Washington State Health Care Authority

Report to the Legislature

Addressing crisis services funding gaps

Final report

Engrossed Substitute Senate Bill 5950; Section 215(19)(b); Chapter 376; Laws of 2024

December 2024

Final report addressing crisis services funding gaps

Acknowledgements

We extend our gratitude to all the workgroup members, as well as our partners Mercer, Milliman, and the Office of the Insurance Commissioner, for their participation, knowledge, and perspective to this body of work.

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Executive summary

The Health Care Authority (HCA) submits this report in response to ESSB 5950; Section 215(19)(b); Chapter 475; Laws of 2024:

> Within these amounts, the health care authority shall 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 and co-response services and recommend options for addressing these gaps including, but not limited to, an alternative funding model for crisis and co-response services.
>
> The assessment must consider available data to determine to what extent the costs of crisis and co-response 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 and co-response services provided by mobile crisis teams and co-response 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 and co-response services and collect a proportional share of the program cost from each health insurance carrier; ((and))
>
> ii. differentiate between crisis and co-response services eligible for Medicaid funding from other non-Medicaid eligible activities; and
>
> iii. simplify administrative complexity of billing for service providers such as the use of a third-party administrator.
>
> 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. Up to $300,000 of the general fund—state appropriation for fiscal year 2024, and $450,000 of the general fund—state appropriation for fiscal year 2025 may be used for the assessment and reporting activities required under this subsection.

The work related to this proviso spans over a two-year period, with HCA originally convening key stakeholders beginning October 2022 to address issues related to crisis facilities funding and payments. The formal workgroup convened for this proviso was assembled in May 2023, and met monthly through November 2024. The Office of the Insurance Commissioner (OIC) was a key partner throughout this work. HCA leveraged contracts with two actuaries, Milliman and Mercer, to conduct provider and payor surveys, provide national environmental scans, and conduct rate analysis. Of note, the amended proviso in 2024

expanded the scope of the proviso work to include co-response services, which proved challenging to fully fold into the already-existing body of work given time constraints.

The Washington State public behavioral health crisis system serves all of Washington on a 24/7 basis and provides services regardless of insurance status or income level. The system and correlated services have three key components:

1. Initial crisis response
2. Stabilization services post initial crisis response
3. Inpatient treatment services

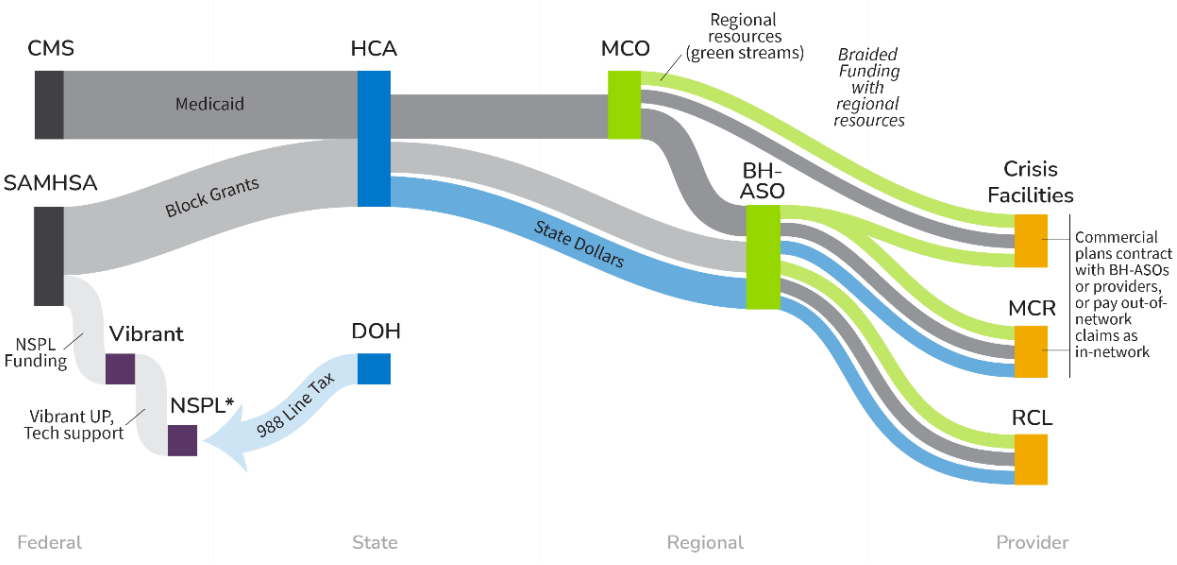
The scope of the work reflected in this report focuses on the first and second components.

HCA contracts with regional Behavioral Health Administrative Service Organizations (BH-ASOs) to administer the crisis system in their regional service areas, including initial crisis response. Each of the ten BH-ASO regions implements services and programs that meet contract requirements tailored to their unique regional needs (**view a map of the BH-ASO regions in Washington**). Initial crisis response under the BH-ASO contractual umbrella includes:

- Regional Crisis Lines (RCL)
- Mobile Crisis Response (MCR) which consists of:
    - Mobile Rapid Response Crisis Teams (MRRCT)
    - Endorsed MRRCT and Community Based Crisis Teams (CBCT) which are capable of responding to the most acute crisis calls.
- Designated Crisis Responders (DCR)

These safety net services are supported by a mix of funding that includes state funds, Medicaid, block grant, local government funds, and private health insurance carriers. It has historically been difficult to bill health carriers for initial crisis response services. With the passage of **E2SHB 1688** in 2022, fully insured and self-funded health plans that opt into **the Balanced Billing Protection Act** are now required to cover behavioral health emergency services. Work to integrate them as regular payors is ongoing and has run into significant issues resulting in delays. In contrast to these safety net services, financing the second component — stabilization services — is contingent upon Medicaid or private health insurance coverage, and other available resources/funding for people who are uninsured or underinsured. The following is a visual representation of the funding and contractual relationships (Figure 3: Funding Pathways).

Funding pathways for safety new services



HCA 82-0440 (12/24)

*NSPLs are funded separately through Vibrant Up, tech support, and DOH's 988 Line Tax.

Acronym legend:
BH-ASO – Behavioral Health Administrative Service Organization
CMS – Centers for Medicare and Medicaid Services
DOH – Department of Health
HCA – Health Care Authority
MCO – Managed Care Organization
MCR – Mobile Crisis Response
NSPL – National Suicide Prevention Lifeline Centers (Now called 988 Suicide and Crisis Lifeline Centers)
RCL – Regional Crisis Line
SAMHSA – Substance Abuse and Mental Health Services

Co-response services were a late addition to this work. There are approximately 61 co-response programs in Washington concentrated mainly in high-density population areas, the majority of which are funded outside of the current crisis system administered by the BH-ASO and Medicaid funded system. An environmental scan for co-response programs can be found in the Mercer report (**appendix 2**). Current funding sources tend to be local or county, rather than Medicaid or health insurance based. More exploration would be needed to determine how to incorporate co-response teams into the current crisis system and what funding mechanisms would be best suited for these providers.

Over the course of two years, workgroup members and surveys conducted by Mercer and Milliman identified many gaps and challenges related to initial crisis response and stabilization pathways. Below is a summarized, albeit not exhaustive, list of key gaps identified:

- Current utilization-based funding methodologies are misaligned and often underfund the need for a "firehouse" crisis system, which requires crisis teams to be at the ready 24/7 when there is a crisis need.
- Current fee-for-service per-diem payment arrangements to facility-based stabilization providers assume a consistently high utilization and census rate, while not accounting for fixed operational

costs. Capacity payments are not allowed under federal Medicaid rules so a Medicaid payment structure that's more of a value-based payment arrangement would be needed, which is not common for these types of facilities.
- Further, smaller rural facilities are financially unstable due to smaller economies of scale. The emerging Crisis Relief Centers, a 23-hour model, will likely face similar challenges.
- Private health carrier payments for these services continue to lag in financially supporting access to the crisis system and other fund sources continue to shore up the costs.
- High administrative burden continues to be placed on both BH-ASOs and providers.
- BH-ASOs ability to leverage Medicaid for the services they provide varies greatly from region to region. The variance is based upon each BH-ASO's unique operational model and negotiated reimbursement with each Medicaid managed care organization (MCO), as well as the region's ability to capture Medicaid encounters.
- Workforce hiring and retention is an ongoing struggle system-wide, with a provider's ability to pay its staff competitive wages being a main factor in staff recruitment and retention.

For the crisis stabilization facilities, provider survey data gathered and analysis provided by Mercer showed that the average reimbursement rates were meaningfully lower than the calculated benchmark rates. Further, the survey results, although not a fully complete sample size, leads to a probable conclusion that the majority of Medicaid and private health insurance carriers' payments are consistently lower and based on a fee-for-service methodology, while the BH-ASOs' payments are capacity-based and elevated to likely compensate for the lower rates on the Medicaid and insurance side, thus shoring up the funding gaps (see **figure 5** in the report).

MCOs report there is confusion on the agreed-upon core services that are represented under the standard per-diem billing practices for these facilities. This lack of shared understanding results in lower reimbursement rates because MCOs are unable to account for the full costs of the services. Private health insurance carriers report that due to being new to paying for these services, they are following the practices of MCOs.

A significant portion of this report includes Mercer's key recommendations, as well as an exploration of an array of alternative payment models (APMs). The full report is linked in **appendix 2**. Also included in this report is a summary of the workgroup members' feedback.

Key findings and recommendations are as follows:

1. **Reducing administrative burden**
   Any future reform should strive to simplify the system and reduce the administrative burden. The BH-ASOs recommend:
   - All crisis services, including stabilization, should be included in the BH-ASO contract and oversight.
   - Medicaid reimbursement should be predictable based on regional population or utilization.
   - Crisis services should be billed to one entity, rather than multiple payors.

2. **Private health insurance carrier engagement**
   Current and future efforts should continue to support current law, **RCW 48.43.093** and **RCW 48.43.005**, which requires commercial health insurance carriers to cover behavioral health crisis services as emergency services. Ongoing work should continue to mitigate the administrative

barriers and complexities that are getting in the way for successful contracting and payment for these safety net services, including compliance with newly adopted **WAC 284-170-205**.

3. **Financing and paying for behavioral health crisis services**
   Further analysis and review should consider the following alternative pathways towards funding. It should be noted that some of these pathways may require a specific waiver or state plan amendment approved through CMS.

   a. Alternative financing models include:

      i. Assessments, such as Covered Lives Assessments and Augmented 988-line tax allow for a more reliable basis of funding. Assessments allow the financing to be balanced between payors and are based on the number of lives or lines in the assessment area.
         1. Covered Lives Assessment is a prospective model that taxes a health carrier and MCO based on the number of lives they cover.
         2. Augmented 988-line tax is a tax on each line of a phone in a mobile phone plan.

      ii. Population or utilization based prospective payment models. Recently, HCA has identified an additional prospective per member per month payment option. The option allows for more predictable Medicaid funding for BH-ASOs based off of population or utilization. HCA and Milliman are partnering to better understand this approach and determine if it's a viable option.

   b. Alternative payment models include:

      i. All-Payor Global Budgets. All-payor global budgets are a prospective payment model that sets a fixed annual budget based upon factors such as anticipated utilization, costs, and potential savings. This model has the advantage of bringing payors who are not involved or difficult to engage into the planning process. An all-payor global budget will be administratively complex to develop and administer for the state.

      ii. All-Payor Accountable Community Organization (ACO) model or an ACO-like model. ACO like APMs assign risk and reward to an entity by giving it incentives to improve care and reduce cost. This model requires payors to contract for the delivery of services as MCOs do with BH-ASOs, but in this model private health insurance carriers and potentially other payors would participate along with the Medicaid program. Any ACO or similar model requires the ACO like entity to assume risk. It would likely require a risk sharing plan for the first few years or until the system can be fully stabilized.

To culminate this work, further analysis with a narrowed focus is needed. HCA, in partnership with OIC, recommends additional work be completed in the following three phases:

1. **Phase one (2025)**
   This phase would leverage remaining 2023–2025 biennium funding to continue work with the actuaries.[1]
   - Further analysis, definitional work, and exploration of the alternative financing and payment model options would occur.
   - Gleaning more information from CMS on population-based methodologies.
   - Costing out a system that fully meets demand, which has been a challenge. However, working with the actuaries to refine what has been gathered thus far could provide a "baseline" funding level, as well as consideration of any increasing capacity needs, to then create a foundation for costing out a firehouse model.
   - Further analysis on what would be needed to finance the system, e.g. APM's – actuarial rate modeling and how this would convert into the identified APM.
   - Further analysis to clearly identify a preferred APM model.
   - A status update report would be provided to the legislature in December 2025.

2. **Phase two (January – March 2026)**
   This phase would work on the identified financing APMs and administration/payment models to lay out a detailed strategy/plan/framework for consideration for future system change.

3. **Phase three (April – June 2026)**
   This phase would work on finalizing recommendations, including timelines, for consideration by legislatures and key partners.

All phases would continue to solicit input from the workgroup members and work collaboratively towards consensus recommendations. Funding is available to continue work through July 2025. Further funding for the fiscal year 2026 would need to be appropriated.

[1] On December 2, 2024, Governor Inslee announced Directive of the Governor 24-19, Freeze on Hiring, Services Contracts, Goods and Equipment Purchases, and Travel (the Directive) to go into effect immediately. The Directive implements a freeze which includes signing new or amended Services Contracts and making Goods and Equipment purchases or leases. HCA would need to seek and receive a contracting exemption to extend this work.

Workplan and 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(19b) since it already included many of the required participants.

Workgroup overview

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 complex systems. Ensuring shared foundational knowledge and understanding of all complexities is critical 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.

Project phases

After the original workgroup was repurposed, a workplan was developed with partners to address the work in for this report. The initial phase worked to define scope and gather appropriate individuals for the group.

Phase one, May 2023 – January 2024

The initial phase of work focused on planning and assembling workgroups to approach this work. This included convening representatives from payors to providers and contracting with actuaries. The workgroup defined the scope of work for both actuaries and the overall work. Milliman started work on understanding the current costs of MRRCT and Mercer kicked off their work with crisis stabilization facilities. Both actuaries completed initial reports:

- Mercer's 2023 preliminary analysis on facility-based crisis stabilization services, included in this report in **appendix 4**.
- 2023 preliminary report to the Legislature, included in **appendix 5**.

Phase two, January – December 2024

Phase two focused on gathering information from payors and providers and identifying gaps. Work was split between Mercer and Milliman with each handling a different aspect of the crisis system that contributed to this report. Milliman continued its work on costing out and creating a funding model for the endorsement of mobile crisis. Mercer finished its work on crisis stabilization units then shifted to costing out involuntary treatment services and developing a cost model for crisis relief centers. Both Milliman and Mercer completed their final reports by gathering feedback from the workgroups.

