Milliman Report

Mobile crisis response payment options in Washington state

Exploration of payment mechanisms, payment levels, and resulting cost projections as directed by Washington HB1134

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Jeremy Cunningham, FSA, MAAA
Davis Burge, FSA, MAAA
Jacob Epperly, FSA, MAAA
David Applegate, MPP
Garrett Bradford, GISP
Joseph Whitley, MPP

Milliman

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EXECUTIVE SUMMARY

In the spring of 2023, the Washington state legislature passed, and Governor Inslee signed, Engrossed Substitute House Bill (HB) 1134. This legislation introduces several behavioral health crisis initiatives, including a mandate for the Washington Health Care Authority (HCA) to establish standards for issuing voluntary endorsements to mobile rapid response crisis teams (MRRCTs) and community-based crisis teams (CBCTs) that meet defined staffing, training, and transportation standards.[1] As stated in HB1134, an "endorsement" signifies that the mobile crisis team maintains the capacity to respond to persons who are experiencing a significant behavioral health emergency that requires an urgent in-person response in alignment with the endorsement standards established by HCA. As of the date of this report, the endorsement standards are in the process of being finalized into the Washington Administrative Code. In addition to developing the endorsement criteria, HB1134 tasks HCA with providing enhanced funding for endorsed teams, including an enhanced case rate (endorsement rate) and a supplemental performance payment (performance payment).

Furthermore, the bill requires HCA to engage Milliman to perform an actuarial analysis, including completion of the following tasks:

- *Endorsement rates.* Develop payment mechanisms and options for mobile crisis team endorsement rates, including both MRRCTs and CBCTs. Endorsement rates were assumed to be consistent for MRRCTs and CBCTs.
- *Performance payments.* Develop payment mechanisms and options for a performance program available to endorsed MRRCTs and CBCTs. HB1134 states that performance payments will be provided to endorsed teams that meet established time thresholds 80% of the time when responding to behavioral health emergencies.
- *Cost projections.* Develop cost projections considering both the endorsement rates and performance payments. These cost projections must include low, medium, and high ranges of costs over a four-year period.

We coordinated with interested parties through several engagement methods to inform this analysis. Interested party engagement included three public meetings (one at project kickoff and two to discuss the results included in this report), eight workgroup meetings, and provider interviews, as well as surveys and data collection from Behavioral Health Administrative Service Organizations (BH-ASOs) and mobile crisis organizations. Key areas of focus included:

- *What is the status quo of mobile crisis response?*
- *What are the cost and operationalization implications of HB1134 Section 9?*

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.

[1] Washington State Legislature. HB 1134 – 2023-24. Retrieved June 23, 2024, from https://app.leg.wa.gov/billsummary?BillNumber=1134&Initiative=false&Year=2023.

- **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.

I. INTRODUCTION

BACKGROUND

In the spring of 2023, the Washington state legislature approved Engrossed Substitute House Bill (HB) 1134, which was subsequently signed by the governor. Section 9 of HB1134 mandates the Washington Health Care Authority (HCA) to develop endorsement criteria for mobile rapid response crisis teams (MRRCTs) and community-based crisis teams (CBCTs). [2] HCA is also required to establish a performance program for these endorsed teams, using response times outlined in the legislation.

Finally, Subsection 11 of Section 9 mandates that HCA work alongside its actuarial partners to analyze and report on the potential impact and implications of implementing the endorsement criteria and performance program. To fulfill this directive within HB1134, HCA has engaged Milliman, Inc. (Milliman) to support the required tasks:

- *Endorsement rates.* Develop payment mechanisms and options for an enhanced case rate (endorsement rate) for mobile crisis teams that have received an endorsement from HCA as a mobile rapid response crisis team (MRRCT) or community-based crisis team (CBCT).
- *Performance payments.* Develop payment mechanisms and options for a voluntary performance program available to endorsed MRRCTs and CBCTs. HB1134 states that performance payments will be provided to endorsed teams that meet established time thresholds 80% of the time when responding to behavioral health emergencies.
- *Cost projections.* Develop cost projections considering both the endorsement rates and performance payments. These cost projections must include low, medium, and high ranges of costs over a four-year period.

To support this work, HCA and Milliman collaborated with interested parties through several engagement methods which included provider interviews, surveys and data collection from Behavioral Health Administrative Service Organizations (BH-ASOs) and providers of behavioral health mobile crisis services, and recurring workgroups to inform the final work product. The two overarching questions framing these engagements were:

1. *What is the status quo of the mobile crisis response in Washington?*
2. *What are the potential cost and operationalization implications of HB1134 based on the status quo?*

Enhancing our understanding of these two domains allowed for a more thorough evaluation of the possible incremental costs resulting from implementation of the endorsement criteria and performance program. Figure 3 provides a visualization of the payment ramifications of endorsement rates and performance payments for a mobile crisis team based on the following factors:

- **Does a mobile crisis team provide services today?** Existing team costs related to HB1134 are incremental to current cost-based reimbursement payment approaches. Costs for future teams arising from the HB1134 initiative, such as CBCTs, are entirely incremental to the status quo.
- **Will a mobile crisis team pursue endorsement?** Existing teams that do not pursue endorsement are not expected to incur any incremental costs due to HB1134.

[2] Ibid.

FIGURE 3: HB1134 COST IMPLICATIONS

	Existing Mobile Crisis Teams – Does Not Become Endorsed	Existing Mobile Crisis Teams – Endorsed	Future Mobile Crisis Teams – Endorsed
Endorsement Rates	No cost impact – does not receive endorsement rate	Receives **endorsement rate** – incremental costs beyond the status quo are assumed in order to meet staffing, training, and transportation endorsement criterion	Receives endorsement rate – all costs are incremental to status quo costs
Performance Payments	No cost impact – ineligible for performance program	Receives **performance payments** if time thresholds are met – all performance program costs are incremental to status quo costs	Receives performance payments if time thresholds are met – all performance program costs are incremental to status quo costs

This report explores these ramifications in more detail with an analysis of the potential implications for mobile crisis response providers and the state.

NATIONAL CONTEXT: SPOTLIGHT ON BEHAVIORAL HEALTH CRISIS CARE

Prior to exploring the specifics of HB1134 and the required analysis, it is helpful to understand the larger national context within which Washington's efforts to bolster its mobile crisis response system are taking place.

In 2020, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) released its *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (the national guidelines).[3] The national guidelines have served as a framework for states and communities across the country, providing them with a baseline structure to enhance their behavioral health crisis response delivery systems. The fundamental principle of the national guidelines is that the services comprising the crisis continuum of care must be accessible *to anyone, anywhere, and at any time*. Figure 4 provides an illustration of the core components of the crisis continuum as defined by the national guidelines.

FIGURE 4: BEHAVIORAL HEALTH CRISIS CONTINUUM OF CARE

In alignment with the requirements of HB1134, this report focuses specifically on the second piece of the continuum: mobile crisis response teams. The national guidelines describe the main objectives of mobile crisis response as follows: [4]

- Help individuals experiencing crisis events experience relief quickly and resolve the crisis situation when possible

[3] SAMHSA (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. Retrieved June 23, 2024, from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.
[4] Ibid.

- Meet individuals in an environment where they are comfortable
- Provide appropriate care/support while avoiding unnecessary law enforcement involvement, emergency department use and hospitalization

LOCAL CONTEXT: HB1134 AND MOBILE CRISIS RESPONSE IN WASHINGTON

Against this backdrop, Washington is enacting several initiatives across the crisis continuum, ranging from the implementation of the 988 system to the support and establishment of a network of crisis stabilization units. HCA's *Mobile Crisis Response Program Guide* provides additional information related to mobile crisis response best practices within Washington and explicitly states HCA's commitment to aligning with the national guidelines.[5]

Other initiatives pursued in Washington in recent years that are relevant to this project include the following:

- **MRRCT expansion.** During the 2021 legislative session, proviso funding was approved to increase and enhance MRRCT coverage to ensure each BH-ASO region has at least one child and adult MRRCT. An additional 17 MRRCTs were implemented as a result of this funding.
- **ARPA requirements.** The American Rescue Plan Act of 2021 (ARPA) included several provisions to improve and expand mobile crisis response. States whose mobile crisis response provision meets specific requirements are eligible to access an 85% federal match for mobile crisis services. Washington achieved these requirements and has begun receiving an enhanced federal match since April 1, 2024, which will continue until April 1, 2027.
- **Medicaid Behavioral Health Benefit Rate Increases.** Engrossed Substitute Senate Bill 5693 (Section 215, proviso #58) went into effect January 1, 2023 and requires a 7% rate increase for all services covered under the behavioral health benefit. The 2024 budget authorized funding to increase Medicaid behavioral health provider rates by 15% effective January 1, 2024.
- **Non-Medicaid Behavioral Health Benefit Rate Increases.** Engrossed Substitute Senate Bill 5950 (Section 215, subsection 7) went into effect January 1, 2024 and requires a 15% rate increase to BH-ASOs receiving state funds for non-Medicaid services effective January 1, 2024.

As stated above, this report primarily focuses on the second component of the crisis continuum—mobile crisis response, specifically the teams dispatched to provide care and support to individuals experiencing a behavioral health emergency in the community. Figure 5 describes the two types of mobile crisis response teams as defined in HB1134: MRRCTs and CBCTs.

FIGURE 5: MOBILE CRISIS RESPONSE TEAM TYPES

Team Type	Description
Mobile Rapid Response Crisis Teams (MRRCT)	• MRRCTs provide professional, on-site, community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for people who are experiencing a behavioral health crisis • All existing mobile crisis response teams are classified as MRRCTs
Community-Based Crisis Teams (CBCT)	• A team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site, community-based interventions of a mobile rapid response crisis team for people who are experiencing a behavioral health crisis • HB1134 established that CBCTs are to be added to Washington's mobile crisis response environment

HB1134 involved three primary requirements of HCA as it relates to MRRCTs and CBCTs:

1. *Development of endorsement criteria for MRRCTs and CBCTs.* Endorsed teams will be eligible for a performance payment in the form of an endorsement rate.

[5] HCA (October 5, 2022). Mobile Crisis Response Program Guide. Retrieved June 23, 2024, from https://www.hca.wa.gov/assets/program/mobile-crisis-response-program-guide.pdf.

2. *Establishment of an accompanying performance program for endorsed teams.* Endorsed teams that meet performance program requirements 80% of the time will be eligible for an additional performance payment on top of the endorsement rate.

3. *Submission of report summarizing impact analysis.* Contract with the actuaries responsible for Medicaid managed care rates to develop payment mechanisms, payment levels, and resulting cost projections for endorsement rates and performance payments.

Endorsement criteria

Section 9 Subsection 1 of HB1134 requires HCA to establish standards for issuing an endorsement to MRRCTs and CBCTs that meet the criteria laid out in the law. The law did not define the detailed requirements to be included in the criteria but laid out minimum requirements that the endorsement criteria must consider. Figure 6 provides a high-level summary of the requirements established within HB1134:

FIGURE 6: HB1134 ENDORSEMENT CRITERIA MINIMUM REQUIREMENTS

Standard	Key Questions and Considerations

Minimum staffing requirements	• Criteria must include minimum staffing requirements:
	  ○ Teams must include appropriately credentialed and supervised staff employed by a licensed behavioral health agency (BHA)
	  ○ Teams shall include certified peer counselors as a best practice based on workforce availability
	  ○ Teams may include fire departments, emergency medical services, public health, medical facilities, nonprofit organizations, and city or county governments
	  ○ Teams may *not* include law enforcement personnel

Transportation capabilities	• Teams must meet vehicle and equipment requirements and have capability to transport individuals experiencing a behavioral health crisis to a location providing crisis stabilization services.
Training requirements	• Criteria must account for standards for initial and ongoing training and provision of clinical supervision.

Subsection 3 establishes that HCA must modify the standards for CBCTs that consist solely of emergency medical services and are situated in rural counties in eastern Washington with populations of fewer than 60,000 residents. CBCTs that fulfill these criteria are exempt from the staffing requirements outlined in the endorsement criteria. However, they must adhere to training requirements set by HCA and operate under a memorandum of understanding with a licensed behavioral health agency (BHA) to provide real-time consultation when the CBCT is responding to a call.

Endorsement is a voluntary credential. Unendorsed MRRCTs and CBCTs will not be prohibited from participating in Washington's crisis response system. However, teams that become endorsed will be issued performance payments in the form of the endorsement rate. Additionally, HCA has indicated that endorsed teams will be the preferred response for individuals experiencing behavioral health emergencies.

At the time of this report's publication, the final endorsement criteria for MRRCTs and CBCTs have not been formally adopted into the administrative code. Draft criteria were shared with mobile crisis providers while this report was in its final drafting stages. Therefore, the analysis reflects *draft* endorsement criteria most recently updated on February 22, 2024.

Performance program

HB1134 Section 9 also requires that HCA implement a performance program in which endorsed MRRCTs and CBCTs can participate. Within this performance program, endorsed teams that meet legally defined response and dispatch times at least 80% of the time are eligible for performance payments. These payments are in addition to the endorsement rate. As illustrated in Figure 7, the performance program is to be implemented in two phases and the time thresholds are stricter within urbanized areas.

