Untreated SPMI populations have elevated rates of violent deterioration, suicide, and police-involved crises [14,22,66–70].
When Idaho eliminates every intensive program that monitors and stabilizes these individuals:

- Violent incidents
- Multi-victim events
- Emergency tactical responses
- Police shootings
- High-harm public crises
- Mass casualty risks

become more probable.

These events cost **tens to hundreds of millions** and cause deep community trauma.
They are not annualized into the conservative fiscal model but represent profound long-term risk.

---

8. Non-Monetized Mortality and Catastrophic Harm

The fiscal model in this report deliberately does **not** assign dollar values to deaths, catastrophic injuries, or mass-casualty events. However, decades of research are clear on one point:
when ACT, supportive housing, early-psychosis teams, PHP/IOP, and Peer Support are removed, **mortality increases**.

Across these programs, studies consistently show that their presence reduces:

- Suicide attempts and suicide deaths among individuals with SPMI and first-episode psychosis;
- Fatal overdoses and violent deaths linked to untreated psychosis and co-occurring substance use;
- Deaths from untreated or destabilized medical conditions (cardiac, metabolic, infectious) that worsen when psychiatric symptoms are uncontrolled;
- Exposure-related deaths among people who become homeless after losing intensive stabilization.

The statewide model counts **only** the fiscal costs of ER use, hospitalization, EMS transports, jail, and child-welfare involvement. It does **not** count the lives lost when those crises are not successfully interrupted.

In other words, the $150M–$180M annual impact is a **financial floor, not a measure of human harm.** The cuts will result in preventable deaths; this report simply avoids converting those deaths into dollars.

---

9. TOTAL COMBINED FISCAL IMPACT (CONSERVATIVE)

Using:

- Low-to-mid effect sizes
- Reduced cross-system multipliers
- Idaho-specific costs
- Removal of overlapping event categories
- Adjusted child-welfare assumptions
- Updated PHP & IOP policy
- And mutually exclusive populations

Idaho incurs:

≈ $150 million to $180 million per year

(Midpoint ≈ $165 million)

This represents the **conservative** estimate of annual statewide fiscal impact.
(See Calculation Appendix Tables 10–11.)

This range **excludes**:

- ADA/Olmstead liability
- DOJ enforcement
- Catastrophic events
- Long-term disability expansion
- Workforce outmigration
- Uncompensated catastrophic medical costs

Actual long-run exposure is significantly higher.

SECTION III — LEGAL RISK

The elimination of ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and the weakening of IOP reimbursement places Idaho in direct violation of the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* integration mandate.

1. DOJ Statement on ADA Integration Mandate (2011):

"Unnecessary institutionalization is discrimination. States must provide services in the most integrated setting appropriate. Policies that foreseeably lead to institutionalization violate the ADA."

2. U.S. v. Georgia (2010) Settlement:

"Georgia shall expand ACT, crisis services, supported housing, and community-based stabilization to ensure individuals with serious mental illness are not unnecessarily institutionalized."

3. U.S. v. Delaware (2011):

"The failure to provide ACT, peer support, and crisis alternatives results in unnecessary segregation in hospitals, ERs, and jails."

4. Amanda D. v. Hassan (New Hampshire):

"ER boarding and excessive inpatient reliance reflect the absence of community-based services required under Olmstead."

5. HHS OCR and DOJ Joint Statement:

"States must maintain adequate community services to avoid foreseeable institutionalization, ER boarding, or incarceration of individuals with mental illness."

6. DOJ Early Psychosis Guidance:

"CSC is the evidence-based service model for first-episode psychosis. Lack of CSC results in preventable hospitalization, disability, and segregation."

The cuts remove **all high-acuity community-based stabilization services**, leaving Idaho with **no integrated setting** for individuals with the most severe psychiatric disabilities.

DOJ has already found Idaho in violation of the ADA in a related Medicaid domain [41-42] (2025 findings), meaning the state is already under federal scrutiny. Removing the **entire** high-acuity continuum guarantees additional enforcement, litigation, and liability.

Although DOJ's 2025 findings focused on another Medicaid domain, the underlying violation — insufficient community-based services causing unnecessary segregation — is the same legal theory applicable to SPMI program cuts.

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1. ADA Integration Mandate

Title II of the Americans with Disabilities Act (ADA) requires states to provide services to individuals with disabilities in the **most integrated setting appropriate**. Under *Olmstead v. L.C.* (1999), states violate the ADA when:

- They **unnecessarily institutionalize or segregate** individuals with disabilities;
- They **fail to provide adequate community-based alternatives** to institutional care;
- Individuals are placed **at serious risk of institutionalization** because needed services are removed;
- Reductions in community services **predictably push people into restrictive settings** such as ERs, jails, group facilities, or shelters.

For adults with Serious and Persistent Mental Illness (SPMI), the U.S. Department of Justice (DOJ) requires states to maintain a **full array of community-based, high-acuity services** to prevent institutionalization. These include Assertive Community Treatment (ACT), subacute residential stabilization (equivalent to Idaho's HART), Coordinated Specialty Care for early psychosis (ESMI/CSC), mobile crisis response, supported housing, supported employment, and **Peer Support**, which DOJ explicitly identifies as an essential integration service built into ACT teams, crisis response, supported housing, and reentry programs (see Appendix 15, items 14.1–14.29).

In Idaho, ACT, HART, ESMI/CSC, Peer Support, PHP, and IOP collectively constitute the **entire ADA-compliant community-based continuum** for adults with SMI. These programs prevent:

- Involuntary hospitalization [1–3,7,8];
- Incarceration and jail cycling [9–12];
- Homelessness and shelter segregation [5–8,13–17];
- ER boarding and emergency medical segregation [2,4,8];
- Long-term disability and institutional trajectories [24–31];
- Disengagement, isolation, and relapse that lead to restrictive placements [18–23].

Removing these programs simultaneously eliminates **all DOJ-required alternatives** for Idaho's distinct, mutually exclusive SMI populations. The result is a direct and foreseeable shift into ERs, inpatient units, long-term institutional settings, jails, shelters, encampments, and other restrictive environments.

Thus, Idaho's cuts constitute a **clear violation of the ADA integration mandate**, because they remove all community-based options that federal law requires states to maintain.

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2. Why Idaho's Cuts Trigger ADA Violations

The ADA requires states to *actively* maintain the community-based supports that prevent unnecessary institutionalization, incarceration, homelessness, and ER boarding. DOJ enforcement actions consistently show that when states eliminate high-acuity services—ACT, supported housing, crisis residential care, early psychosis programs, or Peer Support—they are found to be in violation of ADA/*Olmstead* (see Appendix 15).

Idaho's cuts remove **every major DOJ-required component** of a community mental-health system for SPMI populations:

1. Eliminating ACT

ACT is the **primary** DOJ-required service for adults with the highest psychiatric acuity [32–35]. It is Idaho's only 24/7, mobile, multidisciplinary, in-community stabilization model [1–12]. Without ACT, Idaho eliminates its only DOJ-recognized alternative to hospitalization, incarceration, and ER boarding.

2. Eliminating HART's clinical rate

HART is Idaho's only subacute, clinically staffed residential stabilization program. DOJ requires states to operate **community-based residential alternatives** that prevent hospital readmissions and institutional placement (Appendix 15, items 14.2, 14.8–14.11). Removing the HART clinical rate eliminates every feature that DOJ mandates—24/7 staffing, psychiatric oversight, behavioral support, and crisis stabilization [13–17].

3. Eliminating ESMI/CSC

CSC for early psychosis is required when youth experience ER boarding, inpatient admission, justice-system penetration, or disability due to untreated first-episode psychosis [24–31, Appendix 15.15–14.17]. Idaho removes its only DOJ-approved early intervention.

4. Eliminating Peer Support

Peer Support is **explicitly required** in DOJ settlements as a core integration service (Appendix 15.13, 14.16, 14.21). Peers reduce hospitalization and ER use [18–23], stabilize housing [13–17], prevent relapse, reconnect disengaged individuals to care, support independent community living, and provide non-coercive crisis prevention. Removing Peer Support eliminates one of Idaho's **primary DOJ-required ADA compliance tools**.

5. Eliminating half-day PHP

PHPs serve as DOJ-recognized hospital diversion and step-down programs (Appendix 15.10). They prevent readmission and institutional cycling [45–65]. Idaho removes this entire stabilization layer.

6. Reducing IOP reimbursement

IOP is another DOJ-recognized diversion/step-down service (Appendix 15.10, 14.18). Reducing reimbursement weakens Idaho's crisis-prevention infrastructure, reducing intensity and clinical access exactly where DOJ expects robust programming.

Collective Impact: Idaho Eliminates the Entire DOJ-Required SPMI Continuum

Because each program serves a different, **mutually exclusive** population, eliminating all of them removes:

- **All high-acuity community stabilization (ACT)**,
- **All subacute residential stabilization (HART)**,
- **All early-psychosis stabilization (ESMI/CSC)**,
- **All statewide engagement/retention (Peer Support)**,
- **All post-acute step-down stabilization (PHP)**,
- **And meaningful multi-hour stabilization (IOP)**.

This leaves Idaho with **zero DOJ-recognized integrated-setting alternatives** for adults with SPMI.

The predictable result — and the legally relevant one — is that adults with SPMI will be forced into:

- ERs (segregated medical units),
- Inpatient psychiatric hospitals,
- Jails and forensic pathways,
- Homeless shelters and encampments,
- Quasi-institutional boarding,

- Unsafe, unsupported environments.

DOJ explicitly identifies these as **forms of unnecessary institutionalization and segregation** caused by inadequate community services [32–38].

Conclusion

Idaho's cuts do not reduce unnecessary institutionalization — they **create it**.
Removing its entire high-acuity continuum places Idaho in immediate, predictable, and substantial violation of ADA/*Olmstead* requirements, as established across DOJ enforcement actions summarized in Appendix 15.

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3. DOJ Findings Against Idaho (2025)

In 2025, the U.S. Department of Justice issued formal findings that Idaho was violating the ADA by "unnecessarily segregating adults with disabilities" within another part of the Medicaid system. DOJ cited:

- Insufficient community-based alternatives;
- Failures to authorize needed services;
- Preventable institutionalization;
- Excessive reliance on restrictive or segregated settings.

The cuts to ACT, HART, ESMI/CSC, Peer Support, and PHP mirror and intensify the exact pattern DOJ has already declared unlawful.

Evidence shows that without ACT, HART, ESMI, and PHP, individuals experience:

- Preventable psychiatric hospitalization [1–12,24–31];
- Unnecessary ER boarding [2,4,8,13–17];
- Jail segregation due to untreated smi [9–12];
- Homelessness and encampment placement [5–8,13–17];
- Suicide attempts and violence crises [14,22,66–70];
- Long-term disability progression [24–31].

Under DOJ enforcement history, Idaho is now at **high likelihood** of:

- Investigation,

- Enforcement action,
- Federal oversight,
- And mandatory system rebuilding.

---

4. Federal Enforcement Patterns in Other States

In multiple cases, DOJ and federal courts required states to **expand** high-acuity community-based services, not eliminate them:

- **Georgia (U.S. v. Georgia)**
  - Mandated expansion of ACT, crisis stabilization, supportive housing, and mobile crisis.
- **Delaware (U.S. v. Delaware)**
  - Required ACT teams, peer support, supportive housing, and crisis alternatives.
- **New Hampshire (Amanda D. v. Hassan)**
  - Required ACT expansion and crisis alternatives to eliminate ER boarding.
- **North Carolina, Washington, Illinois**
  - Ordered ACT, CSC, supportive housing, and crisis investments.

Idaho's actions move in the **opposite direction** of every settlement agreement and enforcement action. Instead of expanding ACT, HART-like supportive structures, CSC teams, and crisis alternatives, Idaho is dismantling all of them at once. See Apendix 14.

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5. Idaho-Specific Foreseeability

The Idaho Supreme Court recognized in *Mitchell v. State of Idaho* (2016) that the state may be liable for **foreseeable harm** when it withdraws necessary services from individuals with known psychiatric instability.

Applying this standard:

- The state knows ACT, HART, Peer Support, ESMI/CSC, and PHP prevent hospitalization, incarceration, and homelessness [1–31,66–70].
- The state knows each population is high-risk and mutually exclusive.
- The state is knowingly removing **every program** designed to stabilize high-risk SMI groups.
- The resulting harms—psychiatric hospitalization, arrest, homelessness, suicide attempts—are predictable.

This satisfies Idaho's legal foreseeability threshold.

Mitchell establishes that Idaho can be liable when withdrawing services predictably leads to harm — even when the population is medically or behaviorally complex.

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6. Likely Legal Consequences for Idaho

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1. DOJ Civil Enforcement

DOJ will likely file or threaten enforcement to address:

- Unnecessary institutionalization;
- Psychiatric ER boarding;
- Jail segregation of SMI populations;
- Homelessness as de facto segregation;
- Failure to provide evidence-based community alternatives.

2. Court-Mandated System Rebuilding

Federal courts typically order states to:

- Rebuild ACT programs;
- Establish supportive housing;
- Restore CSC/ESMI teams;
- Create crisis apartments;
- Expand mobile crisis;
- Reduce ER boarding and jail cycling.

Remediation is often **more expensive** than maintaining the programs originally.

3. Private ADA/Olmstead Litigation

Individuals harmed by program elimination—including those incarcerated, hospitalized, or rendered homeless—may sue under Title II and Section 504.

4. Legal Fees, Monitoring, and Oversight

States under ADA scrutiny face:

- Multi-year monitoring;
- Expensive reporting requirements;
- Court-appointed evaluators;
- Substantial legal fees.

5. Liability for Harm

When ACT-, HART-, or ESMI-eligible individuals deteriorate into public violence, suicide, ER boarding, or dangerous crises, liability risks extend to:

- The State of Idaho;
- County governments;
- Hospitals;
- Law-enforcement agencies.

Legal Summary

Eliminating Idaho's entire high-acuity treatment infrastructure—ACT, HART, ESMI/CSC, Peer Support, half-day PHP—removes every evidence-based community alternative that satisfies ADA and *Olmstead* obligations. The state thereby forces individuals with SMI into:

- ERs,
- Jails,
- Shelters,
- Institutional-level care,
- Unsafe home environments,
- Or homelessness.

Because the state has already been cited by DOJ for ADA violations, and because these cuts replicate the exact patterns DOJ has previously condemned, Idaho's legal exposure is **immediate, substantial, and unavoidable**.

SECTION IV — STAKEHOLDER IMPACT SUMMARY

The elimination or weakening of ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and full-fidelity IOP destabilizes every high-acuity population in Idaho. Because the affected populations are **distinct and mutually exclusive**, the consequences are **cumulative**, spreading across state agencies, hospitals, counties, schools, law enforcement, crisis responders, and families.

The following subsections summarize the predictable and well-documented impacts—supported by national evidence [1–31, 66–70], Idaho cost structures [39–44], and the modeling detailed in the **Fiscal Methodology & Calculation Appendix (Tables 3–11)**.

---

1. State of Idaho

A. Fiscal Impacts

The State experiences substantial increases in Medicaid expenditures due to:

- Increased psychiatric hospitalizations [1–3,7,8],
- Increased emergency room utilization [2,4,8],
- Increased medical destabilization across SMI populations [4–8],
- Increased outpatient substitution (episodes of outpatient therapy, case management, CBRS, crisis codes) that do **not** prevent crisis escalation (see Calculation Appendix, Table 7),
- Increased long-term Medicaid and SSI/SSDI enrollment due to loss of early intervention [24–31].

These increases occur even after conservative adjustments to multipliers and cost assumptions.

B. Loss of Federal Funds

Idaho loses substantial federal match associated with state-plan bundled services:

- ACT bundle: majority federal match [1–12]
- ESMI/CSC: federally matched youth-serving bundle [24–31]
- HART clinical bundle: majority federal share [13–17]

- Peer Support: Medicaid benefit with federal match [18–23]

Total federal dollars lost: ≈ $40–$45 million annually.

C. Tax Revenue Loss

Eliminating high-acuity programs removes:

- ≈800 behavioral-health jobs,
- ≈$40–$44M in wages,
- ≈$52–$58M in economic activity,
- ≈$2.4M–$2.7M in state and local tax revenue.

(See Calculation Appendix, Table 8.)

A. Hospital System Impact

Hospitals will absorb the largest single cost shift resulting from the elimination of Idaho's intensive SPMI programs. ACT, HART, ESMI/CSC, Peer Support, PHP, and IOP prevent psychiatric deterioration that would otherwise result in ER boarding, inpatient admissions, and medical crises. When stabilization systems are removed, adults with severe mental illness deteriorate more rapidly and more often require hospital stabilization — a trend consistently demonstrated across multiple large-scale studies [1–12, 13–31].

Loss of Stabilization → Increase in Psychiatric Admissions

ACT and CSC reduce psychiatric hospitalizations by **40–60%** across randomized trials, meta-analyses, and long-term cohort studies [1–12]. When these programs are eliminated, psychiatric admissions and involuntary holds increase substantially, along with medically driven admissions related to untreated psychosis, mania, suicidality, dehydration, and infection [13–31]. Conservative modeling for Idaho estimates **$70–$85 million** in new annual hospital-system costs attributable to the loss of stabilization services.

ER Boarding and Overflow Effects

Emergency departments are not designed for sustained psychiatric care. ER boarding — holding patients for extended periods due to lack of inpatient beds — increases when community stabilization services are removed. Research consistently shows that loss of ACT/CSC capacity increases ER boarding duration, staff time, security needs, and bed blockages in emergency departments [39–44]. ER boarding also increases costs for hospitals through longer observation stays, diversion of staff away from medical patients, and delayed throughput for the entire ER system [39–44]. Idaho ERs are already experiencing these effects, and program cuts will intensify them.

Uncompensated and Indigent Care Burden

Idaho hospitals currently provide roughly **$281 million** annually in uncompensated care (charity care + bad debt) according to Idaho Hospital Association financial reports [45]. Adults with SPMI are disproportionately represented among uninsured and self-pay psychiatric admissions when treatment lapses occur — a pattern confirmed across multiple health-system studies [46–50].
Using a conservative attribution of **5%**, hospitals will absorb **$14–$15 million** annually in uncompensated care attributable directly to SPMI destabilization — a figure well below the 8–12% increases documented in other states following similar cuts [51–54].

Rural Hospital Vulnerability

Rural hospitals experience greater strain due to fewer psychiatric beds, longer transport times, and limited crisis alternatives. Studies show that rural ERs face disproportionate impact when community-based psychiatric services collapse, resulting in longer boarding times, higher uncompensated-care exposure, and increased rates of psychiatric medical complications [32–38]. Idaho's rural regions are particularly vulnerable given geographic barriers, workforce shortages, and limited inpatient capacity.

Summary

The hospital system will experience the most substantial fiscal impact from the elimination of Idaho's intensive SPMI services. Increased psychiatric admissions, expanded ER boarding, medical complications, and rising uncompensated-care burdens collectively shift **$70–$85 million** in annual costs onto Idaho hospitals — costs that will ultimately strain hospital finances, raise insurance premiums, and destabilize rural health infrastructure [1–12, 32–54].

D. Child-Welfare Costs

Loss of ACT, Peer Support, ESMI, PHP, and weakened IOP increases CPS investigations and removals for high-acuity parents [66–70].
Using Idaho-adjusted case costs (Table 9):

Statewide annual child-welfare impact: ≈ $8M–$16M

E. Legal Risk and Liability

Under ADA and *Olmstead*, Idaho must maintain integrated community alternatives to avoid unnecessary hospitalization and incarceration. Eliminating ACT, HART, and ESMI eliminates all such alternatives. DOJ's 2025 findings indicate Idaho is already in violation.

State-level net impact: profoundly negative.

---

2. Counties & Cities

Counties and municipalities absorb many of the costs Idaho avoids by eliminating high-acuity programs.

A. Jail Costs

Without ACT, HART, Peer Support, or PHP, individuals with untreated SMI are arrested for psychiatric behavior rather than criminal intent [9–12]. Jails face:

- Increased psychiatric booking,
- Extended stays due to lack of discharge destinations,
- Higher medical and suicide-watch costs,
- More competency evaluations and court-ordered assessments.

(See Calculation Appendix, Table 4.)

B. Law Enforcement Burden

Police become first responders to:

- Psychosis-driven disturbances [1–12],
- Mania or disorganized behavior,
- Violent or unpredictable crises [14,22,66–70],
- Homelessness resulting from service loss [13–17].

This increases:

- Officer injury risk,
- Liability exposure,
- Overtime costs,
- Response-time delays for non-psychiatric emergencies.

C. Homelessness & Encampments

ACT, HART, and supportive-housing models reduce homelessness 30–40% [5–8,13–17].
When eliminated:

- More individuals lose housing,
- Shelter burdens increase,
- Encampments expand,
- Municipalities face sanitation, nuisance, and safety challenges.

D. Emergency Response

EMS and fire departments respond to complex psychiatric emergencies that once would have been stabilized upstream.

County/City Fiscal Impact

≈ $12M–$15M annually
(conservative; see Calculation Appendix Tables 4–6)

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3. Hospitals & Health Systems

Hospitals experience the fastest and steepest impacts following service elimination.

A. Emergency Departments

Loss of ACT, HART, Peer, ESMI, and PHP leads to:

- Higher psychiatric ER presentations,
- Prolonged ER boarding [2,4,8],
- Increased need for restraints and security staff,
- More agitation and violence risk,
- Repeat ER presentations within days.

B. Inpatient Psychiatric Units

Without community stabilizers:

- More involuntary admissions occur,
- LOS increases due to unsafe discharge pathways,
- Readmissions rise,
- Forensic admissions increase as jails refuse unstable individuals.

C. Medical-Surgical and ICU Units

Psychiatric destabilization drives medical destabilization [4–8]:

- Uncontrolled diabetes,
- Cardiac events,

- Infection complications,
- Seizure relapse,
- Dehydration/malnutrition,
- Injury from disorganized behavior.

D. Uncompensated Care

Hospitals also absorb:

- Unpaid psych admissions,
- Unpaid medical admissions related to SMI,
- Unreimbursed ER boarding,
- Higher uncompensated ambulance drop-offs.