- Mercer finalized Proviso 19(b) report "Facility-Based Crisis Stabilization Centers, Designated Crisis Response Services, and Crisis Relief Centers," which is included in **appendix 2**.
- Milliman finalized HB 1134-directed report "Mobile crisis response payment options in Washington State." The report is specific to endorsement standards identified in HB 1134 and fiscal impact of implementation. The initial analysis is included in this report in **appendix 3**.

Workgroup representation

The workgroup includes representatives from multiple partners, including the BH-ASOs, MCOs, behavioral health providers, private insurance carriers, the Washington State Behavioral Health Council, the Washington State Hospital Association, the Association of Washington Healthcare Plans, and the Office of Insurance Commissioner. For a full list of attendees please view **appendix 1**.

Project scope

Careful consideration was given to ensure coordination of efforts of two operating budget provisos that intersect. Proviso 19 (SB 5950, Sec. 215(19)(b), 2023) required an assessment of gaps in the current funding model for crisis services and to recommend options for addressing those gaps, inclusive of alternative funding models. House Bill (HB) 1134 (2023) directed HCA to establish endorsement standards and supplemental performance payments for MRRCTs and CBCTs. This final report combines information from both the proviso and HB 1134 work, including cost data.

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

Scope determination	In scope of Proviso 19 workgroup (included in Mercer reports, see appendix)	In scope of HB 1134 workgroup (included in Milliman report, see appendix)
Initial crisis-response pathways		
National 988-lifeline network	No	No
Regional crisis lines	**Yes**	No
Mobile crisis response teams	No	**Yes**
Designated crisis responders	**Yes**	No
23-hour crisis relief centers	**Yes**	No
Crisis stabilization facilities	**Yes**	No
Co-response programs*	**Yes**	No
Emergency department services	No	No
WISe teams	No	No
PACT teams	No	No
Stabilization services after initial crisis		
Crisis stabilization facilities	**Yes**	No
Crisis relief centers	**Yes**	No
In-home stabilization	No	**Yes**
New Journeys teams	No	No
Withdrawal management	No	No
Inpatient treatment services		
Evaluation and treatment services	No	No
Secure withdrawal management	No	No
Intensive behavioral health treatment facilities	No	No
Hospital-based services	No	No

*Only preliminary work on co-response programs was completed due to time constraints.

Current state of the crisis system and services

The Washington State public behavioral health crisis system serves all of Washington on a 24/7 basis and provides services regardless of insurance status or income level. The following services are to be provided to any person, including children and families, identifying as experiencing a behavioral health crisis, which could be mental health and/or substance use related:

- 988 Suicide & Crisis Lifeline (administered by the Department of Health)

Under BH-ASOs and HCA oversight (all services are available 24/7, 365 days a year):

- Regional crisis lines
- MRRCTs, providing outreach and crisis intervention services staffed by behavioral health professionals and certified peer counselors
- Application of mental health and substance use involuntary commitment statutes using designated crisis responders to conduct Involuntary Treatment Act (ITA) assessments and file detention petition.

HCA contracts with regional BH-ASOs to administer the crisis system in their regional service areas. Each of the ten BH-ASO regions implements services and programs that meet contract requirements tailored to their unique regional needs (**view a map of the BH-ASO regions**). HCA provides funding and oversite of the regional systems through contracts that with the BH-ASOs that impose the federal and state mandates. Oversite of the BH-ASOs is done through reporting and contract compliance audits. Contracts are amended every six months when new requirements and/or programs are added or removed.

BH-ASOs are responsible for ensuring these safety net services are available to anyone regardless of insurance coverage. A mix of state, Medicaid, block grant, local funds, and private health insurance carriers funding are used to pay for crisis services and infrastructure. The BH-ASOs access Medicaid funding through direct contractual relationships with the MCOs. The amount of Medicaid funds the BH-ASOs receive is subject to negotiation with each MCO and is tied to market share and service utilization. BH-ASOs use a blend of funding to contract crisis providers. Most of the operational decisions, including how services are delivered and programs operate, occur at the local and regional level in partnerships between BH-ASOs and service providers.

In contrast to these safety net services, crisis stabilization services provided in facilities are contingent upon insurance coverage or availability of resources. Facility-based providers must negotiate contracts with MCOs and private health insurance carrier companies to provide stabilization services within a crisis stabilization facility or in the new 23-hour crisis relief centers. BH-ASOs cover these services for those uninsured or underinsured within available resources and funding.

Services for help seekers vary based on level of need and acuity. They start with services like the 988 crisis lifeline and can progress to more intensives services or may lead to involuntary commitment. This section will examine services based on the least acute and easiest access to higher levels of support.

When services are not available due to lack of ability to meet demand or not available in a geographical area, people in crisis tend to utilize emergency system. This system includes fire, emergency medical services, law enforcement, and emergency departments. These services are not always the most effective for a person in crisis. They also tend to be significantly more expensive. People in crisis that are unable to

access crisis services may also become justice involved due to the acuity of their symptoms leading to violating the law.

Figure 2: Overview of the current crisis system, main funding sources, and contracting relationships

Organization contracting services	Funding source	Services funded
DOH	• General Funds State (GF-S) • 988-line tax • SAMHSA Grants	• Washington 988 lifeline network

BH-ASOs	• BH-ASOs receive in a proportional block to fund services:
	  ○ GF-S
	  ○ SAMHSA Mental Health Block Grant
	  ○ 988-lifeline tax
	• BH-ASO then contract with MCOs for Medicaid funding.
		• Regional crisis lines
		• Mobile Crisis
		  ○ Mobile Rapid Response Crisis team (MRRCT)
		  ○ Endorsed MRRCT
		  ○ Endorsed Community Based Crisis Team (CBCT)
		• ITA investigations

Insurance	• MCOs • Fully funded private health insurance • BH-ASOs as the payor of last resort.	• Crisis relief centers • Crisis stabilization facilities • Withdrawal management

Voluntary crisis services

Most services provided by the behavioral health system are voluntary services, meaning people can choose to engage or decline services at any time. These services tend to be the most effective because they meet the person in crisis where they are at. These services are tailored to deescalate a person and support them until they are able resolve their crisis. They can involve referrals to outpatient services, social support, and even involuntary services if the person is in immediate danger.

Crisis contact lines

Washington operates a variety of crisis and non-crisis support lines to assist people. They range from warm lines to support people who just need someone to talk with, to points of access like regional crisis lines (RCLs) and 988.

Regional crisis lines (RCLs): The largest in terms of call volume and the central point of access for regional crisis systems are RCLs that are operated by BH-ASO-contracted providers.

988 lifeline: 988 is a free, three-digit phone number that connects you to a trained crisis counselor via phone, text, or online chat. Crisis counselors are available 24/7 to support those thinking about suicide, concerned about substance use, worried about a loved one, in need of emotional support, and more.

Following the designation of 988 as a new three-digit number to access the previously called National Suicide Prevention Lifeline network. Washington passed ES2HB 1477 (Chapter 302 Laws of 2021) the state has been working to develop Designated 988 contact hubs that will have a robust set of features to track and refer people to crisis services. This work is ongoing and 988 is still being integrated into the response system as the primary entry point for crisis services. Work is underway to implement the new orientation and designated hubs by January 2026.

Recovery Helpline (866-789-1511): The Washington Recovery Help Line is a program of Crisis Connections, offering an anonymous, confidential, 24-hour help line for Washington State residents. This help line is for those experiencing substance use disorder, gambling problem, and/or a mental health challenge. The staff are professionally trained to provide emotional support. They can also connect callers with local treatment resources or more community services.

Mobile crisis

Mobile crisis response (MCR) services offer voluntary community-based interventions to individuals in need, wherever they are located to include home, work, school, courts, or anywhere else in the community where the person is experiencing a crisis. The help seeker, not the provider, self identifies and defines the crisis. These services are provided by two-person teams that include a behavioral health clinician and a certified peer counselor. There are several specialized types of mobile crisis in the state of Washington.

- **Mobile response and stabilization services (MRSS) for youth and family**: MRSS includes the initial response, a 72-hour crisis intervention phase, and then if stabilization is needed, there is in-home stabilization for up to eight weeks. MRSS is a child- and family-specific intervention that recognizes the unique developmental needs of youth. Caregivers and youth are interconnected so when a youth is in crisis, the caregiver's ability to respond to the crisis can be impacted. Supporting the caregiver's response to behavioral health needs decreases the likelihood of calling 911, juvenile justice, or child welfare involvement.
- **Tribal mobile crisis**: Many tribes have expressed desire to operate crisis services for their tribal members. HCA has partnered with Tulalip and Nisqually tribes to pilot funding and staffing models for their mobile crisis teams to develop more resources to expand tribal mobile crisis.
- **Endorsed mobile crisis**: An endorsement is a voluntary credential that a Mobile Rapid Response Crisis Team or Community Based Crisis Team may obtain to signify that it maintains the capacity to respond rapidly to individuals who are experiencing a significant behavioral health emergency requiring an urgent, in-person response. Endorsed teams must meet standards for staffing, training, and transportation, ensuring they maintain the capacity to respond quickly and effectively to the most acute calls received by 988.

Co-response programs in Washington State

As described in the Mercer report (Appendix 2), co-response programs are typically dispatched through 911 centers or nonemergency police lines, which demonstrates the need for strong partnerships and cross-training among law enforcement, local behavioral health providers, and behavioral health staff on co-response teams. Co-response programs can address the needs of specific vulnerable populations who

struggle to get these needs met by other systems or interventions. This may include individuals with challenges such as dementia, chronic and debilitating medical conditions, or homelessness. The analysis included the following:

1. Co-response programs divert people from emergency rooms and the criminal justice system to more appropriate services.
2. Co-response programs interrupt harmful situations by providing immediate services which may include mediation and de-escalation during a crisis episode.
3. Co-response programs act as bridges to close systemic gaps in care by providing connections and resources for individuals to rely on in the long term.

In addition to these observations, Mercer noted that co-response programs in other states and Washington are typically funded by non-Medicaid sources such as local governments (e.g., cities and counties), legislatively appropriated state funding, state taxes, and state or federal grants. It is rare to find a co-response program that bills Medicaid for services. This is largely due to the staff composition of co-response teams (first responders) who are unable to bill Medicaid, licensure and paperwork burdens, and a lack of billing infrastructure like electronic health records.

Facility-based crisis stabilization (often called crisis stabilization units)

According to RCW 71.05.020, facility-based crisis stabilization is a "short-term facility or portion of a facility licensed or certified by the department designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization, or to determine the need for involuntary commitment of an individual."

Facilities are designed for voluntary admissions, or 12-hour police holds. The length of stay typically ranges from three to 14 days. Medical clearance is not required. Individuals will be assessed and then supported for medical stability while in the program. The facility maintains the capacity to deliver care for most minor physical health challenges.

Crisis relief centers

During the 2023 legislative session and through the passage of Second Substitute Senate Bill (2SSB) 5120, the Washington State Legislature authorized the establishment of crisis relief centers as the newest component of Washington's crisis continuum. The bill required the creation of licensure and certification rules in consultation with HCA by January 1, 2024. Crisis relief centers are designed to help people experiencing crises and/or displaying acute behavioral health symptoms by providing walk-in options to these individuals, their families, caregivers, or first responders conducting a drop-off. The goals of crisis relief centers are to:

- Provide a no-wrong-door, no-barrier approach to accessing crisis stabilization services.
- Divert people from emergency departments.
- Improve the care received by people experiencing crises.

Involuntary treatment services

Designated Crisis Responders (DCRs) conduct evaluations and investigations to determine if a person presents with symptoms a mental health or substance use disorder, is at imminent or nonemergent risk of harm. Less restrictive referrals may include assisted outpatient treatment or mobile crisis support.

An initial ITA detention is for 120 hours, not including weekends or holidays. The facility providing the initial ITA treatment and evaluation will determine if additional treatment is needed and will petition the court for either 14 days or placement of the individual on a less restrictive order for 90-day outpatient treatment. If the facility files a petition, the individual will have a probable cause hearing for determination of the additional ITA treatment.

If a DCR does not detain an individual, a family member, guardian, conservator, or tribe may petition the court for review and determination of potential order for involuntary treatment.

Emergency services

Help seekers who are unable to get services through the crisis system will often turn to emergency services like:

- Fire departments,
- Emergency medical services,
- Emergency departments.

These services will respond quickly to a person but may not be equipped to support a person with the same support as the crisis system. The emergency system is better equipped to handle medical emergencies. The emergency system typically lacks the personnel and tools to help keep a person stable in their home. They also do not have the ability to follow up or provide ongoing support. This often results in a person being transported to an emergency department (ED). EDs often get admits from first responders and family members who are unable to get support for the person in crisis. They are equipped to keep a person safe and look for a higher level of support but are often chaotic and unable to give the attention a person in crisis needs. Emergency department admissions are expensive and don't always resolve the person's crisis.

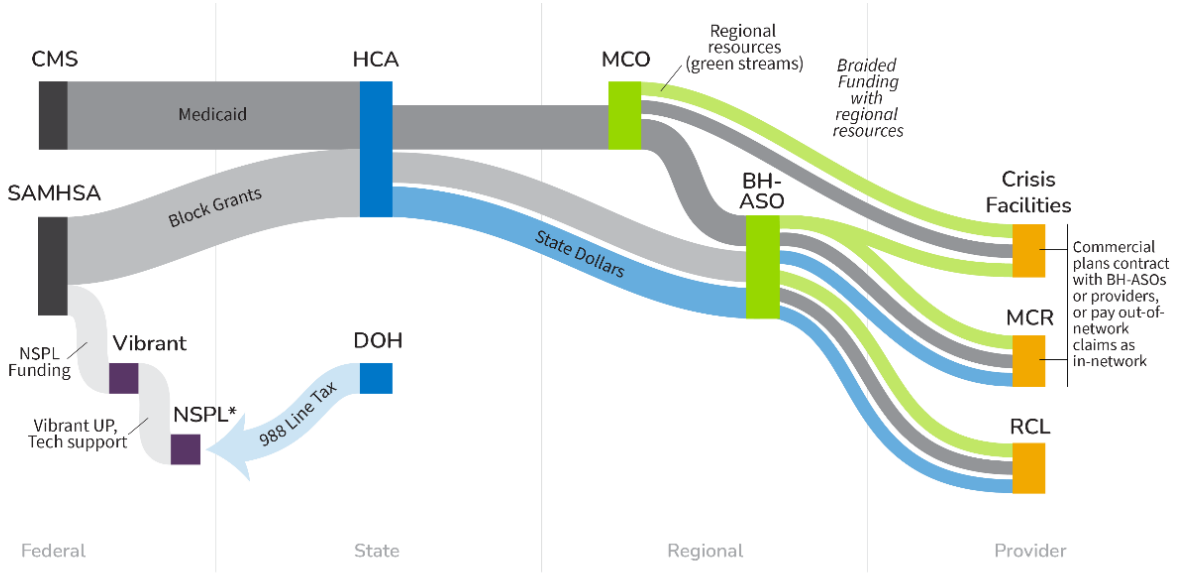
Crisis funding and the firehouse model of crisis services

The Washington public behavioral health crisis system is funded with a blend of funding from multiple sources that each comes with its own requirements. The current funding model is utilization based which has led to a strain on service providers to keep services available during normal lower utilization and struggle to meet demand when it's high. This is not an effective way to support people in crisis nor is it an efficient way to operate the system. When someone cannot be served by the appropriate level of service, they either continue to suffer without help or require higher, and more expensive, forms of care. Creating a new funding model that can ensure access whenever someone needs it will save money in the long run by decreasing higher levels of care or ineffective care routes. Most importantly, it can save lives.

