Washington State Health Care Authority

Report to the Legislature

Preliminary report on addressing crisis services funding gaps

Engrossed Substitute Senate Bill 5187; Section 215(19)(b); Chapter 475; Laws of 2023

January 2024

Financial Services Division
Division of Behavioral Health & Recovery
P.O. Box 42704
Olympia, WA 98501
Phone: 360-725-9421
www.hca.wa.gov

Washington State Health Care Authority

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Executive summary

According to the National Association of Counties, 75 percent of counties have reported an increase in the incidence of behavioral health conditions over the past year and 89 percent reported an increase compared to five years ago.

Half of the U.S. Population lives in a county designated as a mental health professional shortage area. When there is a lack of behavioral health services available, crisis services become the most readily available option for addressing behavioral health concerns.

Ensuring adequate crisis services are readily available and appropriate payment mechanisms are in place becomes even more important in the environment of delayed access to customary treatment. The Health Care Authority (HCA) has been tasked with providing an assessment of gaps in the funding model for crisis services.

This document is the preliminary report as required in Engrossed Senate Substitute Bill (ESSB) 5187 (2023), Section 215(19). Recognizing that the proviso requires a great deal of information that must be provided by many individual representatives of multiple sectors, HCA developed a charter to outline the work and then a project plan.

This report will outline progress made to date in responding to the legislation.

Workgroup overview

In October 2022, HCA convened a workgroup made up of subject matter experts to discuss service and payment challenges for crisis stabilization facilities. This workgroup was repurposed to focus on the directives in ESSB 5197 Section 215(19) since it already included many of the required participants.

The workgroup's initial activities focused on defining the project scope and outlining a project plan. Crisis services contain many elements, with many payors, providers and complicated systems involved. Ensuring appropriate documentation and understanding of all complexities is critical in unraveling the system to ensure the product developed addresses the needs of the stakeholders and meets legislative directives.

The workgroup discussed other related work in the crisis space and ways to incorporate those efforts without duplicating parallel work streams.

Progress to date

- To date the workgroup has completed the following:
  - Convened representatives.
  - Contracted with actuaries.
  - Determined the project scope.
  - Reviewed crisis stabilization facility services and developed the project plan.
- This initial phase also included Mercer's preliminary analysis on facility-based crisis stabilization services. The initial analysis is included in this report in Appendix A.

Proviso language

ESSB 5187; Section 215(19)b directs HCA to:

"…convene representatives from medicaid managed care organizations, behavioral health administrative organizations, private insurance carriers, self-insured organizations, crisis providers, and the office of the insurance commissioner to assess gaps in the current funding model for crisis services and recommend options for addressing these gaps including, but not limited to, an alternative funding model for crisis services. The assessment must consider available data to determine to what extent the costs of crisis services for clients of private insurance carriers, medicaid managed care organizations, and individuals enrolled in medicaid fee-for-service are being subsidized through state funded behavioral health administrative services organization contracts. The analysis shall examine crisis services provided by mobile crisis teams as well as facility-based services such as crisis triage and crisis stabilization units. In the development of an alternative funding model, the authority and office of the insurance commissioner must explore mechanisms that:

(i) Determine the annual cost of operating crisis services and collect a proportional share of the program cost from each health insurance carrier; and

(ii) differentiate between crisis services eligible for medicaid funding from other nonmedicaid eligible activities. The authority must submit a preliminary report to the office of financial management and the appropriate committees of the Legislature by December 1, 2023, and a final report by December 1, 2024…"

Workgroup representation

The workgroup includes representatives from HCA as well as multiple partners, which includes many of the Behavioral Health Administrative Service Organizations, Managed Care Organizations, Providers, Private Insurance Companies, the Washington State Hospital Association, and the Office of Insurance Commissioners.