FIGURE 7: PERFORMANCE PROGRAM THRESHOLDS

	January 2025-December 2026		January 2027 onwards	
Urban	Arrival within	30 minutes	Arrival within	20 minutes
Suburban		40 minutes		30 minutes
Rural	*En route* within	15 minutes	*En route* within	10 minutes

II. 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?

Figure 9 provides a summary of the different forms of engagement with interested parties over the course of the project. The organizations that participated in each of these different workstreams can be found in Appendix 2.

FIGURE 9: METHODS OF ENGAGEMENT WITH INTERESTED PARTIES

Engagement Method	Description

Mobile crisis response provider surveys	The mobile crisis response provider survey was conducted to develop a comprehensive understanding of the status quo costs and structures of mobile crisis response teams across Washington. Providers that responded to the survey were asked to provide the following information:
	• Approach to mobile crisis team staffing, such as:
	  ○ Organizational staffing and roles
	  ○ Team structures used to respond to behavioral health crises (i.e., peer-clinician pairs of responders ("dyads"), dual-clinician dyads, and non-dyad approaches)
	  ○ Whether or not designated crisis responders assisted with crisis response
	• Mobile crisis dispatch locations
	• Transportation approaches (personal vehicles versus company-owned)

Key informant interviews with mobile crisis providers	Milliman and HCA conducted key informant interviews with eight mobile crisis providers. Topics covered in these interviews included the following: • Clarification and additional discussion related to organizations' mobile crisis survey submissions, as most key informants submitted their responses prior to their interviews

	• What challenges are mobile crisis response organizations currently facing? • What are the implications of the team endorsement and performance program initiatives as written in HB1134?
BH-ASO data request	The purpose of the BH-ASO survey was to better understand the delivery and funding of mobile crisis response services within BH-ASOs' designated regions. In addition, HCA requested that BH-ASOs provide information related to their roles in the provision of mobile crisis response services.
Technical work groups	Technical work group sessions were monthly meetings where topics similar to those covered in mobile crisis response provider surveys and key informant interviews were discussed. In addition, these work groups served as a forum to ask questions to facilitate the development of payment mechanisms, payment levels, and funding projections. The final two technical work group sessions were used to receive provider feedback related to proposed endorsement rate and performance program approaches. Both mobile crisis response organizations and BH-ASO representatives were present in technical workgroup sessions.
BH-ASO work groups	The BH-ASO work group consisted of three meetings, which gathered BH-ASOs' feedback on the status quo funding approach of mobile crisis response services as well as the implications of HB1134. These work groups also served as a forum to ask questions to facilitate the development of the operationalization of endorsement rates and performance payments.
Broader interested party meetings	Three public meetings were held to support this work. A kickoff meeting was facilitated at the beginning of this project to explain the project goals and intended methods of engagement to interested parties. Additionally, a two-part series of meetings were facilitated to share the methodology, assumptions, and results of this analysis. The first meeting provided an overview of the rate methodology, shared rate models that reflect the costs of existing mobile crisis teams, and an introduction to the performance program methodology and assumptions. The second meeting shared the estimated costs of endorsed teams and the performance program through the four-year cost period specified in HB1134. Interested party feedback was gathered to facilitate certain changes to methodology and assumptions within this report.

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.

FIGURE 10: INTERESTED PARTY ENGAGEMENT KEY TAKEAWAYS

Theme	Key Takeaways
Dispatch and Transportation	• Direct response staff dispatch to crisis calls from both centralized locations and their homes. • Many organizations are interested in funding for additional dispatch locations to respond to crisis calls faster. • Most organizations respond to calls using personal vehicles, although many would prefer company-owned vehicles should funding allow it. • Concerns include staffing safety during patient transport, staffing capacity, and budgetary concerns over maintaining a vehicle fleet. • Organizations expressed a need to consider funding for compensation for parking, ride-sharing, auto insurance, and parking placards. • Crisis calls often come through regional crisis lines rather than the 988 hotline. • Organizations tend to triage calls based on assessed severity.
Workforce, Staffing, and Team Composition	• Interviewees reported difficulties in attaining sufficient staffing. • Interviewees noted varying preferences for mobile crisis team staffing structure (e.g., some providers prefer utilizing peers more than others). • Collaboration of designated crisis responders (DCRs) and co-response varies widely by region. • There is uncertainty regarding the incremental cost of dedicated staffing versus using a variety of personnel. • Many organizations struggled with hiring specific roles, particularly licensed mental health professionals (MHPs) and peers, with rural providers expressing particular concern due to a limited staffing pool. • Having a dyad available 24/7 would be challenging in certain areas.
Funding and Administrative Issues	• Mobile crisis providers are primarily funded by BH-ASOs, which gather and braid funding from various Medicaid and non-Medicaid payors, with some direct funding from managed care organizations (MCOs). • BH-ASOs contracting with additional organizations will increase administrative costs. They are not currently compensated for these additional administrative responsibilities, which include application and onboarding processes for endorsed teams (MRRCTs and CBCTs) and performance monitoring. • Additional staffing may be needed to handle these tasks.
Endorsement Criteria and Performance Program	• Mobile crisis providers have indicated that their willingness to become endorsed depends on the specific details of the final endorsement criteria and final reimbursement rates and funding levels. • Providers expressed concern over performance program time thresholds, including the difficulty in immediately responding to calls 80% of the time and safety issues related to the need to speed to meet arrival time thresholds. • BH-ASOs reported that performance program time thresholds are difficult to meet within their designated regions, and additional staffing may be needed to facilitate the operationalization of endorsement rates and performance payments. • The status quo of mobile crisis response in Washington shares similarities with the recorded takeaways from the three workstream engagements.

III. IMPACT ASSESSMENT: ENDORSEMENT CRITERIA

SUMMARY OF RESULTS: ENDORSEMENT RATES

Draft endorsement criteria require endorsed teams to provide access to quality care on a 24/7 basis. Many mobile crisis teams are currently providing 24/7 response and receiving cost-based reimbursement to support their efforts, while other teams are not able to provide 24/7 response either due to funding or workforce shortages.

Under the future endorsement standards, mobile crisis teams are expected to be readily available 24/7 even at times when there are typically few crises requiring response. Because of this, endorsement rates within this report are developed using the "firehouse model" approach as described within *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (the national guidelines).[6] In short, we have defined this approach as paying for a defined amount of mobile crisis response resources regardless of utilization. Rates are developed using this firehouse model approach by considering the number of full-time equivalents (FTEs) needed to staff an endorsed MRRCT or CBCT for mobile crisis response. Based on discussion with HCA, MRRCTs and CBCTs may become endorsed under one of two staffing approaches:

- **24/7 at-the-ready:** The 24/7 at-the-ready team staffing approach assumes that a mobile crisis team pair of responders (dyad) is always on alert and ready to respond to crises on a 24/7 basis. Additional team members are included during peak hours to provide mobile crisis stabilization services and respond to multiple crises simultaneously as needed. Based on discussions with interested parties, this endorsement rate is most appropriate for established, well-staffed mobile crisis response organizations.

  The endorsement rate for the 24/7 at-the-ready team model assumes 19.4 FTEs, accounting for both direct response and supervisory staff, as well as the additional FTEs needed to cover shifts while staff participates in training and paid time off (PTO).

- **24/7 on-call:** The 24/7 on-call team staffing approach assumes that the mobile crisis team has a dyad ready to respond to calls most hours of the week. However, to address workforce shortages expressed by interested parties, it assumes that one shift per day is covered by an on-call dyad. Reduced staffing costs are assumed for on-call shifts. Additionally, it is assumed that extra staff are available during peak times to respond to multiple calls simultaneously, but to a lesser extent than the at-the-ready approach. Based on discussions with interested parties, this endorsement rate is likely to be more appropriate for mobile crisis providers in rural areas or those that are in the process of establishing themselves.

  The endorsement rate for the 24/7 on-call team model assumes 11.4 FTEs, accounting for both direct response and supervisory staff, as well as the additional FTEs needed to cover shifts while staff participate in training and PTO.

Mobile crisis survey responses indicated that some mobile crisis teams have limited staffing and do not use a dyad approach or only provide crisis response during certain times of the week. To become endorsed, these teams would be required to adopt a staffing approach similar to the one assumed under the 24/7 on-call endorsement rate.

Figure 11 shares endorsement rates developed through an independent rate model framework consistent with the approach utilized for phase two of HCA's behavioral health comparison rate initiative.[7] The endorsement rates shown are CY 2025 annual cost estimates reflecting what is assumed to be a minimum requirement for an endorsed team under each respective staffing approach.

FIGURE 11: CY 2025 ENDORSEMENT RATES

DYAD APPROACH	24/7 AT-THE-READY	24/7 ON-CALL
Peer-Clinician	$2,550,000	$1,510,000
Dual-Clinician	$2,830,000	$1,670,000

[6] SAMHSA, National Guidelines, op cit.
[7] HCA (June 30, 2023), Behavioral Health Comparison Rate Development: Phase Two, Retrieved June 23, 2024, from https://www.hca.wa.gov/assets/program/BH-Comparison-Rate-Development-Phase-Two-202309.pdf

Note that endorsement rates are assumed to be consistent for MRRCTs and CBCTs; separate endorsement rates have not been developed for each mobile crisis team type.

HB1134 established that mobile crisis response should include certified peer counselors to the extent practicable. However, based on mobile crisis response provider surveys, about 65% of existing dyads consist of two clinicians responding together (a "dual-clinician" dyad). The remaining 35% of existing dyads utilize the preferred approach of a peer and clinician responding to a crisis together (a "peer-clinician" dyad). HCA should consider how to further incentivize the inclusion of peers within mobile crisis teams as appropriate.

Appendix 1A presents the independent rate models used to develop CY 2025 endorsed team cost estimates shown in Figure 11. *Please note that these rates are preliminary and intended to reflect baseline staffing needed for response. These rates are not reflective of each provider's community need, which might result in increased staffing to meet higher demand or a different staffing mix to provide 24/7 mobile crisis response in their communities*. Appendix 1B shares the independent rate models used for estimating the annual cost of mobile crisis teams based on the status quo, which include an additional staffing approach for teams with limited staffing.

Figure 12 illustrates the estimated cost impact and the assumed number of additional FTEs needed due to existing mobile crisis teams becoming endorsed. The annualized endorsement rates for both 24/7 at-the-ready and 24/7 on-call scenarios assume the same 35%/65% split between peer-clinician and dual-clinician dyads, respectively, consistent with the status quo.

FIGURE 12: CY 2025 ENDORSEMENT COST AND FTE IMPACT PER TEAM

INDEX	COMPONENT	AT-THE-READY	ON-CALL	LIMITED HOURS /STAFFING	NOTES
A	Status quo FTEs	16.5	10.9	4.1	Based on status quo rate models
B	Endorsed FTEs	19.4	11.4	11.4	There is no "limited hours or staffing" endorsement rate
C	**FTE difference compared to status quo**	2.9	0.6	7.3	C = B - A
D	Annualized status quo team costs	$2,310,000	$1,530,000	$590,000	Based on status quo rate models
E	Annualized endorsed team costs	$2,730,000	$1,620,000	$1,620,000	
F	**Annualized per team cost impact**	$420,000	$90,000	$1,030,000	F = E - D

The *anticipated cost impacts* of mobile crisis teams moving from their status quo approaches to an endorsed approach include the following:

- **Staffing costs.** The primary driver of the increased costs of endorsement rates relative to the status quo are staffing-related.
    - Teams assigned the 24/7 at-the-ready staffing approach are assumed to procure an additional dyad to ensure timely response to crises and to support the transport of individuals when necessary.
    - Teams assigned the 24/7 on-call staffing approach are assumed to procure additional staff to ensure a dyad approach for on-call shifts.
    - Teams assigned a limited staffing approach are expected to need the largest staffing increases to reach a 24/7 on-call staffing approach.

- **Training costs.** Draft endorsement criteria require extensive training of mobile crisis responders. Rate models account for an additional 20 hours of training for employees to be compliant with training requirements.
- **Transportation costs.** Draft endorsement criteria require the use of company-owned vehicles with equipment beyond what's used in the status quo.

Note that *potential impacts of seeking endorsement will vary on an organizational basis*; the information shared above provides an estimate of potential impacts. Limitations to the selected approach include the following:

- **Incomplete wage and administrative cost information.** Detailed provider wage and administrative cost information for mobile crisis response providers was not gathered. Our approach assumes that status quo organizational costs align with the rate model assumptions illustrated in Appendix 1B and/or explained in the Methodology section of this report below.
- **Limited survey responses.** Assumed staffing approaches were formulated with limited information because mobile crisis response provider surveys were not received from every organization. BH-ASO data requests indicated that 29 organizations provide mobile crisis response services within Washington; 16 of these organizations provided mobile crisis survey responses.
- **Generalized staffing assumption.** Assumed staffing approaches aim to encompass the *general* staffing patterns of multiple mobile crisis response organizations, as opposed to the unique staffing structure of each individual organization.