Crisis funding sources

The current crisis system is funded by a mix of multiple streams braided to pay for services. Costs are modeled at the state level with input from partners. These models are then used to break down the funding sources and payments to the contracted payors. For state, SAMHSA block grant, and special purposed dollars like the 988-line tax funds are all sent to contracted BH-ASOs to fund all required services in the region. Medicaid is provided through a per member, per month (PMPM) capitated rate sent to the contracted MCOs, who are then required to delegate the crisis network and funding to BH-ASOs to pay for Medicaid reimbursable crisis services. The majority of payments to crisis providers come from the region's BH-ASO based on a negotiated payment arrangement between provider and BH-ASO. This payment arrangement contains a mixture of the funding received by BH-ASO and brings the same funding rules for services tied to each payment source. Crisis stabilization facilities contract directly with the payor, receiving reimbursement from the MCO, commercial, or BH-ASO.

Figure 3: Funding pathways



HCA 82-0440 (12/24)

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Medicaid

Pays for Medicaid eligible services identified in **Attachment 3.1-A and 3.1-B section 13.d** of the rehabilitative section of the Washington Medicaid State Plan when delivered to Medicaid-eligible individuals. Crisis services that are allowable under the State Plan include crisis interventions, crisis peer support, and crisis stabilization. These services can be provided in a variety of settings and ways to support a person in crisis.

State allocated funds

These funds are appropriated from the state general operating budget for specific use in the crisis system or crisis programs. Funds are typically used for services not allowable under Medicaid, services to non-Medicaid-eligible individuals which can include people with private health insurance carriers due to difficulty in billing those plans, or to pay for services for people for whom a payor cannot be identified.

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 GF-S dollars 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. SAMHSA requires a 5 percent set aside for crisis services from its mental health block grant which is currently distributed to BH-ASOs to fund crisis services.

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 15 carriers. Additional information can be found on the **OIC's webpage** about the law.

Pragmatic implementation of this law has been challenging. To date, private health insurance carriers funding of crisis services outside of emergency departments play a small role compared to other funding sources such as Medicaid and state dollars.

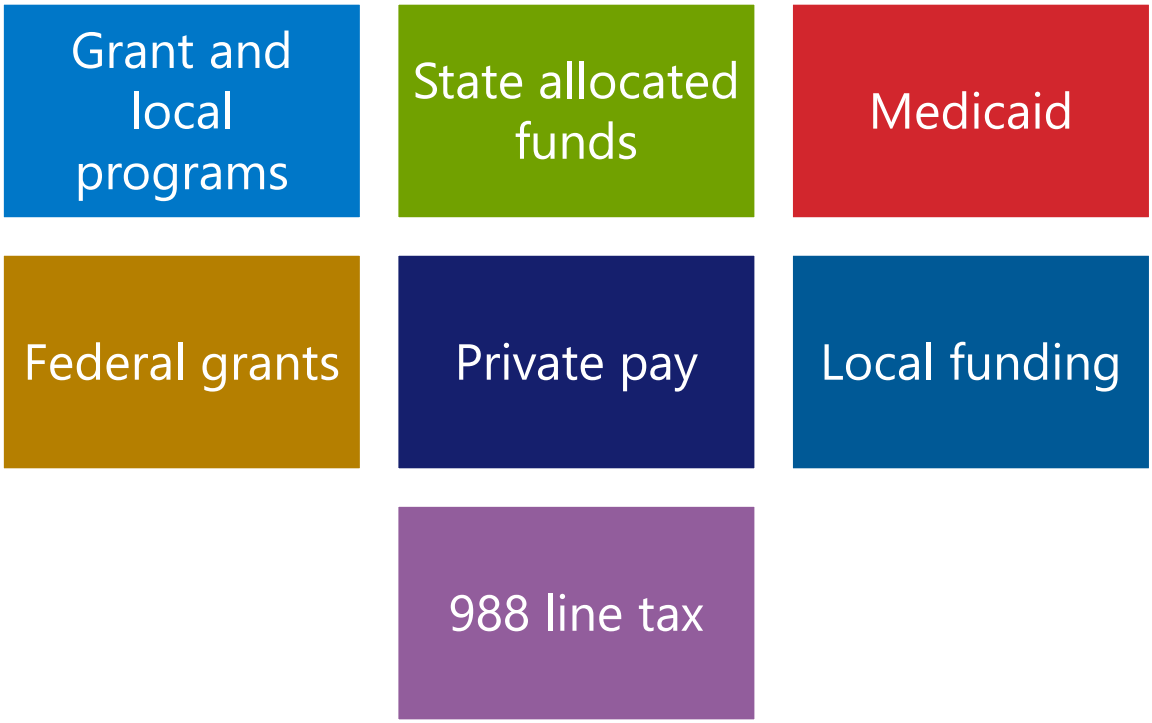
988 tax line account

E2SHB 1477 authorized the creation of a 988-line tax. The tax is like the telecom fee that funds 911. The current tax is 40 cents per line per month. The 988-line tax is authorized to pay for crisis services and currently pays for 988 lifeline networks services and endorsed mobile rapid response crisis teams and community-based crisis teams. In the future funds from the 988-line tax will be used to help pay for designated 988-hubs and the technical platform it will use.

Grant programs and local 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.

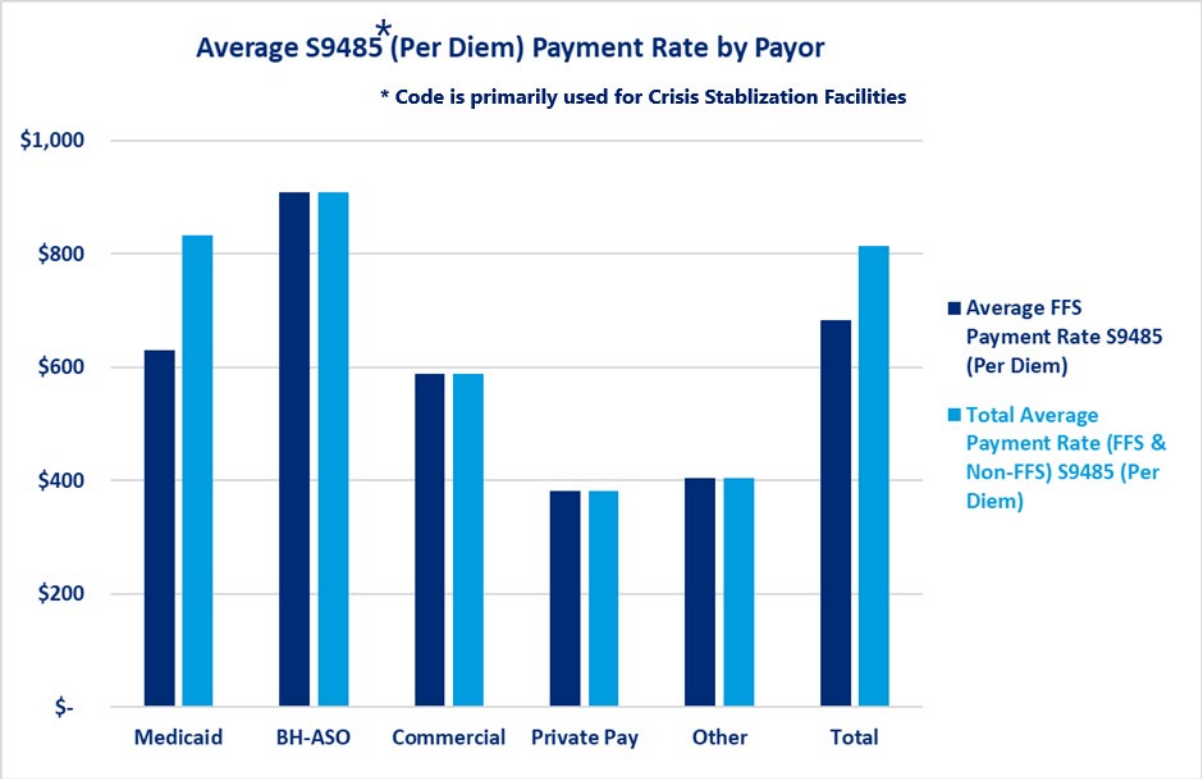
Figure 4: Funding streams that make up the crisis system



Funding inconsistencies

Across the crisis system funding can be inconsistent, with some payers backfilling for underfunded services. At the same time funding cannot be spent in full on some programs due to many factors that restrict how funding can be used. This leads to an uneven distribution of services and an overreliance of emergency or involuntary services due to lack of access to appropriate interventions at the right time. An example of this inconsistency is the funding of service may fall heavily on the BH-ASOs in a region due to regional concern a resource could be lost due to underfunding from other payors.

Figure 5: Average per diem rates by payor for crisis stabilization facilities (source: Mercer report, appendix 2)



The figure above shows encounters using the SERI code S9485 which is used primarily by crisis stabilization facilities. In the figure it shows that commercial and MCO fee-for-service (FFS) funding arrangements are lower, requiring the BH-ASO to increase their rate to keep the facility open. The lack of ability to fund fixed costs for facilities makes them vulnerable to service fluctuations. If BH-ASOs are unable to backfill the funding the facility would likely close. An example of this phenomenon arises with emergency departments admitting people who could be served with lower levels of care or just need a safe place to be during an acute crisis. When these people could be served in a stabilization facility at a lower cost with better services to resolve a crisis. In the outlined example the cost is shifted from some payors to BH-ASOs and emergency departments, who could bill those same plans at a far higher cost.

This can apply elsewhere where the need to backfill funding for some services pulls funding from other services that could be implemented to lower acuity when a person is entering the crisis system. This can contribute to an overreliance on first responders for people to stay safe when other options could be implemented. In these cases, the funding inconsistency is forced onto local jurisdictions to try to fill demand gaps. In some jurisdictions they can set up co-response teams to react to the demand of services, but these programs often suffer from insufficient funding to fully meet demand. Based in part on the inconsistent ways funding is available to teams and the various restrictions that come with it. If funding was allowed to be flexible and adjust to regional needs this inconsistency can be reduced.

The same issues can exist for programs with excess funding that cannot be used elsewhere. Several programs have experienced delays in implementation or expansion due to a variety of issues. This results

in underspends while trying to stand up new programs. Providing flexibility for funding could help mitigate this and ensure services that can be implemented are done so quickly.

Scalability

Services are not one-size-fits-all for each region and local needs. Services need to be scaled to fit the size and needs of a community. An example is the implementation of crisis facilities across the state. Many of these projects are funded but run into problems being sustainable at the size that works for their community. Many cost models are predicated on using economies of scale like maximizing the amount of beds to make these facilities viable. Funding models do not adequately cover the fixed costs of facilities, making smaller facilities that could be located in rural areas and providing important support are never built and the money is not spent. Allowing for more flexibility in funding models to support the core costs of a facility will be able to let smaller facilities manage fluctuations in utilization. An approach that will allow smaller facilities to be a part of established facilities and scale up and down based on utilization would benefit rural areas. An example of this would be building a crisis relief center as part of a health clinic. Staff could focus on other tasks throughout the day including some outpatient work and scale up when a person is brought in by first responders or walks-in.

Administrative burden

A major cost driver and one that reduces the availability of services is the administrative burden required to receive payment for the services. The administrative burden is often placed on BH-ASOs and underequipped providers to manage the diverse array of payors and their billing practices. This has been the most acute in the work to implement commercial payors into the crisis system as set out in the OneHealthPort workgroup. Many providers have reported that even with concessions from plans it is difficult to identify a person's carriers, and even harder for their limited billing departments to submit a payable claim. BH-ASOs have attempted to take on this burden for their mobile crisis teams with similar issues. For MCO-delegated services the administrative burden is shifted onto the BH-ASOs who are tasked with reconciling payments and producing daily crisis logs for the MCOs which often duplicates for the encounter and the log. An example is the amount of administrative work BH-ASOs will do to encounter RCLs. They are only able to gather enough information to submit encounters for 22 percent of all RCL services. This is all done to reconcile funding at the end of a contract period and to keep Medicaid encounters higher to negotiate for a higher per member per month (PMPM) from the MCOs.

Firehouse model

The "firehouse model" is a term that refers to how emergency services like fire, law enforcement, and 911 are funded.[2] These services are typically funded by local levies, property taxes, and other local funding. In the case of Emergency Medical Services (EMS) they are typically funded similarly to other emergency services, but in some cases, they are able to bill insurance plans like Medicaid and private health insurance carriers for their services. They blend this funding with the local funding they receive to ensure services are available at all times. A great example of this is how emergency services are traditionally accessed through 911 works. If you call to get help, 911 operator is available and can send the appropriate service to help with your emergency 24 hours a day 365 days a year. 911 is funded using a telecom fee similar to

[2] National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit - National Guidelines for Behavioral Health Crisis Care
National Guidelines for Child and Youth Behavioral Health Crisis Care - National Guidelines for Child and Youth Behavioral Health Crisis Care

the 988-line tax, and it can also receive funding from local sources to meet local needs. There are a lot of similarities between emergency services and crisis services. EMS are funded by local levies, but can also bill Medicare, Medicaid, and private health insurance in certain circumstances.

Setting up a firehouse model requires a blend of funding that is often braided together to pay for services to always be available. This requires setting up a multiple or all payor system that will integrate not just traditional funding like Medicaid, mental health block grant dollars, and state dollars, but will integrate private health insurance carriers and 988-line tax dollars. Balancing payor responsibility will be a challenge and will probably take some time to get right. Different approaches to funding this system are outlined later in the report. The infrastructure to include different payors is already in place and more is being explored. In fact, for private health insurance carriers, Washington law considered behavioral health emergency services to be "emergency services."[3] Behavioral health emergency services are essential services to save lives and may be needed by anyone at any time. Services provided fluctuate with differing factors, but the need to be ready and available is always there. CMS has issued new guidelines to use Medicaid in a firehouse model as well.