Hospital System Fiscal Impact

≈ $10M–$12M annually
(See Calculation Appendix Tables 3–6.)

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4. Behavioral-Health Workforce

A. Job Losses

Eliminating ACT, HART, ESMI/CSC, and half-day PHP — and weakening IOP and Peer Support capacity — eliminates approximately **800 positions** across:

- Nursing,
- Psychiatry,
- Therapy,
- Peer support,
- Case management,
- Residential staff,
- Clinical team leaders,
- Supervisors.

B. Wage and Economic Activity Loss

Per Calculation Appendix Table 8:

- Direct wage loss: **$40M–$44M**
- Economic ripple: **$52M–$58M**
- Tax rev loss: **$2.4M–$2.7M**

C. Irreplaceable Expertise Lost

HART, ACT, and CSC/ESMI require specialized training not available in Idaho.
Rebuilding these teams takes **5–10 years**; rebuilding fidelity takes longer.

D. Workforce Outmigration

Clinical staff will relocate to states with intact ACT/CSC systems.
Idaho will face a severe shortage of behavioral-health clinicians.

---

5. Schools

Schools face significant destabilization due to elimination of ESMI/CSC, which is the **only evidence-based intervention** for first-episode psychosis [24–31].

A. Increased Behavioral Crises

Without CSC:

- More psychotic onset episodes occur on campus,
- Teachers face serious behavioral instability,
- Administrators initiate more emergency evaluations,
- Students experience academic collapse.

B. Suicide Risk

ESMI reduces suicidality in first-episode youth [14,24].
Without it:

- Suicidal crises escalate quickly,
- Schools become default crisis responders.

C. SRO and Crisis Center Overuse

Schools rely more on law enforcement, SROs, and EMS when CSC is gone.

---

6. Law Enforcement

A. Increased Crisis Calls

Police respond to:

- Acute psychosis [1–12],
- Mania/agitation,
- Violent or unpredictable SMI-driven behaviors [14,22,66–70],
- Homelessness from HART and ACT collapse [5–8,13–17].

B. Officer Injury & Liability

Psychiatric calls are among the highest-risk interactions for police.
Officer injury, use-of-force incidents, and liability exposure rise sharply.

C. Repeated Contacts

Without Peer Support & ACT engagement, the same individuals cycle through:

Police → ER → Jail → ER → Shelter → Police.

---

7. Families & Communities

A. Family Burden

Loss of all high-acuity supports leads to:

- Violent or psychotic episodes in the home,
- Family trauma,
- Caregiver burnout,
- Job loss from crisis management,
- Financial instability,
- CPS involvement when crises escalate [66–70].

B. Community-Level Impacts

Communities experience:

- More public crises,
- More individuals in psychosis in public spaces,
- Homelessness expansion,
- Crime driven by psychiatric disorganization (not criminal intent),
- ER boarding spilling into hallways and waiting rooms,
- Reduced community safety.

---

8. Child-Welfare System

Research shows parents with SMI face substantially elevated CPS risk [66–70], and ACT, HART, CSC, and Peer Support mitigate that risk [18–23,66–70]. Without these services:

- Psychiatric instability increases,
- Parent–child attachment deteriorates,
- School attendance becomes inconsistent,
- Unsafe conditions become more common,
- More removals occur.

Using Idaho-adjusted case costs and conservative volume assumptions (see Calculation Appendix Table 9):

Statewide child-welfare impact: ≈ $8M–$16M/year

Stakeholder Summary Table

Stakeholder	Primary Impacts	Fiscal Impact (Conservative)
State Government	Higher Medicaid costs, lost federal match, ADA liability, lost tax revenue	**–$10M to –$12M (direct)**
Counties & Cities	Jail, law enforcement, homelessness, EMS burden	**–$12M to –$15M**

Hospitals	ER boarding, inpatient overflow, uncompensated care	**–$10M to –$12M**
Behavioral-Health Workforce	Job loss, wage loss, workforce flight	**–$40M wages; –$52M economic activity**
Schools	More crises, emergency evaluations	Not quantified
Law Enforcement	More crises, injuries, liability	Included in justice total
Families & Communities	Home crises, harm, instability	Not monetized
Child-Welfare	More removals, court involvement	**–$8M to –$16M**

SECTION V — FINAL CONCLUSION

Idaho is eliminating the entirety of its high-acuity behavioral-health infrastructure. ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and fully funded IOP form the stabilizing core of Idaho's psychiatric continuum. They are the only interventions that prevent the highest-acuity adults and youth from cycling into psychiatric hospitalization, homelessness, incarceration, violent crises, suicide, and long-term disability [1–31, 45–70].

These programs do not overlap; each serves a distinct and mutually exclusive clinical population. Removing all of them simultaneously does not shrink Idaho's behavioral-health system — **it removes it.**

With the bundled funding models eliminated, these programs cannot operate. Outpatient therapy, case management, CBRS, medication management, and crisis lines cannot replicate the fidelity elements that define ACT [1–12], HART [13–17], or CSC [24–31]. Unbundling is therefore not a restructuring or reimbursement modification. It is a total program elimination.

What Follows Is Predictable and Unavoidable

- **Hospitals** absorb massive increases in ER psychiatric boarding, inpatient admissions, and medical destabilization [1–12, 4–8, 13–17].
- **Jails** absorb untreated psychosis-related behavior, increased arrests, medical holds, suicide risk, and competency evaluations [9–12, 13–17].
- **EMS transports** surge for psychiatric and behavioral crises [13–17, 18–23].
- **Schools** see more first-episode psychosis and behavioral crises without ESMI/CSC [24–31].
- **Peer-supported** populations disengage from care, relapse, and destabilize [18–23].
- **Families** face increased violence, trauma, and CPS involvement [66–70].
- **Communities** see rising homelessness, encampments, public disorganization, and high-risk incidents [5–8, 13–17].
- **Child-welfare** systems experience more removals, supervision, and emergency placement costs [66–70].
- **Federal** matching funds disappear, and ADA/Olmstead liability rises sharply.

Conservative Fiscal Conclusion

As detailed in the **Fiscal Methodology & Calculation Appendix (Tables 3–11)** and supported by decades of ACT, CSC, supportive housing, and peer-reviewed outcomes research [1–31, 13–23, 45–70], Idaho will incur:

≈ $150 million to $180 million in new annual costs

(midpoint ≈ $165 million)

This number already includes:

- Downward adjustments to published effect sizes
- Reduced multipliers
- Idaho-specific cost structures
- Removal of overlapping cross-system categories
- Conservative modeling for homelessness, EMS, and justice involvement
- And reduced child-welfare impact estimates

It **excludes**:

- ADA/Olmstead liability
- DOJ enforcement and long-term monitoring
- Catastrophic events
- Long-term disability expansion
- Workforce outmigration
- Uncompensated-care surges during system collapse

The true long-run cost is significantly higher.

Final Statement

This report demonstrates that Idaho's proposed changes do not shift service delivery; they abolish service delivery. The bundled structures being removed are the mechanisms that make ACT, HART, ESMI/CSC, Peer Support, and PHP function. Their elimination will reverberate across every public system in Idaho — hospitals, jails, law enforcement, EMS, schools, crisis centers, child welfare, families, and communities.

Maintaining or restoring Idaho's evidence-based SPMI programs is not simply a clinical priority. It is a matter of:

- **Fiscal responsibility**,
- **Public safety**,
- **Legal compliance**,
- **Health-system stability**, and
- **Community well-being**.

Removing these programs creates predictable, preventable harm.
Idaho cannot afford — financially, legally, or humanly — to proceed with the proposed cuts.

APPENDICES

APPENDIX 1. POPULATION DEFINITIONS & MUTUAL EXCLUSIVITY

A credible statewide fiscal model requires precise population definitions and strict enforcement of mutual exclusivity across programs. Idaho's behavioral-health service structure is unusual among states because the rules of ACT, HART, ESMI/CSC, PHP, and IOP explicitly prohibit clinical overlap. This is not a modeling preference; it is program policy and clinical necessity enforced through Idaho Medicaid, SAMHSA fidelity standards, and the operational criteria for residential placement.

As a result, each program stabilizes a different population, each with distinct clinical profiles, risk trajectories, and system-cost patterns. Eliminating all programs simultaneously therefore produces cumulative, not duplicative, fiscal impacts.

This section clarifies those distinctions.

1.1 Why Population Exclusivity Is Central to Fiscal Modeling

The populations served by ACT, HART, Peer Support, ESMI/CSC, PHP, and IOP are mutually exclusive by design. This occurs for the following reasons:

1. ACT Populations Cannot Be in Any Other Program

SAMHSA ACT fidelity prohibits enrollment in ACT if a person is inside another structured level of care—particularly residential care such as HART—or in an early-psychosis program (ESMI/CSC). ACT requires:

- Shared team caseloads,
- Daily team review,
- 24/7 coverage, and
- Full responsibility for the consumer's treatment plan [1–12].

A person cannot simultaneously receive ACT and participate in PHP, IOP, or CSC; doing so would break fidelity and invalidate outcomes [1–12].
Therefore, ACT's 400 clients are distinct.

---

2. HART Residents Cannot Be Enrolled in ACT, PHP, or IOP

HART is a residential placement for people requiring 24/7 supervision and in-house clinical stabilization. Residential admission criteria preclude simultaneous enrollment in:

- ACT (a community-based model inconsistent with 24/7 residential care),
- PHP or IOP (outpatient group models), and
- ESMI/CSC (age/dx criteria) [13–17].

Because HART provides on-site psychiatric integration, milieu interventions, and continuous behavioral monitoring [13–17], **its 352 residents form a separate population**.

---

3. Peer Support Serves a Population Not Eligible for ACT or HART

Peer Support programs serve individuals who:

- Do not meet ACT eligibility (highest-acuity SMI),
- Are not in residential care (HART),
- Are not in early psychosis treatment (ESMI/CSC),
- Are not enrolled in PHP or IOP simultaneously [18–23].

This group—approximately 4,500 individuals statewide—is largely composed of adults with recurring relapse risk, partial engagement, moderate SMI symptoms, and high vulnerability to disengagement without a supportive mechanism [18–23].
Thus, they cannot be merged with ACT, HART, or ESMI populations.

---

4. ESMI/CSC Serves Only First-Episode Psychosis (FEP) Youth

The ESMI/CSC cohort is defined strictly by:

- Age (16–25),
- First-episode psychosis, and
- Absence of chronic SMI history characteristic of ACT/HART residents.

These individuals cannot be assigned to ACT or HART without violating fidelity to the early-psychosis model, which requires:

- SEE (Supported Employment/Education),
- Family psychoeducation,
- Weekly team reviews,
- CBT-for-psychosis,
- Medication management optimized for early illness [24–31].

Thus, ESMI/CSC's ~100 youth form a standalone population, and removing CSC destabilizes future lifelong system costs.

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5. PHP (Half-Day) Serves Medically Discharged Individuals in Active Recovery

Half-day PHP is a step-down level serving individuals:

- Recently discharged from inpatient units,
- Not appropriate for ACT, HART, or ESMI,
- Requiring multi-hour daily stabilization [45–65].

PHP clients (~70 individuals) cannot be in ACT/HART/ESMI because:

- PHP requires daily on-site participation;
- ACT/HART/ESMI have incompatible treatment structures;
- Billing rules prohibit concurrent high-acuity enrollment.

Therefore PHP represents a unique transitional cohort.

---

6. IOP Serves a Distinct Moderate-to-High Acuity Outpatient Population

IOP (~70 individuals) is a multi-hour, multi-day stabilization model. IOP populations:

- Are too acute for weekly therapy alone,
- Are not eligible for ACT or HART,
- Do not meet criteria for early psychosis (ESMI), and
- Cannot enroll in PHP concurrently [45–65].

Thus, IOP is also mutually exclusive.

1.2 Population Exclusivity Table (Rewritten)

Program	Population	Exclusive Because…	References
ACT	~400	ACT fidelity prohibits participation in HART, ESMI, PHP, IOP due to 24/7 team responsibility and shared caseloads.	[1–12]
HART	352	Residential placement factors exclude ACT/PHP/IOP; HART stability requires in-house services incompatible with outpatient models.	[13–17]
Peer Support	~4,500	Peers engage individuals not enrolled in any high-acuity program; Peer Support is the only service that consistently reaches disengaged populations.	[18–23]

ESMI/CSC	~100	Age/dx restrictions; CSC fidelity prevents overlap with ACT/HART; SEE and family psychoeducation incompatible with other models.	[24–31]
Half-Day PHP	~70	Step-down model; cannot overlap with ACT/HART/ESMI; time-intensive schedule prevents participation in other modalities.	[45–65]
IOP	~70	Moderate-acuity outpatient stabilization; cannot be combined with ACT/HART/ESMI/PHP.	[45–65]

1.3 Why These Distinct Populations Must Be Added, Not Blended

Because each population is clinically and operationally distinct, the destabilization cost is additive across programs.

Examples:

- An ACT client cannot "shift" into HART or PHP when ACT is removed; they destabilize directly into hospitals, ERs, jails, and homelessness.
- A HART resident cannot be absorbed by ACT or IOP; the residential clinical layer disappears, but the resident remains in-place and destabilizes.
- An ESMI youth cannot join ACT or IOP without violating treatment standards; they worsen into chronic schizophrenia when CSC ends [24–31].
- Peer Support clients are not ACT/HART clients; losing peers affects different thousands of people [18–23].

Thus:

Destabilization of one group does not "offset" or "reduce" destabilization in another.
Each group collapses separately, and the costs accumulate separately.

This is the most important structural rule in the entire fiscal model.

1.4 Narrative Interpretation for Policymakers and Courts

The populations served by Idaho's high-acuity programs collectively represent the most clinically unstable individuals in the state, but they are segmented in ways required by:

- SAMHSA fidelity
- Idaho Medicaid program rules
- Residential licensing requirements
- Diagnostic eligibility (ESMI)
- Step-down medical necessity (PHP/IOP)
- Federal guidance for ACT/CSC teams

Because no population can transfer to another program when one is eliminated, removing ACT, HART, Peer Support, ESMI, PHP, and fully funded IOP simultaneously results in:

- 6 independent destabilization events,
- Each affecting a unique cohort,
- Each producing predictable downstream costs,
- All of which accumulate statewide.

This is why the statewide fiscal impact reaches **$150–$180 million**, and why the model withstands scrutiny:
It does not double-count.
It counts six different population collapses, because that is exactly what the state is initiating.

APPENDIX 2. IDAHO-SPECIFIC UNIT COSTS & COST JUSTIFICATION

Accurate statewide fiscal modeling requires Idaho-specific input values for hospitalization, ER care, crisis response, EMS, jail costs, homelessness, workforce economics, and outpatient billing.
The purpose of this section is to:

1. Define each unit cost used in the model
2. Show why each value is conservative
3. Demonstrate the Idaho-specific sources for each value
4. Explain why underestimating each cost produces a *lower-bound* fiscal projection

Every value in this section has been carefully selected to avoid overstatement, even when federal, regional, or national values are higher.

Where national estimates show larger cost impacts, Idaho values are used instead.
Where Idaho ranges vary, the lowest end of the credible range is chosen for modeling.

This assures policymakers, auditors, fiscal analysts, attorneys, and federal oversight agencies (CMS/DOJ/OCR) that the resulting fiscal estimate is intentionally understated.

2.1 Idaho Unit Cost Table

Table: Idaho Unit Costs Used in All Modeling Calculations

Cost Category	Idaho Value	Explanation & Justification	References
Psychiatric inpatient per diem	**$1,100/day**	Derived from Idaho hospital cost reports, inpatient billing schedules, and payer reimbursements from 2023–2024. Lower than Western regional averages ($1,200–$1,600).	**[39–44]**
Psychiatric Length of Stay (LOS)	**5 days**	Idaho LOS for involuntary psychiatric admissions averages 5–6 days. National SMI admissions average 6–10 days. Using 5 days is intentionally conservative.	**[39–44]**
ER psychiatric visit	**$2,400/visit**	Based on Idaho hospital ER billing and cost-to-charge reports. National psychiatric ER costs often exceed $3,200–$3,800. Idaho's $2,400 is a low estimate.	**[39–44]**

Jail per diem	**$75–$106/day**	Taken from Canyon County Sheriff cost disclosures, Idaho Code §20-237A, and county-level budget filings. Does not include suicide-watch, medical, transport, or psychiatric evaluation costs, making this value very conservative.	**[39–40]**
EMS Transport	**$1,500/transport**	Derived from Idaho EMS billing schedules and typical ambulance transport fees. Excludes multi-agency police–EMS co-response costs, which are common in psychiatric crises.	**[39–44]**
Shelter bed-year cost	**$8,000/year**	Based on Idaho homelessness-services budgets and Western regional benchmarks. National averages range from $12,000–$18,000 per bed-year. Idaho's $8,000 strongly understates real-world costs.	**[13–17]**
Outpatient weekly bundle	**$560.02/week**	Idaho Medicaid fee schedule for: 3 hrs CBRS + 2 hrs counseling + 1 hr CM + limited group + crisis availability + med management. This reflects minimal outpatient stabilization, not HART/ACT/ESMI-level intensity.	**[39–44]**
Annual outpatient bundle	**$29,121/year**	Computed as 52 × $560.02. This assumes continuous weekly engagement, even though many disengage without ACT/HART/Peer Support.	**[39–44]**
Behavioral-health average wage	**$46,000/year**	Based on Idaho wage data for CM, CBRS, Peer roles, and program-level clinical staff. National medians exceed $55,000–$60,000. Idaho's $46k is conservative.	**[39–44]**
Economic multiplier	**1.25–1.3**	Standard Idaho economic multiplier ranges from 1.3–1.5 for healthcare. Using 1.25 minimizes ripple-effect calculations.	**[39–44]**
Tax recovery rate	**7%**	Based on Idaho effective combined tax rate (income + sales). Does not include payroll taxes or employer contributions.	**Idaho Dept. of Revenue**
CPS removal cost (Idaho-adjusted)	**$130,000–$160,000 per case**	Idaho-specific provider and placement costs. National CPS composite ranges from $180k–$260k. Idaho values are deliberately low to avoid overstating effects.	**[66–70]**

2.2 Why These Unit Costs Are Conservative

Idaho-specific unit costs were chosen deliberately to create a low-bound fiscal estimate. This ensures the resulting total (≈$150M–$180M) withstands scrutiny from:

- Legislators
- JFAC analysts
- OPE auditors
- Governor's Office reviewers

- CMS financial analysts
- DOJ/OCR investigators
- Opposing experts in litigation

Key reasons these costs are conservative:

1. Every value uses the *lowest credible Idaho number*

Especially:

- Psychiatric LOS (5 days instead of 6–10),
- ER costs ($2,400 instead of $3,200–$3,800),
- Jail per diem ($75–$106 instead of $150+ when medical/transport included),
- Shelter costs ($8,000 instead of $12,000–$18,000),
- Behavioral-health wages ($46k instead of $55k–$60k).

2. Idaho's rural structure hides systemic costs

Rural EMS, sheriff's offices, and hospitals often absorb unreimbursed overhead not captured in per-occurrence billing.

3. The model excludes several cost categories entirely

To remain conservative, the model does *not* count:

- police overtime
- medical-clearance exams
- ICU-level psychiatric complications
- jail suicide-watch staffing
- psychiatric medications
- indirect system downtime
- homelessness encampment policing
- hospital staffing burnout turnover
- uncompensated ambulance transports
- repeated short-stay ER cycling

Including these would significantly increase the total cost.

4. The CPS cost is severely underestimated

Idaho's $130k–$160k/case estimate is low; national court-reviewed values exceed $250k.
We use the lower Idaho range.

5. The outpatient bundle assumes full weekly engagement

This overstates outpatient success because most high-acuity individuals disengage without ACT/HART/Peer stabilization [18–23].

Thus, outpatient substitution costs are a low estimate of real-world utilization.

2.3 Why Using Idaho Costs Strengthens the Credibility of the Model

When budget committees, reporters, or legal reviewers question the model, Idaho-specific cost structures provide immediate defense:

- "These are Idaho's own numbers, not national proxies."
- "These are taken from Idaho Medicaid, Idaho hospitals, and Idaho statutes."
- "The model uses the *lowest* Idaho estimates, not the highest."

This makes the projection defensible and conservative.

Additionally:

- CMS uses state-specific cost data in Medicaid rate-setting
- DOJ/OCR rely on state-specific cost impacts when assessing harm
- Idaho courts (e.g., Mitchell v. Idaho [43]) have required Idaho-based evidence

Thus, this model is aligned with the standards used by federal oversight agencies and Idaho's own legal precedent.

2.4 Narrative Interpretation for Policymakers

Unit cost selection determines whether a fiscal model is perceived as credible.

Idaho's cost inputs:

- Match real Idaho billing,
- Match real Idaho wages,
- Match real Idaho justice and EMS costs, and
- Fall below national cost averages.

This is why the statewide impact appears larger than expected even using conservative inputs: *the cuts themselves are systemically disruptive, not the cost assumptions.*

Put differently:

The model does not produce a $165M impact because the inputs are generous.
It produces a $165M impact *despite* the inputs being extremely conservative.

That is what makes the fiscal picture so alarming.

APPENDIX 3. HOSPITALIZATION MODELING — CONCEPTUAL BASIS, DELTA LOGIC, AND FULL EXPANDED CALCULATIONS

3.1 Why Hospitalization Is the Anchor of the Entire Fiscal Model

Among all downstream systems, psychiatric hospitalization is the most expensive, most predictable, most rigorously studied, and most immediate consequence of eliminating high-acuity behavioral-health programs.

Across decades of research:

- ACT reduces psychiatric hospitalization 50–80% [1–3,7,8].
- Supportive-housing/HART-like models reduce hospital days and ER crises 30–70% [13–17].
- Peer Support reduces psychiatric readmissions and inpatient churn [18–23].
- ESMI/CSC reduces early-psychosis hospitalization 30–60% [24–31].
- PHP/IOP reduce psychiatric readmissions by 50–80% in post-acute populations [45–65].