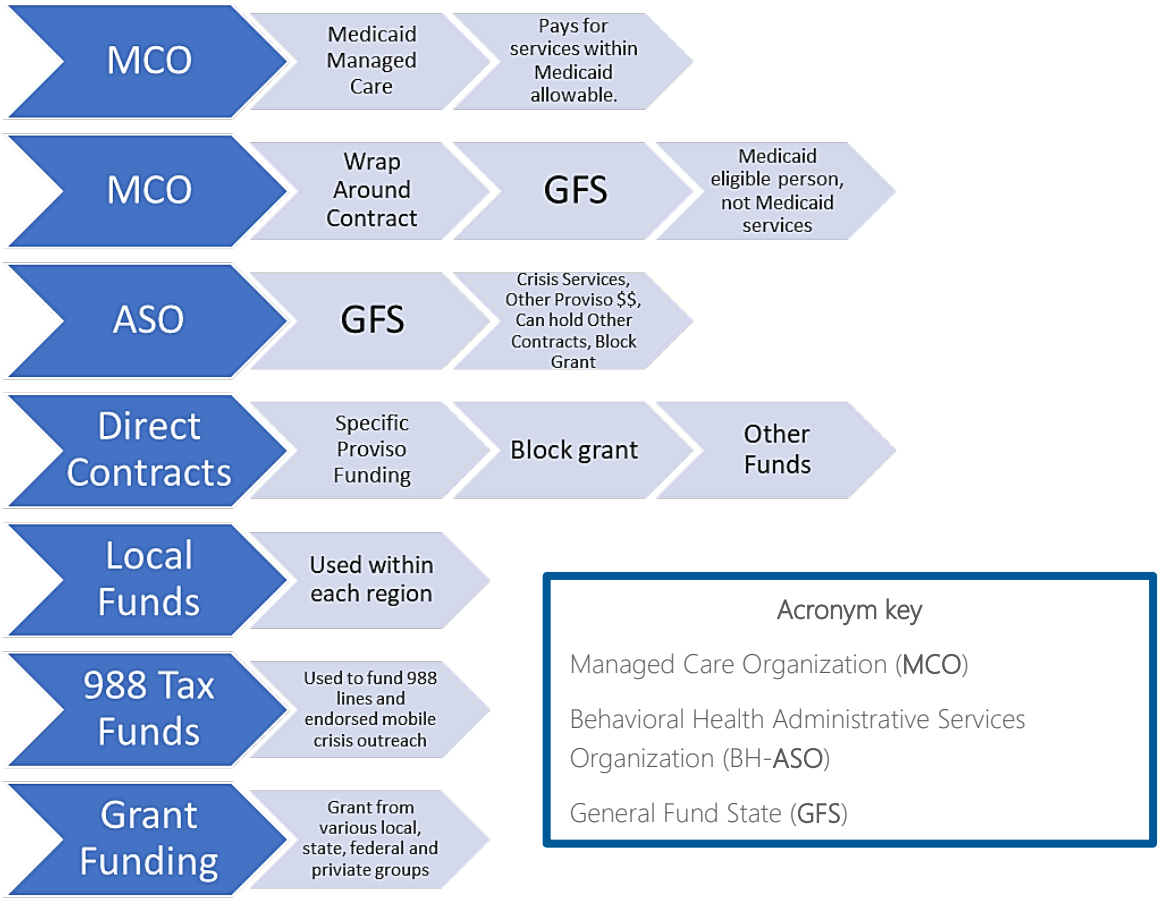
Crisis workgroup participant list	Organization
John Richardson	Amerigroup
Michele Robertson	Amerigroup
Kelly Tower	AWHPNW
Peggi Fu	AWHPNW
Michelle Izumizaki	Cambia Health
Darlene Davies	Carelon
Richard VanCleave	Carelon
Tiffany Villines	Carleon
Heidi Knadel	Catholic Community Services
Connie Mom-chhing	CHPW
Erin Gilliland	CHPW
Dave Guyer	COMPHC
Jodi Daly	COMPHC
Edie Dibble	Comprehensive Healthcare
Chris Santarsiero	Connections

Crisis workgroup participant list	Organization
Michael Transue	Connections
Matt Miller	Connections
Emily Rose	Coordinated Care Health
John Doherty	Coordinated Care Health
Katie Romas	Coordinated Care Health
Basil Dibsie	Elevance Health
Khristopher Rakunas	Elevance Health
Sindi Saunders	Greater Columbia BHASO
Trinidad Medina	Great Rivers BHASO
Chris Park	Kaiser Permanente
Mathew Golden	King County BHASO
Michael Reading	King County BHASO
Arianna Kee	Lifeline Connections
Kinh Reynolds	Lifeline Connections
Kirandeep Kang	Mercer
Laura Henry	Mercer
Laura Trieselmann	Mercer
Maija Welton	Mercer
Sanket Shah	Mercer
Kristen Federici	Molina
Anusha Fernando	Molina
Tory Gildred	Molina
Whitney Howard	Molina
JanRose Ottaway-Martin	North Sound BHASO
Margaret Rojas	North Sound BHASO
Delika Steele	Office of Insurance Commissioner
Jane Beyer	Office of Insurance Commissioner
Clinton Jordan	Pioneer Human Services
Preet Kaur	Premera
Gary Stannigan	Premera
Jolene Kron	Salish BHASO
Diane Boyd	Seattle YMCA
Kurt Beilstein	Spokane BHASO
Justin Johnson	Spokane BHASO
Joe Avalos	Thurston / Mason
Erin Heimbecher	United Healthcare
Sheela Tallman	United Healthcare
Joan Miller	Washington Council
Ashlen Strong	Washington State Hospital Association
Michelle Alger	HCA

Crisis workgroup participant list	Organization
Teresa Claycamp	HCA
Matt Gower	HCA
Ruth Leonard	HCA
Keith Lewis	HCA
Catrina Lucero	HCA
Dallas Morrison	HCA
Kara Panek	HCA
Luke Waggoner	HCA
Michele Wilsie	HCA
Sherry Wylie	HCA

Current state – crisis service funding and payors

Image 1: Explanation of crisis service funding



Funding sources

Medicaid

Pays for Medicaid eligible services identified in Attachment 3.1-A and 3.1-B section 13.d Rehabilitative section of the Washington Medicaid State Plan when delivered to Medicaid eligible individuals.