Adopting a firehouse model for mobile crisis will allow them to respond quicker and improve availability. This has the potential to lower the workload for DCRs who currently need to investigate potential ITA detentions and divert from detentions. Mobile crisis could do the diversion work for them in many cases. Extending the firehouse model to cover the core operating costs of crisis facilities will improve resilience when dealing with shifts in utilization. The remaining costs to operate with people in the facility could be covered with utilization-based payments or included in alternative payment methods.

Developing a system based on the firehouse model can save money in the long run when set up correctly.[4] By reducing the need to send first responders or law enforcement emergency services to help a person in crisis, and instead sending a mobile crisis team to intervene, saves resources and ensure first responders are available for other emergency needs. Further, diverting people away from emergency departments also saves resources and prevents delays in getting care. This can only be achieved if crisis services are available 24 hours a day, 365 days a year and are responsive. The most effective way to implement a firehouse model is through changes to the current payment mechanisms and exploring an alternative payment model. Many of these are explored in more detail later in the report.

[3] RCW 48.43.005 definition of "emergency services" and RCW 48.43.093 - Chapter 48.43 RCW: INSURANCE REFORM

[4] National Guidelines for Behavioral Health Crisis Care

Mercer Report

HCA contracted with Mercer Government Human Services Consulting, to assist with the main components to this work

Mercer report excerpt

This section is a direct excerpt from the Mercer report provided to HCA.
We encourage the reader to read the full report, available in Appendix 2.

Introduction

In 2023, under Engrossed Substitute Senate Bill 5187; Section 215(19)(b); Chapter 475; Laws of 2023 (Proviso 19[b]), the State of Washington's (State/Washington) Health Care Authority (HCA) was directed 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. The analysis must consider to what extent the costs of crisis services are being subsidized through state- funded Behavioral Health Administrative Services Organization (BH-ASO) contracts. This includes crisis services provided to clients of private insurance carriers, Medicaid managed care organizations (MCOs), and individuals enrolled in Medicaid fee-for-service."[1] To assist with this study, HCA engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to analyze facility-based crisis stabilization services. In 2024, Mercer's scope of work was expanded to include an analysis of designated crisis response (DCR) services and under Engrossed Substitute Senate Bill 5950[2], Proviso 19(b), was further expanded to include co-response services.

Proviso 19(b) required two separate analyses to be reported to the legislature and the Office of Financial Management — a preliminary report and a final report.

1. The preliminary report[3], submitted in January 2024, described the current model of facility-based crisis services in the State of Washington, existing reimbursement rates and payors, the array of services provided, and presented an environmental scan of facility-based crisis models in three other states (Arizona, Connecticut, and New Mexico).

2. This second and final report builds on the analyses presented in the preliminary report and fulfills the requirements of Proviso 19(b) by examining the following:

   A. Co-response services in Washington and models of co-response services in other states.
   B. Existing reimbursement rates and payors for facility-based crisis stabilization and DCR services (an expanded analysis of the one presented in the preliminary report).
   C. Estimates of the annual cost of operating facility-based crisis stabilization and DCR services.
   D. The new crisis relief center model in Washington.
   E. The adequacy of current reimbursement levels for facility-based crisis stabilization and DCR services using Mercer-developed benchmark provider rate ranges.

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

[2] 5950-S.PL.pdf (wa.gov)

[3] addressing-crisis-services-funding-gaps-leg-report-jan-2024 (wa.gov)

F. Recommendations for prospective reimbursement methodologies and financing models that address concerns of matching payment to utilization, while maintaining appropriate capacity to fulfill the need for crisis services in Washington.

Methodology

The analyses presented in this final report were informed by five key activities described below. They are:

- HCA led workgroup
- Environmental scan of other states
- Request for information from payors and providers
- Benchmark rate range development
- Interview with OIC

HCA Workgroup

Under Proviso 19(b), HCA was required to "convene representatives from Medicaid managed care organizations (MCOs), BH-ASOs, private insurance carriers, self-insured organizations, crisis providers, and the Office of the Insurance Commissioner (OIC) 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."[4] The workgroup began its work in October 2022 and continued to meet every two to three weeks for hourly meetings until September 2024. A final meeting occurred on November 6, 2024 where HCA solicited feedback about the final report. Each workgroup session included approximately 30 individuals. Workgroup attendees shared their thoughts regarding existing reimbursement levels for facility-based crisis centers (e.g., the efficacy of the per diem rate service code) and DCR services, the balance of utilization and capacity in a crisis model, current gaps in the service array, workforce challenges, the differing needs in rural versus urban areas, and many other applicable topics.

Environmental Scan

Mercer conducted environmental scans for each of the crisis services included in the scope of the final report.

Facility-Based Crisis Stabilization Centers

In the preliminary report, Mercer shared an environmental scan of three states (Arizona, Connecticut, and New Mexico) to further the understanding of how facility-based crisis stabilization services are designed and funded outside of Washington State. *Please refer to the preliminary report for additional information on the environmental scan and its results.*

Co-Response Services

In 2024, under SB 5950, Proviso 19(b) was expanded to include co-response services. While there are over 60 co-response programs in the State of Washington, there is no current statutory definition of the services. The vast majority of co-response programs in Washington are funded outside of Medicaid and the programs vary in operational and clinical design. As such, Mercer's analysis includes an overview of the current array of co-response programs in the State, a spotlight of a program in King County, and an environmental scan of co-response services in Colorado, Connecticut, and Oregon.

The detailed environmental scan of co-response services can be found in Section 3 of Mercer report.

[4] 5187-S.PL.pdf (wa.gov)

DCR Services

After consulting with HCA and independently researching whether other states have a program similar to DCR, Mercer determined that there were no clear look-a-likes to Washington's DCR system. In Washington, the DCR role is statutorily defined to limit the Involuntary Treatment Act (ITA) investigation process to only DCRs who are mental health professionals (MHPs) with an advanced degree. In other states, there is a variety of professionals and non-professionals (e.g., family members or other responsible adults) who may complete the ITA process. Additionally, HCA confirmed that a change to the delivery of DCR services was not an interest or priority for the authority at this time. Therefore, no environmental scan was completed for DCR services.

Requests for Information

Facility-Based Crisis Stabilization Services

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. This same RFI was re-released in May 2024 to solicit feedback from any additional respondents who had not responded in the initial round of surveys. Three additional providers responded to the survey.

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 2022–2023. 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 contracted 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.

DCR Services

In May 2024, Mercer released a second RFI, or survey regarding DCR services. The RFI was distributed to all BH-ASOs for the period of SFY 2022–2023 (July 1, 2022-June-30, 2023). This RFI requested information about DCR providers, the total number of DCR full- time equivalents (FTEs) on staff with each provider, if the DCR FTEs were co-located within a mobile crisis team, if services were offered on a 24/7 basis, the ages or populations served by the provider, the county or counties of service, and the dates of service in SFY 2022– 2023.

The RFI also asked respondents to identify the total units delivered and the average payment rate for each contracted provider under service codes H2011 with HW modifier (Investigation) and 99075 (Medical Testimony) for both FFS and non-FFS arrangements.
The same responses were requested for any other DCR-related procedure codes delivered by their organizations.

Similar to the facility-based survey, the final tab in the RFI asked respondents to provide narrative responses regarding their perceived need for additional crisis DCRs in their region, referral sources for their DCR services, DCR response times, regional differences, and DCR access.

For a full view of the RFIs, see Appendix A and Appendix B. The full analysis of RFI results is detailed in Section 4 of Mercer report.

Benchmark Rate Range Development

To assess the adequacy of existing reimbursement levels for crisis services in the State of Washington, Mercer utilized its proprietary rate model to develop benchmark rate ranges. The steps in the rate development process included:

1. Developing service definitions for the services examined in this report — facility-based crisis stabilization services, DCR services, and crisis relief centers. The service definitions describe key elements of each service, the setting in which each service is delivered, associated service codes and billing guidance, staffing ratios, provider qualifications, and other key cost considerations of each service.

2. Developing services assumptions by gathering data to inform key cost components, including staff wages and benefits, for each service based on the service definitions developed.

3. Calculating the benchmark rate ranges and estimated annual costs for each service.

4. Obtaining input from HCA and stakeholders in the HCA Workgroup.

A detailed description of Mercer's benchmark rate range development and results can be seen in Section 5 of the Mercer report.

OIC Interview

Under Proviso 19(b), HCA was required, in conjunction with the OIC, to "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 non-Medicaid eligible activities."[5] In addition to OIC attending and sharing information during the HCA workgroup meetings, HCA and Mercer also held a separate interview with OIC to discuss alternative payment methodologies that HCA should explore as potential options to address the gaps in the crisis system. The methodologies explored included: assessments, all-payor models, and capacity payments.

Further detail on these models is included in Section 7 of Mercer report.

[5] 5187-S.PL.pdf (wa.gov)

Mercer

End of Mercer report excerpt. The full report can be found in Appendix 2.

HB 1134 endorsement of mobile crisis actuarial analysis

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.

Milliman report excerpt

This section is a direct excerpt from the Milliman report provided to HCA. We encourage the reader to read the full report, available in Appendix 3.

PROJECT APPROACH

Central to understanding Washington's status quo and future mobile crisis response environment was intensive engagement with a range of interested parties within Washington's crisis response system, particularly the Behavioral Health Administrative Service Organization (BH-ASO) and existing providers of mobile crisis response services. The feedback provided by interested parties was crucial to informing the payment mechanisms, payment levels, and cost estimates required by HB1134. Figure 8 provides an overview of the guiding questions and considerations used to assess and understand the existing mobile crisis response delivery system in Washington and the potential impact and incremental costs of the requirements in HB1134, specifically the endorsement criteria and performance program.

FIGURE 8: PROJECT APPROACH

Existing crisis response delivery system	**Impact of HB1134**
What is the status quo of the mobile crisis response in Washington? • Cost, staffing structures, and operations of mobile crisis response providers • Mobile crisis provider reimbursement, mobile crisis payers, and BH-ASO responsibilities • Existing team dispatch locations and capacity to respond to crises in an efficient timeframe Understanding the status quo of mobile crisis response supported better understanding of what the costs of providing mobile crisis response are within the status quo and how organizations are reimbursed.	*What are the potential cost and operationalization implications of HB1134 for the status quo?* • What additional costs may be incurred if mobile crisis teams were to meet endorsement criteria? • How well are organizations able to meet performance program time thresholds? • What payment mechanisms are most appropriate for endorsement rates and performance payments? • What is existing mobile crisis providers' level of interest in becoming endorsed? • How many additional MRRCTs and CBCTs may arise because of HB1134?

As highlighted throughout this report, accurately assessing the full impact of HB1134's implementation was not entirely feasible due to incomplete information. This limitation stemmed partly from insufficient responses from some interested parties and the pending finalization and dissemination of the draft endorsement criteria during the analysis. Specifically, numerous interested parties were hesitant to commit to seeking endorsement without access to the finalized criteria and payment rates. As explored in

Sections IV-VI of this report below, this uncertainty impacted the precision of cost estimates for team endorsements and, to a greater extent, cost estimates for the state.

Nevertheless, each engagement forum offered crucial insights into the status quo of Washington's mobile crisis response system and the potential effects of implementing the endorsement criteria and performance program. This information was essential for developing the models presented in Sections IV-VI of this report below. Figure 10 summarizes the key takeaways from engagement with interested parties.

Key Highlights and takeaways from this report:

Endorsement Rates

Gaining a comprehensive understanding of these two areas allowed us to better understand what incremental costs may arise from endorsement rates and performance payments. To support modeling the estimated fiscal impact of the endorsement rates, we categorized existing providers into one of three staffing approaches based on BH-ASO reported costs for existing mobile crisis providers:

- **24/7 at-the-ready:** A provider utilizing the 24/7 at-the-ready staffing model is staffed 24 hours per day, seven days per week, with staff that are alert and ready for dispatch. These providers respond to crises using pairs of responders unless clinically appropriate not to.
- **24/7 on-call:** A provider utilizing the 24/7 on-call staffing model has staff available 24/7, but not necessarily at-the-ready 24/7. Under this staffing approach, overnight shifts are covered by on-call full-time equivalents (FTEs). These providers currently respond to crises using pairs of responders during the first and second shifts and would be expected to support an on-call pair of responders during the overnight shift in order to achieve endorsement.
- **Limited hours and/or staffing:** Some providers reported that they either did not provide mobile crisis response on a 24/7 basis or responded frequently with a single person. Both limitations do not meet the intent of the draft endorsement standards, and therefore we have not modeled an endorsement rate for this staffing approach.

Figure 1 illustrates the annualized calendar year ("CY") 2025 costs for each of the three existing team staffing approaches (described above) and the estimated fiscal impact of each staffing approach meeting the endorsement standards. Note, there are endorsed staffing approaches for both 24/7 at-the-ready and 24/7 on-call, but no endorsed staffing approach for the limited staffing, so it assumed that limited staffing approaches would meet the endorsed 24/7 on-call staffing approach. The annualized incremental increase per team is due to providers transitioning from their status quo approach to an endorsed one include staffing, training, and transportation expenses, with staffing costs being the primary factor driving higher endorsement rates. Figure 1 is based on statewide estimates, and actual incremental costs for each team are expected to vary.

FIGURE 1: CY 2025 ENDORSEMENT RATE IMPACT PER EXISTING TEAM

COMPONENT	AT-THE-READY	ON-CALL	LIMITED STAFFING
Annualized existing team costs	$2,310,000	$1,530,000	$590,000
Annualized endorsed team costs	$2,730,000	$1,620,000	$1,620,000
Annualized incremental cost per team	$420,000	$90,000	$1,030,000

Performance Payments

Endorsement rates may be further informed through actual endorsed team staffing and/or costs in the future. Provider-specific rates are highly dependent on the provider's staffing plan, which is anticipated to be captured as part of HCA's certification process.

HCA's proposed payment mechanism for performance payments is to assess each organization's compliance with time thresholds on a quarterly basis. If teams meet time thresholds 80% of the time, they would receive a performance payment based on the quarterly firehouse funding provided. Performance payments for teams that meet time thresholds are assumed to be 2% of endorsement rates in the baseline scenario. A geographic information system (GIS) analysis was utilized to assess mobile crisis teams' abilities to meet the performance program's defined time thresholds for responding to behavioral health crisis emergencies. Performance payment thresholds vary based on whether a call is received from an urban, suburban, or rural area.

Cost Projections

Figure 2 illustrates our *medium* cost projection of HB1134 for CY 2025 to CY 2028. Cost projections account for Medicaid and non-Medicaid costs and the phasing in of teams becoming endorsed; existing teams are assumed to become endorsed at different times over the four-year period. Endorsed teams include existing mobile crisis teams as well as new teams that will arise during the cost period.