Hospitalizations are also the first system-level cost to spike once stabilization disappears.
This section models that impact using conservative Idaho parameters. Delta values were selected by taking the lowest effect-size ranges from published literature and reducing them further to prevent overstating program impact

---

3.2 Understanding Delta (ΔRate): The Core Logic of This Model

The ΔRate (Delta Rate) is the percentage *increase* in psychiatric hospitalizations that occurs when an evidence-based program is removed.

It is derived from the fact that each program has a known, documented hospitalization **reduction** effect.

3.2.1 What ΔRate Represents

ΔRate quantifies:

How much more often a person will be hospitalized after their stabilizing program is eliminated.

If ACT reduces hospitalizations by 50–80%, removing ACT increases hospitalizations by approximately the same amount.

3.2.2 Why a Delta Approach Is Required

We are not counting total hospitalizations.
We are counting the increase caused specifically by:

- Ending ACT,
- Ending HART treatment,
- Eliminating Peer Support,
- Eliminating ESMI/CSC,
- Eliminating half-day PHP, and
- Weakening IOP.

Without ΔRate logic, any model would either:

- Undercount the impact (counting only raw events), or
- Double-count the impact (overlapping events).

Using ΔRate isolates the true attributable increase.

3.2.3 Why the ΔRate Used Here Is Deeply Conservative

Research shows:

- ACT → 50–80% hospitalization reduction
- HART-type housing → 30–70% reduction
- ESMI → 30–60% reduction
- PHP/IOP → up to 80% reduction

Despite this, the model uses:

- ACT ΔRate: 35–40%
- HART ΔRate: rolled into 5–8M composite
- Peer ΔRate: 3–5%
- ESMI ΔRate: 50% (lower than some RAISE/CSC outcomes)
- PHP ΔRate: 90%*
- IOP ΔRate: 50–60%

These choices reflect a commitment to producing an estimate that is unassailable, even if the state or external reviewers attempt to challenge effect sizes.

*The 90% ΔRate reflects the extreme relapse risk in the first 10–45 days post-discharge, where PHP models show the highest effect sizes.

3.3 Hospitalization Formula

Two primary formulas drive this section:

(1) Added Hospitalizations

$$\text{Added Hospitalizations} = \text{Population} \times \Delta\text{Rate}$$

This tells us how many *extra* hospitalizations occur if the stabilizing program is removed.

(2) Hospitalization Cost

$$\text{Hospitalization Cost} = \text{Added Hospitalizations} \times \text{Length of Stay} \times \text{Per Diem}$$

Using Idaho-specific inputs:

- LOS = 5 days
- Per Diem = $1,100
- Cost per hospitalization = 5 × 1,100 = $5,500

This is extremely conservative compared to national rates.

3.4 Program-by-Program Hospitalization Modeling

Below are the full calculations for each population, including explanation of clinical context, ΔRate justification, math verification, and narrative interpretation.

3.4A. ACT Hospitalization Model

Clinical Context

ACT serves Idaho's highest-acuity community-dwelling adults: individuals with schizophrenia, mania, disorganization, delusions, chronic relapse, and treatment nonadherence. Without ACT's 24/7 coverage, medication monitoring, crisis interception, and in-field stabilization, hospitalization rises dramatically [1–12].

Process	Impact
Step 1 — Population	400 ACT clients.
Step 2 — ΔRate Selection **Research: ACT reduces hospitalization**	50–80% [1–3,7,8]. To remain conservative: ΔRate = 0.35–0.40.
Step 3 — Added Hospitalizations	Low: 400 × 0.35 = 140 High: 400 × 0.40 = 160

Step 4 — Cost Per Hospitalization	LOS (5 days) × $1,100 = $5,500
Step 5 — Multiply	140 × 5,500 = $770,000 160 × 5,500 = $880,000
Reported Range (Downward Adjusted)	≈ $750,000–$900,000

Why lower?

To avoid double-counting overlap with ER, EMS, or medical destabilization categories.

Interpretation

ACT's elimination adds 140–160 preventable hospitalizations annually — a predictable and well-documented effect.

3.4B. HART Hospitalization Model

Clinical Context

HART is Idaho's only subacute psychiatric residential level. When its clinical layer is removed:

- Residents stay in their ALFs
- The treatment/stabilization layer disappears
- Behavioral destabilization increases sharply
- Crises escalate to ER or inpatient settings
- ALF staff must call 911 for safety events
- Medication lapses trigger psychotic or manic decompensation

Why HART's Hospitalization Is Modeled as a Composite

HART destabilization produces simultaneous surges in:

- ER visits
- Crisis-team responses
- Inpatient psychiatric admissions
- Medical admissions
- EMS transports
- Police-assisted interventions

Rather than break these into multiple categories and risk double-counting, the model includes all HART hospitalization effects within the $5M–$8M HART composite crisis/ER/inpatient impact.

This approach is conservative because:

- It avoids separately counting medical vs. psychiatric admissions
- It compresses multiple cost categories into a single line
- It underestimates the real scope of HART collapse

Hospitalization Impact Included In:

HART Composite: $5M–$8M

3.4C. Peer Support Hospitalization Model

Clinical Context

Peer Support reduces:

- Disengagement
- Relapse
- Crisis episodes
- ER use
- Psychiatric readmissions [18–23]

Peers catch deterioration early by providing:

- motivation
- reminders
- check-ins
- de-escalation
- lived-experience guidance

Process	Impact
Step 1 — Population	≈4,500 individuals (not ACT, HART, or ESMI).
Step 2 — ΔRate Selection	Research: Peer Support reduces admissions 20–40% [18–23]. Conservative ΔRate: 3–5%.
Step 3 — Added Hospitalizations	4,500 × 0.03 = 135 4,500 × 0.05 = 225
Step 4 — Cost	135 × $5,500 = $742,500 225 × $5,500 = $1,237,500

Interpretation

Peer Support stabilizes an enormous population; even a 3–5% ΔRate produces six-figure hospitalization costs, folded into the Peer Support impact total.

3.4D. ESMI/CSC Hospitalization Model

Clinical Context

First-episode psychosis (FEP) is one of the highest-risk events in psychiatry. Without CSC, youth:

- Relapse quickly
- Destabilize severely
- Require inpatient care
- Often enter the disability pipeline [24–31]

Process	Impact
Step 1 — Population	≈100 youth.
Step 2 — ΔRate	CSC reduces inpatient use 30–60% in RAISE studies. Conservative ΔRate: 0.50.
Step 3 — Added Hospitalizations	100 × 0.50 = 50
Step 4 — Cost	50 × $5,500 = $275,000

3.4E. Half-Day PHP Hospitalization Model

Clinical Context

Half-day PHP provides multi-hour post-acute stabilization for recently hospitalized individuals. Removal creates a readmission cliff, driving high relapse rates [45–65].

Process	Impact
Step 1 — Population	~70 individuals.
Step 2 — ΔRate	National PHP outcomes show 60–80% reduction in readmission. At discharge, relapse risk is high. Conservative ΔRate: 0.90 (90%).
Step 3 — Added Hospitalizations	70 × 0.90 = 63
Step 4 — Cost	63 × $5,500 = $346,500

3.4F. IOP Hospitalization Model

Clinical Context

IOP provides multi-hour stabilization for moderate-acuity patients. Cutting reimbursement by 10% reduces:

- Staffing
- Group availability
- Fidelity
- Hours offered
- Follow-up capacity

Relapse increases accordingly.

Process	Impact
Step 1 — Population	≈70 individuals.
Step 2 — ΔRate	Conservative ΔRate: 0.50–0.60.
Step 3 — Added Hospitalizations	70 × 0.50 = 35 70 × 0.60 = 42
Step 4 — Cost	35 × 5,500 = $192,500 42 × 5,500 = $231,000

3.5 Why Hospitalization Modeling Drives the Fiscal Bottom Line

Hospitalization modeling alone accounts for:

- **ACT: ~$0.75–$0.9M**
- **Peer: ~$0.7–$1.2M**
- **ESMI: ~$0.27M**
- **PHP: ~$0.35M**
- **IOP: ~$0.19–$0.23M**
- **HART: included in $5–$8M composite**

Even with conservative inputs, **hospitalizations account for ~20–25%** of the entire statewide fiscal impact.

Because hospitalization is:

- **Extremely expensive**
- **Extremely predictable when stabilization disappears**
- **Extensively researched in every program model**
- **The backbone of Medicaid cost exposure**
- **The primary cause of ER boarding and medical spillover**
- **The largest single liability category under ADA/olmstead**
- **And the most visible strain on hospitals**

…it becomes the foundational cost category in the entire model.

APPENDIX 4. ER & CRISIS-SYSTEM MODELING

4.1 Purpose of This Section

This section models the increase in:

- Psychiatric ER visits,
- Medical ER visits driven by psychiatric deterioration,
- Crisis-center utilization,
- Mobile crisis dispatches, and
- ED boarding time

That occurs when ACT, HART, Peer Support, ESMI/CSC, half-day PHP, and IOP are eliminated or degraded.

Emergency Departments become the front-line containment mechanism for psychiatric destabilization.
Modeling ER impact is essential because:

- ERs have *no exclusion criteria*
- ERs absorb every crisis that used to be intercepted upstream
- ER boarding is extraordinarily expensive
- ER overflow destabilizes the entire hospital system

These patterns are thoroughly documented across ACT, HART/supportive housing, Peer Support, CSC, PHP, and IOP literature [1–31,13–23,45–65].

4.2 Why ER Volume Spikes When Programs Are Eliminated

High-acuity behavioral-health programs prevent ER visits by:

- Detecting relapse early
- Providing in-community intervention
- Interrupting crises before safety thresholds are crossed
- Managing medication adherence
- Containing behavioral escalation
- Responding in real time

When these programs disappear, individuals experience:

- Unsupervised deterioration

- Relapse with no early intervention
- Medication lapses
- Behavioral escalation in public or in ALFs
- Family inability to manage symptoms
- Police or EMS activation
- Transport to ER as the only safe option

This is the exact progression observed repeatedly in the literature:

- ACT reduction → ER increase [1–12]
- Housing loss → ER increase [13–17]
- Peer removal → ER increase [18–23]
- CSC elimination → ER increase for first-episode psychosis [24–31]
- PHP/IOP collapse → post-discharge ER increase [45–65]

Thus, ER utilization is the most immediate and clinically predictable impact.

4.3 Formula for ER Impact

$$\text{ER Cost} = \text{Added ER Visits} \times \$2{,}400$$

Where:

- $2,400 is an Idaho-based average cost for psychiatric ER care [39–44]
- Added ER Visits are calculated using ΔRate formulas similar to hospitalization modeling

This formula is highly conservative, excluding:

- Security costs
- Holding costs
- Medical clearance
- Co-response charges
- ED hallway boarding time
- Repeat presentations within 72 hours

Including those would raise costs significantly.

4.4 ACT ER Modeling

Process	Impact

Step 1 — Baseline ER Use	ACT clients typically average 1.2 psychiatric ER visits/year with ACT support, based on Idaho and multi-state ACT datasets [1–12].
Step 2 — ER Use Without ACT	Without ACT, ER use rises to 1.8–2.0 visits/year (documented in national "treatment-as-usual" cohorts [1–12]). Δ = ~0.6 visits per person per year
Step 3 — Added ER Visits	400 ACT clients × 0.6 = 240 added ER visits Rounded conservatively to 220.
Step 4 — Cost	220 × $2,400 = $528,000
Conservative Reported Range	≈ $400k–$475k

This reduction is intentional to avoid double-counting with inpatient and EMS costs.

4.5 HART ER Modeling

For HART residents:

- Residents remain in ALFs
- The treatment layer disappears entirely
- ALF staff have no clinical training
- Crises escalate faster
- ALFs must call 911 for safety and behavioral emergencies
- Residents are transported to the ER for even moderate instability

HART loss produces:

- Psychotic agitation in residential settings
- Medical destabilization from untreated psychiatric symptoms
- Medication nonadherence events
- Violent or unsafe behavior requiring immediate intervention

Because HART destabilization affects:

- ER
- Inpatient
- Crisis
- EMS
- Law enforcement

…its ER impact cannot be isolated without overcounting.
Thus all ER + crisis + inpatient + EMS costs are rolled into:

HART Composite Crisis/ER/Inpatient Impact: $5M–$8M

This composite is conservative and likely understates true costs.

4.6 Peer Support, ESMI, PHP, IOP ER Modeling

Peer Support

Loss of peers → disengagement → relapse → crisis → ER.
Peer Support reduces ED churn significantly [18–23].
ER costs are included in the Peer Support total (~$4.5M–$5.5M).

ESMI/CSC

First-episode psychosis (FEP) is one of the highest-risk presentations for EDs.
CSC elimination increases FEP ER presentations dramatically [24–31].

PHP

Removing step-down care causes rapid readmission cycles, leading to ER spikes for medication issues, agitation, suicidality [45–65].

IOP

Reducing IOP reimbursement weakens protective capacity, increasing crisis-level ER use.

4.7 Why ER Boarding Magnifies Cost

ER boarding is:

- Expensive
- Dangerous
- Destabilizing for hospitals
- Time-consuming
- Resource-heavy
- Associated with increased staff assault risk

Boarding of psychiatric patients (24–72 hours+):

- Occupies medical beds
- Blocks access for non-psychiatric emergencies
- Forces hallways to become temporary psychiatric units
- Increases staff-to-patient ratios
- Increases police presence demands

These effects are not fully modeled, making the ER impact highly conservative.

APPENDIX 5 — HOSPITAL COST MODEL: CALCULATION FRAMEWORK

This appendix details the full technical methodology used to estimate the statewide hospital-system cost shift resulting from the elimination of ACT, HART, ESMI/CSC, Peer Support, PHP, and reduced IOP reimbursement. All calculations use conservative, bottom-quartile assumptions and Idaho-specific hospital utilization and cost data, supported by national evidence [1–12, 13–31, 32–54].

Hospital-system costs are modeled across four independent components:

1. **Increased psychiatric admissions**
2. **Increased ER boarding and observation time**
3. **Increased medical complications**
4. **Increased uncompensated/indigent care**

5.1 Psychiatric Admission Increase Calculation

5.1.1 Baseline Hospitalization Rate

High-acuity SPMI adults experience approximately **0.7 psychiatric admissions per year** under stabilized conditions. This is consistent with ACT/CSC literature and Idaho multi-provider utilization patterns [1–12, 13–31].

5.1.2 Admission Increase After Program Cuts

ACT and CSC reduce hospitalizations by **40–60%** in randomized trials and multi-state cohorts [1–12]. Eliminating these programs reverses these gains.
To remain conservative, the model applies:

- **40% increase** in psychiatric admissions.

5.1.3 Inpatient Unit Cost

- Average psychiatric length of stay: **5 days**
- Idaho statewide psychiatric per-diem: **$1,100/day** [39–44]

$$\text{Unit Cost} = 5 \times 1{,}100 = \$5{,}500$$

5.1.4 Calculation Formula

$$\text{Increased Admissions} = (\text{SPMI Population}) \times 0.7 \times 0.40$$
$$\text{Hospitalization Cost Shift} = (\text{Increased Admissions}) \times 5{,}500$$

Result: $35–$48 million annually.

5.2 ER Boarding & Observation Cost Calculation

5.2.1 Baseline ER Boarding Burden

Psychiatric ER boarding typically lasts:

- **18–24 hours** per episode (Idaho ER averages).
- ER boarding cost: **$100–$150/hour** (staff, security, bed-blocking overhead) [39–44].

5.2.2 Increase After Program Cuts

Loss of ACT/ESMI increases ER arrivals and extends boarding duration by:

- **20–30%** (lowest end of documented national ranges) [39–44].

5.2.3 Calculation Formula

$$\text{Additional Boarding Hours} = \text{Baseline Hours} \times 20\text{–}30\%$$
$$\text{ER Boarding Cost Shift} = (\text{Additional Hours}) \times 100\text{–}150$$

Result: $18–$24 million annually.

5.3 Medical Complication Cost Calculation

Untreated psychiatric relapse contributes to medical complications such as dehydration, infection, trauma, metabolic crises, medication withdrawal, and suicide attempts [13–31].

5.3.1 Complication Attribution Rate

Evidence suggests **10–15%** of destabilized episodes lead to medical admissions.
To remain conservative:

- Idaho model uses **5–8%**.

5.3.2 Medical Complexity Unit Cost

- Per-episode cost estimate: **$4,500–$6,500** (Idaho hospital case-rate data).

5.3.3 Calculation Formula

$$\text{Medical Cost Shift} = (\text{Psych Admissions Increase}) \times 5\text{–}8\% \times 4{,}500\text{–}6{,}500$$

Result: $3–$6 million annually.

5.4 Uncompensated/Indigent Care Cost Calculation

5.4.1 Idaho Uncompensated Care Baseline

Idaho hospitals currently provide:

- **$281 million** in uncompensated care annually (charity + bad debt) [45].

5.4.2 SPMI Attribution Rate

National studies attribute **8–12%** of uncompensated care to severe mental illness destabilization [46–54].
For conservative modeling:

- Idaho uses **5% attribution**.

5.4.3 Calculation Formula

$$281{,}000{,}000 \times 0.05 = 14{,}050{,}000$$

Rounded for reporting:

$14–$15 million annually.

5.5 Total Hospital System Cost Shift

5.5.1 Component Summary

- Psychiatric admissions: **$35–$48M**
- ER boarding: **$18–$24M**
- Medical complications: **$3–$6M**
- Uncompensated care: **$14–$15M**

5.5.2 Final Estimate

Total A	nnual H

This represents the single largest systems-level fiscal impact associated with Idaho's elimination of intensive SPMI programs.

APPENDIX 6 — Jail, Law-Enforcement & Court Modeling

6.1 Purpose

To quantify how eliminating high-acuity behavioral-health programs increases:

- Arrests**,**
- Jail days,
- Police responses,
- Civil commitments,
- Competency evaluations,
- Court caseloads,
- Probation violations,
- And psychiatric holds.

The justice system becomes a catch-basin for untreated psychiatric crises.

6.2 Why Justice-System Costs Rise Dramatically

1. Criminalization of Psychiatric Behavior

Without stabilization, SPMI symptoms manifest as:

- trespass
- disorderly conduct
- public disorganization
- hallucination-driven behavior
- delusional aggression
- suicidal behavior requiring protective custody

These are clinical failures, not criminal acts.

2. Police Become First Responders

When ACT, HART, Peer, and CSC vanish, families and ALF staff have nobody to call except 911.

3. Jail Becomes Psychiatric Containment

Idaho jails frequently house:

- Acutely psychotic individuals
- Suicidal detainees
- Individuals needing constant monitoring

Jails cannot provide psychiatric stabilization, making deterioration worse.

4. Courts See Increased Psychiatric Caseloads

Including:

- Emergency mental-health holds
- Involuntary commitment petitions
- Competency evaluations
- Guardianship filings

Repeated civil/criminal hearings

6.3 Formulas

$$\text{Jail Cost} = \text{Added Jail Days} \times \text{Jail Per Diem}$$
$$\text{Police Cost} = \text{Added Crisis Calls} \times \$95$$
$$\text{Court Cost} = \text{Added Psychiatric Cases} \times \$150\text{–}\$300$$

These values exclude several significant cost drivers:

- Medical care inside jails
- Suicide-watch staffing
- Sheriff transport
- Emergency court staffing
- Interpreter services
- Legal representation costs
- Booking fees
- Police overtime

The justice model is thus highly conservative.

6.4 ACT Justice Modeling (Full Walkthrough)

Process	Impact
Step 1 — Baseline Jail Days Without ACT	Untreated high-acuity SMI = ~21 jail days/person/year [9–12]. 400 ACT clients → 400 × 21 = 8,400 jail days/year
Step 2 — ΔRate	ACT reduces justice involvement 40–60% [9–12]. Conservative ΔRate = 55%. 8,400 × 0.55 = 4,620 additional jail days
Step 3 — Jail Costs	4,620 × $106 = $489,720
Step 4 — Police + Court Costs	Police crisis calls + court hearings = ~$355,000
ACT Total Justice Impact	**≈ $700k–$850k**

6.5 HART Justice Modeling

HART residents without treatment experience:

- Behavioral disturbances
- Agitation
- Wandering/elopement
- Conflicts with other residents
- Aggression triggered by delusions
- Medication mismanagement

ALF staff must call police because they lack:

- Clinical training
- Crisis protocols
- Psychiatric de-escalation skills

Thus HART elimination triggers:

- Multiple police calls per resident per year
- Law-enforcement transport to ER
- Jail booking for behavior escalation
- Civil commitments

These costs are captured in the HART composite estimate ($5M–$8M).

6.6 Peer, ESMI, PHP, IOP Justice Modeling (Narrative)

Peer Support

Without peers supporting engagement, individuals disengage → relapse → police contact → jail/ER [18–23].

ESMI

FEP youth without CSC frequently enter the justice system for:

- Disorganized behavior
- Aggression
- Public safety concerns [24–31].

PHP/IOP
Loss of step-down stabilization → increased probation violations, crisis calls, and emergency holds.

All these impacts are captured in each program's individualized technical modeling.

APPENDIX 7 — Homelessness & EMS Modeling

7.1 Purpose

To model the increase in:

- Homelessness,
- Housing instability,
- Shelter utilization,
- Encampment growth,
- And EMS medical/psychiatric transports

caused by elimination of upstream stabilization programs.

Homelessness and EMS engagement reflect systemic collapse at the intersection of psychiatry, safety, and medical fragility.

7.2 Why Homelessness Rises When Programs Disappear

ACT prevents homelessness
Through crisis de-escalation, landlord negotiation, ADL support, medication adherence, and daily contact [5–8].

HART prevents homelessness
By providing continuous 24/7 structure for individuals unable to live in independent settings [13–17].
With HART treatment gone, residents destabilize inside ALFs — causing increased EMS, ED visits, and eventual displacement after repeated crises.

Peer Support prevents homelessness
By maintaining engagement and preventing relapse cycles [18–23].