State allocated funds

Funds services not allowable under Medicaid and services to non-Medicaid eligible individuals.

Local funds

Local Funding with community direction over spending decisions. Examples include city or county funding and sales tax revenue.

Federal block grant funds

Pays for services that would otherwise be funded with GFS and fall within the federal requirements for each grant – some BH-ASOs reconcile crisis service individual served to fund crisis services for individuals not Medicaid enrolled via block grant.

Private health insurance

Legislation passed in 2022 which required private health insurance carriers to cover emergency behavioral health services. E2SHB 1688 (Chap. 263, laws of 2022) protects consumers from charges for out-of-network emergencies by addressing coverage of emergency services, which includes behavioral health emergencies. The law also aligns with the Washington state Balance Billing Protection Act and the federal No Surprises Act.

The law became effective March 31, 2022, and applies to fully insured state regulated private health plans, including the Washington state public and school employee health benefit plans (PEBB/SEBB). This includes approximately 19 carriers. Additional information can be found at https://www.insurance.wa.gov/protections-surprise-medical-billing.

988 tax line account

Pays for 988 Lines and endorsed mobile rapid response crisis teams and community-based crisis teams.

Community-based crisis team" means a team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis.

Grant programs

Various grant programs from local, state, federal, and private programs to support often local initiatives. These grants are often specific to a program with limitations of how the funding can be used.

Payors

Behavioral health-administrative service organizations (BH-ASOs)

- Contracts for crisis services are included in the BH-ASO contract for all individuals, regardless of insurance.
  - Crisis line (24/7)
  - Mobile Rapid Response Crisis Teams (MRRCT)*
  - Triage & Stabilization
  - Crisis Intervention
  - Specific funding – PACT, WISe, New Journeys, Discharge, Jail
  - Administer Involuntary Treatment Act (ITA)
  - Conduct ITA investigations via Designated Crisis Responders (DCRs)
  - Write ITA petitions and detain individuals when indicated
  - Monitor compliance with less restrictive treatment services
  - Coordinate necessary services including due process

Medicaid managed care organizations

- Pay for services included in the Medicaid Managed Care contract for enrolled individuals.
- Per the managed care contract, MCOs are required to contract with the BH-ASOs for core crisis services which include:
  - Crisis line,
  - Mobile Rapid Response Outreach Teams,
  - The administration of the Involuntary Treatment Act
  - Designated Crisis Responders
- MCOs directly contract for crisis stabilization services, which could be facility-based or in-home stabilization.

Medicaid fee for service

- Pays for services for Medicaid enrollees who are not enrolled in Managed Care.
- Most fees for service enrollees are from the AI/AN population.

Private health insurance companies

(fully insured state regulated private health plans)

- Pay for emergency behavioral health services for covered individuals according to E2SHB 1688 legislation and OIC regulations. Emergency services include screening, stabilization, and post-stabilization care provided by:
  - Mobile crisis response teams
  - Crisis stabilization units or crisis triage facilities
  - Evaluation and treatment (E&T) facilities, including Secure Withdrawal Management Services (SWMS)
  - An agency certified by DOH under RCW 71.24 to provide outpatient crisis services
  - Withdrawal management provided by an agency certified by DOH under RCW 71.24 to provide medically managed or monitored withdrawal management

SAMHSA block grant funding

- Specific regional services with clear outlines
- Regions may allocate a portion of the block grant funding for crisis services

Grant funded programs

- Funding provided by local, state, federal, and private organizations to fund specific programs and/or initiatives.
- Funding can vary in quantity and restriction based on the entity providing it. It is often specific to an initiative and/or program with a narrow focus.
- This funding can often be short-term resulting in programs starting and terminating.

Project scope

Careful consideration was given to ensure coordination of efforts of two provisos that intersect. Proviso 19 requires a gap analysis of crisis services. House Bill (HB) 1134 (2023) directed HCA to establish endorsement standards and supplemental performance payments for mobile rapid response teams (MRRT) and community-based teams (CBCT). The final report will include the 1134-988 cost data, which is within the scope of that work stream.