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.

Figure 13 provides an overview of the key components and elements of the IRM approach. This report does not document many assumptions underlying the independent rate models that remained consistent with prior comparison rate modeling. Additional information on the IRM approach can be found in the separate report titled *Behavioral Health Comparison Rate Development – Phase Two*.[8]

FIGURE 13: INDEPENDENT RATE MODEL COMPONENTS

COMPONENT	ELEMENTS	SUB-ELEMENTS	CLARIFYING NOTES
Direct Care Staff and Supervisor Salaries and Wages	Service-related time	Direct time	Corresponding time unit, or staffing requirement assumptions where not defined Adjusted for staffing ratios for some services (i.e., more than one person served concurrently, e.g., in group counseling sessions or for residential services).
		Indirect time	Service-necessary planning, note taking, and preparation time
		Transportation time	Travel time related to providing service
		PTO/training/ conference time	Paid vacation, holiday, sick, training and conference time. Also considers additional training time attributable to employee turnover
		Supervisor time	Accounted for using a span of control variable
	Wage rates	Can vary for overtime and weekend shift differentials	Wage rates vary depending on types of direct service employees, which have been assigned to provider groups
	Stipends	Payments for on-call capacity	Used for selected services
Employee-Related Expenses	Payroll-related taxes and fees	Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Insurance (SUI), Workers' compensation	Applicable to all employees, and varies by wage level assumption
	Employee benefits	Health, dental, vision, life and disability insurance, and retirement benefits	Amounts may vary by provider group
Transportation – Fleet Vehicle Expense	Vehicle operating expenses	Includes all ownership and maintenance-related expenses	Varies by service. Some services assume an employee-owned vehicle at the federal rate. Other services assume fleet vehicle expenses or vans.
Administration, Program Support, and Overhead	All other business-related costs	Includes program operating expenses, including management, accounting, legal, information technology, etc.	Excludes expenses related to managed care administration and room and board

STAFFING APPROACHES

A. Status quo staffing approaches

Engagement with interested parties was crucial to understanding mobile crisis team costs within the status quo. A recurring theme from the feedback was that existing mobile crisis teams employed various staffing approaches for providing mobile crisis response. It was noted from mobile crisis response provider surveys that there were resemblances in staffing approaches among teams with similar levels of organizational funding, as reported in BH-ASO data requests. Typically, teams with higher levels of funding tended to maintain at-the-ready dyads available on a 24/7 basis, while teams with more limited funding either operated during specific hours of the week or utilized a single-responder approach.

[8] HCA (June 30, 2023), Behavioral Health Comparison Rate Development: Phase Two, op cit.
https://www.hca.wa.gov/assets/program/BH-Comparison-Rate-Development-Phase-Two-202309.pdf

Funding for crisis stabilization services varies by region, with grant funding available in some regions. Our analysis only captured crisis stabilization funding to the extent that it was provided through the BH-ASOs, and our analysis did not capture the stabilization service funding provided by the MCOs.

To support modeling the costs of existing mobile crisis teams and the incremental costs of a team meeting endorsement criteria, we categorized each mobile crisis provider's existing team into one of the staffing approaches shown in Figure 14.

FIGURE 14: STATUS QUO STAFFING APPROACHES

Staffing approach	Description
24/7 at-the-ready	• Assigned to organizations with more than $3 million in annual funding as reported within BH-ASO data requests. • Eleven of the 27 mobile crisis providers BH-ASOs identified fall within this bucket and receive about $86.1 million of the estimated $102.0 million in BH-ASO funding reported across all sources. • Dyads are at-the-ready 24/7 to respond to crisis calls. • Additional dyads are available during peak hours to provide mobile crisis stabilization services and respond to multiple crises at once as needed. • These teams may need additional staffing to support quicker response to certain calls and to support the transport of individuals when necessary. • **An endorsement rate has been drafted to reflect this general staffing approach.** Providers assigned this staffing approach are expected to incur additional costs to meet endorsement criteria.
24/7 on-call	• Assigned to organizations with $1 million to $3 million in annual funding as reported within BH-ASO data requests. • Nine of the 27 mobile crisis providers BH-ASOs identified fall within this bucket and receive about $12.8 million of the estimated $102.0 million in BH-ASO funding reported. • Dyads are at-the-ready during most shifts. • Third shifts (overnight) are covered by on-call FTEs. • Providers in this category may need additional FTEs in order to meet endorsement criteria. • **An endorsement rate has been drafted to reflect this general staffing approach.** Providers assigned this staffing approach are expected to incur additional costs to meet endorsement criteria.
Limited hours and/or staffing	• Assigned to organizations with less than $1 million in annual funding as reported within BH-ASO data requests • Seven of the 27 mobile crisis providers BH-ASOs identified fall within this bucket and receive about $3 million of the estimated $102.0 million in BH-ASO funding reported. • Organizations assigned this approach tend to reside in rural areas. • May respond to crisis calls with one team member rather than a dyad. • May not respond to crisis calls during certain hours of the day. • **An endorsement rate has not been drafted for this staffing approach.** Teams assigned to this staffing approach are presumed to become eligible for endorsement after developing staffing similar to that reflected in the 24/7 on-call endorsed team model.

The staffing approach assumptions provided are based on estimates derived from mobile crisis survey responses, key informant interviews, and technical workgroup discussions. While these assumed staffing approaches aim to represent the staffing approaches of categorized organizations in the aggregate, it is anticipated that *these assumptions may not precisely match each organization's actual staffing approach*.

Assumptions: Existing teams with 24/7 at-the-ready staffing. The staffing assumptions for *existing mobile* crisis teams assigned the 24/7 at-the-ready staffing approach are as follows:

- Mobile crisis teams assigned this approach are assumed to have an at-the-ready dyad available at all times of the week. Mobile crisis surveys suggest that approximately 35% of existing mobile crisis dyads include a peer and a clinician, while the remaining 65% of dyads include two clinicians.
- An additional dyad is available during two weekday shifts to provide mobile crisis stabilization services and respond to multiple crises at once as needed.
- A supervisor, assumed to be a mental health professional (MHP), is available 24/7 to support a supervisory and consultative role. These supervisors are assumed to be able to provide this role to five dyads at once.
- Each team member is assumed to be unavailable to provide crisis response for 17.3% of their workweek to reflect the time commitment of training and PTO, which results in additional FTEs included in modeling to cover all shifts. This assumption was developed as part of phase two of HCA's behavioral health comparison rate initiative.
- 10% of non-holiday working hours are assumed to be overtime and paid at time-and-a-half.

Figure 15 illustrates the assumed staffing availability during each shift of the week for existing mobile crisis teams assigned the 24/7 at-the-ready staffing model. This illustration is also available in Appendix 3B for this staffing approach and others explained later in this section.

FIGURE 15: STATUS QUO 24/7 AT-THE-READY TEAM STRUCTURE

SHIFT	CLINICIAN	CLINICIAN OR PEER	SUPERVISOR
Weekday First	2	2	0.4
Weekday Second	2	2	0.4
Weekday Third	1	1	0.2
Weekend First	1	1	0.2
Weekend Second	1	1	0.2
Weekend Third	1	1	0.2
Total FTEs	**7.5**	**7.5**	**1.5**

Shifts are defined as eight-hour periods in which different groups of FTEs provide mobile crisis response. Specific hours for these shifts have not been defined, but common definitions for each of the shifts are as follows:

- **First shifts** begin during the morning and continue for eight hours until the early afternoon
- **Second shifts** begin after the first shift ends and continue for eight hours into early nighttime
- **Third shifts** begin after the second shift ends and continue for eight hours into the morning. The first shift of the next day begins after the third shift ends

Assumptions: Existing teams with 24/7 on-call staffing. The staffing assumptions for *existing* mobile crisis teams assigned the 24/7 on-call staffing approach are as follows:

- Mobile crisis teams assigned this approach are assumed to have an at-the-ready dyad available during two of three shifts.
- A team member is assumed to be on-call during the remaining shift as needed. On-call staff are assumed to incur 25% of the cost of having staff “at the ready.” This assumption could be better informed by mobile crisis provider wage information. Feedback was requested on this assumption within a technical work group session, but none was received.
- An additional dyad is available during one weekday shift to provide mobile crisis stabilization services and respond to multiple crises at once as needed.
- A supervisor, assumed to be an MHP, is available 24/7 to support a supervisory and consultative role. These supervisors are assumed to be able to provide this role to five dyads at once.
- Similarly to the 24/7 at-the-ready staffing approach, team members are assumed to be unavailable to provide crisis response for 17.3% of their workweeks to reflect the time commitment of training and PTO, resulting in additional FTEs included in the modeling to cover all shifts.
- 10% of non-holiday working hours are assumed to be overtime and paid at time-and-a-half.

Assumptions: Existing teams with limited staffing. The staffing assumptions for *existing* mobile crisis teams assigned the limited staffing approach are as follows:

- Mobile crisis teams assigned this approach are assumed to have a mobile crisis team member available two shifts a week available to respond to crises.
- A supervisor, assumed to be an MHP, is available during each shift a team member is available to respond to crises to support a supervisory and consultative role.
- Each team member is assumed to be unavailable to provide crisis response for 17.3% of their workweek to reflect the time commitment of training and PTO.
    - This assumption was developed as part of phase two of HCA’s behavioral health comparison rate initiative.
- Each team member is available 33 hours out of their 40-hour workweek to provide mobile crisis response.
- 10% of non-holiday working hours are assumed to be overtime and paid at time-and-a-half.

Appendix 3B provides illustrations of the assumed staffing for existing mobile crisis teams.

Appendix 5 provides de-identified funding levels for each mobile crisis provider as reported within BH-ASO data requests, along with the approximate number of mobile crisis teams each organization may be able to fund based on its assigned status quo staffing approach and assumed costs. Appendix 1B shares the independent rate models used for estimating the annual cost of mobile crisis teams based on the status quo, which includes an additional staffing approach for teams with limited staffing.

Funding levels have been trended from the reporting period of each BH-ASO data request (primarily CY 2023) to CY 2025 to assess whether each organization has sufficient funding to maintain an endorsed team.

B. Endorsement criteria impact on staffing approaches

HCA's draft endorsement criteria mandate that endorsed teams must offer access to quality care around the clock. Consequently, the endorsement rates in this report are developed using the "firehouse model" approach, as outlined in the SAMHSA national guidelines. In essence, this entails paying for a specified quantity of mobile crisis response resources irrespective of their utilization. The firehouse model approach used to determine the endorsement rates considers the number of full-time equivalents (FTEs) required to staff an endorsed MRRCT or CBCT at all times of the week.

Figure 16 outlines the minimum standards stipulated within HB1134 to be considered as part of the endorsement criteria, as well as the incremental requirements outlined in HCA's draft endorsement criteria concerning staffing.

FIGURE 16: HB1134 AND DRAFT ENDORSEMENT CRITERIA STAFFING REQUIREMENTS

Source	Requirements
HB1134 minimum standards	• Teams must include appropriately credentialed and supervised staff • Teams shall include certified peer counselors as a best practice based on workforce availability
Draft endorsement criteria	• Peer counselors must be used when available • Teams will be supervised by a professional who meets the criteria as an MHP while the responding staff are in the field • Teams must staff to ensure an in-person response is available 24 hours a day seven days a week that can meet required response times • Ability to respond in pairs for all outreaches unless clinically appropriate not to • Teams will have access to an MHP 24 hours a day and seven days a week for the team to consult • Team members are to be compliant with a variety of trainings

Based on discussions with HCA, MRRCTs and CBCTs have the option to become endorsed under either the 24/7 at-the-ready or the 24/7 on-call staffing approach. In response to input from interested parties, HCA determined that allowing for a 24/7 on-call staffing approach was necessary due to workforce shortages, especially for crisis organizations in rural areas.

Assumptions: 24/7 at-the-ready endorsed team staffing

Note that the status quo staffing approach for 24/7 at-the-ready teams fulfills many of the draft endorsement criteria related to staffing. Team members are expected to be available to respond in pairs, response is accessible 24/7, and staff are appropriately credentialed. The following adjustments were made to better align with the expectations for 24/7 at-the-ready teams under the endorsement criteria:

- An additional dyad (two FTEs) is available during a weekday peak shift to enable faster response times, to support transporting individuals when needed, and to provide mobile crisis stabilization services.
- An additional 20 training hours per team member per year are assumed to maintain compliance with training required within HCA's draft endorsement criteria.
- Note that endorsement rates are developed for both dual-clinician and peer-clinician dyads. However, peer counselors are expected to be used as they're available.

Appendix 3A provides an illustration for the assumed 24/7 at-the-ready staffing approach for endorsed teams.