ESMI prevents homelessness
FEP without CSC is strongly associated with homelessness and justice involvement [24–31].

PHP and IOP prevent homelessness
By stabilizing individuals after psychiatric discharge [45–65].

When all programs are removed simultaneously, homelessness and EMS crises become unavoidable.

7.3 Formulas

$$\text{Homelessness Cost} = \text{Added Homeless Individuals} \times \$8{,}000$$
$$\text{EMS Cost} = \text{Added EMS Transports} \times \$1{,}500$$

These values significantly understate actual system costs because they exclude:

- Medical clearance
- Multi-agency responses
- Police co-response
- Boarding in ED
- Repeated transports
- Medical-surgical hospitalization
- Shelter security
- Encampment cleanup
- Fire/EMS call stack backlog impacts

7.4 ACT Homelessness & EMS Modeling

Process	Impact
Step 1 — ΔRate for Homelessness	ACT reduces homelessness 30–40% [5–8]. Conservative ΔRate = 4.75%.
Step 2 — Added Homeless Individuals	400 × 0.0475 = 19 additional homeless individuals
Step 3 — Shelter Cost	19 × $8,000 = $152,000
Step 4 — EMS Transport Increase	Without ACT, EMS transports increase dramatically. Estimated additional transports: ~100 per year 100 × $1,500 = $150,000
ACT Homelessness + EMS Impact	**≈ $225k–$275k**

7.5 HART Homelessness & EMS Modeling

Because HART residents remain housed in ALFs:

- Homelessness *does not immediately rise*,

- But medical destabilization skyrockets,
- Leading to more EMS calls,
- More ED visits, and
- More short-notice psychiatric transfers**.**

These costs are absorbed in the:

HART composite = $5M–$8M

APPENDIX 8 — Medical Destabilization Modeling

8.1 Purpose

To quantify the increase in non-psychiatric medical crises, including:

- Diabetic crises
- Cardiac events
- Infections
- Seizure exacerbations
- Dehydration
- Malnutrition
- Uncontrolled medication interactions
- Accidental injuries
- Overdose events

Psychiatric instability leads directly to medical destabilization due to:

- Neglect of self-care
- Medication lapses
- Impaired insight
- Sleep disruption
- Erratic eating
- Disorganized behavior
- Lack of outpatient integration

These events generate high-cost medical admissions and ICU stays.

8.2 Evidence Basis

Integrated psychiatric models consistently reduce medical admissions:
ACT reduces medical hospitalizations 20–40% [4–8].
CSC improves medical engagement and reduces metabolic crises [24–31].
Peer Support reduces emergency medical episodes [18–23].
Supportive housing reduces medical hospitalization [13–17].

Removal of upstream stabilization leads to preventable medical events.

8.3 Formula

$$\text{Medical Cost Increase} = \text{Baseline Medical Cost} \times \text{Medical Destabilization \%}$$

Idaho baseline medical cost for SMI = **$8,500/person/year**
Conservative destabilization % = **25%**

8.4 ACT Medical Destabilization Modeling

Process	Impact
Step 1 — Baseline Medical Costs	400 ACT clients × $8,500 = $3,400,000 baseline
Step 2 — Apply Destabilization Percentage	$3,400,000 × 0.25 = $850,000 (raw)
Step 3 — Conservative Reporting	Reported as $650k–$750k to avoid overlap with ER/inpatient categories.

8.5 HART Medical Destabilization

HART residents:

- Lose daily medication supervision
- Lose nursing oversight
- Lose vital-sign observation
- Lose staff able to recognize medical warning signs
- Remain in alfs without medical capacity

Thus:

- EMS responds more often
- ED boarding increases
- Inpatient medical beds fill with preventable cases

All of these are included in HART's composite ($5M–$8M).

8.6 Narrative Interpretation

Medical deterioration is one of the most predictable outcomes when high-acuity stabilization disappears. Because the fiscal model uses conservative assumptions and avoids double-counting

ICU stays or medical-surgical admissions, the real medical cost shift is likely substantially higher than modeled.

APPENDIX 9 — Outpatient Substitution Modeling

9.1 Purpose of This Section

Outpatient substitution modeling answers a critical policy question:

"To what extent can standard outpatient billing replace the intensive services Idaho is eliminating?"

The short answer, supported by extensive ACT, HART, CSC, Peer, PHP, and IOP literature, is:

Only 10–15% of eliminated service intensity can be replaced with outpatient codes.
And the portion that *can* be replaced still **costs Idaho money** without preventing deterioration.

This section explains:

- What outpatient billing can and cannot cover;
- Why outpatient capacity is structurally inadequate for high-acuity populations;
- How substitution is calculated;
- Why substitution costs are real but stabilization effects are small;
- How substitution leads to greater downstream system dependency.

9.2 Why Outpatient Codes Cannot Replace High-Acuity Programs

Standard outpatient billing (therapy, case management, CBRS, crisis codes, med management) cannot fund the required intensity for:

- ACT-level community stabilization [1–12],
- HART-level 24/7 residential clinical oversight [13–17],
- CSC's multi-component early psychosis team [24–31],
- Peer Support's continuous engagement layer [18–23],
- PHP and IOP's multi-hour daily programming [45–65].

Outpatient billing fails because it:

- Pays only for discrete, scheduled encounters, not continuous involvement
- Does not support multiple contacts per day
- Cannot fund team meetings, staff coordination, or shared caseload work
- Cannot fund in-home visits at meaningful frequency

- Pays nothing for relapse detection or proactive intervention
- Pays nothing for milieu intervention in HART
- Does not pay for 24/7 crisis availability
- Cannot fund environmental safety supports
- Cannot fund in-house peer support
- Cannot fund nursing oversight or psychiatric integration

Thus:
Outpatient care is not a "lighter version" of ACT/HART/ESMI.
It is a **different service entirely**, and cannot stabilize these populations.

9.3 The Outpatient Bundle (Idaho-Specific Model)

The outpatient bundle approximates the maximum outpatient effort that can reasonably be delivered under fee-for-service billing to individuals losing ACT/HART/ESMI/Peer/PHP services.

Component	Hours/Week	Rate	Weekly Cost
CBRS	3 hours	~$61.76/hr	$185.28
Counseling	2 hours	~$105.37/hr	$210.74
Case Mgmt	1 hour	~$71.56/hr	$71.56
Group	1 session	~$44	$44
Crisis Availability	prorated	~$25	$25
Med Management	prorated	~$23.44	$23.44
Total Weekly	—	—	$560.02

Annual Cost = 52 × $560.02 = **$29,121/year**

This is the highest realistic outpatient engagement, not the average (average is much lower).
Thus, this number **overstates outpatient capacity** and is conservative.

9.4 ACT Substitution Example

Process	Impact
Step 1 — Identify Substitutable ACT Population	ACT Population: 400 Based on national ACT-to-outpatient substitution studies, only ≈30% will reliably engage in outpatient care once ACT is removed [1–12].

	Thus: 400 × 0.30 = 120 individuals
Step 2 — Apply Annual Outpatient Bundle Cost	120 × $29,121 = $3,494,520
Step 3 — State Share	Idaho's Medicaid FMAP yields state share ≈ $1.05M per year for ACT substitution.

This new outpatient spending **does not offset deterioration**, because outpatient intensity cannot replace ACT-level stabilization.

9.5 Outpatient Substitution Across Programs

HART

Only a fraction of HART's clinical work translates to outpatient billing because:

- ALF residents do not reliably attend clinic-based services
- Outpatient providers cannot be in the facility multiple times per day
- Peer support inside ALFs disappears entirely
- Crisis-day structure dissolves

Estimated outpatient substitution:
≈ $2.2M–$3.0M statewide.

Peer Support

A small number of Peer recipients shift into therapy/CM, adding outpatient cost ≈ $1.2M–$1.4M.

ESMI

CSC has many components not billable outpatient (SEE, family psychoed, team meetings). Only partial substitution occurs.

Outpatient substitution ≈ $1.0M–$1.3M.

PHP/IOP

Replacement with outpatient care is minor compared to lost intensity**.**

PHP → ~$500k–$750k
IOP → included in IOP cut modeling.

9.6 Narrative Interpretation

Outpatient substitution adds millions in new Medicaid costs while preventing almost none of the deterioration. This phenomenon is widely documented:

- ACT-to-outpatient substitution fails [1–12]
- CSC-to-outpatient substitution fails [24–31]
- Peer Support cannot be replaced with outpatient services [18–23]
- PHP/IOP reductions increase relapse [45–65]

Thus:

Outpatient substitution is a cost add, not a cost offset.

APPENDIX 10 — Workforce & Economic Modeling

10.1 Purpose

To quantify how eliminating ACT, HART, Peer Support, ESMI, PHP, and weakening IOP impacts:

- Direct behavioral-health workforce wages
- Secondary economic activity ("ripple effects")
- Idaho's tax revenues
- Regional clinical capacity
- Long-term workforce availability

Behavioral-health programs are major employers.
Removing them simultaneously removes salaries, benefits, spending power, and economic circulation.

10.2 Workforce Categories Eliminated

1. ACT

- Multidisciplinary teams of ~30–40 statewide
- Includes psychiatry, nursing, CM, therapy, specialists
- Eliminated entirely → ≈ 40–50 FTE lost

2. HART

- Clinical staff for 10 residential facilities
- Psychiatric integration, nursing, milieu staff, peers
- Eliminated entirely → ≈ 250–275 FTE lost

3. Peer Support

- ~450 peers statewide
- Loss of engagement role across Idaho
- Eliminated → ≈ 450 FTE lost

4. ESMI/CSC

- Small specialized teams

- Eliminated → ≈ 25 FTE lost

5. PHP

- Half-day staff, clinicians, group facilitators
- Eliminated → ≈ 20 FTE lost

6. IOP

- Reduced fidelity reduces staffing
- Lost hours → ≈ 20–30 FTE lost

Total FTE eliminated across system: ~800–850 positions

10.3 Wage Modeling

Process	Impact
Step 1 — Wage Baseline	Average Idaho BH wage: $46,000 Including: • direct wages • overtime • rural adjustments across ALFs • lower-tier licensed staff This is conservative (national median $55–$60k).
Step 2 — Compensation + Benefits	$46,000 × 1.25 = $57,500 average loaded compensation.
Step 3 — Total Wage Loss	850 FTE × $57,500 = $48,875,000 ≈ $40M–$44M after conservative downward rounding.

10**.4 Economic Ripple Effects**

Healthcare wages ripple through the economy at a multiplier of 1.25–1.3 (Idaho-specific).

Ripple Calculation

$40M–$44M × 1.25–1.3
= $50M–$58M
Reported £$52M–$58M

This reflects:

- Lost spending

- Reduced household consumption
- Lower economic activity
- Decreased business revenue
- Reduced local economic circulation

10.5 Tax Revenue Loss

Idaho's effective combined tax rate: **≈7%**

Tax Loss Calculation
$40M–$44M × 0.07 = **$2.4M–$2.7M**

These are recurring annual tax losses.

10.6 Workforce Interpretation

Eliminating 850 clinical positions:

- Removes ~10–12% of Idaho's BH workforce
- Destabilizes rural treatment systems
- Destroys years of specialized ACT/CSC/HART/Peer experience
- Cannot be rapidly replaced
- Creates a clinical "vacuum" in high-acuity care
- Produces state-level shortages that cannot be reversed quickly

This is particularly significant because courts (e.g., Delaware, Georgia, New Hampshire) have required expansion—not elimination—of staffing under DOJ enforcement.

APPENDIX 11 — Child-Welfare Modeling

11.1 Purpose

To quantify how eliminating ACT, HART, Peer Support, ESMI/CSC, PHP, and weakening IOP increases:

- CPS investigations
- Safety assessments
- Emergency removals
- Long-term foster placements
- Court involvement
- Multi-year case management
- Educational disruption
- Psychiatric hospitalization of parents and youth

These costs are large, often multi-year, and particularly relevant under ADA/Olmstead foreseeability standards.

11.2 Why Child-Welfare Costs Rise

Parents with SMI experience:

- high relapse rates,
- medication nonadherence,
- crisis episodes,
- violence risk during destabilization,
- impaired supervision capacity,
- inability to maintain routines,
- financial instability,
- comorbid medical issues,
- substance-use escalation during stress [66–70].

Programs like ACT, Peer Support, and CSC directly reduce child-welfare involvement by:

- Stabilizing parents
- Maintaining routines

- Preventing severe decompensation
- Intervening during early relapse
- Coordinating with schools and CPS workers

When these programs disappear, CPS involvement spikes.

11.3 Formula

$$\text{CPS Cost} = \text{Additional Removals} \times (\$130{,}000–\$160{,}000)$$

These amounts include:

- Case management
- Foster placements
- Emergency shelter care
- Supervised visitation
- Legal expenses
- Therapeutic services
- Educational support

National values are higher ($180k–$250k), making Idaho's estimate conservative.

11.4 ACT Example

Process	Impact
Step 1 — Added Removals	ACT removes ~50–75% of CPS involvement among ACT households [66–70]. Conservative added removals: 20–30 cases
Step 2 — Cost	20 × $130k = $2.6M 30 × $160k = $4.8M
ACT Child-Welfare Impact	**≈ $4M–$6M**

Removal estimates are based on Idaho-specific CPS involvement rates for SMI parents, adjusted downward from the rates reported in [66–70] to avoid overstating impact.

11.5 Peer Support, ESMI, PHP, IOP Child-Welfare Impact

Peer Support

Peer Support reduces CPS involvement dramatically [18–23], especially among parents with co-occurring SUD and SMI.

ESMI/CSC

FEP in young adults often destabilizes households:

- School failure
- Medical crises
- Legal crises
- Suicidal or violent episodes
  CSC prevents these crises, reducing cps activation [24–31].

PHP/IOP

Post-discharge stability supports safe parenting.
Loss of these services increases neglect/supervision concerns.

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Systemwide Estimate

Child-welfare impact across all program eliminations:
≈ $8M–$16M annually

APPENDIX 12 — Combined Statewide Total

12.1 Purpose

To present the consolidated statewide fiscal impact after:

- Removing ACT,
- Eliminating HART treatment,
- Eliminating Peer Support,
- Eliminating CSC/ESMI,
- Eliminating half-day PHP,
- Reducing IOP reimbursement, and
- Accounting for child-welfare, justice, homelessness, EMS, and medical destabilization spillover.

12.2 Program-by-Program Low/High Ranges

Program	Annual Fiscal Impact	Reference
ACT	**$35M–$40M**	[1–12]
HART	**$53M–$60M**	[13–17]
Peer Support	**$45M–$50M**	[18–23]
ESMI/CSC	**$7M–$9M**	[24–31]
PHP (half-day)	**$3M–$4.5M**	[45–65]
IOP (10% cut)	**$2M–$2.8M**	[45–65]
Child-Welfare	**$8M–$16M**	[66–70]

This sum does *not* include:

- ADA/Olmstead liability
- DOJ enforcement
- Catastrophic public events
- Uncompensated-care surges
- Cost-shift to private hospitals
- Workforce flight (future costs)
- Increased disability enrollment
- Long-term homelessness costs

Thus:

Idaho's conservative consolidated statewide fiscal impact is ≈ $150M–$180M annually. Midpoint = ≈ $165 million.

12.3 Why This Range Is Conservative

The following cost drivers were deliberately *excluded* to avoid overstatement:

- Medical ICU admissions
- Police overtime
- ER boarding beyond 72 hours
- Jail suicide-watch costs
- State hospital overflow
- Homelessness encampment costs
- Uninsured medical admissions
- Crisis center overtime
- Litigation defense costs
- Decades-long disability costs

Had these been included, total estimated impact could exceed $250–$300 million.

12.4 Legal & Policy Interpretation

The consolidated total represents:

- foreseeable
- preventable
- attributable
- measurable
- policy-induced

harm to Idaho's public systems.

Under ADA and Olmstead [32–38], predictable system deterioration following removal of community-based services constitutes:

- **Unnecessary segregation,**
- **Denial of community-based alternatives,**
- **Failure to maintain the most integrated setting,**
- **State liability for foreseeable harm (Mitchell v. State of Idaho [43]).**

The fiscal impact is thus not only a budgetary concern; it is a civil-rights exposure.

APPENDIX 13 — Impact of Eliminating Idaho's Evidence-Based SPMI Programs (ACT, HART, and ESMI/CSC)

Idaho is moving toward eliminating the bundled funding models that sustain the state's three highest-acuity behavioral health programs: Assertive Community Treatment (ACT), High Acuity Residential Treatment (HART), and Early Serious Mental Illness / Coordinated Specialty Care (ESMI/CSC). These programs serve the individuals who are most likely to experience psychiatric hospitalization, homelessness, incarceration, violent crises, and long-term disability 9,12,17,22,30.

All three models share a common structure:

- A bundled, team-based, high-frequency treatment model
- Multidisciplinary staffing requirements
- Intensive community- or facility-based interventions
- Continuous monitoring and rapid crisis response
- Prevention of hospitalizations, ER visits, homelessness, and incarceration

Unbundling these programs into standard counseling, case management, CBRS, crisis codes, and medication visits eliminates the evidence-based components that make them effective. The result is the collapse of every intensive treatment program Idaho provides for individuals with the highest psychiatric acuity.

13.1 Assertive Community Treatment (ACT)

ACT is Idaho's only federally recognized intensive community-based treatment model for adults with the most severe and persistent mental illness. ACT reduces hospitalization by 50–80% 12, criminal justice involvement by 40–60% 22, and dramatically improves housing stability 30.

Why ACT Requires a Bundled Model

ACT fidelity standards require:

- 24/7 crisis availability
- High-frequency contact (3–7+ contacts/week)
- In-home and in-community care (not office-based)
- Shared caseloads and multidisciplinary staffing
- Medication monitoring and rapid intervention

Most ACT work is preventive, crisis-interruptive, or milieu-based—and is not billable under outpatient codes. Unbundling eliminates:

- After-hours stabilization
- Real-time relapse detection
- Medication adherence checks
- Home visits preventing ER/hospital use
- Team-based intervention

Once unbundled, the program is no longer ACT under SAMHSA definitions.

System Impact of ACT Collapse

Research consistently shows increased:

- Hospitalizations and ER visits 1,12
- Homelessness 30
- Arrests and jail days 22
- Suicide risk and violent crises 14
- Use of involuntary commitments

ACT removal also causes:

- Loss of federal Medicaid match dollars
- Increased general fund expenditures
- ADA and Olmstead liability for failure to provide “most integrated setting” care

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13.2 High Acuity Residential Treatment (HART)

1. HART Homes are Idaho’s only subacute psychiatric residential program for individuals too unstable for standard residential care but not requiring hospitalization. The program relies on a bundled clinical structure including:
   Clinical Services Rate – $171.49/day
   a. Funded crisis stabilization, daily in-milieu interventions, medication oversight, and psychiatric supervision.
2. Residential Rate – ~$65/day
   a. Room, board, and basic staffing.
3. ADL / Medical Needs Rate – $130–$145/day
   a. Health-related supports, not psychiatric care.

Eliminating the $171.49/day clinical rate and requiring providers to “fill the gap” with outpatient codes destroys the HART model.

Why Unbundling Breaks HART

HART fidelity requires:

- 24/7 clinical oversight
- On-site crisis stabilization
- High staffing ratios
- Continuous behavioral monitoring
- Environmental management and safety protocols

Outpatient codes cannot fund:

- Overnight supervision
- In-milieu behavioral shaping
- Multiple daily interventions
- On-call clinical availability
- Team-based stabilization

Under SAMHSA definitions, a fee-for-service model cannot meet HART criteria and becomes a standard residential facility without psychiatric stabilization capacity.

System Impact of HART Collapse

Loss of HART produces:

- Significant increases in psychiatric hospitalizations
- Higher ER utilization
- Greater law enforcement contact and jail admissions
- Homelessness escalation for individuals unable to maintain housing stability
- Loss of federal match dollars
- Increased Medicaid, state, and uncompensated-care expenditures

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13.3 Early Serious Mental Illness / Coordinated Specialty Care (ESMI/CSC)

ESMI/CSC is Idaho’s only evidence-based early psychosis intervention. First-episode psychosis is a high-cost, high-risk condition where timely coordinated care dramatically improves long-term outcomes 3,14,19.

CSC programs reduce:

- Hospitalization by 30–60%
- Suicide attempts and completions 14
- Chronic disability and long-term schizophrenia-spectrum costs 19
- Justice-system involvement
- Homelessness

Why ESMI/CSC Requires a Bundled Team Model

Federal CSC fidelity requires:

- A full multi-disciplinary team
- Supported Employment/Education (SEE)
- CBT for psychosis
- Family psychoeducation
- Rapid medication management
- Frequent community-based contact
- Weekly team meetings

Outpatient billing collapses these functions by:

- Eliminating SEE (not billable)
- Eliminating coordinated team reviews
- Moving from integrated care to fragmented encounters
- Restricting frequency to code-based caps
- Removing preventive monitoring that avoids hospitalization and suicide

Once unbundled, the program is no longer CSC under SAMHSA criteria.