Table 1: Project scope comparison of Proviso 19 and Proviso 1134 Workgroups

Scope Determination	In Scope of Proviso 19 Workgroup	In Scope of 1134 Workgroup
Initial Crisis Response Pathways		
National Crisis Lines		
Regional Crisis Lines	***X***	
Mobile Crisis Response Teams		***X***
Designated Crisis Responders	***X***	
23 Hour Crisis Relief Centers	***X***	
Crisis Stabilization Facilities	***X***	
Wise Teams		
PACT Teams		
Stabilization Services After Initial Crisis		
Crisis Stabilization Facilities	***X***	
Crisis Relief Centers	***X***	
In Home Stabilization		***X***
New Journeys Teams		
Withdrawal Management		
Inpatient Treatment Services		
Evaluation and Treatment Services		
Secure Withdrawal Management		
Intensive Behavioral Health Treatment Facilities		
Hospital Based Services		
Emergency Department Services		

Project plan

1. **Workgroup established**
   - Convene workgroup
   - Invite Private payors
   - Draft orientation slide deck for new members
   - Set cadence and scheduling
   - Invite individual to group for FFS perspective
   - Logistics - Establish document control
2. **Determine Tribal involvement**
   - Consult HCA Office of Tribal Affairs
   - Ensure that tribal involvement and potential impacts are considered when defining scope
3. **Define scope**
   - Small internal team to do initial draft of "crisis services, mobile crisis, and facility-based services"
   - Define the scope of involvement of private payors and the Office of the Insurance Commissioner -
   - Vet scope definitions with actuaries
   - Vet scope definitions with workgroup
   - Refine as needed
4. **Work with actuaries**
   - Hold initial planning meeting with to Mercer establish roles and expectations.
   - Get contract in place
   - If more than one actuary, clearly define roles - Milliman
   - Determine data needs
   - Determine when to bring actuary to workgroup and why
   - Determine approach or roadmap to assess gap
   - Define and outline current funding model(s) - align w/ scope
   - Identify what previous work we can leverage
5. **Work with OIC and private payors**
   - Initial work with OIC - schedule meeting to start
   - Vet with workgroup
6. **Preliminary report**
   - Determine realistic objectives and scope for initial report
   - Draft report
   - Review - workgroup
   - Internal review
   - Submit report to LAA
7. **Map out 2024 workplan & timeline**
   - Drafted workplan
   - Review with workgroup
   - Submit report

Report provided by Mercer actuaries

HCA contracted with Mercer Actuaries to provide a current state report on crisis stabilization facilities. This information will be utilized to assist in the gap analysis to determine needs within the state for those facilities. Further work will include recommendations for community needs of those facilities as well as other supports that may assist in ensuring crisis services are appropriate to the needs of the region.

Mercer report excerpt

Pages 11-16 contain an excerpt from the Mercer report provided to HCA.
The full report is available in the Appendix.

Introduction

Under Senate Bill 5187 Proviso 19(b), the State of Washington's Health Care Authority (HCA) was tasked by the State Legislature to examine "gaps in the current funding model for crisis services and recommend options for addressing these gaps, including but not limited to, an alternative funding model for crisis services."[1] To assist with this study, HCA engaged with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to analyze facility-based crisis services (i.e. crisis triage and crisis stabilization units) with an emphasis on the following areas:

- Determine the annual cost of operating facility-based crisis services.
- Determine the proportional share of program costs among payors.
- Differentiate between facility-based crisis services paid for by Medicaid and non-Medicaid payors.

Results of the analysis will be reported to the Legislature and the Office of Financial Management across two deliverables:

1. A preliminary report due to the Legislature by mid-January 2024.
2. A final report due by December 1, 2024.

This document serves as the preliminary report describing the current model of facility-based crisis services in the State of Washington, existing reimbursement rates and payors, the array of services provided, and an environmental scan of facility-based crisis models in three other states (Arizona, Connecticut, and New Mexico).

The final report will include the information presented in this preliminary report and an overview of the new crisis relief centers, evaluation of the adequacy of current reimbursement levels for facility-based crisis stabilization services, estimates for the annual cost of operating facility-based crisis stabilization services, and recommendations for prospective reimbursement methodology that addresses concerns of matching payment to utilization while maintaining appropriate capacity to fulfill the need for crisis services in Washington.

[1] 5187-S.PL.pdf (wa.gov)

Methodology

The analysis in this preliminary report was informed by three key activities described below.

HCA workgroup

Under Proviso 19(b), HCA was required to "convene representatives from Medicaid managed care organizations (MCOs), behavioral health administrative organizations (BH-ASOs), private insurance carriers, self-insured organizations, crisis providers, and the Office of the Insurance Commissioner to assess gaps in the current funding model for crisis services and recommend options for addressing these gaps including, but not limited to, an alternative funding model for crisis services."[2] The workgroup began its work in October 2022 and to this date, meets every two weeks for an hour with approximately 30 individuals in attendance. Workgroup attendees shared their thoughts regarding the existing payment methodology for facility-based crisis centers (i.e., the efficacy of the per diem rate service code), utilization and capacity rates, current gaps in the service array, workforce challenges, the differing needs in rural versus urban areas and many other applicable topics.

The workgroup will continue meeting into 2024 to provide important feedback and input into the rate-setting process.

Request for Information

In October 2023, Mercer released a Request for Information (RFI), or "survey", to MCOs, BH-ASOs and providers of facility-based crisis stabilization services for the period of state fiscal year (SFY) 2022–2023 (July 1, 2022–June 30, 2023). The RFIs differed slightly depending on the recipient — MCOs and BH-ASOs or providers of facility-based crisis stabilization services.