FIGURE 2: TOTAL HB1134 INCREMENTAL IMPACT – MEDIUM COST PROJECTION (VALUES IN $ MILLIONS)

SCENARIO	CY 2025	CY 2026	CY 2027	CY 2028
Status quo costs (statewide funding with no endorsed or new teams)	$ 114.4	$ 118.7	$ 123.2	$ 127.9
Incremental impact of existing teams becoming endorsed	$ 9.0	$ 14.1	$ 17.8	$ 20.6
Incremental impact of new teams becoming endorsed	$ 0.0	$ 12.4	$ 24.0	$ 33.4
Incremental impact of performance program	$ 0.7	$ 1.3	$ 1.6	$ 1.9
Total mobile crisis environment costs under HB1134	$ 124.1	$ 146.5	$ 166.5	$ 183.8
Number of existing teams becoming endorsed	23	34	41	45
Number of new teams becoming endorsed	0	6	11	15

Range of costs. Low, medium, and high cost projections were developed by varying the number of teams becoming endorsed. The medium cost projection of HB1134 estimates an annual incremental increase of $55.9 million in CY 2028. The low and high cost projections are approximately $20 million lower and higher, respectively, than the medium cost projection. On a percentage basis, the estimated fiscal impact of HB1134 under the baseline scenario ranges from a 27% to a 61% increase above the status quo costs ($127.9 million).

As Washington progresses with the implementation of the initiatives outlined in HB1134, the analysis and results presented in this report offer insights into the potential impact these changes may have on the behavioral health crisis care system in Washington. This includes the effects on organizations that provide care and the individuals who receive it. While specific figures may vary, the model serves as a valuable tool to guide the state in considering important implementation and operational decisions in the future.

Key Limitations

Endorsement rates, performance payments, and cost projections shared within this report are theoretical and based on a suite of assumptions. Key areas of uncertainty include the following:

- *Provider interest in becoming endorsed*. Endorsement criteria were in draft as this project was underway and providers expressed that interest in becoming endorsed depends on endorsed rate payment levels and requirements within the endorsement criteria. Cost estimates in this report are very sensitive to the number of endorsed teams, as illustrated in the range of costs in Figure 2.
- *Payment levels*. The state has the ultimate authority for determining the payment levels of endorsement rates and performance payments. Cost projections will be impacted to the extent that actual payment levels differ from the assumed payment levels within this report. Additionally, the status quo costs used as a baseline for developing the incremental impact of endorsement criteria reflect a point in time. The crisis landscape is changing rapidly, including but not limited to new teams being procured and new funding to support stabilization services following the initial crisis response.
- *Performance program considerations*. HCA recommends that the performance program time thresholds only apply to behavioral health emergencies. If the time thresholds are applicable to all crisis responses, time thresholds may be less achievable.
- *Wage Assumptions*. This analysis relies upon the wages assumptions underlying the most recent Behavioral Health Comparison Rate report. Within that report, we used the average of the 50th and 75th percentile of wages using BLS. We are not able to opine on the current wage levels relative to the assumed wages included in our analysis. Therefore, we have not made an explicit adjustment for the 15% state directed increase in 2024 that would increase reimbursement for mobile crisis services. This adjustment will be considered in future analyses related to mobile crisis.

The findings of this analysis are theoretical, and actual cost impacts will vary from our projected costs to the extent that HB1134's implementation varies from the assumed approach.

1134 endorsement Rate Model Approach

We used an independent rate model (IRM) approach to estimate the annual costs that a reasonably efficient Washington mobile crisis response team would incur while delivering mobile crisis response services under both the status quo and the future environment based on HCA's endorsement criteria:

- **Status quo**: Resembling *existing* mobile crisis response teams' staffing, training, and transportation practices.
- **Meeting endorsement criteria**: Resembling staffing, training, and transportation practices of a team that meets HCA's draft endorsement criteria.

Developing rate models under both the status quo and future environment allowed us to better estimate the incremental costs incurred by mobile crisis response teams who meet endorsement criteria.

Another benefit of this approach is that rates are developed independently from actual costs incurred. While relying on Washington utilization and cost data was considered, the following considerations led us to pursue an IRM approach:

- **Transparency.** Washington managed care encounter data has limited cost transparency as mobile crisis encounter reporting is inconsistent. Encounters that are reported within managed care encounter data contain limited information regarding mobile crisis response approaches (e.g., team structure, transportation approach, and training of team members).

  One of the benefits of the IRM approach is to provide transparency as to the expected reasonable and necessary costs required to provide mobile crisis response.
- **Rate structure.** Under the firehouse model approach, funding is anticipated to be provided regardless of utilization. Instead, the funding is tied to the resources required to maintain 24/7 access to mobile crisis services (i.e., the number of mobile crisis teams and corresponding FTEs). Note that funding developed through this approach accounts for Medicaid and non-Medicaid costs; a breakout of Medicaid-specific costs will be provided in Section V of this report.
- **Incremental costs.** Endorsed teams will be subject to incremental staffing, training, and transportation costs, which would not be reflected in status quo cost data.

NEXT STEPS: PAYMENT MECHANISMS AND OPERATIONAL CONSIDERATIONS

As the state moves forward with implementation of the endorsement criteria and supplemental performance payments laid out in HB1134, there are several operational considerations and decision points it may need to consider, most notably the approach or mechanisms through which providers will be paid.

Payment approach. Based on discussions with HCA, the flow of funding from the state to mobile crisis providers may need to be refined as the state implements HB1134. Currently, mobile crisis response services are primarily funding from the BH-ASOs that receive Medicaid and non-Medicaid funding from HCA, the managed care organizations (MCOs), and other sources. Mobile crisis providers also receive some funding currently from MCOs (e.g., related to crisis stabilization services). While this report outlines a fiscal impact estimate of HB1134, it is not intended to provide the estimated funding necessary for each provider across the state to meet the endorsement criteria and performance standards. Provider-specific

rates are highly dependent on the provider's staffing plan, which is anticipated to be captured as part of HCA's certification process.

As the state looks to implement endorsement criteria, it might explore an alternative funding structure where the full endorsement rate is provided directly by the BH-ASOs instead of the current approach where stabilization services are funded by the MCOs. This approach would eliminate discrepancies in funding between the total amount received by endorsed teams and their respective endorsement rates. Depending on the structure and especially whether additional funding sources emerge (e.g., private pay insurance), a reconciliation process may be required with the providers or BH-ASOs to ensure that the funding received matches the intended funding.

HCA will also need to determine whether it would like to "model" payments to mobile crisis providers or continue the existing "cost-based" framework with the BH-ASOs. In either case, HCA may wish to implement cost reporting for the "endorsed" providers to ensure a defined amount of funding supportive of 24/7 access. In addition to cost reporting, further tasks to advance implementation might involve: gaining an understanding of mobile crisis provider wage levels within Washington; development of provider-specific "firehouse" rates given staffing needs vary across the state; considerations for oversight and accountability of providers under a "firehouse" model; potential inclusion in capitation rates; and state-directed payment support.

In addition to establishing how the endorsement rates will be funded from the state to the providers, the state must also decide on the mechanism through which eligible providers will receive performance payments for successfully meeting response time thresholds. The state needs to determine whether these performance payments will be issued directly by HCA or, similar to the endorsement rates, channeled through the BH-ASOs. This decision would necessitate the establishment of formal processes for monitoring the ability of endorsed teams to meet the specified response time thresholds and for the subsequent distribution of performance payments. If the BH-ASOs are to assume these responsibilities, it will likely call for additional planning and consideration regarding how to operationalize these processes.

Additional operational considerations. In addition to refining the payment mechanism, there are critical considerations and questions that the state must address as it progresses with the implementation of the endorsement criteria and performance program. Many of these considerations relate to their practical implementation, including the allocation of responsibilities among different entities.

- *Braiding of funding*. It will be important to clearly delineate whether the BH-ASO will be responsible for braiding the majority (as it stands today) or all funding and whether the provider will receive any funding for mobile crisis services outside of the BH-ASOs. Additionally, determining whether the BH-ASOs are braiding all mobile crisis funding, which is an allowable approach established through Proviso 19, will be an important consideration if additional non-Medicaid payers begin funding mobile crisis services.
- *Contracting and endorsement*. In addition to the BH-ASOs' relationships with the state, it's important to consider their contractual and operational relationships with providers of mobile crisis response services. BH-ASOs will be responsible for overseeing the application and onboarding processes for all mobile crisis teams within their designated regions. This duty

entails modifying existing contracts as needed and establishing contracts with new MRRCTs and CBCTs created following the enactment of HB1134. Specifically, for CBCTs, separate contracts with behavioral health agencies (BHAs) will be necessary for both the funding and staffing of teams, as well as for data collection and oversight.

- *BH-ASO administrative costs.* During discussions with interested parties, BH-ASOs highlighted that the extra duties associated with contracting, endorsing, and monitoring the performance of mobile crisis response providers would lead to increased administrative costs. These added responsibilities may necessitate additional staffing to meet these administrative demands. During engagement with interested parties, BH-ASOs suggested the potential need for a single additional FTE staff to assist with these tasks, but HCA may benefit from additional engagement with BH-ASOs once their responsibilities are fully outlined as part of the implementation process.

- *Tribal considerations.* During our analysis, HCA was actively engaging two Tribal providers working to establish mobile crisis teams. Additional engagement is necessary to understand the extent to which Tribal mobile crisis providers will be required to meet the endorsement criteria and the corresponding endorsement rates.

As the state moves forward with the implementation of HB1134's endorsement criteria and performance program, there will likely be additional operational decisions and considerations, particularly regarding payment mechanisms for providers. The choice between adopting a new payment model or continuing with the existing cost-based framework through BH-ASOs will significantly impact the structure of mobile crisis response services. Furthermore, the implementation of cost reporting and additional operational tasks such as firehouse rate development and the integration of performance payments underscore the complexity of ensuring efficient, accountable, and accessible crisis response services. Addressing these considerations requires a comprehensive approach that balances the need for financial sustainability with the goal of delivering high-quality, timely crisis intervention services, necessitating thoughtful planning and collaboration among all interested parties.

HCA and Milliman continue the workgroup to implement crisis teams' endorsement criteria, performance program which began in August 2024

End of Milliman report excerpt. The full report can be found in the Appendix 3.

Mercer report gaps and recommendations

Mercer identified important gaps and recommendations through surveys, direct interviews, and workgroup discussions.

Mercer report excerpt

This section is a direct excerpt from the Mercer report provided to HCA. We encourage the reader to read the full report, available in Appendix 2.

Gaps

Throughout the work on Proviso 19(b), a handful of gaps/themes in the funding model for crisis services continued to arise in conversations with the HCA workgroup, OIC, and HCA, as well as in survey responses. These themes are detailed below.

Balancing Capacity and Utilization

A consistent gap that was shared during the process was the balancing act of ensuring capacity while reimbursing crisis services based on direct utilization. The HCA workgroup, as well as HCA, endorsed a firehouse model of crisis staffing that ensures individuals are able to access services whenever needed. The challenge of designing reimbursement to support firehouse models is that traditional FFS models can struggle to account for the missed productivity or utilization when facility census or community calls do not fill the entire capacity of staff on duty. This is particularly true for facility-based crisis services, where 75% of reported utilization was reimbursed through FFS arrangements.

Commercial Engagement

Another major gap raised in conversations with HCA and OIC is the lack of commercial engagement and education. While commercial carriers are now required to cover crisis services, there is a significant gap in the knowledge base of commercial carriers on the widespread delivery and need for crisis services. This is evident in the 11% of total units delivered in SFY 2022–2023 that were attributed to commercial payors when compared to the 17% of units funded by BH-ASOs and the 71% of units funded by Medicaid.

Under current law, carriers are obligated to cover behavioral health crisis services, as defined in statute, whether the provider is in-network or out-of-network (i.e., whether the carrier is contracted with the provider or not).[68,69] Additionally, a carrier cannot impose prior authorization requirements as a condition of covering behavioral health crisis services.

House Bill 1688 also requires that carriers include behavioral health crisis service providers in their provider networks.[70] Shortly after the legislation was enacted in 2022, OIC and HCA reached out to OneHealthPort to facilitate a work group of carriers, BH-ASOs, and behavioral health crisis service providers to develop a pathway for carriers to contract with either BH- ASOs or directly with crisis providers. The group reached a consensus approach to contracting to facilitate consistent billing across Medicaid and commercial health plans. To assist in the effort, HCA created a crisis code guide that is used by payors and providers.[71]

[68] RCW 48.43.093 (wa.gov)

[69] RCW 48.43.005 (wa.gov)

[70] HB 1688 - 2021-22 (wa.gov)

[71] https://www.hca.wa.gov/assets/billers-and-providers/crisis-code-guide-private-insurance-plans.xlsx

The workgroup encountered challenges related the ability of behavioral health crisis providers to identify an individual's health care coverage. BH-ASOs can find out whether a person they serve is a Medicaid client via access to Medicaid eligibility data. However, there is no comparable data source for commercial health plans. The ability to bill commercial claims is dependent upon a provider obtaining insurance information for a person in crisis that they've served. This challenge is a key factor in evaluating the appropriate mechanisms to finance the behavioral health crisis system.

OIC is currently engaged in Balance Billing Protection Act rulemaking. Due to concerns expressed by behavioral health agencies related to contracting with carriers, OIC is developing rules to implement the work group's consensus in law, which will set out how carriers must contract with BH-ASOs or behavioral health agencies and process behavioral
health service claims. OIC anticipates having final rules in place by the end of 2024.

Funding Levels

Current funding for crisis services comes in short of allowing the necessary investment in the continuum needed to ensure access to all for crisis services. Both surveys had re-occurring themes of additional need for services across the State, existing reimbursement not allowing for competitive wages to recruit and retain qualified staff, and populations that are underserved today (e.g., youth, individuals with co-occurring diagnoses, and individuals residing in rural and frontier areas).

While survey respondents reported a wide range of payment rates for both facility-based crisis and DCR services, the average reimbursement rates from the surveys for facility-based services were meaningfully lower than the benchmark rates calculated for this report.
Further, feedback from stakeholders indicates that funding levels require additional review.

Mercer Report Recommendations

While many recommendations were raised during the work performed to respond to Proviso 19(b), the two primary recommendations that consistently came up in conversations and analyses were:

1. Enhancing commercial engagement
2. Exploring alternative payment methodologies

These two recommendations, which are detailed further below, address many of the concerns shared throughout the process and align with the direction of Proviso 19(b).

Enhance Commercial Engagement

Commercial engagement was frequently cited as a gap in the funding of crisis services in Washington. As described above, upcoming rulemaking will clarify standards for commercial carriers to contract with behavioral health crisis service providers via rulemaking. That rulemaking, as well as previous work group efforts, provide an opportunity to further educate commercial carriers regarding coverage of behavioral health crisis services and prevent cross-subsidization by other payors. Additionally, the challenge to identify health insurance coverage for individuals in crisis remains a factor in commercial engagement as well as the evaluation of appropriate financing mechanisms for the behavioral health crisis system.