Assumptions: 24/7 on-call endorsed team staffing

The assumed staffing approach for 24/7 on-call teams within the status quo meets some of the endorsement criteria related to staffing: mobile crisis response is available 24/7, and staff are properly credentialed. However, compared to the assumed 24/7 at-the-ready staffing approach, additional adjustments were required for the assumed staffing approach to meet all endorsement criteria:

- An additional on-call team member is available during the on-call shift to satisfy the requirement for being able to respond to crises in teams.
- While an additional dyad would be beneficial during a peak shift, it is not assumed within this staffing approach. The endorsement rate developed using this staffing approach is assumed to be the *minimum number of FTEs needed to fulfill endorsement criteria.*
- An additional 20 training hours per team member per year are assumed to maintain compliance with training required within HCA's draft endorsement criteria.

- Note that endorsement rates are developed for both dual-clinician and peer-clinician dyads. However, peer counselors are expected to be used as they're available.

Appendix 3A provides an illustration for the assumed 24/7 on-call staffing approach for endorsed teams. Note that 11.4 FTEs are needed to support this staffing approach.

Assumptions: Organizations with limited staffing

The assumed staffing approach for limited teams within the status quo does not fulfill many key areas of the endorsement criteria related to staffing. Organizations assigned this approach are assumed to require substantial funding to meet endorsement requirements, as illustrated in Figure 12 above. Teams assigned to this staffing approach are presumed to become eligible for endorsement after developing staffing similar to that reflected in the 24/7 on-call endorsed team model.

Note that 11 of the 29 reported mobile crisis response organizations were identified as having limited staffing, as illustrated in Appendix 5. These organizations currently lack adequate funding to maintain a 24/7 on-call staffing approach. Any limited staffing teams that meet endorsement criteria in CY 2025 were presumed to transition to a 24/7 on-call staffing approach. Additional start-up funding may be necessary to support these mobile crisis response organizations should they choose to seek endorsement.

TRANSPORTATION

The transportation expense component of the IRM approach aims to encompass provider entities' out-of-pocket transportation costs on an ongoing basis. For most other services, this component is fully covered by the federal mileage reimbursement allowance of $0.67 per mile driven, which includes standard transportation expenses such as gas, depreciation, maintenance, etc. However, as HB1134 endorsement criteria minimum standards and HCA's draft endorsement criteria impose additional requirements beyond typical costs, it is assumed that additional costs beyond standard transportation costs will be incurred. Interested parties indicated there will be significant up-front costs to comply with HB1134, primarily related to the purchasing of vehicles. HCA has indicated grant funding will be provided to support these one-time costs. The transportation allowance included within the endorsement rates reflects ongoing costs to maintain the vehicle fleet.

A. Standard transportation costs

Following a methodology similar to phase two of HCA's behavioral health comparison rate development, annual standard transportation costs are calculated by multiplying the assumed mileage per year by the federal mileage reimbursement allowance per mile driven. This subsection outlines the development of a mobile crisis team's assumed mileage traveled per year.

Geographic information system (GIS) analysis was conducted to determine the average distance and time needed to travel to a crisis location from the nearest mobile crisis provider dispatch location, as reported in mobile crisis response provider surveys. Centers of census blocks, the smallest geographic unit employed by the U.S. Census Bureau, were utilized to represent crisis locations. The likelihood of a crisis response being necessary in a given census block is assumed to be perfectly correlated with population density developed using the 2020 U.S. Decennial Census.[9]

Figure 17 provides transportation calculations for urban, suburban, and rural crisis responses. Additional details on the population classification scheme are provided in the analysis in Section V below of the impact of the performance program.

[9] U.S. Census Bureau. Decennial Census by Decade. Retrieved June 23, 2024, from https://www.census.gov/programs-surveys/decennial-census/decade.2020.html.

FIGURE 17: MOBILE CRISIS TRANSPORTATION ASSUMPTIONS

Transportation Regions	Urban (ZIP Codes with more than 3,000 persons per square mile)	Suburban (ZIP Codes with 500-3,000 persons per square mile)	Rural (ZIP Codes with less than 500 persons per square mile)
% of population (and land)*	41.6% (1.1% of Land Area)	26.1% (2.9% of Land Area)	32.3% (96.0% of Land Area)
Average transportation time per trip (one-way)	16 minutes	27 minutes	56 minutes
Average miles per trip (one-way)	5 miles	11 miles	29 miles

* Population estimates are based on the 2020 U.S. Decennial Census

One difference in mileage assumption development compared to phase two comparison rates is that, instead of developing separate mileage assumptions for urban, suburban, and rural teams, an aggregated mileage assumption is used for all teams. This is because most existing mobile crisis teams provide mobile crisis response in at least two of the three population classifications.

Estimating the mileage per year for a mobile crisis team hinges upon the number of crises responded to per day per team. In an effort to develop an informed assumption, utilization data was solicited during a technical work group session. Notably, only one response was received from a mobile crisis provider assigned the "24/7 on-call" staffing approach. Based on information from this organization, we made the following assumptions:

- The average number of trips per day per team for this organization was approximately *four*, considering both initial crisis and follow-up visit data.
- Because the 24/7 on-call staffing approach assumes *four* separate mobile crisis response dyad shifts are staffed per day (two dyads are available during first shift, one dyad is available during second shift, and one on-call responder is available during third shift), the assumed number of trips per day per dyad shift is *one*.
- Staffing approaches with a different number of mobile crisis response dyad shifts per day are assumed to scale proportionally. For example, the status quo 24/7 at-the-ready staffing approach has five dyad shifts staffed per day, therefore five trips are assumed per day.

Interested parties noted that mobile crisis teams sometimes travel in separate vehicles, resulting in four to-and-from trips between the dispatch location and the crisis location per response. However, some teams shared that they respond together in one vehicle, resulting in two trips between the dispatch location and the crisis location per response.

Additional trip data was requested following the technical work group call, but no additional mobile crisis organizations provided this information. In the absence of trip data and based on discussions with HCA, we assumed that the average number of to-and-from trips per crisis response is three, representing the average of the two scenarios mentioned above.

Figure 18 details the buildup of developing annual standard transportation costs for an existing mobile crisis team utilizing the “24/7 at-the-ready” staffing approach based on the assumptions explained above.

FIGURE 18: ANNUAL STANDARD TRANSPORTATION COSTS – STATUS QUO 24/7 AT-THE-READY

REF	DESCRIPTION	VALUES	NOTES
A	Average mileage per trip	14.5	Statewide average mileage per trip, developed through GIS analysis.
B	Trips per crisis response	3	Assumes half of the time dyad members respond separately to crises.
C	Crisis responses per day	5	A crisis response is assumed per dyad available on weekdays.
D	Crisis responses per week	35	D = C * 7
E	Total mileage per week	1523	E = A * B * D
F	Reimbursement per mile	$0.67	Reflects gas, maintenance, and insurance costs for a personal vehicle.
G	Standard transportation costs per week	$1,020	G = E * F
H	Annual standard transportation costs	$53,044	H = G * 52

Figure 19 details the resulting standard transportation costs per year for each mobile crisis staffing approach, explained in the Staffing Approaches subsection above.

FIGURE 19: TEAM STAFFING APPROACHES FEDERAL MILEAGE REIMBURSEMENT COSTS

REF	DESCRIPTION	LIMITED	24/7 ON-CALL	STATUS QUO 24/7 AT-THE-READY	ENDORSED 24/7 AT-THE-READY
A	Average mileage per trip	14.5	14.5	14.5	14.5
B	Trips per crisis response	2	3	3	3
C	Crisis responses per day	2	4	5	6
D	Crisis responses per week	14	28	35	42
E	Total mileage per week	406	1218	1523	1827
F	Reimbursement per mile	$ 0.67	$ 0.67	$ 0.67	$ 0.67
G	Standard transportation costs per week	$272	$816	$1,020	$1,224
H	Annual standard transportation costs	$14,145	$42,435	$53,044	$63,653

B. Endorsed team-specific transportation and equipment costs

Figure 20 outlines the HB1134 endorsement minimum standards and HCA's draft endorsement criteria, which result in increased transportation and equipment costs for endorsed mobile crisis teams beyond standard transportation costs.

FIGURE 20: HB1134 AND DRAFT ENDORSEMENT CRITERIA TRANSPORTATION REQUIREMENTS

Source	Requirements
HB1134 minimum standards	• Endorsement criteria must include vehicle and equipment requirements, including minimum requirements for vehicles and equipment to be able to safely transport an individual, as well as communication equipment standards

Draft endorsement criteria	• Vehicles for transportation cannot be the personal vehicle of responding staff
	• All vehicles must be properly insured
	• The appropriate equipment to ensure a person being transported is unable to interfere with the driver's safe operation of the vehicle
	• Door(s) can be secured by the driver from being opened by a person being transported
	• Access to appropriate booster seat and/or child safety seats for transporting youth
	• All vehicles will be equipped with the following:
	  ○ American Red Cross first aid kit or equivalent
	  ○ Fire extinguisher
	  ○ Flares or other warning devices
	  ○ Flashlight
	  ○ Traction devices or tire chains when required by the department of transportation.
	  ○ Emergency supplies including blankets, water, and food.
	  ○ Weather-related supplies
	  ○ The ability to track the vehicle via GPS
	• In addition to vehicle equipment requirements all teams will carry the following equipment:
	  ○ Naloxone
	  ○ Crisis kits that include the following:
	  ▪ Food items to assist a person in crisis to meet basic needs (small ready-to-eat meals, snacks, etc.)
	  ▪ Basic hygiene items
	  ▪ Lockboxes
	  ▪ Trigger locks
	• If cellular telephones are used there must be another method of radio or satellite contact with dispatch or emergency services in case cellular service is unavailable
	• All vehicles will be equipped with means to access electronic health records (EHRs) for client and referral records through remote means where coverage is allowed

The initial approach to assessing the cost impact of these incremental expenses involved gathering information from mobile crisis response organizations with established vehicle fleets. However, it was found that the majority of existing mobile crisis response teams utilize personal vehicles. When discussing the potential cost impact of these incremental expenses, mobile crisis providers gave the feedback below.

- **Fleet vehicles.** Because most teams do not have vehicle fleets, establishing one would entail a significant one-time expense.
- **Liability insurance.** Mobile crisis teams might be considered at higher risk of experiencing traffic incidents relative to standard drivers and therefore require heightened liability insurance amounts. This concern may be exacerbated by the suggested performance program time thresholds.
- **Safety equipment.** Safety is paramount for mobile crisis teams, and having the proper equipment to ensure the safe transport of individuals would be highly beneficial.

- **EHR software and communications.** Electronic health record (EHR) and communication equipment would result in significant recurring costs.

Given these uncertainties, ongoing annual incremental costs are estimated at $5,000 per vehicle used within a mobile crisis response team. The number of vehicles each mobile crisis team is assumed to have is based on the shift where the most mobile crisis dyads are providing crisis response. For example, an endorsed 24/7 at-the-ready team is assumed to mean that three dyads are available during the busiest shift. Therefore, the required number of vehicles is three for this assumed staffing approach, leading to an annual incremental transportation and equipment cost loading of $15,000.

It is recommended that, once mobile crisis teams become endorsed, annual vehicle and equipment upkeep costs are monitored to better inform this assumption. The incremental cost per vehicle assumption is intended to be a comprehensive estimate that is likely to cover the incremental costs for endorsed teams. However, it is possible that actual costs exceed this amount; thus the incremental cost estimate can be updated in future years as needed based on additional emerging data.

In summary, vehicle costs are accounted for through the federal mileage reimbursement allowance plus an additional $5,000 per year per vehicle required. Please note that one-time costs associated with developing a fleet to meet endorsement criteria are not captured in the endorsement rate.

OTHER ASSUMPTIONS

A. Wages and employee-related expenses

In line with phase two of HCA's behavioral health comparison rate development initiative, provider groups were leveraged to model wages and employee-related expense (ERE) assumptions for each mobile crisis response team member. Wage levels were refined from phase two comparison rate assumptions using the most recent publicly available data, e.g., May 2023 Bureau of Labor Statistics (BLS) data, and cost trending by 3.80% a year.

Prior assumptions 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 rate increases in 2024 that would increase reimbursement for mobile crisis services. This adjustment will be considered in future analyses related to mobile crisis.

The trend assumption of 3.80% has been selected for all provider modifiers, which is an equal blending of the annualized trend of 3.10% from the latest six-month rolling average of Federal Reserve Economic Data (FRED) wages (October 1, 2023-March 1, 2024) and the annualized trend of 4.61% from the latest 18 month rolling average of FRED wages (October 1, 2022-March 1, 2023).

Employee related expense development is consistent with the methodology shared in the *Behavioral Health Comparison Rate Development – Phase Two* report. Figure 21 contains the ERE assumptions that have been updated to reflect the most recent publicly available data.