For MCOs and BH-ASOs, the RFI requested a list of contracted providers, the number of beds, chairs, or recliners available, if services were offered 24 hours, 7 days per week (24/7) if the provider serves a specific age or population, county or counties of service, and dates of service in SFY 2023. The RFI also asked respondents to identify the total units delivered and the average payment rate for each contracted provider under service codes S9485 (Crisis Intervention Per Diem) and S9484 (Crisis Intervention Per Hour) for both fee-for-service (FFS) and non-fee-for-service (non-FFS) arrangements. The same responses were requested for any other crisis-related procedure codes delivered by their facilities.

For providers, the RFI asked respondents to identify the number of beds, chairs, or recliners available, the total units delivered and the average reimbursement rate under service codes S9485 (Crisis Intervention Per Diem) and S9484 (Crisis Intervention Per Hour) for both FFS and non-FFS arrangements by payor. Similar to the MCO and BH-ASO RFI, the same responses were requested for any other crisis-related procedure code delivered by their facility or facilities.

The final tab in both RFIs asked respondents to provide narrative responses regarding the need for additional crisis facility-based services, referral sources for their facilities, and the availability of services on a 24/7 basis.

[2] Ibid

Environmental Scan

The final component of the analysis included an environmental scan of three states to understand how facility-based crisis services are designed and funded outside of Washington. The review included, but was not limited to; eligibility, payors, and payment methodology, permitted provider types and qualifications, and the number of available facilities (including in rural versus urban areas). The intent of the scan was to determine if any design element or payment structure may be replicable in Washington and could be used to inform the rate-setting process that will occur in 2024. In collaboration with HCA, Mercer identified the states to be studied as Arizona, Connecticut, and New Mexico. Each was chosen either due to their proximity to the State of Washington and/or a national recognition of their existing crisis system. Mercer's analysis was limited to publicly available information; however, it is worth noting that these three states share a great deal of information about their crisis systems in the public sphere. For a full view of the environmental scan, see Section 4 of this report.

To supplement the environmental scan, Mercer also developed a state profile for Washington and each of the states studied that includes relevant publicly available information such as population, demographics, health insurance coverage type, Medicaid program delivery systems, median wages, minimum wages, and cost of living indices. When considering the design and funding of public services such as crisis services, it's helpful to understand these factors as contributing elements to the decision-making process. The table below represents a summary of key comparable data for each state.

Data Point	Washington	Arizona	Connecticut	New Mexico
Total Population	7,830,827	7,453,517	3,629,055	2,110,011
Cost of Living Index	115.7	110	113.9	93.9
Statewide Minimum Wage	$ 15.74	$ 13.85	$ 15.00	$ 12.00
Statewide Median Wage	$ 27.08	$ 21.77	$ 24.90	$ 19.19
Health Insurance by Coverage Type:				
○ **Employer**	52%	46%	53%	36%
○ **Medicaid**	21%	21%	22%	34%
○ **Medicare**	14%	16%	14%	16%
○ **Other**	7%	7%	6%	6%
○ **Uninsured**	6%	10%	5%	8%

State Profile — Washington

Total Population: 7,830,827 | Native American Population Percentage: 2.85%

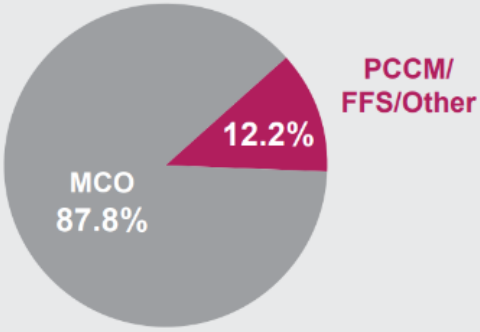
Source: World Population Review (2023)

	Health Insurance Coverage Type				
Demographic	**Employer**	**Medicare**	**Medicaid**	**Other Coverage**	**Uninsured**
Total Population	52.3%	14.1%	20.7%	6.9%	6.0%
Elderly 65+	6.7%	78.5%	12.7%	1.1%	1.0%
Adults 19-64	65.3%	1.3%	16.0%	8.7%	8.7%
Children 0-18	51.0%	0.0%	39.3%	7.0%	2.7%

Source: KFF - State Health Facts (2021)