Explore Alternative Payment Methodologies

One of the primary objectives that HCA was tasked with under Proviso 19(b) was to explore alternative payment methodologies that could allow Washington to address gaps in the existing funding model for crisis services. All three of the primary gaps identified in the Proviso 19(b) work could benefit from one or more of the alternative payment methodologies detailed in this section.

After discussions with HCA, OIC, and the HCA workgroup, Mercer recommends consideration of three categories of models when discussing potential implementation of an alternative payment methodology for crisis services:

1. Assessments
2. All-payor models
3. Capacity payments

For each of the categories, Mercer has highlighted existing methodologies, examples of states implementing those methodologies, and potential benefits and drawbacks of each methodology. Additionally, in Table 14 below, we have included a comparison of the methodologies under each category and their focus on bringing all payors together, establishing consistent revenues unbound to FFS, and increasing quality through performance-based payments.

Table 14: Alternative Payment Model Summary

	Bringing All Payors Together	Establishing Consistent Revenues Unbound to FFS	Increasing Quality through Performance-Based Payments
988 Fee Augmentation		●	●
Covered Lives Assessment	●	●	
All-Payor Global Budgets	●	●	
All-Payor ACOs	●	●	●
All-Payor Rate Setting	●		
Sub-Capitated Payments		●	
Grant-Funded Capacity Payments		●	

● Assessments
● All-Payor Models
● Capacity Payments

It is important to note for many of the models discussed that federally regulated health plans and programs (e.g., Medicare, TRICARE, etc.), are exempt from State regulation. Additionally, self-funded group health plans governed by the Employee Retirement Income Security Act [ERISA] are exempt from State regulation of benefit design and central administrative functions. However, as seen in the examples shared in this report, there are ways to operationalize alternative payment methodologies that include these health plans and programs.

Additionally, the models described below can theoretically be and historically have been used in conjunction with each other to address funding, access, and patient care concerns. If HCA opts to explore any of these models further, additional research, planning, and design will be needed to ensure the legality and viability of the chosen methodology for the crisis system in Washington.

1. Assessments

Assessments were one of the alternative payment methodology categories discussed in the HCA workgroup as well as in the interview with OIC. Assessments have historically been used in a number of states to ensure funding is allocated to a specific program or to cover a specific category of

expenses. The methodology for assessments can vary, but in general, an assessment includes a payment made to Washington State by an assessed entity, which could include payors, providers, or even the general public as seen in the 988 legislation.

Assessments are designed to ensure that a reliable source of revenue is dedicated to funding a program. In the case of the crisis system in Washington, an assessment would allow HCA to support crisis providers outside of the traditional insurance environment. The design of assessments and the resulting distribution of funds in many cases is more flexible than many of the options discussed in this section. A theoretical example discussed was an assessment that would cover the first 72 hours of crisis care for individuals regardless of payor. As discussed below in the example of an existing HCA assessment, the design of an assessment can include considerations for collecting a proportional share from assessed entities based on expected liabilities or covered lives to avoid any subsidization across payors. The subsections below provide examples of assessments that HCA could consider for the crisis system in Washington.

A. Covered Lives Assessment

A covered lives or payor assessment could be used to support funding for crisis services. Effectively, this type of assessment requires a payor to remit a portion of its revenues to the State for a purpose specified in law. Therefore, it necessitates legislative and/or regulatory action for proper implementation. States have flexibility in the design of such an assessment and can apply it generally to all State-regulated payors (e.g., Medicaid, commercial insurers, State employee health plans, etc.) or target it to certain payor types. As noted previously, the State will need to consider how to appropriately treat federally regulated payors and self-funded group health plans for the purposes of an assessment.

An example of a covered lives assessment can be seen in HCA's Partnership Access Lines (PAL) program. HCA currently collects an assessment to fund components of the Washington State PAL program by virtue of legislation (House Bill 2728) passed in 2020. The PAL assessment directs funding to BH supports, including the partnership access line, MH referral services for children and teens, perinatal psychiatric consultation for providers, and psychiatric consultation. The assessment applies to assessed entities, which for the purpose of this assessment include health insurance carriers, self-insured multiple employer welfare arrangements, and employers or other entities that provide health care benefits in Washington. Notably, the proportional share collected from the assessed entities excludes lives covered under the Medicaid managed care program.[72,73] The Medicaid program pays its proportional share of the cost of these programs through State general fund and federal Medicaid matching fund appropriations.

Considering the preceding, HCA and the Legislature could explore creating a new covered lives assessment or augment the existing assessment to specifically include crisis services. Moreover, if Washington determines certain payor types are disproportionately financing crisis services today, the State could structure a crisis assessment that seeks to create payor equity in crisis services funding.

An assessment would allow for consistent revenues to fund the crisis system or specific parts of the system in Washington and could grant additional flexibility to operationalize certain aspects or time windows of care outside of the traditional insurance model. In the example mentioned earlier, this could

[72] https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2728-S.SL.pdf?q=20240802110931

[73] https://www.hca.wa.gov/billers-providers-partners/program-information-providers/partnership-access-lines-pal

take shape as a covered lives assessment covering the first 72 hours of crisis care regardless of the coverage that an individual has.

Despite the flexibility that an assessment provides, it poses an additional operational and administrative burden, does not directly address underlying issues with service reimbursement, and poses a significant political and regulatory challenge as opposition is expected for any new or increased assessments.

B. 988 Fee Augmentation

Federal statute allows states to levy a fee on telecommunication services in order to support 988-related systems and services, including: personnel and the provision of acute mental health, crisis outreach, and stabilization services directly responding to individuals contacting the Lifeline.[74] While different from assessing payors for covered lives, the 988 fee is broadly similar in that it seeks collections from assessed entities to enhance funding for the crisis system. Taking advantage of this opportunity, Washington established a 988 fee via House Bill 1477 in 2021 and further augmented its application to include endorsements and funding for rapid response crisis teams through House Bill 1134 in 2023.[75,76] The 988 fee as of January 1, 2023 is $0.40 per line and generated $38.3 million in Fiscal Year 2022–2023.[77]

HCA is required to establish an endorsed crisis team performance program using a portion of the 988 funding. The program must include: (1) establishment grants to support crisis teams in meeting endorsement standards; (2) performance payments in the form of an enhanced case rate for crisis teams that have received an endorsement; and (3) supplemental performance payments in the form of an enhanced case rate for endorsed crisis teams that meet specific response times and in-route times. House Bill 1134 mandates ten percent of the annual receipts for the Statewide 988 Behavioral Health Crisis Response and Suicide Prevention Line Account must be dedicated to the grant program and the endorsement activities. Up to 30% of these funds for the grant program and endorsement activities must be dedicated to 988 teams affiliated with a tribe in Washington.[78]

The 988 fee or funding distribution could theoretically be augmented to broaden the types of crisis services eligible to receive financing support under the fee.

Similar to the covered lives assessment described above, 988 fee augmentation has the benefit of establishing consistent revenues for the crisis system but faces challenges in developing and implementing changes related to the existing fee levels, collection, and distribution.

2. All-Payor Models

As the crisis system in Washington is funded by a variety of payors, Mercer explored alternative payment methodologies that focus on the ability to bring payors of health care services together to ensure equitable financing. In respect to this report, all-payor models would bring each of the payors of crisis services in Washington to the table and develop necessary and reasonable payments to providers. Additionally, many of the all-payor models described below have the advantage of being tied to covered populations rather than the number of services rendered as seen under a strictly FFS system. This allows health care providers to better coordinate and deliver care while minimizing unnecessary or repetitive care.

74 https://docs.fcc.gov/public/attachments/DOC-388659A1.pdf

75 https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20210830125021

76 https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1134-S2.SL.pdf?q=20240802124324

[77] https://www.hca.wa.gov/assets/program/988-system-leg-report-2023.pdf

[78] https://lawfilesext.leg.wa.gov/biennium/2023-24/Htm/Bill%20Reports/House/1134%20HBR%20APP%2023.htm

These models may manifest through various mechanisms, such as a global budget, a per member per month (PMPM) payment through an Accountable Care Organization (ACO) or requiring all payors to cover crisis services using consistent payment rates. The subsections below provide examples of all-payor models that HCA could consider for the crisis system in Washington.

A. All-Payor Global Budgets

A global budget is a prospective payment made to a provider or health system that covers a specified portion of a covered person's care. An example of an all-payor global budget is Maryland's Total Cost of Care model. Under demonstration authority with the Center for Medicare and Medicaid Innovation (CMMI), Maryland established global all-payor budgets for certain hospitals.[79] Theoretically, global budgets could be paid through a PMPM payment or an annual payment and could be tailored to a specific set of services and/or providers, such as crisis services.

Federal authority from CMMI or other federal agencies would likely be required for participation from Medicare or other federally regulated programs. In addition to Medicare, ERISA-governed plans would likely need to opt-in to participation depending on the methodology design. CMMI demonstration models to date have not specifically focused on crisis services, but there have been opportunities for BH more generally, such as the Innovation in Behavioral Health model (IBH). CMMI's IBH Model seeks to bridge the gap between behavioral and physical health. Specialty behavioral health practices under the IBH Model will screen and assess patients for select health conditions, as well as mental health conditions or SUD, or both. The IBH Model is a state-based model, led by state Medicaid agencies, with a goal of aligning payment between Medicaid and Medicare for integrated services.[80] Outside of CMMI demonstration models, a state may be able to leverage State Plan or waiver authorities to implement a global budget specific to the Medicaid population.

While this process could be administratively burdensome for Washington to implement and maintain, a global budget has the benefit of establishing consistent revenues for the crisis system as well as encouraging the elimination of unnecessary or repetitive care. Additionally, global budgets allow for a shift in focus from total units delivered to the total cost of the system.

B. All-Payor Accountable Care Organizations

The goal of ACO models is to increase care quality, reduce unnecessary or repetitive care, and promote better care coordination. This methodology encourages accountability for care by assigning risk to ACOs, and potentially providers, to receive shared savings for quality care and receiving penalties for poor performance. Theoretically, an all-payor ACO specific to crisis services would receive funding from each of the participating payors (e.g., Medicaid, commercial, etc.) and then distribute payment to participating crisis providers or health systems. These payments could be designed to either be paid FFS or on a prospective monthly basis. In either case, the ACO model is generally designed to adjust payments at the end of a reporting period based on performance against quality metric benchmarks.

The Vermont All-Payer Model is a prime example of an all-payor ACO model. Similar in concept to the global budget cited above, the Vermont model goes further by addressing services beyond hospitals and health systems. The Vermont model leverages distinct federal authorities for the Medicaid and Medicare components — a section 1115(a) Medicaid demonstration and an Advanced Alternative

[79] https://www.cms.gov/priorities/innovation/innovation-models/md-tccm

[80] https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model

Payment Model under CMS' Quality Payment Program, respectively. Provider and other payor participation (including commercial and self-funded plans) is voluntary.[81] The CMS evaluation of the first five performance years of the model demonstrated a reduction in Medicare and Medicaid spending and a reduction in hospital admissions.[82]

The ACO model has the benefit of shifting some of the operational and administrative burden from the State to its ACO partners. Despite this shifting of responsibility, there will still be significant oversight and effort needed to establish the program.

An all-payor ACO model allows for focus on quality of care and care outcomes. Depending on payment design, an ACO model still has the potential to focus on the volume of services delivered as payments to providers can be made on an FFS basis.

C. All-Payor Rate Setting

All-payor rate setting models look to bring each payor to the table by requiring that they reimburse providers or health systems at a consistent level. The Substance Abuse and Mental Health Services Administration, or SAMHSA, endorses this model for crisis services in their best practice toolkit and states:

> *"It is recommended that states, counties or local jurisdictions establish rates for their communities that can be applied to all payers. Otherwise, local jurisdictions will be forced to cover the shortfall in funding from the legally or contractually responsible payers who offer lower reimbursement for care that is always made available to all community members. In essence, the lead of local government to establish reasonable reimbursement rates for best practice crisis services amongst all responsible payers offers a sustainable model that reduces the demand on communities to cover health care expenses that should be covered by an insurer" [83].*

One example can be found in Maryland's All-Payer Model. Under demonstration authority with CMMI, Maryland requires hospitals receive the same payment for specific treatments delivered to Medicare, Medicaid, commercially insured, or self-pay patients [84]

If all-payor rate setting was pursued in Washington for crisis services, federal authority from CMS or other federal agencies would likely be a prerequisite for participation from Medicare or other federally regulated insurers. In addition to Medicare, self-funded ERISA-governed plans would likely need to opt-in to participation. As mentioned previously, to date, CMMI demonstration models have not specifically focused on crisis services. However, in general, there have been opportunities for BH innovations.

All-payor rate setting ensures providers are receiving equitable payment regardless of payor. While the methodology does not completely eliminate the administrative burden of contracting with multiple payors, it reduces the burden by simplifying the negotiation of payment rates. In contrast to a few other models described, all-payor rate setting does not directly shift the focus from volume of services to access to care or funding a capacity or firehouse model. However, the provider rates set under this methodology could include considerations for firehouse-style staffing and acknowledgements of productivity and capacity offsets.

[81] https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model

[82] https://www.cms.gov/priorities/innovation/data-and-reports/2024/vtapm-4th-eval-report-aag

[83] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[84] https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model

3. Capacity Payments

The HCA workgroup consistently shared concerns regarding the focus on the volume of services delivered and the challenge of balancing that priority with ensuring adequate capacity is available for individuals who need crisis care under a firehouse model. Capacity payments aim to provide funding to the crisis continuum to ensure capacity is always available through sustainable revenue independent of utilization. Funding for capacity payments could come from a myriad of sources or be tied to a specific payor, such as Medicaid. Many of the all-payor models described above already include or could include consideration for capacity payments. The subsections below provide examples of capacity payments that HCA could consider for the crisis system in Washington.

A. Sub-Capitated Payments

One of the most common types of capacity payments is a sub-capitation arrangement. In a sub-capitation arrangement, a payor (e.g., MCO, ACO) provides prospective payments to a provider based on expected utilization and commensurate costs for the provision of services. In theory, this offers a predictable and consistent revenue stream unbound from typical FFS billing/payments. It also may afford flexibility in the provision of services by allowing a provider to tap a diverse set of team members to deliver the service, as appropriate. A recent and innovative application of a sub-capitation arrangement as a capacity payment is the Massachusetts Primary Care Sub-Capitation Program, which is part of the state's MassHealth ACO model authorized by a section 1115(a) demonstration waiver. Participating providers receive monthly payments based on the size of their patient panels with no reconciliation to utilization, which is what makes this model unique.[85, 86] Providers are still expected to submit claims/encounters, but for record keeping and compliance purposes. As such, the providers share in upside and downside risk with a key point being that payments do not have to be returned if utilization falls below estimated levels. Translated to crisis services, this would afford providers the assurance necessary to maintain consistent levels of staffing without regard to meeting billing quotas.