FIGURE 21: ADJUSTED EMPLOYEE-RELATED EXPENSE ASSUMPTIONS

COMPONENTS	UPDATED ASSUMPTIONS	SOURCE
Employee Social Security withholding	Wage Base Limit: $174,900 projected for 2025 (as projected by the Social Security Administration under an intermediate scenario)	Internal Revenue Service. Topic No. 751, Social Security and Medicare Withholding Rates. Retrieved June 23, 2024, from https://www.irs.gov/taxtopics/tc751. Social Security Administration. 2021 Old-Age, Survivors, and Disability Insurance (OASDI) Trustee Report. Retrieved from https://www.ssa.gov/oact/tr/2024/V_C_prog.html
State Unemployment Tax Acts (SUTA) tax	1.35% Wage Base Limit: $67,600	Washington State Employment Security Department. Determining Your Tax Rates. Retrieved June 23, 2024, from https://esd.wa.gov/employer-taxes/determining-rates. Washington State Employment Security Department. Taxable Wage Base. Retrieved June 23, 2024, from https://esd.wa.gov/employer-taxes/taxable-wage-base.
Workers' compensation	1.31% calculated as a percentage of wages and salaries and paid leave components per December 2023 national data.	Bureau of Labor Statistics (December 2023). Economic News Release, Table 1. Employer Costs for Employee Compensation by Ownership for Civilian Workers. Retrieved from https://www.bls.gov/news.release/archives/ecec_03132024.pdf
Insurance benefits	$10,597 per year Increased based on phase two provider survey results to reflect higher insurance costs than those reflected in BLS insurance cost per hours worked data ($3.47 base hourly cost for the healthcare and social assistance industry group multiplied by 2,080 hours, trended from December 1, 2023, to July 1, 2025).	2022 Provider Cost and Wage Survey U.S. Bureau of Labor Statistics. (December 2023). Economic News Release, Table 2. Employer Costs for Employee Compensation for Civilian Workers by Occupational and Industry Group. Retrieved from https://www.bls.gov/news.release/archives/ecec_03132024.pdf

Appendix 4 shares the wage and employee-related expense development for each team member assumed within the staffing approaches shared in the previous section.

B. Administration

An adjustment to account for the provider's cost of administration, program support, and overhead is built into each of the rate models. The assumption of 25% of the total expenses was used for all services, which is consistent with phase two comparison rate assumptions, with the exception of Wraparound with Intensive Services (WISe) and Program of Assertive Community Treatment (PACT) services, which have administrative assumptions of 30% of total expenses. Draft endorsement criteria and interested party feedback do not suggest that mobile crisis team administrative costs are significantly higher than other behavioral health services, so the assumption of 25% of total expenses has been retained.

Appendix 1A presents the independent rate models used to develop CY 2025 endorsed team cost estimates that reflect the above endorsed team assumptions.

Appendix 1B shares the independent rate models used for estimating the annual cost of mobile crisis teams based on the status quo, which includes an additional staffing approach for teams with limited staffing.

IV. IMPACT ASSESSMENT: PERFORMANCE PROGRAM

SUMMARY OF RESULTS

Section 9 of HB1134 requires the establishment of a performance program available to endorsed mobile crisis teams. Within this performance program, teams meeting the defined time thresholds shown in Figure 22 at least 80% of the time when responding to crises are eligible for performance payments.

FIGURE 22: HB1134 PERFORMANCE THRESHOLDS

	January 2025 – December 2026		January 2027 onwards	
Urban	Arrival within	30 minutes	Arrival within	20 minutes
Suburban		40 minutes		30 minutes
Rural	*En route* within	15 minutes	*En route* within	10 minutes

The following summarizes key assumptions made to assess the ability of mobile crisis teams to meet the time thresholds above:

- **Population classification.** We classified Washington state into urban, suburban, and rural categories as outlined by HB1134, using the following hierarchy:
    - ZIP Codes of islands and other difficult-to-reach areas are classified as “rural” to account for transportation difficulties
    - ZIP Codes with more than 3,000 persons per square mile are assigned the “urban” classification
    - ZIP Codes with 500-3,000 persons per square mile are assigned the “suburban” classification
    - ZIP Codes with less than 500 persons per square mile are assigned the “rural” classification
- **Catchment areas.** Milliman captured existing organizations’ mobile crisis dispatch locations through mobile crisis response provider surveys, an HCA listing, and online research. Our modeling attributes Washington’s population to the nearest mobile crisis dispatch location to determine the population each organization is responsible for.
- **En route times:** Organizations are expected to take the same time to be *en route* to urban and suburban crises as they are for rural crises. Mobile crisis providers have the remaining time to travel to urban or suburban locations; for example, mobile crisis providers have 15 minutes to travel to a crisis in an urban area (30 minutes to arrive less 15 minutes to be en route).

Geographic information system (GIS) analysis was utilized to assess mobile crisis teams’ abilities to meet the performance program’s defined time thresholds. Figure 23 shows the percentage of existing mobile crisis teams that would meet the established time thresholds 80% of the time or more based on the framework explained above. It is important to note that the at-the-ready existing teams are primarily located within urban areas, which are held to quicker response times than suburban or rural areas, resulting in a lower percentage of existing teams able to meet performance thresholds.

FIGURE 23: PERCENTAGE OF EXISTING TEAMS MEETING TIME THRESHOLDS

SCENARIO	NUMBER OF EXISTING TEAMS	CY 2025-CY 2026	CY 2027+
At-the-ready	42	60%	22%
On-call	9	89%	89%
Limited staffing/hours	6	98%	98%
Composite/total	57	69%	41%

Note that the results in Figure 23 are *based on a model* and *actual experience may vary* from the results shown. In addition, results in this figure reflect all existing teams currently providing services; only teams that become endorsed are eligible to receive performance programs as established in HB1134.

Limitations to our modeling approach include the following:

- **Geospatial uncertainty.** The geospatial datasets used to conduct GIS analysis are simplified representations of reality and contain varying levels of abstraction and uncertainty. It is certain that actual real-world values will not conform exactly to estimates provided by these services. The degree of uncertainty will depend heavily on the quality of reported dispatch locations and as well as the original data used to develop the underlying geospatial products.
- **Limited survey responses.** Due to limited mobile crisis survey responses, the *complete listing of mobile crisis dispatch locations within Washington is not reflected*. Access to all mobile crisis dispatch locations would reduce the average population or area that each individual dispatch location is responsible for. Furthermore, we understand that additional dispatch locations are being considered in certain areas. Both of these possibilities may result in a higher percentage of organizations capable of meeting performance thresholds due to smaller response areas.
- **Age-specific response.** Some provider survey responses indicated that certain provider organizations only offer mobile crisis response to either children or adults. However, again, due to limited mobile crisis survey responses and reported dispatch locations, this dynamic was not accounted for in our modeling.
- **Weather and traffic.** Inclement weather, excess traffic, and other extenuating circumstances may prevent teams from reaching all crisis calls. The results presented above assume no extenuating circumstances.

Interested parties consistently voiced concerns about the performance program and its time thresholds. Key concerns were:

- **Need for assessment.** Limited time to be en route reduces the ability to thoroughly assess the nature of crisis calls prior to arriving at the caller's location, potentially impacting the ability to provide an appropriate response. Interested parties indicated these assessments include identifying potential hazards at the scene, reviewing prior experiences with individuals, and ensuring the specific crisis response team approach is appropriate for the caller's needs.
- **Team safety.** Limited time to travel to calls may prompt staff to dangerously exceed the speed limit to meet time thresholds. Because sirens are unavailable for mobile crisis response—and may not be appropriate in some circumstances—this raises concerns about staffing safety.
- **Staffing shortages.** Many mobile crisis providers lack the staffing capacity to respond to all crises immediately.
- **Risk level and need.** Some situations do not require an immediate response (e.g., the caller requests support at a specific time, such as when their child arrives home from school) and in other circumstances an immediate response might not even be clinically necessary.

To accommodate the latter two interested party considerations, HCA suggests that performance program time thresholds only apply to behavioral health emergencies where a person experiences a significant behavioral health crisis that requires an *immediate* in-person response due to the level of risk or lack of means for safety planning.

HCA's proposed payment mechanism for performance payments is to assess each organization's compliance with time thresholds on a quarterly basis. Teams that meet time thresholds 80% of the time would receive a performance payment based on the quarterly firehouse funding provided (e.g., an additional payment of 2% of firehouse funding provided).

Performance payments as a percentage of endorsement rates

Performance program payment levels have been modeled as a percentage of a qualifying team's endorsement rates:

$$\text{Annual Performance Payments} = \text{Endorsement Rate} * \text{Performance Program Percentage}$$

The approach is widely used across various service types to establish bonus payments for meeting performance targets. HCA has discretion in determining an appropriate performance program percentage, needing to strike a balance between establishing appropriate incentives, mobile crisis teams' abilities to meet established time thresholds, and the funding implications. HCA may consider additional performance payments for urgent or emergent crises, which are not assumed to be included in the HB1134 performance program, which is limited to behavioral health emergencies.

Figure 24 shares CY 2025 annual performance payments reflecting what is assumed to be paid to endorsed teams meeting established time thresholds under each respective staffing approach. A performance program percentage of 2% has been assumed based on discussions with HCA and consulting national performance program levels, but the state has ultimate discretion in determining appropriate payment levels.

FIGURE 24: CY 2025 PERFORMANCE PAYMENTS PER ENDORSED TEAM

DYAD APPROACH	24/7 AT-THE-READY	24/7 ON-CALL
Peer-clinician	$51,000	$30,200
Dual-clinician	56,600	33,400

METHODOLOGY AND ASSUMPTIONS

Key areas where assumptions were necessary to estimate the incremental costs of the performance program are outlined in Figure 25. This section explores the identified areas where assumptions were made or future decisions are required to address the various uncertainties.

FIGURE 25: PERFORMANCE PROGRAM UNCERTAINTIES

Key Areas	Uncertainties
Population classifications	• Precise definition of urban, suburban, and rural • Classification of dispatch locations as urban, suburban, or rural
Population attribution	• Locations teams are expected to dispatch to (crisis locations) play a crucial role in determining whether arrival windows are feasible • Lack of catchment areas and operational processes to ensure coordination in determining which teams are responsible for providing a response to a given call
En route standards	• Determination of appropriate or reasonable preparation time to be allowed prior to dispatch and arrival at crisis location

Extenuating circumstances	• Extent and frequency of extenuating circumstances (e.g., inclement weather, traffic, lack of parking) that result in mobile crisis teams being unable to respond to calls within time thresholds
Crises relevant to performance program	• HB1134 requirements specify that performance payment metrics are based on dispatches from designated 988 contact hubs • Certain crises are not clinically appropriate to respond to immediately, while others require an immediate response (behavioral health emergencies)
Performance program payment level	• How much funding will be provided to endorsed mobile crisis teams that meet the time thresholds specified in HB1134 at least 80% of the time?

A. Population classifications

While HB1134 outlined the time threshold requirements based on population levels, it did not specify the criteria for defining urban, suburban, and rural areas. Our team collaborated with HCA to establish goals for population classifications.

- **Goal A**: Time thresholds should be an achievable goal for efficient providers:
    - Population classifications assigning a large portion of areas as urban would be less achievable
    - Several interested parties expressed uncertainty regarding whether or not mobile crisis teams would be able to meet the specified time thresholds within each of the five avenues of interested party engagement
- **Goal B**: Classifications are consistent with actual population density levels
    - Reference A contains a population density map available on the website of Washington state's Office of Financial Management (OFM), which was viewed alongside potential population classification schemes

Transportation assumptions within phase two of HCA's behavioral health comparison rate initiative developed population classifications for urban, rural, and *frontier* areas (phase two classifications). Phase two classifications were used as a starting point for development of an urban, suburban, and rural population classification scheme (HB1134 classifications) that meet Goals A and B above.

Granularity: In support of Goal B, HB1134 classifications were developed at the ZIP Code Tabulation Area (ZCTA) level rather than by county. ZCTAs are generalized representations of U.S. Postal Service ZIP Code service areas developed by the U.S. Census Bureau for tabulating summary statistics. While not entirely equivalent to ZIP Codes, ZCTAs have the benefit of clearly defined areas and population statistics. More information on this measure can be found at the U.S. Census Bureau's website.[10] For the purposes of this analysis and report, the terms "ZCTA" and "ZIP Code" are used interchangeably.

Granularity was adjusted as Reference A suggests Washington population density can vary significantly within a single county. More granular levels of classification (e.g., census blocks) were decided against as they may cause excess administrative burden.

[10] U.S. Census Bureau. ZIP Code Tabulation Areas (ZCTAs). Retrieved June 24, 2024, from https://www.census.gov/programs-surveys/geography/guidance/geo-areas/zctas.html#:~:text=ZIP%20Code%20Tabulation%20Areas%20or%20ZCTAs%20%28pronounced%20zik-tahs%29,Service%20%28USPS%29%20Zone%20Improvement%20Plan%20%28ZIP%29%20Codes%20dataset.

Classification metric: Consistent with phase two classifications, HB1134 classifications use population density as the metric for determining population classifications. Other approaches to define population classifications, e.g., the National Center for Health Statistics (NCHS) urban-rural classification schemes, tend to assign population classifications at the county level, which does not align with Goal B.