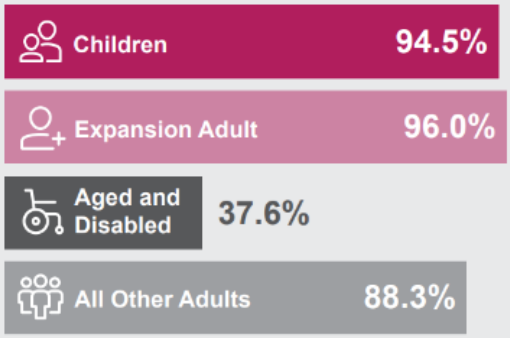
Medicaid Program Delivery Systems

Enrollment by Delivery System



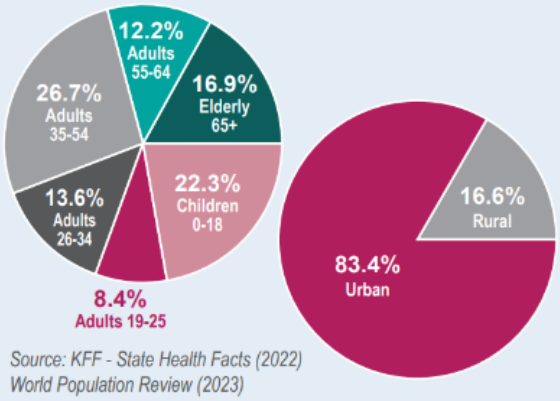
Source: KFF - State Health Facts (2022)

Managed Care Enrollment by Eligibility Group



Source: KFF - State Health Facts (2022)

Population Statistics

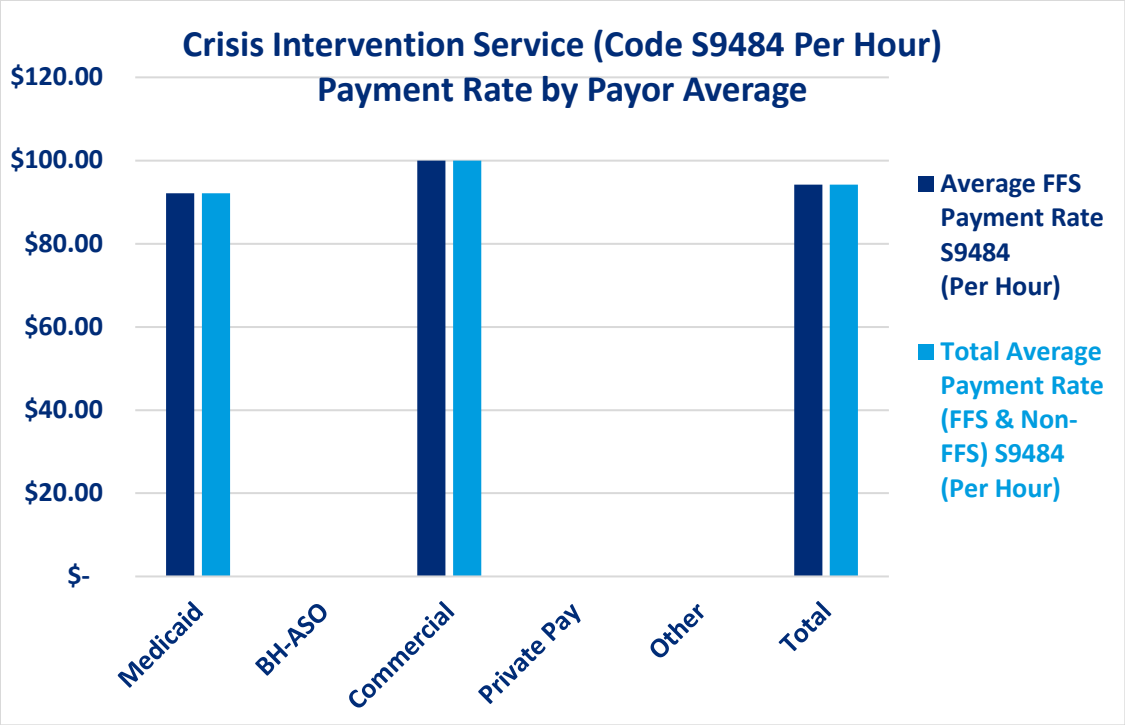


Source: KFF - State Health Facts (2022)
World Population Review (2023)