System Impact of ESMI Collapse

Without ESMI:

- Hospitalization and suicide risk sharply increase
- Educational and employment trajectories collapse
- Lifetime disability costs rise significantly
- Homelessness and justice involvement increase
- Federal match dollars are lost
- ADA/Olmstead compliance risk increases for young adults with FEP

13.4 Combined System Impact Across ACT, HART, and ESMI/CSC

Eliminating Idaho's three evidence-based SPMI programs and replacing them with unbundled outpatient billing codes results in:

1. Explosion in Hospital and ER Utilization
    a. All programs prevent hospitalization; unbundling reverses these gains. 1,12,30
2. Increased Homelessness
    a. These programs stabilize the individuals most likely to lose housing.
3. Higher Criminal Justice Costs
    a. Police callouts, jail days, court involvement, competency proceedings, and conservatorships increase significantly. 22
4. Loss of Federal Medicaid Match Dollars
    a. The majority of ACT and ESMI clinical funding is federal money flowing into Idaho. 71,76–78,80–82
5. Disability and Workforce Impacts
    a. Loss of ESMI increases long-term disability, SSI/SSDI enrollment, and lost workforce participation. 3,14,19,76–79
6. Major Legal Exposure Under ADA and Olmstead
    a. Idaho would no longer offer an evidence-based "most integrated setting" for:
        i. High-acuity adults (ACT)
        ii. Subacute residential stabilization (HART)
        iii. Early psychosis (ESMI)
7. Increased Uncompensated Care and Hospital Burden
    a. Hospitals absorb a significant portion of costs when intensive community programs are removed.
8. Greater Risk of High-Cost Sentinel Events
    a. Without early intervention—especially ACT and ESMI—rates of violent crises, public-safety incidents, and mass casualty events rise. Literature shows untreated SPMI populations are associated with significantly higher rates of violent deterioration and police-involved crises. 14,22

APPENDIX 14 — Appropriateness of Legacy Mental Health Services for High-Acuity SPMI Populations

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14.1 Purpose and Scope

This appendix evaluates whether Idaho's remaining legacy mental-health service types—specifically Psychosocial Rehabilitation / Community-Based Rehabilitation Services (PSR/CBRS), standard (brokered) case management, office-based counseling/psychotherapy, and combinations of these services—constitute evidence-based practices (EBPs) for the highest-acuity Serious and Persistent Mental Illness (SPMI) population currently served by ACT/HART/ESMI programs.

This section synthesizes national guidelines, systematic reviews, and authoritative evidence to determine whether these service models meet the intensity, team-based structure, outreach requirements, and fidelity standards necessary to be considered appropriate substitutes for ACT-level care.

14.2 Defining the High-Acuity SPMI Population

High-acuity SPMI refers to individuals who:

- Have **severe, persistent psychotic disorders** (schizophrenia, schizoaffective disorder, bipolar disorder with psychosis).
- Experience **frequent psychiatric hospitalizations**, crisis episodes, or involuntary holds.
- Exhibit **poor engagement** with traditional clinic-based, appointment-driven services.
- Are at high risk of **homelessness, incarceration, or dangerous deterioration** without intensive community support.

The SAMHSA ACT Evidence-Based Practices (EBP) KIT specifies that ACT is designed for *"people with the most serious mental illnesses who do not benefit from traditional clinic-based services" and who require multidisciplinary, outreach-based, 24/7 care.* [80]

Similarly, the Schizophrenia PORT recommendations and NICE guidelines identify a distinct "high-need" or "complex psychosis" group requiring specialized community teams—not standard outpatient services. [81] [83] [84]

14.3 Psychosocial Rehabilitation / CBRS

14.3.1 Description

Psychosocial Rehabilitation (PSR) and CBRS emphasize skills training, social functioning, role recovery, independent living skills, and community participation. These services are delivered through structured sessions—group programs, day treatment, or scheduled community visits—and presuppose a baseline level of engagement and stability.

These services are not crisis-oriented and do not include medication management, outreach, or 24/7 responsibility.

14.3.2 Evidence Base and Limitations

Research shows PSR can improve functioning, social skills, and rehabilitation outcomes among engaged, moderately stable SMI individuals. [85]
However, systematic reviews emphasize that PSR populations typically consist of participants stable enough to attend regular sessions, not those with frequent hospitalizations or treatment avoidance. [86]

The international mental-health rehabilitation literature notes that evidence for PSR is heterogeneous, and its efficacy for the highest-acuity SPMI population has not been established. [86]

14.3.3 Appropriateness for High-Acuity SPMI

PSR/CBRS is **not equivalent** to ACT or other intensive team models. It lacks:

- Assertive **outreach**
- **Low staff-to-client ratios**
- **24/7 crisis availability**
- **Integrated medication management**
- A **multidisciplinary team** structure

Therefore, PSR/CBRS services cannot meet the needs of individuals who decompensate rapidly, refuse or forget to attend office appointments, or require medically supervised stabilization.

14.3.4 Summary Conclusion

PSR/CBRS is a useful rehabilitation service for lower-acuity, treatment-engaged clients, but it is **not an evidence-based substitute** for intensive community-treatment models in the high-acuity SPMI population.

14.4 Standard/Brokered Case Management

14.4.1 Description

Standard case management (also called brokered case management) assigns a case manager with a large caseload (often 1:40–1:80) who assists with housing, benefits, referrals, and monitoring. These services are not multidisciplinary, not outreach-based, and not responsible for crisis response or medication delivery.

14.4.2 Evidence on Intensity and Outcomes

The Schizophrenia PORT guidelines identify ACT / intensive case management (ICM) as the evidence-based model for individuals with high service use or risk of homelessness or incarceration—not standard case management. [81]

Cochrane reviews show that ICM (low caseload, outreach, team-based) reduces hospitalization and treatment disengagement, while standard case management does not show the same benefit for high-need individuals. [87]

Comparative studies demonstrate that ACT delivers significantly better continuity of care and integrated treatment compared to standard case management. [88]

14.4.3 Appropriateness for High-Acuity SPMI

Standard case management lacks:

- **24/7 responsibility**
- **Shared caseloads**
- **Integrated psychiatric/nursing care**
- **High-frequency contact requirements**
- **Assertive outreach**

Because of these deficits, standard case management does not meet EBP criteria for ACT-level SPMI clients and is not indicated as a primary treatment model for them.

14.4.4 Summary Conclusion

Standard case management is appropriate for lower or mid-acuity clients but is **not evidence-based** for the highest-acuity SPMI population.

14.5 Office-Based Counseling/Psychotherapy

14.5.1 Description

Office-based counseling (e.g., CBT, supportive therapy, family therapy) is delivered in scheduled clinic appointments, typically weekly or biweekly. These services require client attendance, continuity, and the ability to engage in structured dialogue.

14.5.2 Evidence and Guidelines

The NICE CG178 Guidelines endorse CBT for psychosis and related therapies for schizophrenia—but specifically within **multidisciplinary community teams**. [84]

Similarly, the NICE guideline for complex psychosis recommends care delivered through **specialist community rehabilitation teams**, not stand-alone therapy. [83]

14.5.3 Appropriateness for High-Acuity SPMI

Office-based therapy:

- Requires the client to **attend appointments**
- Does **not** include outreach
- Does **not** include medication management
- Provides **no crisis response**
- Does **not** operate 24/7

High-acuity clients—by definition—fail consistently in appointment-based care and require assertive, team-based engagement. Counseling is an adjunct, not a substitute, for ACT-level care.

14.5.4 Summary Conclusion

Office-based counseling is **valuable as a component** of comprehensive care but is **not appropriate** as the primary service for high-acuity SPMI populations.

14.6 Evidence-Based Intensive Team Models (for Contrast)

Evidence-based practices for the **highest-acuity SPMI** population include:

- **ACT (Assertive Community Treatment)**
- **ICM (Intensive Case Management)**
- **FACT (Flexible ACT)**
- **Forensic ACT in justice-involved populations**

These models share foundational features:

- **Low caseloads**
- **Shared team responsibility**
- **24/7 crisis availability**
- **Integrated medication, therapy, and rehabilitation**
- **Assertive outreach to the client's environment**

Studies consistently show these models reduce hospital days, incarceration, homelessness, and treatment disengagement—outcomes *not* achieved by legacy service models. [80] [81] [87] [91] [92]

14.7 Combined Legacy Service Packages (CM + PSR/CBRS + Counseling)

14.7.1 Description

In many systems, the default "usual services" consist of a **mix** of:

- Standard case management
- Clinic-based counseling
- PSR/CBRS rehabilitation sessions

These bundles are often proposed as substitutes for ACT/HART-level services during unbundling efforts.

14.7.2 Evidence on "Usual Care" Combinations

The PORT studies describe these mixed combinations as non-evidence-based **usual care**, noting that few clients receiving such combinations ever receive ACT, supported employment, or family psychoeducation—the recognized EBPs. [81]

Implementation science literature emphasizes that stacking multiple non-EBP services does **not** create an EBP; only fidelity-based models (e.g., ACT, SE, IMR) produce consistent outcomes. [82]

Cochrane and meta-analytic evidence confirm that service intensity, outreach, and team structure—not the number of separate services—determine outcomes for people with SMI. [87] [89] [90]

14.7.3 Do Combined Legacy Packages Meet EBP Standards?

No major guideline or research study equates standard case management + counseling + PSR/CBRS bundles with ACT-level intensive services. Instead, these bundles represent the **comparison condition** ("usual care") in virtually every ACT trial—and ACT **outperforms** such combinations on all major outcomes, including:

- Hospitalization
- Engagement
- Homelessness
- Criminal-justice involvement

14.7.4 Summary Conclusion

Combining legacy outpatient services does not create a fidelity-based model. For the highest-acuity SPMI population, these combined packages remain **non-EBP usual care** and consistently yield worse outcomes than defined intensive team models.

APPENDIX 15 — DOJ Requirements for ADA/Olmstead-Compliant Services for Adults With Serious & Persistent Mental Illness (SPMI)

The U.S. Department of Justice (DOJ) enforces the Americans with Disabilities Act (ADA) and *Olmstead v. L.C.* by requiring states to provide **sufficient community-based services** for adults with Serious and Persistent Mental Illness (SPMI). These services must prevent unnecessary:

- Hospitalization,
- ER boarding,
- Incarceration,
- Institutional placement,
- Homelessness, and
- Long-term segregation.

DOJ has issued findings letters, guidance documents, and settlement agreements with more than a dozen states. Across all cases, DOJ requires a standard, predictable array of high-acuity community services that collectively ensure people with SPMI can live in the "most integrated setting appropriate" [32–38].

Idaho's ACT, Peer Support, ESMI/CSC, mobile crisis, IOP/PHP, and especially HART align directly with these requirements.

Below is the complete DOJ service array, rewritten to clearly show:

1. **What the DOJ requires**,
2. **Why these services are required**, and
3. **How Idaho's HART program fulfills these requirements** even though DOJ uses different terminology.

15.1 High-Acuity Community Stabilization (Core DOJ Requirement)

1. Assertive Community Treatment (ACT)

DOJ identifies ACT as the **primary community-based alternative** to hospitalization and incarceration for adults with SPMI. Required elements include:

- Multidisciplinary team: psychiatry, nursing, therapy, peer support
- 24/7 crisis response
- In-home / in-community treatment
- High-frequency contact (3–7+ contacts/week)

- Medication outreach
- Rapid relapse detection
- SHARED caseloads

ACT reduces hospitalization, ER use, homelessness, and jail days [1–12], making it foundational in DOJ enforcement [32–35].

(Idaho currently eliminates ACT by unbundling 100% of its required team functions.)

15.2 Community-Based Residential Stabilization (Where HART Fits)

2. Subacute Residential Treatment / Crisis Residential / Transitional Residential Programs

DOJ does **not** use Idaho's program name "HART," but it repeatedly requires the **functional equivalent** of HART in nearly every settlement.

DOJ-required features for residential stabilization programs include:

- 24/7 onsite staffing
- Psychiatric oversight
- Daily therapeutic structure
- Milieu-based behavioral interventions
- Medication management and monitoring
- Crisis de-escalation capacity
- Safety checks and environmental controls
- Discharge planning into ACT or supported housing
- Non-institutional, community-integrated setting

These requirements appear under different names depending on the state:

- "Residential Treatment Services (RTS)" — Georgia
- "Crisis Residential Programs" — New Hampshire
- "Intensive Residential Supports" — Delaware
- "Transitional Residential Treatment (TRT)" — North Carolina
- "Community-Based Residential Alternatives (CBRA)" — Illinois & Washington

How HART meets DOJ criteria

HART is Idaho's only program that:

- Provides **24/7 clinically staffed stabilization**,
- Supports individuals who are too unstable for standard residential care,
- Prevents hospitalization and incarceration [13–17],
- Provides daily behavioral monitoring,

- Offers medication oversight,
- Maintains continuous environmental safety supports,
- And is integrated within the community.

HART is therefore Idaho's **only** DOJ-compliant residential stabilization model.

Eliminating the HART clinical rate removes all required components, converting HART into a non-clinical custodial setting — a model explicitly insufficient under DOJ standards [32–38].

15.3 Crisis Response & ER/Jail Diversion

3. Mobile Crisis Teams (24/7)

DOJ requires in-person mobile crisis teams that respond to psychiatric crises where they occur and divert individuals from ERs and jails [32–38].

4. Crisis Stabilization Units (CSUs) / Crisis Apartments

DOJ expects states to provide short-term, subacute, non-hospital crisis beds with clinical support and 24/7 staffing [32–35].
They function as hospital alternatives.

5. Behavioral Health Urgent Care

DOJ requires states to provide walk-in crisis access that prevents emergency-room boarding.

(Idaho's crisis centers partially meet this requirement but cannot function without ACT, HART, and CSC upstream.)

15.4 Supported Housing & Community Living

6. Scattered-Site Supported Housing

Mandatory in every DOJ settlement.
Supports include:

- ACT or ICM wrapped around housing placement
- Voluntary services
- Tenant-controlled leases

- Rapid access models
- Landlord mediation

Supported housing reduces homelessness, hospitalization, and incarceration [13–17].

7. Housing First

DOJ explicitly rejects "treatment-first" housing when it functions as a barrier to community integration.
Housing First is required for high-risk SMI populations.

8. Bridge Housing / Step-Down Residences

Used to prevent post-discharge homelessness or prolonged institutionalization.

(HART overlaps significantly with DOJ's "bridge housing" expectations, but has higher clinical intensity — making it even more aligned with DOJ needs.)

15.5 Clinical & Rehabilitation Services

9. Intensive Case Management (ICM)

Required where ACT is not appropriate.
ICM must have:

- Smaller caseloads than standard CM,
- Community outreach,
- Relapse monitoring,
- Integration with housing and crisis services [2,4,8,32–35].

10. Integrated Dual-Diagnosis Treatment (IDDT)

Required in ACT/ICM for co-occurring SPMI + SUD [9–12,18–23].

11. Psychiatric Rehabilitation / Skills Training

Evidence shows these services improve functioning and reduce homelessness [5–8,13–17].

12. Peer Support Services

Mandated in multiple DOJ settlements and recommended in ADA guidance.
Peers reduce hospitalization and ER use [18–23].

13. Supported Employment (IPS)

Mandatory in DOJ settlements.
IPS improves recovery and employment for SPMI [24–31].

14. Supported Education

Required for transition-age youth and early psychosis [24–31].

15.6 Early Psychosis Intervention

15. Coordinated Specialty Care (CSC / ESMI)

Where youth are boarded in ERs or admitted to psychiatric hospitals due to first-episode psychosis, DOJ requires CSC programs [24–31,32–35].

CSC includes:

- Psychiatric care,
- CBT for psychosis,
- Family psychoeducation,
- Supported employment & education,
- Rapid medication management,
- Community outreach.

CSC substantially reduces hospitalization and disability progression [24–31].

16. Transition-Age Youth (TAY) Supports

Targeted services for ages 16–25 reduce long-term institutionalization.

15.7 Justice System Diversion & Reentry

17. Jail Diversion (CIT, MH Courts, Pre-Arrest Diversion)

DOJ requires MH courts and diversion programs when SPMI adults are repeatedly jailed due to untreated symptoms [9–12,32–35].

18. Forensic Reentry

Individuals with SPMI must be discharged directly into ACT/ICM/housing supports [9–12].

19. Community-Based Competency Restoration

Required to avoid unnecessary institutional restoration.

15.8 Discharge Planning, Coordination & Oversight

20. Hospital Discharge Planning

Hospitals must discharge individuals into community-based services (ACT, CSC, ICM, HART, supported housing), not ERs or shelters [32–38].

21. Jail/Prison Discharge Planning

Similarly required to prevent homelessness, relapse, and re-incarceration [9–12].

22. Cross-System Coordination

States must coordinate MH, Medicaid, housing, corrections, crisis systems, and hospitals [32–38].

23. Fidelity Monitoring

DOJ requires fidelity monitoring for ACT (TMACT), CSC, supported employment (IPS), and housing models [1–31,13–17,24–31].

24. Public Reporting & Independent Monitoring

All settlements impose multi-year independent monitoring with required reporting of:

- Hospitalizations,
- ER boarding,
- Homelessness,
- Arrests/jail use,
- Housing placements,
- ACT/CSC fidelity [32–38].

15.9 Summary: DOJ-Compatible System Requirements for SPMI

In sum, DOJ expects states to maintain:

- **High-acuity clinical stabilization**: ACT (and FACT), ICM, Peer Support.
- **Crisis and diversion capacity**: mobile crisis, CSUs, urgent behavioral health access.
- **Housing**: scattered-site supported housing, Housing First, short-term bridge options.

- **Rehabilitation and recovery supports**: integrated dual-diagnosis care, psychiatric rehabilitative services, supported employment (IPS), supported education.
- **Early intervention**: CSC/ESMI for first-episode psychosis, TAY supports.
- **Justice diversion & reentry**: MH courts, jail diversion, forensic reentry.
- **System infrastructure**: coordinated discharge planning, fidelity monitoring, and public reporting.

When these services are reduced or eliminated, DOJ has repeatedly found states in violation of ADA/*Olmstead* and required extensive, court-monitored rebuilding [32–38].

Key DOJ / ADA / Olmstead Sources Referenced in This Appendix

- DOJ Statement on the ADA Integration Mandate and Olmstead [32]
- DOJ Olmstead case list and enforcement summaries [33–35]
- Olmstead/ADA analysis from Bazelon and HHS OCR community-integration materials [36–38]
- ACT, CSC, supportive housing, Peer, and PHP/IOP evidence base [1–31,13–17,18–23,45–65]
- Homelessness, justice-system, and child-welfare research tied to SPMI [39–44,66–70]

You can now cite this appendix in your main text as:

"See Appendix 15 (DOJ-Compliant SPMI Service Array) for a complete list of federally required services under ADA/Olmstead enforcement."

CITATION INDEX

Methodology: How to Read This Citation Appendix

This appendix is organized by evidence domain (ACT, HART/supportive housing, Peer Support, ESMI/CSC, ADA/Olmstead, PHP/IOP, Child Welfare, and Evidence-Based Practice Guidelines).

For each citation, you will find:

1. Primary Citation + Summary

The original, authoritative source used in the report (trial, meta-analysis, guideline, or legal document).

2. Crosswalk

A short list of *other citations within Appendix IV* that reinforce the same claim.
Crosswalks show where evidence clusters together — for example, multiple ACT trials validating the same outcome.

3. External Supporting Studies

Two additional high-quality studies (RCTs, meta-analyses, systematic reviews, or federal guidelines) that independently confirm the core claim of the primary citation.
These:

- strengthen evidentiary weight,
- demonstrate consensus across research, and
- provide a DOJ-ready, court-ready evidentiary base.

External studies always include a **title**, **year**, a **direct link**, and a **brief description**.

This structure ensures every conclusion in the white paper is backed by:

- **multiple** internal citations,
- **multiple** external citations,
- all of which have aligned conclusions.

A. ACT EVIDENCE (1–12)

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1. Latimer EA (1999). "The Economic Impact of Assertive Community Treatment."

Shows ACT reduces psychiatric hospital use by 50–80% and produces substantial cost offsets. High-utilizers achieve net savings when ACT reduces inpatient days.
https://pubmed.ncbi.nlm.nih.gov/10389605/

Crosswalk: 6, 8, 81, 82
External supporting studies:
• **Marshall M, Lockwood A, et al. (2011).** "Assertive community treatment for people with severe mental disorders." *Cochrane Review.*
https://doi.org/10.1002/14651858.CD001089.pub2
– Meta-analysis of 38 ACT trials showing large reductions in hospitalization and improved service engagement.
• **Bond GR, Drake RE, Mueser KT, Latimer E. (2001).** "Critical ingredients of ACT."
https://doi.org/10.2165/00115677-200109040-00003
– Identifies core ACT fidelity elements (team-based care, shared caseloads, 24/7 availability) and shows outcomes collapse when fidelity is lost.

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2. Lehman AF et al. (1997). Randomized Trial of ACT With Homeless Adults.

Demonstrates major reductions in hospitalizations, increased engagement, and improved housing stability in ACT recipients.
https://pubmed.ncbi.nlm.nih.gov/9366661/

Crosswalk: 2, 5, 13–15, 81
External supporting studies:
• **Mueser KT et al. (1998).** "RCT of ACT for homeless persons with SMI."
https://doi.org/10.1176/ajp.155.7.996
– ACT significantly improves housing stability and reduces psychiatric symptoms among homeless adults.
• **Tsemberis S et al. (2004).** "Housing First & support vs. treatment-first models."
https://doi.org/10.2105/AJPH.94.4.651
– Demonstrates Housing First + ACT-level support outperforms traditional treatment-first pathways.

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3. Lehman AF et al. (1999). Cost-Effectiveness of ACT for Homeless SMI.

ACT sharply reduces inpatient, ER, and shelter use and is cost-effective relative to standard services.
https://pubmed.ncbi.nlm.nih.gov/10533554/

Crosswalk: 1, 6, 8, 15, 82
External supporting studies:
• **Rosenheck R et al. (2003).** "ACT vs. standard care cost-effectiveness."
– Shows ACT offsets program costs by reducing inpatient and crisis service utilization.
• **McDonel EC et al. (1997).** "ACT vs. case management cost outcomes."
– Demonstrates ACT reduces hospital days and total costs compared to standard case management.

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4. Druss BG et al. (2001). Integrated Medical Care RCT.

ACT-style integrated models cut medical hospitalizations by 43% and reduce total medical costs by 39%.
https://pubmed.ncbi.nlm.nih.gov/11545670/

Crosswalk: 4, 7, 8, 87, 90
External supporting studies:
• **Druss BG et al. (2010).** "Integrated care for SMI: randomized trial."
https://doi.org/10.1192/bjp.bp.109.070316
– Integrated psychiatric + primary care significantly lowers medical hospitalization.
• **Parks J et al. (2006).** "Morbidity & Mortality in SMI."
– Shows excess medical burden among SMI and recommends ACT-style integrated care.

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5. Coldwell & Bender (2007). Meta-analysis of ACT Housing Outcomes.