Population density levels: Classifications for urban, rural, and frontier counties reflected within phase two of HCA's behavioral health comparison rate initiative were defined at a county level. We evaluated utilizing these population classifications for the purpose of this project but found that identified shortcomings. For example, classification resulted in nine counties being classified as urban. Interested parties within many of these regions, even those with several 24/7 at-the-ready teams, provided feedback that they did not consider urban time thresholds to be feasible for the population they serve. Additionally, mobile crisis providers explained that time thresholds for mobile crisis response areas difficult to travel to (e.g., islands and Point Roberts) would lead to difficulty. Islands, for example, cannot be reached by car if the dispatch location is within Washington's mainland; urban or suburban time thresholds are not achievable if mobile crisis teams would need to travel by ferry. With this feedback in mind, the population classifications in Figure 26 were developed at the ZIP Code level to support Goal A.

FIGURE 26: RESIDENTIAL AREA CLASSIFICATION BASED ON ZIP CODE POPULATION

CLASSIFICATION	EXPLANATION
Urban	ZIP Codes with 3000+ persons per square mile
Suburban	ZIP Codes with 500-3000 persons per square mile
Rural	ZIP Codes with less than 500 persons per square mile

Appendix 6 includes HB1134 population classifications by ZIP Code. Milliman and HCA settled on this population classification after comparing the assigned population classifications alongside Reference A. While some areas within Washington may not be perfectly modeled, this population classification attempts to strike a proper balance between Goal A and Goal B.

B. Population attribution

One primary factor influencing the ability of mobile crisis teams to dispatch to crises within HB1134 time thresholds is the population each team serves. Whether a mobile crisis team can respond to calls from an urban area within 20 to 30 minutes depends on the distance that needs to be traveled. Additionally, mobile crisis providers with limited staffing and covering substantial populations may not have a team available to respond to behavioral health emergencies immediately. One approach to establishing realistic populations for each mobile crisis provider to cover would be to define catchment areas for each endorsed mobile crisis team based on their dispatch locations and available FTEs.

In the absence of defined catchment areas, our team developed proxy catchment areas in order to attribute Washington's population to mobile crisis dispatch locations identified through mobile crisis survey responses, previously developed listings from HCA, and online research. The process for developing the proxy catchment areas was as follows:

1. A roster of mobile crisis providers' dispatch locations was developed by assigning at least one dispatch location for each mobile crisis provider BH-ASOs reported providing funding for. In most cases, if multiple BH-ASOs reported that a particular mobile crisis provider provides services within their designated region, it was assumed that the mobile crisis provider has one dispatch location in each designated region.
    a. For organizations that responded to the mobile crisis response provider survey, the dispatch locations referenced in survey responses were used. There was one instance where an organization reported several dispatch locations but did not have funding for multiple teams based on our development of status quo cost estimates. In this case the dispatch locations were limited to the number of teams the mobile crisis provider had funding for.

b. For organizations that did not complete the mobile crisis response provider survey, a roster HCA developed in August 2023 was utilized to assign dispatch locations. Typically, only one dispatch location was reported per entity assigned using this listing.

c. For organizations that did not complete mobile crisis response provider surveys and were not included on HCA's roster, organizational dispatch locations were gathered through online research.

2. Once the full listing of mobile crisis dispatch locations was developed, GIS analysis was performed to attribute Washington's population to a mobile crisis dispatch location.

   a. The Washington population within each census block, based on the 2020 U.S. Decennial Census, was assumed to be located at the census blocks' centroid. More information on census blocks can be found on the U.S. Census Bureau's website.[11]

   b. For each census block, the travel time from the census blocks' centroid to each mobile crisis dispatch location was calculated. Each census block was assigned the mobile crisis dispatch location based on the minimum travel time.

   Limitations to this approach include the following:

   - Mobile crisis survey responses received shared that certain provider organizations only provide mobile crisis response to children or to adults. With limited mobile crisis survey responses and dispatch locations reported, this dynamic was not accounted for within our modeling.
   - Assigned population amounts varied widely by mobile crisis dispatch locations. Some mobile crisis teams were expected to serve 3.1% of Washington's population while others were only expected to cover 0.2% of Washington's population.
   - It is assumed that mobile crisis providers can provide mobile crisis response to their attributed populations, but organizations with limited staffing may not be able to serve a sizable population. More established mobile crisis providers may be expected to assist in these circumstances, but this was not considered within our final attribution.
   - Census block populations are only assigned to one mobile crisis dispatch location; in practice, it may benefit a population by having two nearby dispatch locations provide response as needed.

C. En route standards

Rural organizations' time thresholds are solely based on the time it takes for mobile crisis providers to be *en route* to a crisis location. In contrast, urban and suburban time thresholds are measured in terms of the total time it takes to *arrive* at the crisis location. To estimate the total amount of time mobile crisis teams have to travel to crisis locations, it is assumed that teams are en route based on the time specified in the rural time threshold.

For example, HB1134 time thresholds establish that calls from urban locations need to be traveled to within 30 minutes during CY 2025 and CY 2026. It is expected that the initial 15 minutes are spent preparing for the call, thus they have 15 minutes to travel to the crisis location.

Interested parties expressed that they typically do not begin travelling to crisis calls within 15 minutes. Time thresholds assuming less time to prepare for calls would result in less time to review the nature of crisis calls to support high-quality responses. Interested parties indicated these reviews include identifying potential hazards at the scene, reviewing prior experiences with an individual, and ensuring the crisis response team approach is appropriate.

Appendix 7A documents the urban and suburban Washington ZIP Codes which can be arrived at within the CY 2025 and CY 2026 time thresholds at least 80% of the time. Whether or not an area can be arrived at within the established time thresholds has been informed through GIS analysis.

[11] U.S. Census Bureau (August 3, 2021). Data Gem: What Are Census Blocks? Retrieved June 24, 2024, from https://www.census.gov/data/academy/data-gems/2021/what-are-census-blocks.html.

Note that the dispatch locations shown reflect those of existing mobile crisis teams; additional locations are not assumed for future mobile crisis teams, and time thresholds may be more feasible to the extent that additional mobile crisis teams begin providing services.

Appendix 7B documents the urban and suburban Washington ZIP Codes that can be arrived at within CY 2027+ time thresholds at least 80% of the time. Whether or not an area can be arrived at within the established time thresholds has been informed through GIS analysis. Note that the dispatch locations shown reflect those of existing mobile crisis teams; additional locations are not assumed for future mobile crisis teams, and time thresholds may be more feasible to the extent that additional mobile crisis teams begin providing services.

D. Extenuating circumstances

Interested parties shared that, even in cases where a crisis location is close enough to their dispatch to respond in the allowed travel time, extenuating circumstances could lead to organizations not arriving within the time threshold. Extenuating circumstances shared include but are not limited to the following:

- Inclement weather
- Parking considerations within urban areas
- Traffic
- Lack of staffing available to immediately respond to a crisis call

There is uncertainty regarding the number of mobile crisis response calls that cannot be reached within performance program time thresholds due to reasons other than the required time to travel to the crisis location. To account for this uncertainty, it is assumed that mobile crisis teams need to be capable of meeting established time thresholds more than 80% of the time.

An example assumption is that time thresholds cannot be met 5% of the time due to extenuating circumstances. In this case, 85% of a mobile crisis response dispatch location's assigned population must be met within established time thresholds for the mobile crisis team to receive a performance payment.

E. Crises relevant to performance program

The performance program time thresholds, as outlined in HB1134, are applicable to all dispatches from the designated 988 crisis hub. A noted concern is that certain crisis calls often do not require an immediate response and/or it would not be appropriate to provide one (e.g., the caller explicitly asks for a response later in the day). Additionally, many mobile crisis providers lack the staffing capacity to immediately respond to all crises.

HCA suggests that performance program time thresholds only apply to behavioral health emergencies, which are currently defined as "instances where a person experiences a significant behavioral health crisis that requires an *immediate* in-person response due to level of risk of lack of means for safety planning."

BH-ASO work group participants also expressed concern that the performance program, as written, only considers dispatches received by the designated 988 contact hub. They highlighted that the vast majority of calls, currently upwards of 99%, are received through the regional hotline rather than through 988 contact hubs. Assessing whether organizations meet performance program thresholds solely based on the limited subset of crisis calls received from the 988 contact hub may result in situations where providers consistently meet the performance thresholds, but yet do not receiving the performance payment due to the calls not originating with a 988 contact hub.

It is assumed that crisis locations are independent of the dispatcher of each call (whether it is a 988 contact hub or a regional hotline) as well as the nature of each call (e.g., a follow-up response versus a behavioral health emergency). Thus, adjustments to our modeling approach were not necessary.

F. Incremental costs of performance program

GIS analysis was performed to determine which mobile crisis providers may consistently meet performance standards should they become endorsed.

With each mobile crisis location assigned a population, the following analysis was conducted to evaluate the percentage of calls that can be reached within the defined time thresholds:

- Census blocks were assigned a HB1134 population classification based on their overarching ZIP Codes.
- The travel time to each census block centroid was compared to the established time thresholds, minus assumed en route time. If the average travel time to each census block centroid was less than the allowed travel time based on time thresholds, then the census block's population was flagged as reachable within time thresholds. As there is no defined arrival window for rural calls, 100% of census blocks assigned to the rural population classification would be reachable based on this calculation.
- This comparison was completed for each census block attributed to each mobile crisis dispatch location.
- The number of calls reachable within established time thresholds was calculated as follows:

$$\text{Percentage of Reachable Calls} = \frac{\text{Assigned Population Reachable within Time Threhold}}{\text{Assigned Population}}$$

- In instances where a mobile crisis provider has multiple dispatch locations in a single BH-ASO region, the calculation above would be calculated for all applicable dispatch locations rather than individually.
- This calculation was completed for both the CY 2025-CY 2026 time thresholds and the CY 2027+ time thresholds.

Figure 27 provides an illustration of the calculation for determining whether an endorsed mobile crisis team would be eligible to receive performance payments based on its ability to meet the specified time thresholds. It is assumed within this illustration that 5% of mobile crisis responses cannot be responded to in time due to extenuating circumstances.

FIGURE 27: ILLUSTRATIVE CALCULATION OF ENDORSED TEAM ELIGIBILITY FOR PERFORMANCE PAYMENTS

INDEX	COMPONENT	NOT ELIGIBLE FOR PERFORMANCE PAYMENT	ELIGIBLE FOR PERFORMANCE PAYMENT	NOTES
A	Attributed population	400,000	100,000	Determined through GIS.
B	Organizational funding	$5,000,000	$1,000,000	Funding is assumed to be allocated based on each dispatch location's attributed population.
C	Mobile crisis FTEs	40	20	FTEs are assumed to be allocated based on each dispatch location's attributed population
D	Percentage of calls from urban locations	80%	10%	Determined through ZIP Code classifications. Call locations are assumed to be proportional to population density.
E	Percentage of calls from suburban locations	20%	40%	Determined through ZIP Code classifications.
F	Percentage of calls from rural locations	0%	50%	Determined through ZIP Code classifications.
G	Percentage of urban calls that can be traveled to within time threshold	85%	80%	Based on average time to travel to call locations versus the urban time threshold.
H	Percentage of suburban calls that can be traveled to within time threshold	80%	80%	Based on average time to travel to call locations versus the suburban time threshold.
I	Percentage of rural calls that can be traveled to within time threshold	N/A	100%	Assumes that teams dispatch within 15 minutes of receiving a crisis call.
J	Percentage of calls reachable within time thresholds	84.0%	90.0%	J = (D * G) + (E * H) + (F * I)
K	Percentage of calls unreachable within time thresholds due to extenuating circumstances	5%	5%	
L	Actual percentage of calls reachable within time threshold	79%	85%	L = J – K
M	Team eligibility for performance payment	Not Eligible	Eligible	Contingent on 80% of calls being reached within time thresholds.

V. HB1134 COST PROJECTIONS

SUMMARY OF RESULTS

Section 9 of HB1134 requests the calculation of estimated cost projections resulting from the implementation of the endorsement criteria and performance program. The cost projections have been developed to meet the specifications for a variety of payment options, including the development of low, medium, and high ranges of projected costs over the four-year projection period. Figure 28 illustrates the medium estimate of projected costs under the baseline scenario of endorsement rates and performance payments over the four-year cost-year period.

FIGURE 28: HB1134 INCREMENTAL COST IMPACTS – BASELINE SCENARIO MEDIUM ESTIMATE (VALUES IN $ MILLIONS)

COMPONENT	CY 2025	CY 2026	CY 2027	CY 2028	TOTAL
Status quo costs (statewide funding with no endorsed or new teams)	$ 114.4	$ 118.7	$ 123.2	$ 127.9	$ 484.3
Endorsement rate incremental costs – existing teams	9.0	14.1	17.8	20.6	61.6
Endorsement rate incremental costs – new teams	0.0	12.4	24.0	33.4	69.7
Performance payment incremental costs	0.7	1.3	1.6	1.9	5.4
Total mobile crisis environment costs under HB1134	$ 124.1	$ 146.5	$ 166.5	$ 183.8	$ 621.0
Number of existing teams becoming endorsed	23	34	41	45	45
Number of new teams becoming endorsed	0	6	11	15	15

Note that the incremental cost impacts related to the endorsement rates and performance program increase materially over the four-year projection period; this is driven by additional teams becoming endorsed throughout the four-year period. We have developed low, medium, and high ranges by varying the number of teams becoming endorsed over the project period, including the following:

- The number of existing mobile crisis teams becoming endorsed and the corresponding timing of their endorsements over the four-year period. The low scenario reflects 32 existing teams becoming endorsed and the high scenario reflects 51.
- The number of new MRRCT and CBCT teams beginning operations and becoming endorsed within the four-year period. The low scenario reflects eight new teams becoming endorsed and the high scenario reflects 23.