Minimum Wages, Median Wages, and Cost of Living

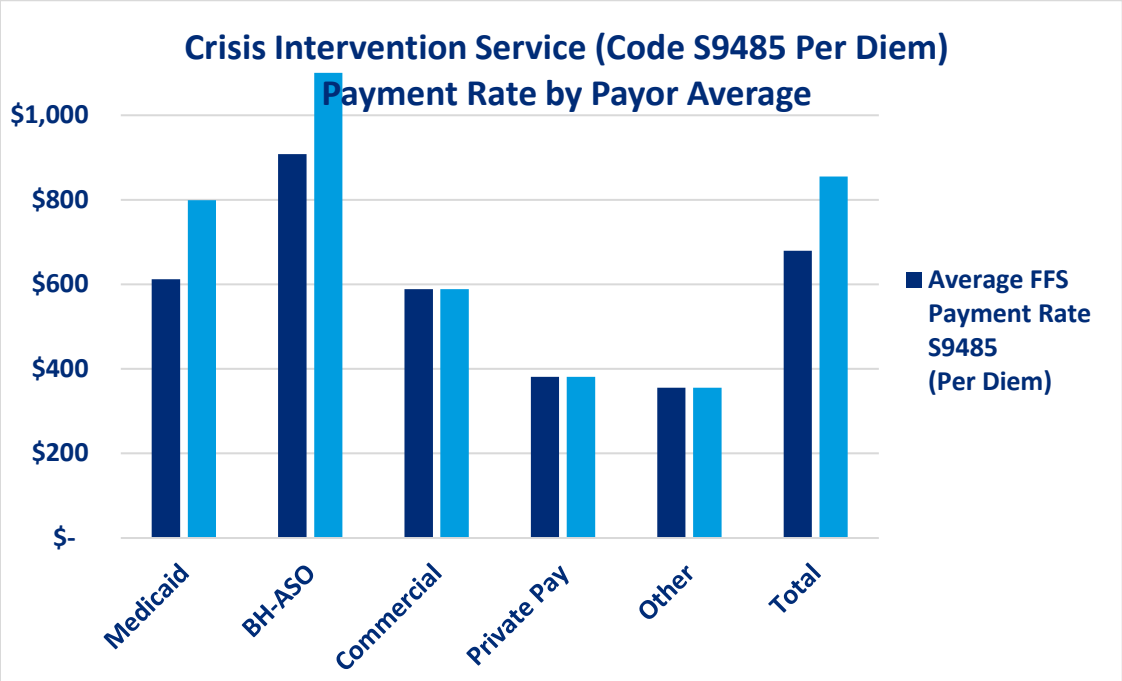
State Minimum Wage	**$15.74**
Cost of Living Index	**115.70**
All Occupations	**$27.08**
Healthcare Practitioners and Technical Occupations	**$46.41**
Healthcare Support Occupations	**$18.44**

Source: U.S. Department of Labor (2023), MERIC - Cost of Living Index (2023), U.S. Bureau Of Labor Statistics - State Occupational Employment And Wage Estimates (May 2022)



For S9495, private pay and other funding sources were reported as significantly lower than other payor categories but due to lack of data available for these categories, this may not be replicable with a more comprehensive dataset.

Table 7: Average S9485 Payment Rate by Payor



Narrative Responses

Additional Need for Facility-Based Crisis Stabilization Services

As part of the survey, recipients were asked if there was a perceived need for additional crisis facilities in the region. Of those who responded, the responses were mixed. Some respondents indicated a need for additional adult facility-based support and reported low levels of unfilled capacity. However, other respondents reported existing capacity in their facilities and did not perceive a need for additional adult facilities.

Many respondents indicated interest and excitement about the development of crisis relief centers in rural areas, due to lengthy drive times to access crisis support in rural parts of Washington. Most respondents agreed that the greatest current need is for specialized crisis providers. This is especially true for youth and adolescent providers, as respondents reported there are few or no providers for this population in their region. Other populations that could benefit from additional support are individuals who are geriatric, those with co-occurring mental health and intellectual/developmental disability (I/DD), and those with co-occurring mental health/substance use disorders (SUDs).

While many survey recipients reported a need for additional facilities, workforce capacity is a well-known challenge. Almost all submissions agreed that adequate staffing is the greatest barrier to opening any new facilities. Providers, BH-ASOs, and MCOs all expressed concerns regarding the availability of qualified staff, particularly mental health professionals (MHPs) and nurses, to support any new facilities. Respondents reported that staffing was a critical issue in rural areas of the state where qualified staff are already in short supply.

End of Mercer report excerpt. The full report can be found in the Appendix.

Intersection with HB 1134; Sections 9, 10, 11

As previously mentioned in this report, the intersection with HB 1134 requires analysis of the mobile crisis response teams and the gaps in service that may exist in Washington state. This portion of the report will detail the intersection of that work as well as provide a status update.

Project status of HB 1134 – 988 work

HB 1134

Section 9 state HCA shall establish endorsement standards and supplemental performance payments for mobile rapid response teams (MRRT) and community-based crisis teams (CBCT).

This includes minimum staffing requirements, transportation capabilities and initial/ongoing training and clinical supervision. Teams that meet the endorsement criteria are eligible for an enhanced case rate.

Establishes a performance program with explicit thresholds for response and dispatch times based on the service area (rural, suburban, urban). Teams that meet both the endorsement criteria and these performance thresholds will receive supplemental performance payments.