States also may be able to leverage 1115 demonstration waivers for serious mental illness or SUD services to invest in capacity payments for crisis services. In fact, these waivers require, at minimum, a maintenance of effort of community-based BH services in exchange for the authority to pay for services provided in an Institute for Mental Disease for those aged 21 years–64 years old. A state could also seek expenditure authority for diversionary BH services (services meant to divert beneficiaries from inpatient setting), including the potential for crisis capacity payments.[87]

While sub-capitated arrangements establish a consistent revenue source for providers and reduce the focus on volume of services rendered, these arrangements do not reduce administrative and operational complexity when implemented alone. If sub-capitated arrangements were not implemented on an all-payor basis, each provider or health system would need to set up an arrangement with each individual payor covering the recipients based on expected caseload. This is likely happening to some degree in the system today as we know there are facility-based crisis services funded on a non-FFS basis.

[85] https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview

[86] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-dmnstn-aprl-atchmt-p.pdf

[87] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

B. Federal and Other Grant Funded Capacity Payments

Depending on the funding source and the terms of the award, a state may be able to leverage grant funding to provide capacity payments for crisis services. The federal Substance Use and Mental Health Block Grants, administered by SAMHSA, provide resources for states to build out crisis services. Moreover, the Mental Health Block Grant specifically has a minimum 5% crisis services set-aside requirement that must be used to support an evidence-based crisis system.[88] States may leverage these grants, applicable federal discretionary grants, and other grants to support capacity payments for crisis services.

Grant funding is a supplemental funding source that can be crucial to bolster the delivery of services, but by itself is not enough to ensure the system is fully funded and payors reimburse services at an equitable level.

88 42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart i: block grants for community mental health services

End of Mercer report excerpt. The full report can be found in Appendix 2.

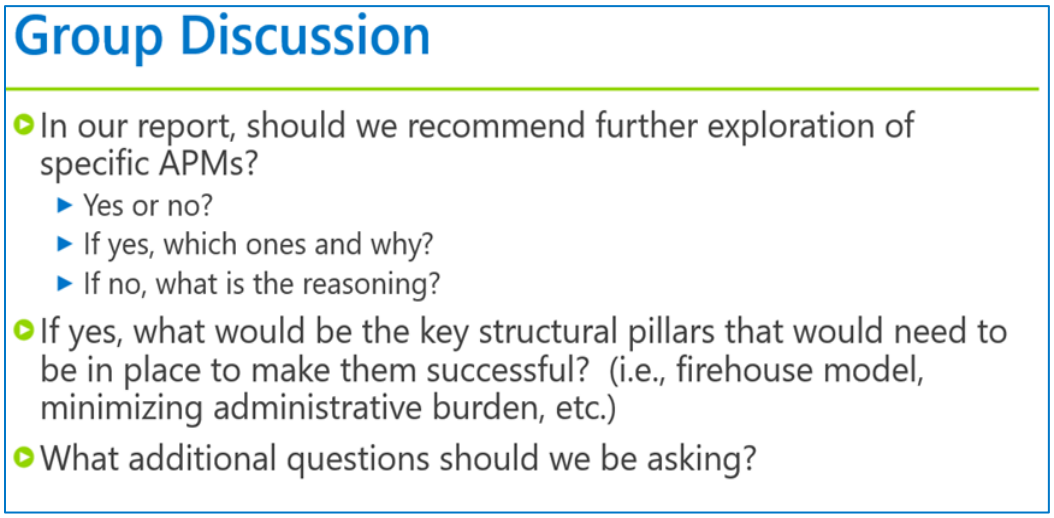
Workgroup feedback on alternative payment models

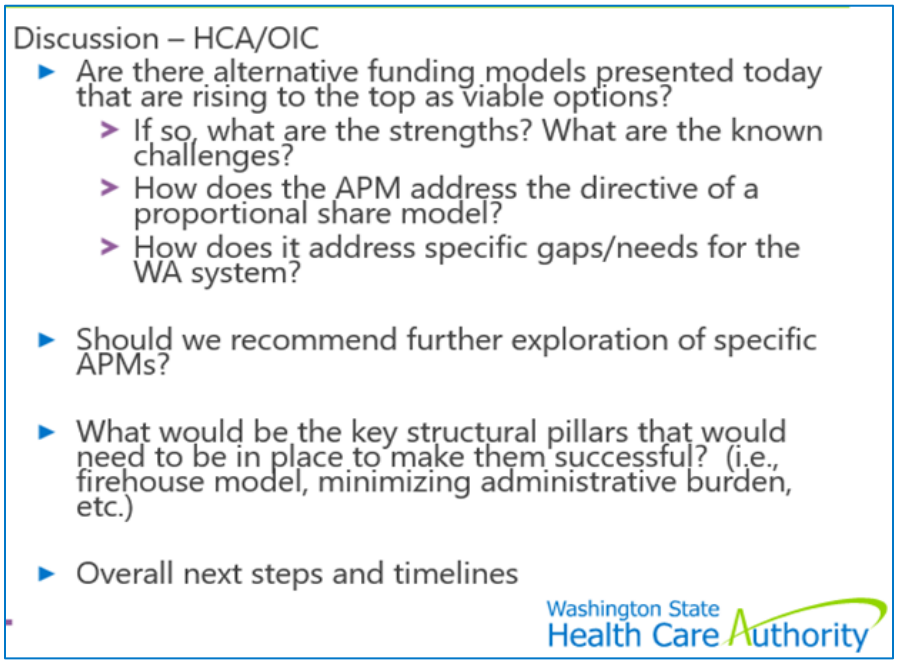
Feedback from the workgroup was limited partially due to time constraints. Most of the previous work was spent trying to understand the costs and drivers, payment arrangements, and eventual cost models. This work to longer than anticipated due to competing requests with multiple different projects with the same groups involved.

Due to the limited response time the feedback below is incomplete, and more work will need to be done before any Alternative Financing Model (AFM) and APMs is implemented to ensure buy in from payors.

Questions asked to the workgroup

Questions were originally posed to the workgroup after some education about AFMs and APMs was provided below are some slides related to this discussion to illustrate the questions asked.





Summary of feedback received

After the workgroup discussions, a survey was sent out to all payors to gather feedback. The survey mirrored the questions in the workgroup. The response rate was inconsistent across the categories of payors. We have the feedback broken down into BH-ASOs, MCOs, and commercial payors.

Behavioral Health Administrative Service Organizations

On September 4, 2024, HCA solicited feedback from our BH-ASO workgroup members. We offered a variety of options to receive feedback, including in the large group meetings, one-on-one meeting, or through writing. The eight BH-ASOs coordinated, and their concerns, recommendations, and feedback are summarized below.

- **All crisis services be included under the regional systems.**
  The concerns that there are some crisis services that are not currently under the BH-ASO management. The suggestion is to simplify the system with all crisis services being under the regional BH-ASO management.
- **Crisis services be billed to one entity with one simplified payment model for all payors.**
  The BH-ASOs are currently working with multiple entities for rate negotiations, payment authorizations, payment schedules, billing, and tech issues. This process is time-consuming, staff-intensive, and problematic. The recommendation is to reduce the administrative burden by creating a simplified payment model that allows billing through one entity.
- **Need for further focused analysis needed on three alternative financing and payment models.**
  Requesting further information on alternative payment models that bring all payors to the table, including Covered Lives Assessment, All Payor Global Budgets, and All Payor ACO. There has been discussion of a potential combination of these models and the BH-ASOs would like to better under these models and the potential risks to the BH-ASOs.

Medicaid managed care organizations

On September 4, 2024, HCA solicited feedback from our Medicaid MCO workgroup members. We offered to receive feedback through a variety of means, including in the large group meetings, one-to-one meetings, or through writing. Of the five MCOs we received feedback from three MCOs, and it is summarized below.

- **Consideration for alternative payment models.**
  There was support for a Fee-For-Service model of payment, but the MCO also acknowledged that this model has fluctuations in the revenue stream making it difficult to budget. There was also support for expanding and modifying the existing payment model, however a drawback mentioned was the annual reconciliation process which is time and labor intensive for both MCO and providers. Finally, it was mentioned that no single model addresses the current system needs comprehensively. A combination of models may best meet the system needs.
- **Constraints and challenges for consideration**.
  The MCOs stated they have very limited visibility in the BH-ASOs downstream contracting process and also that administrative costs can vary considerably between BH-ASOs, creating challenges.
- **A combination of models may best meet the system needs.**
  Finally, it was mentioned that no single model addresses the current system needs comprehensively.

Commercial plans

On September 4, 2024, HCA solicited feedback from our commercial payors. We unfortunately never received any feedback from commercial plans. In discussions they indicated that they preferred the current state as recommended by the SB 1688 workgroup. This recommendation has been difficult to implement and has seen little improvement over previous billing practices. One of Mercer's major recommendations is to continue to engage commercial payors in their feedback.

OIC feedback

Under current law, RCW 48.43.093 and RCW 48.43.005, commercial health insurance carriers must cover behavioral health crisis services as emergency services. Because these crisis services are considered emergency services, they must be covered whether a behavioral health crisis provider is an in-network or out-of-network provider, i.e., whether the carrier is contracted with the provider or not. Carriers cannot impose any prior authorization requirements for emergency services.

RCW 48.49.135 also requires that carriers include a sufficient number of behavioral health crisis providers in their health plan provider networks. When the law was passed in 2022, HCA and the OIC reached out to OneHealthPort to facilitate a work group of carriers, BH-ASOs and BH crisis providers. The goal of the work group was to develop a pathway for carriers to contract with either BH-ASOs, or directly with behavioral health crisis providers. The group reached a consensus approach to contracting. For example, to facilitate consistent billing across Medicaid and private health insurance carriers, HCA created a **crisis code billing guide** that is used by payors and providers. The working group website will be migrated to OIC's website in December 2024.

In addition, OIC is currently completing Balance Billing Protection Act (BBPA) rulemaking. Due to concerns expressed by behavioral health crisis service providers related to contracting with carriers, OIC recently adopted those rules to implement the consensus approach that set out how carriers must contract with BH-ASOs or behavioral health agencies and process behavioral health crisis service claims. .

To assist the work group, OIC analyzed claims data from the Washington State All Payer Claims Database (APCD). Carriers are required to submit all claims for fully insured health plans, PEBB, and SEBB to the APCD. The analysis examined how frequently claims were paid by private health insurance carriers in 2022 and 2023 for behavioral health crisis services and for emergency room visits with a primary diagnosis of a mental health condition. During the work group's discussions, both behavioral health crisis service providers and carriers noted that it can be challenging for behavioral health crisis providers to obtain information about health insurance coverage for the people they serve. A behavioral health crisis service provider can find out whether a person they serve is a Medicaid client via access to Medicaid eligibility data. However, there is no comparable data source for private health insurance carriers.

The table below displays the claims information obtained from the All Payer Claims Database analysis. It indicates that in 2022 and 2023, the vast majority of behavioral health crisis services paid for by private health insurance carriers were provided in hospital emergency departments or evaluation and treatment facilities.

Figure 6: APCD analysis

Number of claims and payment information for BH crisis services

Only includes claims with payment

Behavioral Health Service Type	Service Year	Number of Claims	Average Allowed Amount	Average Insurer Paid Amount	Average Costsharing Amount	Median Allowed Amount
Crisis Stabilization Services - In-home stabilization services provided by stabilization teams	2022	1,564	$ 1,552.94	$ 1,424.94	$ 127.99	$ 1,243.56
	2023	892	$ 2,082.06	$ 1,978.50	$ 103.55	$ 1,737.12
Crisis Stabilization Services - In "living room" model within a crisis stabilization setting or in a 23-hour crisis receiving center	2022	22	$ 1,033.64	$ 975.32	$ 58.31	$ 148.00
	2023	34	$ 349.83	$ 120.44	$ 229.38	$ 171.96
Crisis Stabilization Services - In facility licensed by DOH as crisis stabilization unit, crisis triage, or E&T	2022	17	$ 364.98	$ 297.61	$ 67.36	$ 352.92
	2023	26	$ 371.43	$ 348.19	$ 23.23	$ 398.31
Free standing, non-hospital based evaluation and treatment	2022	8,914	$ 2,477.88	$ 2,344.03	$ 133.85	$ 1,687.00
	2023	6,503	$ 2,531.32	$ 2,369.08	$ 162.23	$ 1,550.00
Mobile Crisis Response - Peer support provided by MCR team	2022	125	$ 250.27	$ 180.61	$ 69.65	$ 219.53
	2023	100	$ 278.26	$ 218.66	$ 59.59	$ 119.51
Mobile Crisis Response - Crisis Intervention	2022	225	$ 267.75	$ 185.68	$ 82.07	$ 126.36
	2023	129	$ 223.84	$ 174.89	$ 48.94	$ 84.53
ED visits with a MH primary diagnosis	2022	11,951	$ 1,622.51	$ 1,349.39	$ 273.11	$ 410.28
	2023	9,120	$ 1,469.22	$ 1,161.93	$ 307.28	$ 428.92
Secure Withdrawal Management*	2022	<11 claims	<11 claims	<11 claims	<11 claims	<11 claims
	2023	<11 claims	<11 claims	<11 claims	<11 claims	<11 claims
Withdrawal Management - clinically managed*	2022	478	$ 3,037.53	$ 2,742.03	$ 295.50	$ 2,600.00
	2023	198	$ 3,977.72	$ 3,291.74	$ 685.97	$ 3,300.00
Withdrawal Management -medically managed*	2022	19	$ 1,406.68	$ 959.14	$ 447.53	$ 820.00
	2023	<11 claims	<11 claims	<11 claims	<11 claims	<11 claims

Discussion on how alternative funding and payment models can address gaps

The feedback we received provided differing views of how to improve the payment structure and achieve a firehouse model. We attempt to reconcile the different feedback and proposals on how to move forward with this work. The feedback continued the themes we heard from the workgroups throughout the various stages of this work. Payors report the need to be more transparent on what services provide and how they are medically necessary for their enrollees. This concern comes from how many facilities operate and bill. The facilities bill a per diem for services that are provided in the facility. The services that are provided vary from facility to facility and even within a facility based on patient needs. Payors report that getting individual information on what services an enrollee is receiving while admitted to the facility is difficult and administratively burdensome. BH-ASOs report they need more sustainable funding that is not reliant on negotiation with other payors and is not based on utilization to ensure their services are adequately funded for a firehouse model. The current system is a utilization-based system that suffers from gaps in the funding and payment model that results in:

- Providers report that it is difficult to keep robust services open without stable payments due to normal fluctuations in service delivery.
    - This results in services being unavailable during peak times and services close or reduce availability because of inability to fund services in low demand times.
    - People are unable to get the correct level of support and either seek help with higher or less effective forms of support. Resulting in lives lost, higher overall costs, less effective system people do not engage in.
    - Transparency issues lead to poor insight for some payors into what services are being provided which results in reluctance to authorize or refer a person in crisis to those services.
- Administrative burden also was a constant theme for almost all parties paid using an FFS model.
    - Reconciling services for FFS models and billing commercial payors were the highest sources of administrative burden reported.
    - Other issues like incorrect codes, incorrect units reported, and other billing errors from different billing processes contributed to higher administrative burden for payors.