ACT increases housing stability by 37% and reduces psychiatric symptoms and crises.
https://psychiatryonline.org/doi/10.1176/ajp.2007.164.3.393

Crosswalk: 2, 5, 13–17, 81
External supporting studies:
• **Morse GA et al. (1997).** "Intensity trial: ACT vs. standard CM."
– High-intensity ACT models improve housing and symptom outcomes over standard case management.
• **Lehman AF et al. (multiple ACT trials).**
– Multiple RCTs confirm consistent improvements in housing and stability.

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6. Lehman AF et al. (1999). ACT Cost-Effectiveness (High-Acuity Populations).

Finds ACT reduces hospitalization — the main driver of cost savings — especially for high-utilizers.
https://pubmed.ncbi.nlm.nih.gov/10533554/

Crosswalk: 1, 3, 8, 15, 81, 82
External supporting studies:
• **Bond GR et al. (2001).** "ACT: critical ingredients & outcomes."
– High-fidelity ACT is cost-effective due to hospitalization reductions.
• **Dieterich M et al. (2017).** Cochrane review of ICM/ACT.
https://doi.org/10.1002/14651858.CD007906.pub3
– High-intensity ACT-style models consistently outperform standard CM.

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7. Morse GA et al. (1997). Case Management Intensity Trial.

High-intensity ACT-style interventions reduce hospital days, homelessness, and crisis use.
https://pubmed.ncbi.nlm.nih.gov/9090733/

Crosswalk: 5, 7, 87, 89, 91
External supporting studies:
• **Stein & Test (1980).** Foundational ACT RCT: ACT reduces rehospitalization.
• **Bond GR et al. (2001).** ACT fidelity predicts outcomes; low-intensity models fail.

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8. Latimer EA et al. (2005). Economic Analysis of ACT.

High-fidelity ACT reduces inpatient days, increases community tenure, and produces substantial cost savings.
https://pmc.ncbi.nlm.nih.gov/articles/PMC1197281/

Crosswalk: 1, 3, 6, 8, 82
External supporting studies:
• **Rosenheck R et al. (2003).** Cost offsets of ACT.
• **McCrone P et al. (2009).** Intensive community models reduce costs and inpatient use.

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9. Cusack KJ et al. (2010). Forensic ACT Justice Outcomes.

ACT/FACT reduces jail days by ~50% and re-arrests by ~39%.
https://pubmed.ncbi.nlm.nih.gov/20217230/

Crosswalk: 9, 10, 11, 12, 51, 92
External supporting studies:
• **Lamberti JS et al. (2001).** ACT reduces arrests, jail days.
• **Skeem JL et al. (2011).** Forensic ACT is a best practice for reducing recidivism.

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10. Lamberti JS et al. (2004). ACT & Offending Reduction.

ACT clients show dramatically fewer arrests and jail days compared to standard outpatient care.
https://pubmed.ncbi.nlm.nih.gov/15534018/

Crosswalk: 9, 11, 12, 51, 92
External supporting studies:
• **Hodgins S et al. (2011).** Community treatment reduces offending.
• **Morrissey J et al. (2007).** Intensive supervision + treatment reduces recidivism.

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11. Ventura J et al. (1998). Forensic ACT Outcomes.

ACT participants experience fewer arrests, fewer police contacts, and improved community tenure.
https://pubmed.ncbi.nlm.nih.gov/9589753/

Crosswalk: 9, 10, 12, 51, 92
External supporting studies:
• **Lovell D et al. (2002).** MH court + ACT reduces recidivism.
• **Sirotich F (2009).** Jail diversion + ACT dramatically reduces justice involvement.

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12. R-FACT RCT (2017).

Randomized trial showing a 36% reduction in jail days with forensic ACT teams compared to usual services.
https://pmc.ncbi.nlm.nih.gov/articles/PMC7369621/

Crosswalk: 9, 10, 11, 51, 92
External supporting studies:
• **Lamberti JS et al. (2004).** Early FACT model reducing incarceration.
• **Morgan RD et al. (2012).** Systematic RCT review supporting FACT efficacy.

B. HART / SUPPORTIVE HOUSING EVIDENCE (13–17)

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13. Culhane DP, Metraux S, Hadley T. (2002).

"Public Service Reductions Associated With Placement of Homeless Persons With Severe Mental Illness in Supportive Housing."

Shows that placing high-need homeless adults with SMI into supportive housing significantly reduces shelter, hospital, and jail use, often offsetting nearly all program costs.
https://core.ac.uk/download/pdf/214177080.pdf

Crosswalk (supporting internal citations): 5, 14, 15, 16, 17, 44

External supporting studies:
• **Rog DJ, Marshall T, Dougherty RH, et al. (2014).**
"Permanent Supportive Housing: Assessing the Evidence." *Psychiatric Services.*
https://doi.org/10.1176/appi.ps.201300261
– Reviews multiple PSH programs and finds consistent reductions in homelessness, ER use, and inpatient utilization among SMI.
• **Henwood BF, Cabassa LJ, Craig CM, Padgett DK. (2013).**
"Permanent Supportive Housing: Addressing Homelessness and Health Disparities?" *AJPH.*
https://doi.org/10.2105/AJPH.2013.301490
– Shows PSH improves long-term housing tenure and reduces reliance on crisis and institutional services.

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14. Tsemberis S, Gulcur L, Nakae M. (2004).

"Housing First, Consumer Choice, and Harm Reduction…"
Housing First programs providing immediate housing and wraparound support for SMI + SUD individuals produce higher housing stability and fewer crises than treatment-first models.
https://pmc.ncbi.nlm.nih.gov/articles/PMC1448313/

Crosswalk (supporting internal citations): 5, 13, 15, 16, 17

External supporting studies:
• **Padgett DK, Gulcur L, Tsemberis S. (2006).**
"Housing First Services for People Homeless With SMI and Substance Abuse." *Research on Social Work Practice.*
https://doi.org/10.1177/1049731505282593
– Longitudinal analysis showing Housing First dramatically improves housing retention and reduces psychiatric crises.
• **Gulcur L, Stefancic A, Shinn M, Tsemberis S, Fischer SN. (2003).**
"Housing, Hospitalization, and Cost Outcomes…" *Journal of Community & Applied Social Psychology.*
– Housing First participants had fewer hospital days and lower overall public-service costs than continuum-of-care participants.

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15. Latimer EA, Rabouin D, Cao Z, et al. (2019).

"Cost-Effectiveness of Housing First With ACT: At Home/Chez Soi Trial."
Across five Canadian cities, Housing First + ACT produced major reductions in shelter use, inpatient days, and justice involvement while improving housing stability and quality of life.
https://pmc.ncbi.nlm.nih.gov/articles/PMC6707012/

Crosswalk (supporting internal citations): 13, 14, 16, 17, 44

External supporting studies:
• **Stergiopoulos V, Gozdzik A, et al. (2015).**
"Scattered-Site Housing + ICM: Randomized Trial." *JAMA.*
https://jamanetwork.com/journals/jama/fullarticle/2113335
– Intensive community support + rent supplements increases housing stability and reduces homelessness vs usual services.
• **Ly A, Latimer E. (2015).**
"Housing First Impact on Costs." *Canadian Journal of Psychiatry.*
https://pmc.ncbi.nlm.nih.gov/articles/PMC4679128/
– Systematic review showing HF consistently decreases shelter, ER, and inpatient costs across jurisdictions.

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16. National Low-Income Housing Coalition (NLIHC). (2022).

"The Evidence Is In: Supportive Housing Works."
Comprehensive evidence review showing PSH reduces homelessness 80–90%, improves health outcomes, and decreases use of high-cost public systems.
https://nlihc.org/sites/default/files/Housing-First-Evidence.pdf

Crosswalk (supporting internal citations): 13, 14, 15, 17, 44

External supporting studies:
• **Goering PN, Veldhuizen S, Watson A, et al. (2014).**
"At Home/Chez Soi Final Report."
https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/at_home_report_national_cross-site_eng_2_0.pdf
– The largest HF trial ever conducted; shows strong improvements in housing and major reductions in shelter/hospital usage.
• **Nelson G, Aubry T, Lafrance A. (2007).**
"Review of Housing and Support, ACT, and ICM." *American Journal of Orthopsychiatry.*
– Concludes PSH and ACT/ICM consistently reduce homelessness and increase service stability.

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17. UCSF Curry TB Center.

"Homelessness Is Expensive."
Documents extreme public costs of chronic homelessness — including ~$14,480/year in average jail & law-enforcement spending — and demonstrates cost savings when housing is provided.
https://www.currytbcenter.ucsf.edu/sites/default/files/product_tools/homelessnessandtbtoolkit/docs/background/Factsheet/Homelessness%20is%20Expensive.pdf

Crosswalk (supporting internal citations): 13, 14, 15, 16, 44

External supporting studies:
• **Larimer ME, Malone DK, Garner MD, et al. (2009).**
"Housing for Chronically Homeless With Alcohol Problems." *JAMA.*
https://doi.org/10.1001/jama.2009.414
– Housing First reduced total public cost by 53% in six months, including steep reductions in jail and hospital costs.
• **Hwang SW. (2001).**
"Homelessness and Health." *CMAJ.*
https://pmc.ncbi.nlm.nih.gov/articles/PMC80688/
– Reviews high medical and crisis-service utilization among unhoused individuals, reinforcing the necessity of supportive housing.

C. PEER SUPPORT EVIDENCE (18–23)

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18. Mental Health America (2019). "Evidence for Peer Support."

Comprehensive synthesis of the peer-support literature showing improvements in hope, empowerment, engagement, treatment adherence, and reductions in hospital use for people with SMI.
https://mhanational.org/wp-content/uploads/2025/02/Evidence-Peer-Support-May-2019.pdf

Crosswalk: 19, 20, 21, 22, 23
External supporting studies:
• **Repper J, Carter T. (2011).** "A Review of the Literature on Peer Support in Mental Health Services." *Journal of Mental Health.*
https://doi.org/10.3109/09638237.2011.583947
– Reviews 30+ studies showing peer support improves hope, social connection, community functioning, and reduces inpatient service use.
• **Fuhr DC, Salisbury TT, De Silva MJ, et al. (2014).** "Effectiveness of Peer-Delivered

Interventions…" *Social Psychiatry & Psychiatric Epidemiology.*
https://doi.org/10.1007/s00127-014-0857-5
– Meta-analysis demonstrating significant improvements in empowerment, symptoms, and functioning with trained peer providers.

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19. SAMHSA (2024). "Supporting and Financing Peer Support Services."

Federal designation of peer support as an evidence-based practice. Provides guidance on training, supervision, financing, fidelity, and integration into mental-health systems.
https://library.samhsa.gov/sites/default/files/supporting-financing-peer-services-pep24-02-012.pdf

Crosswalk: 18, 20, 21, 22, 23
External supporting studies:
• **Lloyd-Evans B, Mayo-Wilson E, Harrison B, et al. (2014).** "Systematic Review and Meta-Analysis of Peer Support RCTs." *BMC Psychiatry.*
https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-39
– Peer support added to usual care improves hope, empowerment, and reduces readmissions.
• **Davidson L, Chinman M, Sells D, Rowe M. (2006).** "Peer Support Among Adults With SMI." *Schizophrenia Bulletin.*
https://doi.org/10.1093/schbul/sbl042
– Identifies mechanisms (shared experience, role modeling) through which peer support improves engagement and functioning.

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20. North Carolina Office of State Budget & Management (2020). "Peer Support ROI Study."

Economic evaluation showing peer-support services generate a $1.19 return per $1 invested through avoided crisis, inpatient, and high-utilization services.
https://www.osbm.nc.gov/peer-support-services-rf-summary/download?attachment=

Crosswalk: 18, 19, 21
External supporting studies:
• **Chinman M, George P, Dougherty RH, et al. (2014).** "Peer Support for SMI & SUD: Systematic Review." *Psychiatric Services.*
https://doi.org/10.1176/appi.ps.201400047
– Peer support reduces inpatient use and improves self-management among clients with co-occurring SMI/SUD.
• **van Ginneken N, Tharyan P, Lewin S, et al. (2013).** Cochrane Review of nonspecialist/peer providers.

https://doi.org/10.1002/14651858.CD009149.pub2
– Shows trained peer and nonspecialist providers can deliver mental-health interventions with proven symptom and functioning improvement.

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21. RI International (2022). "Programs and Outcomes: Peer-Run & Crisis Services."

Shows peer-run crisis and recovery programs reduce psychiatric readmissions by 56% and improve engagement post-discharge.
https://riinternational.com/wp-content/uploads/2022/09/RIA-Programs-and-Outcomes.pdf

Crosswalk: 18, 19, 20, 22, 23
External supporting studies:
• **Walker G, Bryant W. (2013).** "Peer Support in Adult Mental Health Services: Metasynthesis." *Psychiatric Rehabilitation Journal.*
https://doi.org/10.1037/prj0000019
– Shows peer support improves trust, collaboration, and recovery orientation, reducing isolation.
• **Solomon P. (2004).** "Peer Support/Peer Provided Services." *Psychiatric Rehabilitation Journal.*
https://psycnet.apa.org/doi/10.2975/28.2004.392.401
– Explains how peer support reduces crisis escalation by providing early engagement and relational stabilization.

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22. Kelly EL, Fenwick K, Barr N, et al. (2021).

"Systematic Review of Peer Support for People With Serious Mental Illness."
Concludes peer-support programs improve hope, empowerment, engagement, and quality of life; identifies factors that increase effectiveness (supervision, training).
https://pubmed.ncbi.nlm.nih.gov/33887952/

Crosswalk: 18, 19, 20, 21, 23
External supporting studies:
• **Bellamy C, Schmutte T, Davidson L. (2017).** "Growing Evidence Base for Peer Support."
https://doi.org/10.1108/MHSI-03-2017-0014
– Peer support improves satisfaction, reduces rehospitalization, and enhances engagement.
• **Perry Y, Petrie K, Buckley H, et al. (2020).** "Peer Worker-Led Interventions: Meta-Analysis." *Psychiatric Services.*
– Peer-led interventions improve symptoms and service satisfaction, particularly within integrated teams.

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23. Cooper RE, et al. (2024). "Peer Support for People With Serious Mental Illness: Umbrella Review."

Synthesizes dozens of systematic reviews covering thousands of participants. Finds peer support improves recovery outcomes, reduces inpatient episodes, and is highly acceptable to service users.
https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-024-03260-y

Crosswalk: 18, 19, 20, 21, 22
External supporting studies:
• **Bouchard L, Montreuil M, Gros C, et al. (2010).** "Peer Support Among Persons With Severe Mental Illness." *Canadian J. Community Mental Health.*
– Peer support increases social functioning, decreases isolation, improves recovery markers.
• **Gagne C, Finch WL, Myrick K, Davis LM. (2018).** "Peer Workers in Behavioral-Health Workforce." *Psychiatric Annals.*
https://doi.org/10.3928/00485713-20180305-04
– Shows peer workers improve engagement and continuity and reduce reliance on formal crisis services.

D. ESMI / EARLY PSYCHOSIS EVIDENCE (24–31)

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24. SAMHSA (2023). "Costs and Outcomes of Coordinated Specialty Care for Early Psychosis" (PEP23-01-00-003).

Describes Coordinated Specialty Care (CSC) for first-episode psychosis (FEP). Summarizes extensive evidence that CSC reduces hospitalizations, improves functioning, increases school/work participation, and is cost-effective relative to usual care.
https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf

Crosswalk: 25, 26, 27, 28, 29, 30, 31, 76, 77, 78, 79

External supporting studies:
• **Kane JM, Robinson DG, Schooler NR, et al. (2016).**
"Comprehensive Versus Usual Community Care: 2-Year Outcomes of NAVIGATE." *American Journal of Psychiatry.*
https://pubmed.ncbi.nlm.nih.gov/26481174/
– RCT showing CSC produces significantly better quality of life, lower symptoms, and better work/school outcomes than usual care.

• **Correll CU, Galling B, Pawar A, et al. (2018).**
"Early Intervention vs Treatment As Usual: Meta-analysis." *JAMA Psychiatry.*
https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2679758
– Demonstrates that CSC and early-intervention models significantly reduce relapse, hospitalization, and symptom severity.

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25. Breitborde NJK, Moreno FA, Mai-Dixon V, et al. (2015). "EPICENTER Trial."

Shows $17,101 in cost savings per FEP client in six months due to reduced inpatient and justice involvement. Highlights rapid benefits of early high-intensity treatment.
https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-015-0650-3

Crosswalk: 24, 26, 27, 28, 29, 30, 31, 76, 77

External supporting studies:
• **Birnbaum ML, Sharif-Razi M, Frazier R, et al. (2018).**
"Implementation and Utilization of Early Psychosis Specialty Care in the U.S." *Psychiatric Services.*
https://doi.org/10.1176/appi.ps.201700581
– Demonstrates improved outcomes, reduced crises, and better engagement when CSC programs are implemented with fidelity.
• **Chang WC, Chan GH, Jim OT, et al. (2015).**
"Optimal Duration of Early Intervention for Psychosis: RCT." *British Journal of Psychiatry.*
https://doi.org/10.1192/bjp.bp.114.150144
– Shows extended early-intervention programs provide superior long-term functioning and relapse prevention.

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26. Murphy SM, McGinty EE, Tong L, et al. (2016). "Cost-Effectiveness of CSC: RAISE-ETP Trial."

Economic evaluation of the NAVIGATE CSC model. Finds CSC achieves favorable cost per QALY due to reductions in inpatient care and improved functional outcomes.
https://pmc.ncbi.nlm.nih.gov/articles/PMC6314808/

Crosswalk: 24, 25, 27, 28, 29, 30, 31, 76, 79

External supporting studies:
• **Puntis S, Ruggeri M, et al. (2018).**
"The Cost-Effectiveness of Early Intervention: Systematic Review." *Epidemiology & Psychiatric Sciences.*
https://doi.org/10.1017/S2045796018000061

– Finds early-intervention services consistently cost-effective across multiple countries and models.

• **Alonso-Sánchez EB, García-Portilla MP, Bobes J, et al. (2020).**
"Cost-Effectiveness of Early Intervention in Psychosis: Systematic Review." *Early Intervention in Psychiatry.*
– Shows early intervention often reduces total long-term system costs.

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27. Rosenheck RA, Leslie DL, Sint K, et al. (2016). "Cost-Effectiveness of Integrated Care in RAISE Early Treatment Program."

CSC (NAVIGATE) improves functioning and quality of life at acceptable additional cost, with many expenses offset by reduced inpatient use.
https://cdr.lib.unc.edu/concern/articles/gf06g806x

Crosswalk: 24, 25, 26, 28, 29, 30, 31, 79

External supporting studies:
• **van der Gaag M, Smit F, Bechdolf A, et al. (2013).**
"Preventing First-Episode Psychosis: Meta-analysis." *Schizophrenia Research.*
https://doi.org/10.1016/j.schres.2013.08.013
– Early intensive interventions reduce risk of transition to psychosis in high-risk youth.
• **Nordentoft M, Rasmussen JO, Melau M, et al. (2014).**
"How Successful Are First-Episode Programs?" *Current Opinion in Psychiatry.*
https://doi.org/10.1097/YCO.0000000000000061
– Reviews global evidence showing CSC reduces relapse and improves recovery far more than usual care.

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28. Humensky JL, Olfson M, Koyanagi C, et al. (2021). "Medicaid-Financed Care for Youth With Early Psychosis."

Claims and utilization study showing Medicaid youth with early psychosis heavily rely on ER/inpatient services due to inadequate CSC access—demonstrating unmet need and cost inefficiency.
https://pmc.ncbi.nlm.nih.gov/articles/PMC8570971/

Crosswalk: 24, 25, 26, 27, 29, 30, 31, 76, 77

External supporting studies:
• **Schiffman J, et al. (2015).**
"Early Intervention for Psychosis in the U.S.: From Science to Policy." *Psychiatric Services.*
https://doi.org/10.1176/appi.ps.201400313

– Explains policy gaps that prevent CSC adoption and the resulting high crisis-service costs.
• **Addington DE, et al. (2013).**
"International Guidelines for Early Psychosis." *Early Intervention in Psychiatry.*
https://doi.org/10.1111/eip.12048
– Establishes CSC as global best practice requiring multidisciplinary delivery, frequent contact, and family involvement.

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29. Washington Health Care Authority (2020). "CSC Outcomes and Costs."

Statewide CSC evaluation showing reduced inpatient stays, fewer ED visits, improved functioning, and significant cost savings per client.
https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCA+Report+-+Coordinated+Specialty+Care+for+First+Episode+Psychosis_71be4d6c-a572-469c-8a10-c5acc37e774a.pdf

Crosswalk: 24, 26, 28, 30, 31, 79

External supporting studies:
• **Calvo A, Moreno M, Ruiz-Sancho A, et al. (2014).**
"Psychosocial Interventions for FEP: Systematic Review."
– Shows integrated, team-based FEP services improve adherence, functioning, and reduce relapse.
• **Garety PA, Craig TK, Dunn G, et al. (2006).**
"Specialist Early Intervention (SEI) RCT." *British Journal of Psychiatry.*
https://doi.org/10.1192/bjp.bp.105.019505
– Demonstrates SEI significantly improves outcomes vs. usual outpatient care.

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30. Aceituno D, Vera N, Prina AM, et al. (2019). "Cost-Effectiveness of Early Intervention Versus TAU."

Systematic review concluding early-intervention programs (CSC, EIP) are cost-effective compared with usual care due to reduced relapse and inpatient use.
https://pubmed.ncbi.nlm.nih.gov/30696495/

Crosswalk: 24, 25, 26, 27, 28, 29, 31, 79

External supporting studies:
• **Alvarez-Jimenez M, Parker AG, Hetrick SE, et al. (2016).**
"Preventing the Second Episode…" *Schizophrenia Research.*
https://doi.org/10.1016/j.schres.2016.02.020
– Structured interventions after FEP significantly reduce relapse risk and improve long-term

outcomes.
• **Bird V, Le Boutillier C, Leamy M, et al. (2010).**
"Early Intervention Services & CBT/Family Work." *Psychiatric Services.*
https://doi.org/10.1176/ps.2010.61.11.1162
– Early intervention programs integrating family work and CBT outperform outpatient TAU.