Workgroup members

HCA

- Teresa Claycamp
- Matt Gower
- Catrina Lucero
- Sherry Wylie

MCO

- Whitney Howard – Molina
- Anusha Fernando – Molina
- Stacey Lopez – UHC
- Emily Rose – CCW
- John Doherty - CCW
- John Richardson – Amerigroup
- Basil Dibsie – Amerigroup
- Christopher Rakunas – Amerigroup
- Connie Mum-Ching - CHPW
- Teresa Trout – Coordinated Care
- Megan Gillis – Molina
- Michele Robertson - Amerigroup

ASO

- Joe Avalos
- Stephanie Lewis
- Justin Johnson
- Kurt Beilstein
- Tiffany Villines
- Karen Richardson
- Joe Valentine
- Charles DeElena
- Michael Reading
- Matthew Goldman

Providers

- Cascade Community Healthcare
- Catholic Community Services and Catholic Housing Services of Western Washington
- Columbia Wellness
- Compass Health
- Comprehensive Healthcare
- Downtown Emergency Service Center
- Discovery Behavioral Healthcare
- Kitsap Mental Health Services
- Central Kitsap Fire and Rescue
- MultiCare Health
- Pend Orielle County Counseling Services
- Quality Behavioral Health Services
- Snohomish County

- YMCA of Greater Seattle

Project plan

Core questions

- What is the current state of mobile crisis response?
- What are the anticipated impacts of the endorsement criteria on mobile crisis response teams?
- What is needed for the teams to realistically meet the defined performance metrics?

Stakeholder engagement

- Informational Sessions
- Technical workgroup
- Key informant interviews

Final report

- Considerations for different scenarios and time/support needed to meet standards
- Options for enhanced case rate
- Supplemental rate for teams meeting performance thresholds

Project status

Over the past six months, Milliman and HCA have been collecting the information needed to serve as a baseline for the analysis. To date, the project has focused on the first of the two phases mentioned above. This includes a detailed review of the current mobile crisis response system in Washington, specifically as it relates to the current staffing structure and service delivery model. Multiple stakeholder engagement strategies have been leveraged to gather this information.

Thus far, this has included:

- A general stakeholder information session in September 2023
- Monthly technical workgroup meetings since October 2023
- A survey of all mobile crisis response providers in Washington (17 responses received)
- Individual interviews with 7 behavioral health agencies providing mobile crisis response services.

The feedback received through these various forums has helped establish a foundational understanding of the current costs and operations of mobile crisis response providers.

Project status for proviso 19 work

To date, HCA has convened the required representation for the workgroup and regular monthly meetings are occurring. In this initial phase HCA partnered with Mercer to complete the analysis for facility-based crisis stabilization services. The preliminary report is complete and contained in the Appendix. Mercer will continue to assist with the next phase of the work. The next phase includes analysis of Designated Crisis Response teams, costs to administer involuntary treatment and potential gaps in those areas. Additionally, further partnership with the Office of the Insurance Commissioner will focus on private insurance and the intersection with HB 1688.

Per the proviso, HCA will submit a final report on December 1, 2024. The final report will contain the required elements, which includes gaps in the current funding models, as well as recommendations for addressing these gaps inclusive of alternative funding model options for crisis services.

Conclusion

Work is progressing on both projects. Expected deliverable dates for the Milliman HB 1134 work, which will be utilized for the mobile crisis response portion of the gap analysis in work for Proviso 19 is expected to be complete in April of 2024. The final report from Mercer is expected to be completed in September of 2024.

Next steps

HB 1134 related work

Milliman and HCA will continue the assessment of the current mobile crisis response delivery system. Specifically, this will include an increased focus on elements such as:

- **BH-ASOs**
  - Funding streams and operational considerations related to the regional coordination of mobile crisis response services.
- **CBC teams**
  - Distinct considerations for mobile crisis response teams using a co-response model and/or operating in rural communities.
- **Tribal organizations**
  - Unique factors impacting the delivery of mobile crisis response services in tribal communities.
  - HCA expects to finalize the endorsement criteria in the spring of 2024. Following this, Milliman will begin a formal analysis of the potential impact and incremental cost increases associated with the new standards and performance program. The findings of this analysis will be consolidated into a final report, which is slated for completion in summer 2023.

Proviso 19 related work

Many outstanding issues were brought forward by the workgroup. These considerations will be integral to ensuring the appropriate analysis is completed, and the information is contained in the report. As we review discussion points, the group will be considering alternatives to ensure gaps and suggestions to remedy the gaps are included in the final report.

Some of the discussion points below will be reviewed and analysis will be done to determine the impact of these considerations.

- **Alternative payment mechanisms**
  - Perhaps billing intake then move to an hourly rate.
  - Talked about threshold of hours before daily code, billing mechanism appropriate?
  - Per diem has a menu of services that are offered, anything unusual could be billed alongside that per diem.
  - Funding models that are currently being utilized; how do we need to change them?
  - Hourly, daily, capacity, fixed cost-plus utilization, hours of service and then roll over to a per diem at a certain point, separate billing for intake and then hourly, then per diem as appropriate.
  - What goes into the hourly and daily services: following the work group schedule, going to add to the define funding model's section.
  - Need shared consensus on what we need in terms of payment mechanisms.
- **Underutilization of existing facilities**
  - Why are facilities not being utilized?

- What causes a decrease in census?

- **Region needs**
  - Not every region needs a full 16 bed facility
  - Scope the facility to the region
  - Scope the stabilization services to the region needs

Appendix: Mercer report

Facility-Based Crisis Stabilization Services; Proviso 19(b) Preliminary Report; prepared by Mercer Government Human Services Consulting.