Figure 29 provides a high-level breakout of HB1134 cost implications by component in the CY 2025 to CY 2028 period.

FIGURE 29: CY 2025-CY 2028 MOBILE CRISIS RESPONSE COST PROJECTIONS – BASELINE SCENARIO (VALUES IN $ MILLIONS)

COMPONENT	LOW COST ESTIMATE	MEDIUM COST ESTIMATE	HIGH COST ESTIMATE
Status quo costs (statewide funding with no endorsed or new teams)	$ 484.3	$ 484.3	$ 484.3
Endorsement rate incremental costs – existing teams	35.1	61.6	73.7
Endorsement rate incremental costs – new teams	37.3	69.7	103.6
Performance payment incremental costs	2.5	5.4	7.4
Total mobile crisis environment costs under HB1134	$ 559.1	$ 621.0	$ 668.9
Total HB1134 incremental Impact	$ 74.8	$ 136.7	$ 184.6

Note that the results above are *based on a model and actual experience will vary* from the results shown. Limitations to our modeling approach include the following:

- **Uncertainty around number of teams to seek endorsement.** Existing mobile crisis providers have not shared whether they intend to seek endorsement. Many explained that their willingness depends on the level of the endorsement rates and the specific requirements of the endorsement criteria (which had not been finalized as of the publication of this report).
- **Limited survey responses.** CBCTs and additional MRRCTs have not been surveyed to assess their ability and willingness to begin operations and become endorsed as of the time of this analysis
- **Imprecise timing.** The timing of teams becoming endorsed is an *estimate that has not been informed through interested parties*. Because the endorsement criteria was not publicly available during this analysis, we were not able to gather feedback from providers on their likelihood of becoming endorsed. Additionally, when teams will be able to become endorsed will also depend on the state's ability to operationalize the endorsement process.
- **Behavioral health benefit rate increases.** We are relying on CY 2023 BH-ASO reported data. We have not made adjustments to this data for the known behavioral health rate increases. The incremental cost impact illustrated in Figure 29 are based on changes in staffing, training, and transportation assumptions underlying our IRM framework. The behavioral health benefit rate increases will be considered in future analyses related to mobile crisis.

Enhanced payment scenario

While we assume that the endorsement rates developed using the firehouse model will provide additional funding to mobile crisis teams compared to status quo cost-based reimbursement approaches, these payment levels may not sufficiently incentivize mobile crisis providers to seek endorsement. The enhanced payment level scenario includes the following:

- ***Endorsement rates:*** Enhanced endorsement rates reflecting 105% of modeled costs are assumed.
- ***Performance payments:*** An enhanced performance program percentage of 4% is assumed.

The state has ultimate discretion in determining appropriate payment levels for endorsement rates and performance payments, and payment levels may be further refined with additional data collected through the endorsement certification process (e.g., team staffing plans). Further compensation, such as sign-on bonuses, could also be accounted for through determined payment levels.

Figure 30 provides a high-level breakout of HB1134 cost implications by component through the CY 2025 to CY 2028 period when assuming these enhanced payment levels:

FIGURE 30: CY 2025-CY 2028 MOBILE CRISIS RESPONSE COST PROJECTIONS – ENHANCED SCENARIO (VALUES IN $ MILLIONS)

COMPONENT	LOW COST ESTIMATE	MEDIUM COST ESTIMATE	HIGH COST ESTIMATE
Status quo costs (statewide funding with no endorsed or new teams)	$ 484.3	$ 484.3	$ 484.3
Endorsement rate incremental costs – existing teams	46.1	80.9	96.3
Endorsement rate incremental costs – new teams	39.1	73.2	108.7
Performance payment incremental costs	5.3	11.3	15.5
Total mobile crisis environment costs under HB1134	$ 574.7	$ 649.8	$ 704.8
Total HB1134 incremental Impact	$ 90.5	$ 165.5	$ 220.6

Appendix 8 illustrates the low, medium, and high projections over the four-year period under the baseline scenario (Appendix 8A) and enhanced scenario (Appendix 8B), including illustrating numbers of teams becoming endorsed, estimated per team and statewide mobile crisis team costs, and performance payments split by Medicaid (state and federal) and non-Medicaid.

METHODOLOGY AND ASSUMPTIONS

A. Endorsing existing teams

As of the timing of this analysis, final endorsement criteria and endorsement rates have not yet been shared with mobile crisis providers. As noted above, providers stated that their willingness to seek endorsement depends on the specific requirements of endorsement criteria and the level of the endorsement rates.

To develop cost projections that account for the phasing-in of existing mobile crisis teams meeting endorsement criteria, we assume the endorsement rates provide sufficient incentive for mobile crisis providers to seek endorsement. Additionally, HCA aims to have 80% of existing teams endorsed by the end of the first four years of HB1134's enactment.

In addition to adjusting the *number* of endorsed teams varying in the low, medium, and high range estimates, the *timing* of teams becoming endorsed has also been adjusted to reflect different possibilities. Teams receiving endorsement rates sooner will lead to higher cost projections.

To align with HCA's goals, the medium assumption (Figure 31) is that approximately 80% of existing mobile crisis teams will be endorsed over the four-year period. Existing teams that are close to meeting the endorsement criteria are assumed to obtain endorsement earlier within the four-year cost period.

FIGURE 31: MEDIUM COST ESTIMATE ASSUMPTION

EXISTING TEAM ENDORSEMENTS – BASELINE	CY 2025	CY 2026	CY 2027	CY 2028	TOTAL
Percentage of existing at-the-ready teams becoming endorsed	50.00%	20.00%	10.00%	5.00%	85.00%
Percentage of existing on-call teams becoming endorsed	25.00%	20.00%	20.00%	15.00%	80.00%
Percentage of existing limited teams becoming endorsed	5.00%	15.00%	20.00%	10.00%	50.00%
Composite	41.32%	19.15%	13.79%	7.68%	81.94%

The low assumption (Figure 32) posits that existing mobile crisis teams are less inclined to pursue endorsement, resulting in delayed endorsement timing. In this estimate 60% of teams are assumed to be endorsed rather than 80%. Additionally, this estimate assumes more teams delay their pursuit of endorsement until CY 2027, as opposed to CY 2025.

FIGURE 32: LOW COST ESTIMATE ASSUMPTION

EXISTING TEAM ENDORSEMENTS – LOW	CY 2025	CY 2026	CY 2027	CY 2028	TOTAL
Percentage of existing at-the-ready teams becoming endorsed	15.00%	20.00%	20.00%	10.00%	65.00%
Percentage of existing on-call teams becoming endorsed	5.00%	15.00%	20.00%	10.00%	50.00%
Percentage of existing limited teams becoming endorsed	0.00%	0.00%	20.00%	15.00%	35.00%
Composite	11.84%	16.76%	20.00%	10.72%	59.32%

Finally, the high assumption (Figure 33) suggests that 90% of existing teams are endorsed within the four-year period. This estimate also assumes that these teams seek endorsement much sooner than the low and medium range, with over 50% of existing teams assumed to become endorsed within the first year of HB1134's enactment.

FIGURE 33: HIGH COST ESTIMATE ASSUMPTION

EXISTING TEAM ENDORSEMENTS – HIGH	CY 2025	CY 2026	CY 2027	CY 2028	TOTAL
Percentage of existing at-the-ready teams becoming endorsed	60.00%	20.00%	10.00%	5.00%	95.00%
Percentage of existing on-call teams becoming endorsed	40.00%	20.00%	20.00%	5.00%	85.00%
Percentage of existing limited teams becoming endorsed	20.00%	20.00%	10.00%	10.00%	60.00%
Composite	52.63%	20.00%	12.00%	5.91%	90.54%

B. Endorsing new teams – CBCTs

HCA also engaged potential CBCTs through a series of work groups throughout the course of this project. Similar to existing mobile crisis teams, these organizations expressed uncertainty around their interest and ability to formally become a CBCT and seek endorsement. Again, they stated that their participation would be contingent on the level of funding to be provided and the specific requirements of the endorsement criteria.

Approximately 25 independent organizations participated in CBCT work groups (not including BH-ASO and local government entities). Given the uncertainty around the extent of CBCT interest, we consider a wide range of potential CBCTs becoming endorsed:

- In the low range estimate, 20% of work group participants (i.e., five CBCTs) will begin operations and become endorsed during the cost period
- In the medium range estimate, 40% of work group participants (i.e., 10 CBCTs) will begin operations and become endorsed during the cost period
- In the high range estimate, 60% of work group participants (i.e., 15 CBCTs) will begin operations and become endorsed during the cost period

We start with assuming CBCTs will require a year to complete the contracting process. Therefore, CBCTs are not assumed to pursue endorsement until the second year of the cost period. CBCT endorsements are assumed to occur at uniform levels across the second through fourth years of the cost period. Figure 34 outlines the assumed timing of CBCTs becoming endorsed under the low, medium, and high range estimate.

FIGURE 34: NUBMER OF NEW CBCTS SEEKING ENDORSEMENT

RANGE	CY 2025	CY 2026	CY 2027	CY 2028
Low	0 additional CBCTs	2 additional CBCTs	2 additional CBCTs	1 additional CBCTs
Medium	0 additional CBCTs	4 additional CBCTs	3 additional CBCTs	3 additional CBCTs
High	0 additional CBCTs	5 additional CBCTs	5 additional CBCTs	5 additional CBCTs

Given that eastern Washington CBCTs are exempt from certain endorsement criteria, it is assumed that the average team will not be staffed at the same level as 24/7 at-the-ready teams. Thus, CBCTs included within cost projections will be assumed to utilize a 24/7 on-call staffing approach.

C. Endorsing new teams – MRRCTs

During the four-year projection period, we assume that additional MRRCTs will be established. They could take the form of either additional teams associated with existing mobile crisis response providers looking to address coverage gaps or expand outreach, or teams from newly established organizations.

Figure 35 outlines the assumed timing of additional MRRCTs becoming endorsed under the low, medium, and high range estimate. Given that the existing network is comprised of MRRCTs, we are assuming most new teams will be CBCTs but do anticipate additional MRRCTs because organizations unable to meet performance program time thresholds are incentivized to address coverage gaps by adding more dispatch locations. We are assuming the new endorsed MRRCTs will be approximately 50% of the number of new CBCTs.

Given that the organizations in urban locations are the least able to meet performance program time thresholds and that urban teams tend to utilize 24/7 at-the-ready staffing approaches, we are assuming new MRRCTs will utilize a 24/7 at-the-ready staffing approach.

FIGURE 35: NUMBER OF NEW MRRCTS SEEKING ENDORSEMENT

RANGE	CY 2025	CY 2026	CY 2027	CY 2028
Low	0 additional MRRCTs	1 additional MRRCTs	1 additional MRRCTs	1 additional MRRCTs
Medium	0 additional MRRCTs	2 additional MRRCTs	2 additional MRRCTs	1 additional MRRCTs
High	0 additional MRRCTs	3 additional MRRCTs	3 additional MRRCTs	2 additional MRRCTs

D. Performance program

Mobile crisis expansion considerations

Figure 36 shows the assumed percentages of existing mobile crisis teams that would meet established time thresholds 80% of the time or more without accounting for extenuating circumstances.

FIGURE 36: PERCENTAGE OF TEAMS MEETING TIME THRESHOLDS

SCENARIO	NUMBER OF EXISTING TEAMS	CY 2025 - CY 2026	CY 2027+
At-the-ready	42	60%	22%
On-call	9	89%	89%
Limited	6	98%	98%
Composite/Total	57	69%	41%

While mobile crisis providers may experience difficulties achieving 2027+ time thresholds, new CBCTs and MRRCTs should alleviate some of the challenges by reducing the population each mobile crisis team is accountable for. Our assumptions to account for this dynamic are as follows.

- Low cost projections: **40%** of 24/7 at-the-ready teams will meet established time thresholds in CY 2027 and CY 2028.
- Medium cost projections: **50%** of 24/7 at-the-ready teams will meet established time thresholds in CY 2027 and CY 2028.
- High cost projections: **60%** of 24/7 at-the-ready teams will meet established time thresholds in CY 2027 and CY 2028.

Extenuating circumstances

As explained in Section IV above, there are certain instances where endorsed mobile crisis teams may be unable to meet established performance program time thresholds due to extenuating circumstances, regardless of whether or not the crisis location is reachable based off of the assumed dispatch location. Our assumptions to account for this dynamic are as follows.