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31. Sediqzadah S, et al. (2022). "Long-Term Cost-Effectiveness of Early Intervention."

Modeling study showing CSC/EIP produce long-term savings by reducing hospitalization, disability, unemployment, and justice interactions over the lifespan.
https://pubmed.ncbi.nlm.nih.gov/35193372/

Crosswalk: 24, 26, 27, 29, 30, 76, 79

External supporting studies:
• **Hsiao CJ, et al. (2020).**
"Long-Term Outcomes of Early Intervention: Meta-analysis." *Psychological Medicine.*
– Shows sustained reductions in relapse and improved long-term functioning after CSC.
• **McCrone P, et al.**
"Economic Impact of Early Intervention." *World Psychiatry.*
– Confirms early-intervention programs reduce lifetime system costs (hospital, disability, unemployment).

E. ADA / OLMSTEAD / LEGAL SOURCES (32–38)

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32. U.S. Department of Justice (2011). "Statement on ADA Integration Mandate."

Defines the ADA Title II "most integrated setting" requirement and clarifies that states violate the ADA when they:
• unnecessarily institutionalize people with disabilities,
• fail to provide adequate community-based services, or
• implement policies that *foreseeably* push people into hospitals, jails, or other segregated settings.
https://www.ada.gov/resources/olmstead-mandate-statement/

Crosswalk: 33, 34, 35, 36, 37, 38, 41, 43, 71–75

External supporting studies:
• **U.S. DOJ Civil Rights Division (2011–2025).**

"Updated Guidance on ADA & Olmstead."
https://www.ada.gov/resources/olmstead-mandate-statement/
– Reinforces that eliminating community services (e.g., ACT, CSC, crisis teams) can violate the ADA because it creates foreseeable institutionalization.
• **Olmstead v. L.C. (1999), 527 U.S. 581 (U.S. Supreme Court).**
https://www.law.cornell.edu/supct/html/98-536.ZO.html
– The foundational ADA integration ruling: states must provide services in the *most integrated setting appropriate*, and unjustified institutionalization = discrimination.

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33. U.S. DOJ. "Olmstead Case List."

Catalog of federal enforcement actions in which states were required to expand ACT, supported housing, crisis services, and other community programs to comply with ADA/Olmstead.
https://archive.ada.gov/olmstead/olmstead_cases_list2.htm

Crosswalk: 32, 34, 35, 36, 37, 38, 41, 71–75

External supporting studies:
• **American Bar Association (2025).**
"The Olmstead Decision at 25: Federal Enforcement of Integration Mandate."
https://www.americanbar.org/groups/crsj/resources/human-rights/2025-july/olmstead-decision-federal-integration-mandate-people-disabilities/
– Summarizes 25 years of DOJ cases requiring states to expand ACT, mobile crisis, and supported housing to meet integration standards.
• **District of Columbia Office of Disability Rights (2014).**
"Olmstead Community Integration Initiative."
https://odr.dc.gov/sites/default/files/dc/sites/odr/publication/attachments/olmstead_community_integration_initiative.pdf
– Example of a state-level implementation plan expanding community services to avoid ADA violations.

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34. United States v. Georgia (2010) — DOJ Settlement Agreement.

DOJ found Georgia violated ADA/Olmstead by overrelying on institutional care. Settlement required expansion of ACT, supported housing, mobile crisis, peer support, and community-based stabilization.
https://www.justice.gov/opa/pr/justice-department-obtains-comprehensive-agreement-regarding-state-georgia-s-mental-health

Crosswalk: 32, 33, 35, 36, 37, 38, 41, 71–75

External supporting studies:
• **U.S. DOJ (2010).**
"Agreement Regarding the State of Georgia's Mental Health System."
https://www.justice.gov/opa/pr/justice-department-obtains-comprehensive-agreement-regarding-state-georgia-s-mental-health
– Details required system redesign: ACT expansion, 24/7 crisis, mobile teams, supported housing, supported employment.
• **DOJ Civil Rights Division (2023). Annual enforcement report excerpt.**
https://www.justice.gov/criminal/criminal-fraud/file/1333881/dl
– Notes measurable reductions in hospital use & institutional reliance after Georgia expanded ACT & housing per the settlement.

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35. United States v. Delaware (2011) — DOJ Settlement Agreement.

Delaware was found in violation of ADA/Olmstead due to unnecessary institutionalization and insufficient community services. The settlement required ACT, mobile crisis, peer support, supportive housing, and crisis centers.
https://www.justice.gov/opa/pr/justice-department-obtains-comprehensive-agreement-regarding-state-delawares-mental-health

Crosswalk: 32, 33, 34, 36, 37, 38, 71–75

External supporting studies:
• **DOJ (2011). "Letter of Findings: Investigation of Delaware's Mental Health System."**
– Found that lack of ACT, crisis teams, and supported housing caused predictable institutionalization.
• **Disability Rights Delaware (2015).**
"Implementing the Delaware Mental Health Settlement."
– Confirms expansion of ACT, peer support, mobile crisis, and community housing as required remedies.

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36. Amanda D. v. Hassan (2014) — U.S. v. New Hampshire Settlement.

DOJ determined NH violated ADA by overrelying on ER boarding, inpatient units, and failing to provide ACT, mobile crisis, and community alternatives.
https://www.justice.gov/sites/default/files/crt/legacy/2014/02/19/nh-ada_agreement_2-12-14.pdf

Crosswalk: 32, 33, 34, 35, 37, 38, 41, 71–75

External supporting studies:
• **United States v. New Hampshire (2014). Settlement Agreement.**

– Required ACT expansion, crisis apartments, mobile crisis teams, and supported housing.
• **Disability Rights Center — NH (2018).**
"Progress & Challenges Under NH Mental Health Settlement."
– Summarizes system reforms, including widespread ACT & crisis services expansion.

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37. Bazelon Center for Mental Health Law (2019). "ADA at 35: The Right to Community Integration."

Summarizes integration-mandate requirements and identifies ACT, mobile crisis, supported employment, supported housing, and peer support as necessary to comply with ADA/Olmstead.
https://www.bazelon.org/the-ada-at-35-the-right-to-community-integration/

Crosswalk: 32, 33, 34, 35, 36, 38, 71–75

External supporting studies:
• **Miller E & Flanders J. (2019).**
"Implementing the Integration Mandate: Lessons from Olmstead Enforcement."
– Analyzes federal cases requiring community-service expansion (ACT, crisis, housing) to avoid ADA violations.
• **Center on Budget and Policy Priorities (2024).**
"Medicaid Is Key to Implementing Olmstead."
https://www.cbpp.org/blog/medicaid-is-key-to-implementing-olmsteads-community-integration-requirements-for-people-with
– Shows Medicaid-funded ACT/housing services are essential to meet federal integration requirements.

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38. U.S. HHS Office for Civil Rights — "Community Living & Olmstead."

Describes federal requirements for community-based mental-health systems, including ACT, supported housing, mobile crisis, and peer services, to prevent unnecessary institutionalization.
https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html

Crosswalk: 32, 33, 34, 35, 36, 37, 71–75

External supporting studies:
• **SAMHSA (2024).** "Olmstead Resources: Community Integration for People With SMI."
https://www.samhsa.gov/about/laws-regulations/olmstead
– Provides explicit guidance on designing community systems (ACT, CSC, crisis care) to comply with ADA.
• **McDonough J. (2021).**

"Prison Reform and Olmstead." *The Regulatory Review.*
https://www.theregreview.org/2021/04/13/mcdonough-prison-reform-and-olmstead/
– Shows Olmstead applies to individuals with SMI in correctional settings, requiring community alternatives such as ACT and crisis teams.

F. IDAHO-SPECIFIC LEGAL & COST SOURCES (39–44)

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39. Idaho Code §20-237A — Jail Per-Diem Reimbursement

Shows that Idaho's state jail reimbursement rate is far below the actual per-day cost of incarceration in county jails, creating predictable unfunded cost-shifts when behavioral-health crises spill into jails.
https://law.justia.com/codes/idaho/2024/title-20/chapter-2/section-20-237a/

Crosswalk: 40, 43, 44, 13–17, 51

External supporting studies:

• Vera Institute of Justice (2015). "The Price of Jails: Measuring the Taxpayer Cost of Local Incarceration."
https://www.vera.org/publications/the-price-of-jails
– Demonstrates that local jail costs exceed publicly reported numbers, and that people with mental illness significantly increase staffing, medical, and monitoring expenses.

• Steadman HJ, Osher F, Robbins P, Case B, Samuels S. (2009). "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services.*
https://ps.psychiatryonline.org/doi/10.1176/ps.2009.60.6.761
– Shows high prevalence of SMI in jail populations, confirming that jail settings inherently incur higher costs when used as de-facto psychiatric facilities.

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40. Canyon County Sheriff (Idaho) — Actual Jail Cost Data

Confirms that Idaho jails spend roughly **$75–$90/day** per incarcerated person — far higher than the state reimbursement rate — creating direct fiscal exposure for counties when psychiatric crises increase jail utilization.
https://www.canyoncounty.id.gov/elected-officials/sheriff/jaileducation/

Crosswalk: 39, 41, 43, 51, 17

External supporting studies:
• **Urban Institute (2017). "The Hidden Costs of Pretrial Detention."**
https://www.urban.org/research/publication/hidden-costs-pretrial-detention
– Finds jurisdictions incur significant unfunded costs housing people with behavioral-health needs (medical monitoring, suicide prevention, emergency transport).

• **Bureau of Justice Assistance (2021). "Behavioral Health and Justice Systems: Costs and Impacts."**
– National assessment showing per-capita jail spending for people with SMI is substantially higher than for the general jail population due to elevated medical and behavioral-health needs.

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41. U.S. DOJ Findings on Idaho (2025)

DOJ determined Idaho was **already violating the ADA's integration mandate** by unnecessarily segregating adults with disabilities in institutional settings due to inadequate community services — before the proposed SPMI cuts.
https://www.justice.gov/opa/pr/justice-department-finds-idaho-violates-americans-disabilities-act-unnecessarily-segregating

Crosswalk: 32–38, 43, 71–75

External supporting studies:
• **U.S. Commission on Civil Rights (2023).**
"Subminimum Wages and the ADA: Modernizing Community Integration."
https://www.usccr.gov
– Explains that states failing to maintain adequate community supports risk ADA violations because institutionalization becomes foreseeable and preventable.

• **National Council on Disability (2021). "Beyond Guardianship."**
https://ncd.gov
– Concludes that inadequate community-based mental-health services predictably lead to institutionalization and thus create ADA exposure.

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42. Idaho Capital Sun (2025). "DOJ: Idaho Violates ADA…"

Summarizes DOJ's findings that Idaho's Medicaid system was already segregating disabled adults due to insufficient community-based services — increasing institutionalization, ER boarding, and nursing-home placement.
https://idahocapitalsun.com/2025/01/16/doj-idaho-violates-ada-nursing-homes/

Crosswalk: 41, 43, 32–38

External supporting studies:
• Kaiser Family Foundation (2022). "Medicaid's Role in Mental Health & Community Supports."
https://www.kff.org
– Shows that cuts to community services drive increased institutionalization and trigger ADA/Olmstead enforcement.

• NPR/Marshall Project (2018). "Insane: America's Criminal Treatment of Mental Illness."
– Documents that when states underfund community services, jails and hospitals become default institutions — a condition repeatedly deemed inconsistent with ADA integration requirements.

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43. Mitchell v. State of Idaho (2016).

The Idaho Supreme Court recognized that the state may be liable when failure to provide required behavioral-health services contributes to foreseeable harm. This ruling establishes **foreseeability**, a key ADA/Olmstead factor relevant to SPMI cuts.
https://law.justia.com/cases/idaho/supreme-court/2016/42990.html

Crosswalk: 39, 40, 41, 32–38

External supporting studies:
• DeShaney v. Winnebago County (1989).
– Establishes the principle that liability may arise when the state creates or exacerbates danger — foundational to foreseeability analysis.

• Campbell v. State (Idaho Court of Appeals, 2023).
– Reinforces that State of Idaho agencies may be liable when predictable harm results from failing to follow required procedures or standards of care.

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44. New Path Community Housing Report (Boise, Idaho).

Local supportive-housing data showing reduced homelessness, fewer crisis-service contacts, improved stability, and cost savings for high-acuity populations in Boise.
https://www.boisestatepublicradio.org/local-news/2019-02-19/new-path-community-housing-opens-in-downtown-boise

Crosswalk: 13, 14, 15, 16, 17

External supporting studies:
• Corporation for Supportive Housing (CSH, 2020). "Supportive Housing Works."
https://www.csh.org

– Demonstrates across multiple states that supportive housing reduces shelter stays, jail days, and hospital utilization.

• **National Alliance to End Homelessness (2022). "Housing First Outcomes and Evidence."**
https://endhomelessness.org
– Shows HF/PSH reliably lower chronic homelessness and reduce reliance on high-cost crisis services.

G. PHP / IOP SOURCES (45–65)

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45. Magellan of Idaho (2025). "Outpatient Rates."

Contains Idaho's closest proxy for PHP half-day reimbursement and documents the structure of fee-for-service outpatient billing within the Idaho Behavioral Health Plan.
https://magellanofidaho.com/documents/2446693/3042025/IBHP_rates_op.pdf

Crosswalk: 46, 47, 48, 50, 58, 59

External supporting studies:
• **SAMHSA (2016).** "Designing and Delivering Partial Hospitalization and Intensive Outpatient Services."
https://store.samhsa.gov
– Federal guidance establishing PHP/IOP as multi-hour structured programs unsustainable under standard outpatient billing codes.
• **CMS Medicare Benefit Policy Manual, Chapter 6.**
https://www.cms.gov
– Distinguishes partial hospitalization as a **separate level of care** with unique staffing and reimbursement requirements.

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46. Magellan of Idaho (2024). "Intensive Outpatient Program (IOP) Manual."

Defines IOP requirements (frequency, duration, staffing, documentation) and clarifies distinctions between IOP and standard outpatient therapy.
https://magellanofidaho.com

Crosswalk: 45, 47, 49, 50, 60, 65

External supporting studies:
• **ASAM (2020).** "ASAM Criteria: Level 2.1 – Intensive Outpatient Services."

https://www.asam.org
– Establishes national definition of IOP as multi-hour, multi-day intensive treatment.
• **NCQA (2018).** "Behavioral Health Level-of-Care Guidelines."
https://www.ncqa.org
– Describes IOP as a structured service level requiring specific staffing, programming, and clinical oversight.

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47. Clarke DE, Dusome D, Hughes L. (2013). "Emergency Department From the MH Client's Perspective."

Shows that PHP/IOP programs reduce unnecessary ED visits and improve continuity of care for high-utilizing psychiatric patients.
https://pubmed.ncbi.nlm.nih.gov/23852120/

Crosswalk: 48, 50, 54, 55, 58, 59

External supporting studies:
• **Bauer AM et al. (2018).** "Psych ED Outcomes in IOP-Enrolled Patients." *Gen Hosp Psychiatry.*
https://doi.org/10.1016/j.genhosppsych.2018.07.003
– IOP-enrolled patients show fewer repeat ED visits and better stabilization.
• **Fawcett J et al. (2009).** "Role of Partial Hospitalization in Psychiatric Illness."
– PHP reduces ED presentations and prevents inpatient admission.

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48. Olfson M, Marcus SC. (2010). "National Patterns in Psychiatric Day Hospitalization."

Nationwide analysis showing that partial hospitalization programs significantly reduce inpatient admissions for psychiatric conditions.
https://pubmed.ncbi.nlm.nih.gov/20603451/

Crosswalk: 47, 50, 52, 54, 58

External supporting studies:
• **Glick ID, Sharfstein SS, Schwartz HI. (2011).** "Inpatient Psychiatric Care Reform."
https://doi.org/10.1176/ps.2011.62.2.206
– Argues PHP/IOP are effective substitutes for inpatient care, improving continuity.
• **Moo LR et al. (2014).** "Partial Hospitalization for Older Adults."
– Demonstrates PHP effectiveness across age groups.

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49. Richardson T et al. (2018). "IOP & Emergency Department Utilization."

Completion of IOP results in a 45–55% reduction in ER visits.
https://pubmed.ncbi.nlm.nih.gov/30073523/

Crosswalk: 47, 48, 50, 54, 60, 61, 63

External supporting studies:
• **Schmutte T et al. (2010).**
"ED Use Before and After PHP Implementation."
https://doi.org/10.1176/ps.2010.61.4.447
– PHP implementation significantly reduces ED recidivism.
• **Comtois KA et al. (2011).**
"IOP for Chronic Suicidal Behavior." *Archives of Suicide Research.*
– IOP reduces crisis service use among high-risk individuals.

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50. Baek J et al. (2021). "Crisis Service Reductions in PHP/IOP."

Finds 40–60% reductions in psychiatric crisis contacts following PHP/IOP engagement.
https://pubmed.ncbi.nlm.nih.gov/33387917/

Crosswalk: 47, 48, 49, 54, 58, 60, 61

External supporting studies:
• **Bateman AW, Fonagy P. (1999).**
RCT showing PHP dramatically reduces self-harm and crisis events.
https://pubmed.ncbi.nlm.nih.gov/10518167/
• **Ben-Porath DD, Peterson GA. (2004).**
"Role of IOPs in Psychiatric Treatment." *Curr Psychiatry Rep.*
– Evidence that IOP/PHP reduce acute psychiatric destabilization.

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51. Steadman HJ et al. (2000). "Psychiatric Treatment & Justice Outcomes."

Structured psychiatric programs (including PHP/IOP + case management) reduce arrests and jail days by 20–40% among adults with SMI.
https://pubmed.ncbi.nlm.nih.gov/10686226/

Crosswalk: 9–12, 47–50, 56, 63

External supporting studies:
• **Brekke JS et al. (2001).**
"Risks for Individuals With Schizophrenia Living in the Community."
– Intensive treatment reduces arrest risk.
• **Skeem JL et al. (2011).**

"Correctional Policy for Offenders With Mental Illness."
– Emphasizes importance of intensive community-based programs (ACT/FACT/IOP).

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52. Schutt RK & Goldfinger SM. (2011). "Psychiatric Rehabilitation & Housing Outcomes."

Psychiatric rehabilitation combined with mid-level programs (PHP/IOP) improves housing stability and reduces homelessness.
https://pubmed.ncbi.nlm.nih.gov/21459988/

Crosswalk: 47–50, 13–17, 56

External supporting studies:
• **Mueser KT et al. (2003).**
"Integrated Treatment for Dual Disorders."
– Combining psychosocial rehabilitation + structured care improves outcomes.
• **Leff HS et al. (2009).**
"Meta-analysis of Housing & Support Services."
– Programs combining psychiatric rehab + housing supports lower homelessness.

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53. Luciano A & Meara E. (2014). "Economic Impact of MH Disability."

Mid-intensity programs such as PHP/IOP reduce entry into long-term disability by 25–30%.
https://pubmed.ncbi.nlm.nih.gov/24699545/

Crosswalk: 47–50, 54, 58–60

External supporting studies:
• **Goldman HH et al. (2008).**
"Economic Costs of Mental Illness." *Psychiatric Services.*
– Discusses the financial benefits of early, intensive intervention.
• **Wykes T et al. (2011).**
"Meta-analysis of cognitive remediation."
– Shows structured interventions improve functioning enough to reduce disability reliance.

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54. Jaffe A et al. (2019). "IOP & Hospitalization Reduction."

IOP participation reduces psychiatric hospitalizations by **50–65%**.
https://pubmed.ncbi.nlm.nih.gov/31675207/

Crosswalk: 47, 48, 49, 50, 55, 58, 60, 63

External supporting studies:
• **Schmutte T et al. (2010).**
– PHP implementation reduces inpatient and ED use.
• **Chernomas WM et al. (2000).**
– IOP reduces hospital recidivism and symptom severity.

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55. Phillips ML et al. (2014). "IOP Outcomes in Mood & Psychotic Disorders."

Shows reduced readmissions and improved follow-up for high-utilizing patients after IOP completion.
https://pubmed.ncbi.nlm.nih.gov/23975013/

Crosswalk: 47, 49, 50, 54, 58, 60, 61

External supporting studies:
• **Zimmerman M et al. (2008).**
Partial hospitalization/IOP improves symptoms and functioning.
• **Meagher J et al. (2013).**
Structured IOP in community mental-health settings reduces inpatient readmissions.

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56. Henwood BF et al. (2015). "Housing & Justice After Structured Treatment."

Shows psychiatric rehab + IOP/PHP reduces homelessness and arrests for SMI individuals.
https://pubmed.ncbi.nlm.nih.gov/25799293/

Crosswalk: 47–50, 52, 53, 13–17, 51

External supporting studies:
• **Rosenheck R et al. (2003).**
Case management + housing reduces homelessness and crisis use.
• **Drake RE, Wallach MA, McGovern MP. (2005).**
Integrated structured outpatient services reduce rehospitalization and justice involvement.

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57. Bateman AW & Fonagy P. (1999). "PHP Suicide-Prevention Effects."

Specialized PHP reduces suicide attempts and self-harm compared to outpatient care.
https://pubmed.ncbi.nlm.nih.gov/10518167/

Crosswalk: 47, 50, 54, 58, 59, 64

External supporting studies:
• **Linehan MM et al. (2006).**

Intensive programs (DBT day treatment) reduce suicide attempts.
• **Jobes DA et al. (2005).**
Intensive crisis-focused treatment reduces suicidal behavior.

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58. Rubenson MP et al. (2024). "Systematic Review of PHP Outcomes."

Finds consistent reductions in inpatient admissions and improved clinical functioning with PHP participation.
https://www.sciencedirect.com

Crosswalk: 47, 48, 50, 54, 55, 57, 59

External supporting studies:
• **Marshall M et al. (2011).**
Cochrane review: day hospitals are effective substitutes for inpatient care.
• **Pasic J, Russo J, Roy-Byrne P. (2005).**
High-utilizers suffer due to lack of mid-level care; PHP reduces ED overuse.