A future funding model needs to take all the reported problems into account when it is designed and implemented. Many of the APMs could help mitigate some of these issues.

Alternative financing models

The current method of financing the crisis system is based on utilization. As stated previously, this methodology has significant drawbacks and is not sufficient to fund a firehouse model. New financing models should be explored to more efficiently fund the crisis system. These models range from current funding sources to adding new Alternative Financing Models (AFM).

Assessments

Assessments are a form of APM that puts an assessment on a good or service that provides funding upfront based on assumed receipts from the assessment. Fully funding the entire crisis system with an assessment could be difficult due to the high cost of the assessment. However, tying the assessment to

pay for a limited array of services or specific period of time could make this approach feasible. An example of this approach comes from Arizona where the first 72 hours of care is covered by their BH-ASO equivalent, the Regional Behavioral Health Administration. A similar approach could use an assessment to fund the first 24 to 72 hours of services then direct ongoing services to a carrier. As discussed above, the two assessment APMs that have been looked into are:

- Covered lives assessment
- 988-line tax augmentation

Covered lives assessment

Covered lives assessments provide more balanced funding by bringing in all payors into the funding mix. This can include a mix of Medicaid, state, fully funded commercial plans, and even possibly self-funded plans. This approach would put a PMPM assessment on each plan that would be collected by carriers and paid to the state. This approach is currently used to fund the PALs line. Using this approach to fund crisis services, even a narrowed timeframe or specific services would be a larger PMPM and could invite some resistance in implementing. More work could focus on finding an appropriate balance of utilization by the payor and ensuring services are available. Restrictions on how funding is utilized or who can provide services will likely remain.

988-line tax augmentation

Similar to the covered lives assessment levying an assessment APM on health plans. A 988-line tax augmentation would levy an assessment on all radio access lines (cell phones), Voice Over Internet Protocols (VOIP), or any switched access lines. This tax already exists at a current rate of $0.40 a line per month to fund 988 lifeline centers and endorsed crisis teams. The tax could be increased to fund more services. The FCC's authorization for levying the line tax allows for this tax to fund crisis services, as it currently does for endorsed crisis teams. It is not known if this authorization would support funding a diverse array of crisis services or if the tax could be increased enough to fund even a limited amount of services. It would also place a burden on telecommunication plans instead of health plans which could invite opposition. This approach would avoid requirements from other funding streams altogether, which could simplify administrative processes.

New authorities under CMS for population-based payments

Recently, HCA has identified an additional prospective PMPM payment option. Note that this information is a new option and thus has not been shared with the workgroup.

Working with Milliman to develop a payment methodology for endorsed mobile crisis teams has presented new information regarding a population based prospective payment model that could include a PMPM rate or periodic payment. CMS made these new approaches an option as of October 1, 2024, and we are in preliminary conversations with CMS to further understand this population-based payment option within the Medicaid environment, as well as further understanding on how other payors such as private health insurance carriers could be incorporated.

The new approach comes from changes to 42 CFR 438.6 that implemented population based directed payments. Our preliminary understanding is that population-based payments must be tied to delivery of a Medicaid covered service for an enrollee with the goal of increasing value and improved care. A population-based payment would require the state to show how using a population-based directed

payment would be beneficial to the individual receiving care and to the overall value for the system. The state would need to develop metrics to demonstrate how this payment approach brings better care and value for an enrollee. These metrics would require a full analysis of data going back no more than three years to establish a baseline to compare changes to. Performance targets would then need to be gathered and calculated with at least one metric showing improvement over the baseline.

HCA and Milliman are partnering to better understand this approach and to determine if this would be a viable option for the endorsement payment methodology (see Milliman report in appendix 3 for details on endorsement teams). Exploration of this population based directed payment could determine if the approach could also be used for a future APM like an all-payor global budget or an all-payor ACO model.

Alternative payment models

Other APMs like all payor models are also plausible alternatives. The model will need to develop a perspective payment that accounts for costs, populations, and is equitable to all payors. Either the all-payor global budget or an ACO-like model could take advantage of this work. The most popular options reported to us from BH-ASOs were:

- All-payor global budgets, or
- The creation of something similar to ACOs to manage the entire crisis continuum.

All-payor global budget

All-payor global budgets are a perspective model that brings all payors to set a rate that divided up based on factors like assumed utilization, costs, and potential savings. They have the advantage of bringing payors who are not involved or difficult to engage into the planning process. An all-payor global budget will be administratively taxing for the state. Risk of underestimating true costs would fall to the state or BH-ASO depending on set up and potentially providers could feel the impact. Risk of overestimating could result in payors overpaying for their share. Mechanisms could be developed to mitigate each risk by evaluating data as it comes in.

Accountable Care Organization models

ACO-like APMs assign risk and reward to an entity by giving it incentives to improve care and reduce cost. This model requires payors to contract for the delivery of services like the MCOs do with BH-ASOs, but in this model private health insurance carriers and potentially other sources. Any ACO or similar model does require the ACO like entity to assume risk which can be difficult to predict right now due to large systemic changes. It would likely require a risk-sharing plan for the first few years or until the system can be fully accounted for. An ACO-like model would be more difficult for the ACO entities, likely BH-ASOs, to implement. Some current BH-ASOs may not be able to administratively handle this mode. These approaches would provide stable funding while holding regions accountable for proper utilization and promote cost saving innovation.

Capacity payments for a firehouse model

Either a covered lives assessment, all-payor global budget, or an ACO could pay providers with a sub-capitated payment that would provide funding stability to ensure the firehouse model. Sub-capitated or predictable payment types are preferred by providers for a firehouse model due to the low administrative burden and predictable payments. This would move providers away from unpredictable fees for service models that rely on utilization and negotiated amounts to pay for costs to a firehouse model.

Other alternative payment mechanisms

Other APMs like all-payor rates could be viable options and seemed to be the preferred method for MCOs, but we did not get direct feedback on this model. Funding solely or even mostly reliant on grants and federal funding will likely be insufficient and prone to instability.

Implementation of alternative financing and payment models for a firehouse model

More work will need to be done to explore the implications of any AFM and APM on the firehouse model to better understand their impacts. This will require HCA to work closely with partners and CMS to determine the right solution for the state. This solution will also consider whether any federally regulated programs like Medicare and Tricare can be included in the eventual solution. Working with CMS we will determine if there needs to be any special permissions or authorities like a section 1115(a) Medicaid demonstration waiver, an Advanced Alternative Payment Model under CMS' Quality Payment Program, or a demonstration authority with the Center for Medicare and Medicaid Innovation. Once a solution is determined we can work with states that have implemented similar solutions to learn from their experience.

Any solution will take time to implement and will require more work to ensure any solution follows federal and state laws. This will include partnering with system partners to build buy-in. In the near-term new authorities from CMS can work to integrate Medicaid into an AFM and APM. This will be discussed in more detail later. From our current analysis legislation will likely be needed to implement any assessments. A full analysis of HCA's authority or legislation explicitly authorizing HCA would be needed to implement all-payor approaches. A state plan amendment will be likely to enact any changes.

Next steps: further analysis with narrowed focus

Recommended next steps

It is recommended that work continue exploring an alternative payment model (APM). This work would also focus on engaging CMS and other states to learn from their expertise implementing other APMs. Work would be done in phases.

Additional analysis

Per the proviso:

> 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 and co-response services and collect a proportional share of the program cost from each health insurance carrier; ((and))
>
> ii. Differentiate between crisis and co-response services eligible for Medicaid funding from other non-Medicaid eligible activities; and
>
> iii. Simplify administrative complexity of billing for service providers such as the use of a third-party administrator.

The three APMs that are the most promising and that bring all payors to the table are:

1. Covered Lives Assessment
2. All-Payor Global Budgets
3. All-Payor ACO model or an ACO-like model

Each of these APMs would create an alternative funding model that ensures all payors are participating in payment for the behavioral health crisis system in Washington State and would allow all Washington State residents to access the system, while simplifying processes and administrative burden for providers.

More information should also be obtained on the late breaking updates from CMS on a possible population-based methodology. However, it is unclear at this time how this approach would fold in full participation from other payors.

Further analysis should consider a deeper dive, to include:

- Understanding risks
- Understanding costs
- Understanding implementation
- Additional collaboration with workgroup and other key partners

A combination of models may best meet the system needs. Additionally, the model selected should align with service delivery expectations.

Key considerations

1. Further analysis may reveal that the best APM solution for crisis teams, DCRs, RCLs, and possible addition of co-responder teams may differ from the approach for facility-based crisis stabilization services.
2. The existing BH-ASOs and structure should be fully leveraged.
3. A simplified model/structure that reduces administrative burden is the goal. To reduce administrative burden, a new APM and structure would ideally have all crisis providers contracting and billing one entity rather than multiple entities. The BH-ASOs are already positioned and thus could be leveraged to be the main contracting entity, or the state could consider the viability of alternative third-party administrators serving this role.
4. Key structural pillars to consider:
    - All payors participating in paying for the system
    - Maintaining and expanding the firehouse model of behavioral health services where appropriate
    - Establishing consistent revenues for firehouse model and/or fixed costs components unbound from fee for service, as it is difficult to impossible to maintain firehouse models, beds, and services when agencies do not have consistent funding that they can count on.
    - Funding models/contracts that ensure strong partnerships with necessary community partners (counties, first responders, criminal justice system, etc.) especially in connection to the behavioral health crisis continuum of services.

Phase one, Q1-Q4 2025

This phase would leverage remaining funding to continue work with the actuaries.

- Further analysis, definitional work, and exploration of the APM options would occur.
- Gleaning more information from CMS on population-based methodologies.
- Costing out a system. Costing out the system that fully meets demand has been a challenge. However, working with the actuaries to refine what has been gathered thus could provide a "baseline" funding level, as well as consideration of any increasing capacity needs, to then create a foundation for costing out a firehouse model.
- Further analysis on what would be needed to finance the system, e.g. APMs actuarial rate modeling and how this would convert into the identified APM.
- Further analysis to clearly identify a preferred APM model.
- A status update report would be provided to the legislature in December 2025.

Phase two, Q1 2026

This phase would work on the identified AFM(s) and APM(s) and lay out a detailed strategy/plan/framework for consideration for future system change.

Phase three, Q2 2026

This phase would work on finalizing recommendations, including timelines, for consideration by legislatures and key partners.

Appendices

Appendix 1: Full list of workgroup participants

Crisis workgroup participant list since 2023	Organization
Kelly Tower	Association of Washington Healthcare Plans (AWHP)
Peggi Fu	AWHP
Michelle Izumizaki	Cambia Health
Darlene Davies	Carelon
Richard VanCleave	Carelon
Tiffany Villines	Carleon
Heidi Knadel	Catholic Community Services
Connie Mom-Chhing	Community Health Plan of Washington (CHPW)
Erin Gilliland	CHPW
Bryan Winkler	CHPW
Erin Hafer	CHPW
Courtney Ward	CHPW
Dave Guyer	COMPHC
Jodi Daly	COMPHC
Edie Dibble	Comprehensive Healthcare
Chris Santarsiero	Connections
Michael Transue	Connections
Matt Miller	Connections
Emily Rose	Coordinated Care of Washington
John Doherty	Coordinated Care of Washington
Katie Romas	Coordinated Care of Washington
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
Isabel Jones	King County
Dennis Villas	King County
Arianna Kee	Lifeline Connections
Kinh Reynolds	Lifeline Connections
Kirandeep Kang	Mercer
Laura Henry	Mercer
Laura Trieselmann	Mercer
Maija Welton	Mercer
Sanket Shah	Mercer
Jon Villasurda	Mercer

Crisis workgroup participant list since 2023	Organization
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
Steven Biehl	Optum
Clinton Jordan	Pioneer Human Services
Preet Kaur	Premera
Gary Stannigan	Premera
Jane Douthit	Regence
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
Todd Henry	United Healthcare
Joan Miller	Washington Behavioral Health Council
Michele Fasano	CHOICE Network
Ashlen Strong	Washington State Hospital Association
John Richardson	Wellpoint
Michele Robertson	Wellpoint
Michelle Alger	HCA
Teresa Claycamp	HCA
Demetria Hawkins	HCA
Matt Gower	HCA
Ruth Leonard	HCA
Brian Cameron	HCA
Catrina Lucero	HCA
Dallas Morrison	HCA
Ruth Leonard	HCA
Kara Panek	HCA
Luke Waggoner	HCA
Michele Fasano (Wilsie)	HCA
Sherry Wylie	HCA
Lisa Westlund	HCA

Appendix 2: Mercer report, 2024

View a PDF of the full Mercer report: Facility-Based Crisis Stabilization Centers, Designated Crisis Response Services, and Crisis Relief Centers.

Appendix 3: Milliman report, 2024

View a PDF of the full Milliman report: Mobile crisis response payment options in Washington state.

Appendix 4: Mercer preliminary report

View a PDF of the full Mercer preliminary report: Facility-Based Crisis Stabilization Services Proviso 19(b) preliminary report.

Appendix 5: HCA Proviso 19 preliminary report

View a PDF of the HCA Proviso 19 preliminary report: Preliminary report on addressing crisis services funding gaps.

Appendix 6: Glossary

Acronym	Full name
ACO	Accountable Care Organization
APM	Alternative Payment Model
BH	Behavioral Health
BH-ASOs	Behavioral Health Administrative Service Organizations
CBCT	Community-based Crisis Team
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CRC	Crisis Relief Center
DCR	Designated Crisis Responder
DOH	Department of Health
ED	Emergency Department
EMS	Emergency Medical Services
ESSB	Engrossed Senate Substitute Bill
FFS	Fee for Service
GFS	General Fund State
HB	House Bill
HCA	Health Care Authority
ITA	Involuntary Treatment Act

Acronym	Full name
MCO	Managed Care Organization
MCR	Mobile Crisis Response
MRRT/MRRCT	Mobile Rapid Response Team/Mobile Rapid Response Crisis Team
MRSS	Mobile Response and Stabilization Services
NSPL	National Suicide Prevention Lifeline
OIC	Office of the Insurance Commissioner
PAL	Partnership Access Line
PEBB/SEBB	Public and School Employee Benefit Plan
PMPM	Per Member, Per Month
RCL	Regional Crisis Line
RCW	Revised Code of Washington
RFI	Request for Information
SAMHSA	Substance Abuse and Mental Health Service Administration
SERI	Service Encounter Reporting Instructions guide
SFY	State Fiscal Year