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59. Murphy JW et al. (2021). "Military PHP Outcomes."

Military PHPs reduce crisis episodes and inpatient utilization.
https://pmc.ncbi.nlm.nih.gov/articles/PMC10013512/

Crosswalk: 47, 48, 54, 57, 58, 60, 63

External supporting studies:
• **Oldham JM (2014).**
PHP milieu models reduce rehospitalization.
• **Cuijpers P et al. (2007).**
Structured intensive interventions outperform standard outpatient treatment.

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60. Delaney RK et al. (2020). "IOP for High-Need Patients: A Systematic Review."

IOPs reduce ER visits, hospitalizations, and symptom severity for high-acuity psychiatric populations.
https://pubmed.ncbi.nlm.nih.gov/33044534/

Crosswalk: 47, 49, 50, 54, 55, 58, 59, 61

External supporting studies:
• **Gualtieri CT et al. (1983).**
Day hospitals reduce inpatient length of stay.

• **Helsley J et al. (2018).**
IOPs in general hospitals reduce readmissions and crisis-service utilization.

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61. Gliske K et al. (2023). "Youth IOP & ER Reductions."

Youth participating in IOP demonstrate sharp reductions in psychiatric ER admissions and improved follow-up adherence.
https://formative.jmir.org/2023/1/e47895

Crosswalk: 49, 50, 54, 55, 60, 62, 63, 64

External supporting studies:
• **Asarnow JR et al. (2011).**
ED-based intensive intervention reduces suicidal behavior and ED revisits.
• **Wharff EA et al. (2012).**
Family-based crisis intervention reduces need for inpatient admission.

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62. Bero KM et al. (2024). "Adolescent IOP Outcomes."

Adolescent IOP improves symptoms and reduces psychiatric hospitalizations.
https://www.sciencedirect.com

Crosswalk: 49, 50, 54, 55, 60, 61, 64

External supporting studies:
• **Greenfield B et al. (2002).**
Day treatment improves functioning in adolescents.
• **Brophy M & Holmberg J (2014).**
Review confirms adolescent IOP effectiveness.

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63. Louisiana Healthcare Connections (2019). IOP Medicaid Pilot.

Pilot demonstrated **84% reduction in readmissions** and **58% reduction in ER visits** after IOP engagement.
https://www.louisianahealthconnect.com/newsroom/intensive-outpatient-pilot-yields-double-digit-reduction-in-hosp.html

Crosswalk: 49, 50, 54, 55, 60, 61, 62

External supporting studies:
• **Rosenbaum S et al. (2016).**
Medicaid financing of IOP reduces admissions statewide.

• **National Council for Mental Wellbeing (2020).**
Policy brief supporting IOP as essential post-acute and diversion service.

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64. Kennard B et al. (2019). "Youth Suicide-Prevention IOP."

RCT showing youth IOP significantly reduces suicidal behaviors and inpatient admissions.
https://www.jahonline.org/article/S1054-139X(18)30430-0/fulltext

Crosswalk: 50, 54, 57, 59, 60, 61, 62

External supporting studies:
• **Brent DA et al. (2009).**
Intensive post-attempt treatment reduces repeat attempts.
• **King CA et al. (2017).**
Youth IOP improves engagement and reduces self-harm.

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65. Center for Health Care Strategies (2024). "IOP Coverage Policy."

Describes evolving Medicaid coverage standards for IOP and the need for IOP as a distinct level of care with multi-hour programming.
https://www.chcs.org/resource/new-changes-to-intensive-outpatient-program-coverage/

Crosswalk: 45, 46, 54, 55, 59, 60, 62, 63, 64

External supporting studies:
• **SAMHSA (2019). "National Guidelines for Behavioral Health Crisis Care."**
Describes IOP/PHP as essential crisis-diversion and step-down programs.
• **National Council for Mental Wellbeing (2018).**
Supports IOP/PHP as critical to reducing inpatient burden and improving continuity.

H. CHILD-WELFARE / CPS IMPACT EVIDENCE (66–70)

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66. Kaplan K et al. (2019). "Child Protective Services Disparities and Serious Mental Illness."

Shows that parents with SMI are approximately **8× more likely** to experience CPS involvement and up to **26× more likely** to have a child removed, even after controlling for socioeconomic factors and co-occurring conditions.

Crosswalk: 67, 68, 69, 70; 1–12 (ACT), 24–31 (ESMI), 39–43 (Idaho foreseeability)

External supporting studies:
• **Pediatrics (2024). "Parental Mental Illness and Likelihood of Out-of-Home Care: A National Cohort Study."**
https://publications.aap.org/pediatrics/article/153/3/e2023061531
– National registry analysis of 1.25 million children demonstrating increased out-of-home placement risk associated with parental psychiatric disorders.
• **Nusslock R, Miller GE. (2016). "Early-Life Adversity and Health Across the Lifespan."** ***Biological Psychiatry.***
– Reviews evidence linking parental mental illness with child stress exposure, disruptions, and CPS involvement due to instability.

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67. Ostrow L, Kaplan K, Zisman-Ilani Y, et al. (2021). "Risk Factors for CPS Involvement Among Parents with SMI."

Large national dataset showing that psychiatric instability, missed treatment, relapse, and crisis events are the primary drivers of CPS involvement among parents with SMI — and that strong engagement services reduce these risks.
https://pubmed.ncbi.nlm.nih.gov/32907477/

Crosswalk: 66, 68, 69, 70; 1–12 (ACT), 18–23 (Peer Support), 24–31 (ESMI)

External supporting studies:
• **Reupert A, Maybery D. (2007).**
"Families Affected by Parental Mental Illness." *American Journal of Orthopsychiatry.*
https://pubmed.ncbi.nlm.nih.gov/17696664/
– Shows parental psychiatric instability is a strong predictor of CPS involvement; stable treatment reduces risk.
• **Tungpunkom P, Maybery D, Reupert A, et al. (2017).**
"Family-Focused Mental Health Practice." *BMC Health Serv Res.*
https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2761-7
– Demonstrates that integrated, family-focused services reduce CPS referrals among SMI parents.

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68. White LM, MacDonald S, Lahey L. (2013). "Parents Served by ACT Teams."

Study confirms a substantial subset of ACT clients are parents, and that ACT's intensive support improves parental stability, reduces crises, and provides protective effects for dependent children.
https://pmc.ncbi.nlm.nih.gov/articles/PMC3980453/

Crosswalk: 1–12 (ACT), 66, 67, 70; 18–23 (Peer), 24–31 (ESMI/CSC)

External supporting studies:
• **Nicholson J, Sweeney E, Geller JL. (1998).**
"Mothers With Mental Illness: Competing Demands." *Psychiatric Services.*
– Identifies ACT-style intensive support as critical to preventing child removal.
• **Nicholson J, et al. (2001).**
"Parents With SMI and Their Children." *Families in Society.*
– Emphasizes the need for integrated adult-child services to reduce CPS involvement.

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69. Havelková A, Havelka D, Bartošová K. (2024). "Parenthood Among Hospitalized Adults With SMI."

Analysis of several thousand psychiatric inpatients showing **~35% are parents**, illustrating the scale of child impact when adult psychiatric crises escalate.
https://pmc.ncbi.nlm.nih.gov/articles/PMC11287770/

Crosswalk: 66, 67, 68, 70; 39–43 (Idaho foreseeability)

External supporting studies:
• **Reupert A, Maybery D. (2016).**
"What Do We Know About Families Where Parents Have Mental Illness?" *Child & Youth Services.*
– Finds parental psychiatric episodes create predictable child-welfare risks.
• **Pediatrics (2024).** "Parental Mental Illness and Out-of-Home Care."
– Confirms parental psychiatric crises elevate CPS intervention rates.

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70. Harries CI, Smith DM, Gregg L, Wittkowski A. (2023). "Parenting and SMI: Systematic Review & Meta-Synthesis."

Comprehensive review demonstrating that untreated SMI elevates household stress, safety concerns, and supervision gaps — increasing the probability of CPS involvement — while intensive services reduce risk.
https://pmc.ncbi.nlm.nih.gov/articles/PMC10123049/

Crosswalk: 66, 67, 68, 69; 1–12 (ACT), 18–23 (Peer), 24–31 (ESMI/CSC)

External supporting studies:
• **Reupert A, Maybery D. (2007).**
"Families Affected by Parental Mental Illness."
– Highlights the effectiveness of intensive supports in preventing CPS escalation.
• **Gammage R et al. (2021).**

"Family Functioning in Families with Parental Mental Illness." *Family Process.*
https://pubmed.ncbi.nlm.nih.gov/34360277/
– Shows that family functioning improves significantly when parents receive adequate behavioral-health support.

I. EVIDENCE-BASED PRACTICE GUIDELINES (71–92)

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71. SAMHSA – ACT Evidence-Based Practices KIT: Building Your Program.

Defines Assertive Community Treatment as a **bundled, multidisciplinary, 24/7** team delivering in-vivo services and shared caseload management. SAMHSA explicitly states ACT **cannot be delivered** through fee-for-service outpatient codes.
https://library.samhsa.gov/sites/default/files/sma08-4344-buildingyourprogram.pdf

Crosswalk: 1–12, 80–82, 87–91, 32–38

External supporting studies:
• **Bond GR & Drake RE. (2015).** "Critical Ingredients of ACT." *World Psychiatry.*
https://pubmed.ncbi.nlm.nih.gov/25655147/
– Identifies non-negotiable fidelity requirements; outcomes collapse when any element is removed.
• **Allness DJ, Knoedler WH. (2003).** "PACT Model Training Manual."
– Defines ACT operations and demonstrates why ACT cannot be broken into outpatient billable components.

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72. SAMHSA – ACT EBP KIT: Training Frontline Staff.

Describes daily team huddles, field-based contacts, crisis coverage, and shared caseload requirements — none of which are billable under therapy/CBRS/CM codes.
https://library.samhsa.gov/sites/default/files/sma08-4344-trainingfrontlinestaff.pdf

Crosswalk: 71, 80–82, 87–91

External supporting studies:
• **Phillips SD et al. (2001).** "Moving ACT Into Standard Practice." *Psychiatric Services.*
– Shows ACT only works when fidelity is maintained; outpatient codes cannot support staffing requirements.
• **Dieterich M et al. (2017).** Cochrane Review of intensive case management.
https://doi.org/10.1002/14651858.CD007906.pub3
– High-intensity models outperform outpatient case management; fidelity is essential.

73. SAMHSA (2025). "Model Definitions for Crisis & Emergency Behavioral Health Services."

Defines crisis stabilization as **24/7/365, clinically staffed, immediate-access** programs requiring bundled/per-diem funding — never fee-for-service.
https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-08/SAMHSA_Model_Definitions_508_080525.pdf

Crosswalk: 13–17, 50–52, 32–38, 74–75

External supporting studies:
• **NAMI (2023).** "988 Crisis Continuum White Paper."
– Emphasizes per-diem crisis staffing and rejects outpatient billing for crisis levels of care.
• **National Action Alliance for Suicide Prevention (2022).**
– Identifies mobile crisis + crisis stabilization as essential, continuous-access programs.

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74. SAMHSA (2025). National Guidelines for Behavioral Health Crisis Care.

Federal expectations for crisis systems: 24/7 mobile crisis, crisis stabilization units, and subacute beds — all require per-diem or bundled funding.
https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf

Crosswalk: 73, 13–17, 50, 59, 32–38

External supporting studies:
• **Livingston JD et al. (2014).** Crisis intervention systematic review.
– Mobile crisis teams reduce arrests and inpatient admissions vs outpatient care.
• **Fisher WH & Geller JL. (2015).** "Crisis Services: Lessons Learned."
– Shows crisis systems fail when funded via outpatient codes.

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75. CMS – SHO Letter 25-004 (2025). Medicaid Coverage of Crisis Services.

CMS directs states to fund crisis care consistent with SAMHSA definitions, requiring **bundled/per-diem payment**, not outpatient codes.
https://www.medicaid.gov/federal-policy-guidance/downloads/sho25004.pdf

Crosswalk: 73, 74, 13–17, 32–38

External supporting studies:
• **CMS (2023). Medicaid Crisis Services Toolkit.**

– Establishes federal expectation for sustainable non-FFS funding for crisis teams.
• **NASMHPD (2018). "Crisis Services: Financing & Sustainability."**
– Outpatient billing is inadequate for crisis service staffing.

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76. NIMH – RAISE Early Psychosis Initiative.

Defines CSC as a **multi-component team model** that outperforms outpatient services for first-episode psychosis.
https://www.nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/recovery-after-an-initial-schizophrenia-episode-raise

Crosswalk: 24–31, 77–79, 30–31, 32–38

External supporting studies:
• **Kane JM et al. (2016).** NAVIGATE RCT — superior outcomes vs usual care.
• **Puntis S et al. (2020).** Systematic review confirming CSC superiority.

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77. SAMHSA – CSC for First-Episode Psychosis (PEP23-01-00-003).

Describes the required CSC components: SEE, family therapy, CBT-P, care coordination, psychiatric treatment, frequent contact. Outpatient codes **cannot bill** SEE or integrated team operations.
https://library.samhsa.gov/sites/default/files/pep23-01-00-003.pdf

Crosswalk: 24–31, 76, 78, 79

External supporting studies:
• **Addington DE et al. (2013).** International Guidelines for Early Psychosis.
• **Correll CU et al. (2018).** Meta-analysis confirming CSC outperforms outpatient care.

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78. NAMI – Coverage of Coordinated Specialty Care (CSC).

Identifies CSC as the gold standard for early psychosis. Notes that SEE and care coordination are **not billable** under standard outpatient Medicaid codes.
https://www.nami.org/advocacy/policy-priorities/improving-health/coverage-of-coordinated-specialty-care-csc-for-early-or-first-episode-psychosis/

Crosswalk: 76, 77, 79, 24–31

External supporting studies:
• **Heinssen RK et al. (2014).** Rationale for CSC — integration is essential.
• **Humensky JL et al. (2021).** Medicaid analysis showing CSC reduces ER/inpatient use.

79. NRI (National Research Institute). "CSC: A Smart Investment."

Shows CSC reduces long-term disability, unemployment, and hospitalization and is cost-saving from a societal perspective.
https://nri-inc.org/media/1558/nri_csc_smart_investment.pdf

Crosswalk: 24–31, 76, 77, 78, 30–31

External supporting studies:
• **McCrone P et al. (2009).** Early intervention reduces long-term system costs.
• **Aceituno et al. (2019).** Systematic review confirming cost-effectiveness.

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80. SAMHSA (2008–2024). ACT EBP KIT.

Defines ACT as a high-intensity, multidisciplinary, in-vivo service with 24/7 crisis coverage.
https://library.samhsa.gov/product/assertive-community-treatment-act-evidence-based-practices-ebp-kit/sma08-4344

Crosswalk: 1–12, 71–72, 87–91

External supporting studies:
• **Rosenheck RA et al. (2003).** ACT reduces hospital use and improves community tenure.
• **Nielsen CM et al. (2021).** FACT outcomes align with ACT superiority.

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81. Dixon LB et al. (2010). Schizophrenia PORT Recommendations.

ACT, supported employment, and family psychoeducation are EBPs; outpatient-only approaches are insufficient for high-acuity populations.
https://doi.org/10.1093/schbul/sbp115

Crosswalk: 1–12, 71–72, 80, 82–91

External supporting studies:
• **Torrey WC et al. (2001).** Outpatient fragmentation fails SMI populations; EBPs required.
• **NICE CG178 (2014).** Recommends multidisciplinary teams for complex psychosis.

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82. Torrey WC, Drake RE, Dixon L, et al. (2001). Implementing EBPs for SMI.

Shows that usual care is fragmented and non-evidence-based; only structured EBPs (ACT, CSC, IPS) achieve meaningful outcomes.
https://doi.org/10.1176/appi.ps.52.1.45

Crosswalk: 1–12, 71–72, 80–81, 87–91

External supporting studies:
• **Drake RE et al. (2001).** Implementation barriers for EBPs.
• **Bond GR et al. (2012).** Fidelity essential across EBPs.

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83. NICE NG181 (2020). Rehabilitation for Adults With Complex Psychosis.

Recommends **specialist multidisciplinary rehabilitation teams**, not isolated outpatient therapy.
https://www.nice.org.uk/guidance/ng181

Crosswalk: 1–12, 71–72, 80–82, 87–91

External supporting studies:
• **Killaspy H et al. (2016).** Rehab teams improve functioning & quality of life.
• **Farkas M, Anthony WA. (2010).** Intensive team care outperforms low-intensity services.

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84. NICE CG178 (2014). Psychosis and Schizophrenia Treatment.

Supports CBT-P & family intervention but *only as part of multi-component team care*.
https://www.nice.org.uk/guidance/cg178

Crosswalk: 1–12, 81–83, 85–91

External supporting studies:
• **Wykes T et al. (2008).** CBT-P produces modest improvements; needs team support.
• **Pfammatter M et al. (2006).** Psychological therapy must be embedded within robust services.

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85. Yildiz M et al. (2021). Psychosocial Rehabilitation Review.

Finds psychosocial rehabilitation improves functioning in stable SMI populations but does **not** replace ACT/CSC for high-acuity individuals.
https://pmc.ncbi.nlm.nih.gov/articles/PMC8498820/

Crosswalk: 5, 13–17, 80–84, 86–87

External supporting studies:
• **Bengtsson-Tops A et al. (2014).** PSR benefits but excludes highest-acuity patients.
• **Farkas M, Frey J. (2006).** Most impaired individuals require intensive team care.

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86. Dalton-Locke C et al. (2020). Rehabilitation Services Systematic Review.

Finds moderate improvements in functioning with heterogeneous rehab models; limited evidence for highest-acuity SMI.
https://www.frontiersin.org/articles/10.3389/fpsyt.2020.607933

Crosswalk: 83, 85, 87–91

External supporting studies:
• **Priebe S et al. (2013).** Community rehab has modest benefit; ACT/CSC outperform.
• **Killaspy H et al. (2012).** Specialist rehab must be paired with ACT/housing supports.

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87. Dieterich M et al. (2017). Intensive Case Management Cochrane Review.

Confirms that **high-intensity, fidelity-driven** models (ICM/ACT) reduce hospital use; low-intensity CM fails.
https://doi.org/10.1002/14651858.CD007906.pub3

Crosswalk: 1–12, 71–72, 80–82, 88–91

External supporting studies:
• **Burns T et al. (2007).** ICM/ACT in Europe — fidelity = outcomes.
• **Marshall M et al. (2000).** ACT far superior to low-intensity case management.

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88. Essock SM et al. (2006). ACT vs Standard Case Management.

ACT produces better integration of services and adherence for SMI + SUD populations.
https://doi.org/10.1176/ps.2006.57.2.185

Crosswalk: 1–12, 80–82, 87, 89–91

External supporting studies:
• **Drake RE et al. (2004).** Integrated dual-diagnosis treatment outperforms standard CM.
• **Mueser KT et al. (2003).** ACT framework enhances dual-diagnosis treatment success.

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89. Gorey KM et al. (1998). Case Management Meta-Analysis.

Shows case management outcomes depend on model intensity; brokered (low-intensity) CM underperforms, supporting ACT/ICM models.
https://doi.org/10.1023/A:1018755100043

Crosswalk: 7, 87, 88, 90–91

External supporting studies:
• **Hoult J & Rosen A. (1984).** Home-based intensive treatment reduces rehospitalization.
• **Bond GR et al. (1990).** High-intensity ACT models outperform CM in reducing hospital days.

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90. Lim CT et al. (2022). Care Management Systematic Review.

Finds that high-fidelity intensive models (ICM/ACT) produce consistent improvements; diffuse or low-intensity CM does not.
https://doi.org/10.1176/appi.ps.202000727

Crosswalk: 1–12, 87–89, 91

External supporting studies:
• **Dieterich M et al. (2017).** Confirms intensity/fidelity = outcomes.
• **Kreyenbuhl J et al. (2010).** PORT update endorsing ACT for highest-acuity SMI.

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91. Nielsen CM et al. (2021). FACT (Flexible ACT) Model.

FACT integrates ACT fidelity with graduated intensity. Improves community engagement and reduces hospitalization relative to non-FACT CM.
https://doi.org/10.1186/s13033-021-00504-3

Crosswalk: 1–12, 80–82, 87–90, 92

External supporting studies:
• **van Veldhuizen JR (2007).** FACT model description; strong outcome improvements.
• **Firn M et al. (2012).** FACT adoption improves continuity and reduces hospital use.

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92. Lamberti JS et al. (2025). Forensic ACT Best Practice.

Shows Forensic ACT significantly reduces justice involvement and hospitalization among high-risk SMI populations.
https://doi.org/10.1017/S1092852925000123

Crosswalk: 9–12, 51, 88, 91

External supporting studies:
• **Swanson JW et al. (2013).** Cost and effectiveness evaluation confirming FACT reduces incarceration.
• **Lamberti JS et al. (2017).** FACT review showing major reductions in recidivism and rehospitalization.

CITATIONS COMPLETE

Version Update Log

White Paper Version 1.2 — Revision Notes (from v1.1)

1. Correction to IOP Reimbursement Reduction

- The previous version (v1.1) stated that Intensive Outpatient Program (IOP) services were subject to a **15% reimbursement reduction**.
- This has been corrected in Version 1.2 to reflect the accurate reduction: **10%**.

2. Impact on Modeling and Fiscal Estimates

- The correction does **not** affect any downstream cost-shift calculations in the statewide fiscal model.
- IOP reductions are not a primary driver of hospitalization, EMS, jail, or homelessness cost projections in the model, and therefore adjusting this figure from 15% to 10% **does not change**:
    - Total statewide annual downstream cost estimate
    - Category-level impacts (hospitals/ER, jails/police, EMS/cities, child welfare)
    - Any cited ranges or fiscal conclusions
- Version 1.2 remains fully consistent with the $150–$180 million estimated statewide impact.

3. Narrative Alignment

- All narrative references to the IOP reduction have been updated to reflect the **10%** rate cut.
- No other program-level descriptions were altered.