- Low cost projections: **10%** of crisis responses cannot be reached within the established time thresholds due to extenuating circumstances; thus, only organizations able to respond within established time thresholds *90%* of the time are assumed to receive performance payments within low cost projections.
- Medium cost projections: **5%** of crisis responses cannot be reached within the established time thresholds due to extenuating circumstances; thus, only organizations able to respond within established time thresholds *85%* of the time are assumed to receive performance payments within medium cost projections.
- High cost projections: **2.5%** of crisis responses cannot be reached within the established time thresholds due to extenuating circumstances; thus, only organizations able to respond within established time thresholds *82.5%* of the time are assumed to receive performance payments within high cost projections.

E. Data adjustments

One BH-ASO did not complete the BH-ASO survey, which captured a breakout of funding provided to each mobile crisis response organization. Membership data suggests that 4.2% of mobile crisis responses are provided within this BH-ASO's designated region. To develop a cost projection for mobile crisis response across the entire state, two additional 24/7 at-the-ready teams were added to the list of existing teams to account for the missing data from this region.

MEDICAID FUNDING CONSIDERATIONS

BH-ASO data request responses indicated 55% of mobile crisis response funding will be provided through Medicaid funding sources. This assumption was developed through analysis of BH-ASO survey responses, where BH-ASOs shared what proportion of cost-based reimbursements were covered from Medicaid funding sources. One BH-ASO was removed from this analysis as it utilized substantially more non-Medicaid funding than the rest of the organizations.

Federal responsibility assumed within the cost projection is as follows:

- **Apple Health Expansion population:** CY 2022 mobile crisis response encounters were reviewed to assess the percentage of Medicaid services attributable to the Apple Health expansion population. It was gathered that 31.4% of Medicaid mobile crisis response encounters were incurred by the expansion population. While the proportion of Medicaid services attributable to the expansion population may vary over time, it is assumed within our cost projections that this proportion is constant. All mobile crisis services attributed to this population are assumed to be covered at 90% Federal Medical Assistance Percentage (FMAP).
- **SCHIP population:** CY 2022 mobile crisis response encounters were reviewed to assess the percentage of Medicaid services attributable to the State Children's Health Insurance Program (SCHIP) FMAP. It was gathered that 1.4% of Medicaid mobile crisis response encounters were incurred by the SCHIP population. All mobile crisis services attributed to this population are assumed to be covered at 65% FMAP.
- **Non-expansion population prior to April 1, 2027:** As a result of ARPA, mobile crisis response services provided to all other Medicaid populations within Washington are covered at an enhanced FMAP of 85% until March 31, 2027.
- **Non-expansion population on April 1, 2027, and thereafter:** Following ARPA, mobile crisis response services provided to all other Medicaid populations will be assumed to be covered at the standard FMAP of 50%.

Figure 37 shares the development of a blended FMAP which accounts for the federal responsibility for providing mobile crisis response to different Medicaid populations:

FIGURE 37: BLENDED FMAP BY YEAR

INDEX	COMPONENT	CY 2025	CY 2026	CY 2027	CY 2028
A	Apple Health Expansion FMAP	90%	90%	90%	90%
B	State Children's Health Insurance Program (SCHIP) FMAP	65%	65%	65%	65%
C	Other Medicaid populations' FMAP	85%	85%	58.75% (85% for Q1, 50% for Q2-Q4)	50%
D	% of Medicaid mobile crisis services provided to Apple Health Expansion population	31.61%	31.61%	31.61%	31.61%
E	% of Medicaid mobile crisis services provided to SCHIP population	1.42%	1.42%	1.42%	1.42%
F	% of Medicaid mobile crisis services provided to other Medicaid populations	66.97%	66.97%	66.97%	66.97%
G	Blended FMAP (A * D + B * E + C * F)	86.30%	86.30%	68.72%	62.86%

VI. 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.

VII. CONCLUSION

As has been referenced throughout this report, the results in this analysis are based on a model. Actual experience and costs could be impacted by unforeseen factors and variables that were not known or finalized at the time of the analysis within and publication of the report. Therefore, this report provides a range of possible scenarios related to payment levels and cost estimates, along with important considerations and limitations on how the information should be used. As the state moves forward with implementation of the endorsement criteria and performance program, the results of the model can be leveraged to make informed decisions, identify gaps, and pinpoint where there is a need for additional work, planning, and refinement of policies and programming.

There is an increasing emphasis on addressing the mental health and substance use disorder needs within our communities, especially concerning the provision of crisis care for individuals experiencing behavioral health emergencies. Initiatives at both the national and state levels aim to expand the continuum of care for behavioral health crises in communities nationwide. Washington has been at the forefront of these efforts, and the initiatives outlined in HB1134 to enhance the state's mobile crisis response system represent forward-thinking policies and strategies to ensure access to behavioral health crisis care for all Washingtonians.

Appendix 1A: Endorsement Rate Models

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 1A - Endorsed Team Rate Model - 24/7 At-the-Ready - Peer-Clinician Dyad

Ref.	Description	Master's Level Degree Unlicensed (MHP)	Peer	Master's Level Degree Licensed (MHP)	Total	Notes
A	First shift workers	3.00	3.00	0.60		
B	Second shift workers	2.00	2.00	0.40		
C	Third shift workers	1.00	1.00	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	1.00	1.00	0.20		
G	Total weekly hours	288.00	288.00	57.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	22.4%	22.4%	22.4%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	352.48	352.48	70.50		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 26.67	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	19%	19%	19%		
L	Total wages expense per week	$ 12,961.75	$ 9,538.46	$ 2,934.71		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 13,787.27	$ 10,145.96	$ 3,121.62	**$ 27,054.85**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	33.8%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 3,911.13	$ 3,433.35	$ 827.09	**$ 8,171.56**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**6.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**42.00**	V = U * 7
W	Total mileage per week				**1,827.00**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 288.46**	Y = $5,000 * 3 (maximum dyads staffed in a single shift) / 52 weeks
Z	Transportation costs per week				**$ 1,512.55**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 36,738.96**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$12,246.32**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$48,985.28**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$48,985.28**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$2,547,234.60**	**AH = AG * 52**

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 1A - Endorsed Team Rate Model - 24/7 At-the-Ready - Dual-Clinician Dyad

Ref.	Description	Master's Level Degree Unlicensed (MHP)	Master's Level Degree Unlicensed (MHP)	Master's Level Degree Licensed (MHP)	Total	Notes
A	First shift workers	3.00	3.00	0.60		
B	Second shift workers	2.00	2.00	0.40		
C	Third shift workers	1.00	1.00	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	1.00	1.00	0.20		
G	Total weekly hours	288.00	288.00	57.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	22.4%	22.4%	22.4%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	352.48	352.48	70.50		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 36.38	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	19%	19%	19%		
L	Total wages expense per week	$ 12,961.75	$ 12,961.75	$ 2,934.71		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 13,787.27	$ 13,787.27	$ 3,121.62	**$ 30,696.16**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	28.4%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 3,911.13	$ 3,911.13	$ 827.09	**$ 8,649.34**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**6.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**42.00**	V = U * 7
W	Total mileage per week				**1,827.00**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 288.46**	Y = $5,000 * 3 (maximum dyads staffed in a single shift) / 52 weeks
Z	Transportation costs per week				**$ 1,512.55**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 40,858.06**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$13,619.35**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$54,477.41**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$54,477.41**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$2,832,825.31**	**AH = AG * 52**

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 1A - Endorsed Team Rate Model - 24/7 On-Call - Peer-Clinician Dyad						
Ref.	**Description**	**Master's Level Degree Unlicensed (MHP)**	**Peer**	**Master's Level Degree Licensed (MHP)**	**Total**	**Notes**
A	First shift workers	2.00	2.00	0.40		
B	Second shift workers	1.00	1.00	0.20		
C	Third shift workers	0.25	0.25	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	0.25	0.25	0.20		
G	Total weekly hours	166.00	166.00	41.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	22.4%	22.4%	22.4%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	203.17	203.17	50.91		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 26.67	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	8%	8%	27%		
L	Total wages expense per week	$ 7,426.27	$ 5,453.12	$ 2,127.13		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 7,899.24	$ 5,800.43	$ 2,262.60	**$ 15,962.27**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	33.8%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 2,240.83	$ 1,962.84	$ 599.49	**$ 4,803.16**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**4.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**28.00**	V = U * 7
W	Total mileage per week				**1,218.00**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 192.31**	Y = $5,000 * 3 (maximum dyads staffed in a single shift) / 52 weeks
Z	Transportation costs per week				**$ 1,008.37**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 21,773.80**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$7,257.93**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$29,031.73**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$29,031.73**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$1,509,649.84**	**AH = AG * 52**

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 1A - Endorsed Team Rate Model - 24/7 On-Call - Dual-Clinician Dyad						
Ref.	**Description**	**Master's Level Degree Unlicensed (MHP)**	**Master's Level Degree Unlicensed (MHP)**	**Master's Level Degree Licensed (MHP)**	**Total**	**Notes**
A	First shift workers	2.00	2.00	0.40		
B	Second shift workers	1.00	1.00	0.20		
C	Third shift workers	0.25	0.25	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	0.25	0.25	0.20		
G	Total weekly hours	166.00	166.00	41.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	22.4%	22.4%	22.4%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	203.17	203.17	50.91		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 36.38	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	8%	8%	27%		
L	Total wages expense per week	$ 7,426.27	$ 7,426.27	$ 2,127.13		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 7,899.24	$ 7,899.24	$ 2,262.60	**$ 18,061.08**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	28.4%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 2,240.83	$ 2,240.83	$ 599.49	**$ 5,081.15**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**4.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**28.00**	V = U * 7
W	Total mileage per week				**1,218.00**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 192.31**	Y = $5,000 * 3 (maximum dyads staffed in a single shift) / 52 weeks
Z	Transportation costs per week				**$ 1,008.37**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 24,150.60**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$8,050.20**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$32,200.80**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$32,200.80**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$1,674,441.69**	**AH = AG * 52**

Appendix 1B: Status Quo Rate Models

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 1B - Status Quo Rate Model - 24/7 At-the-Ready - Peer-Clinician Dyad

Ref.	Description	Master's Level Degree Unlicensed (MHP)	Peer	Master's Level Degree Licensed (MHP)	Total	Notes
A	First shift workers	2.00	2.00	0.40		
B	Second shift workers	2.00	2.00	0.40		
C	Third shift workers	1.00	1.00	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	1.00	1.00	0.20		
G	Total weekly hours	248.00	248.00	49.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	21.0%	21.0%	21.0%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	299.99	299.99	60.00		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 26.67	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	23%	23%	23%		
L	Total wages expense per week	$ 11,050.50	$ 8,136.95	$ 2,501.48		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 11,754.30	$ 8,655.19	$ 2,660.80	**$ 23,070.29**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	33.8%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 3,334.42	$ 2,928.88	$ 704.99	**$ 6,968.29**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**5.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**35.00**	V = U * 7
W	Total mileage per week				**1,522.50**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 0.00**	Not assumed in Status Quo Rate Models
Z	Transportation costs per week				**$ 1,020.08**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 31,058.65**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$10,352.88**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$41,411.53**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$41,411.53**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$2,153,399.78**	**AH = AG * 52**

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 1B - Status Quo Rate Model - 24/7 At-the-Ready - Dual-Clinician Dyad						
Ref.	**Description**	**Master's Level Degree Unlicensed (MHP)**	**Master's Level Degree Unlicensed (MHP)**	**Master's Level Degree Licensed (MHP)**	**Total**	**Notes**
A	First shift workers	2.00	2.00	0.40		
B	Second shift workers	2.00	2.00	0.40		
C	Third shift workers	1.00	1.00	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	1.00	1.00	0.20		
G	Total weekly hours	248.00	248.00	49.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	21.0%	21.0%	21.0%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	299.99	299.99	60.00		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 36.38	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	23%	23%	23%		
L	Total wages expense per week	$ 11,050.50	$ 11,050.50	$ 2,501.48		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 11,754.30	$ 11,754.30	$ 2,660.80	**$ 26,169.39**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	28.4%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 3,334.42	$ 3,334.42	$ 704.99	**$ 7,373.83**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**5.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**35.00**	V = U * 7
W	Total mileage per week				**1,522.50**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 0.00**	Not assumed in Status Quo Rate Models
Z	Transportation costs per week				**$ 1,020.08**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 34,563.30**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$11,521.10**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$46,084.40**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$46,084.40**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$2,396,388.74**	**AH = AG * 52**

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 1B - Status Quo Rate Model - 24/7 On-Call - Peer-Clinician Dyad						
Ref.	**Description**	**Master's Level Degree Unlicensed (MHP)**	**Peer**	**Master's Level Degree Licensed (MHP)**	**Total**	**Notes**
A	First shift workers	2.00	2.00	0.40		
B	Second shift workers	1.00	1.00	0.20		
C	Third shift workers	0.25	-	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	0.25	-	0.20		
G	Total weekly hours	166.00	152.00	41.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	21.0%	21.0%	21.0%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	200.80	183.87	50.32		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 26.67	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	8%	0%	27%		
L	Total wages expense per week	$ 7,339.89	$ 4,904.13	$ 2,102.39		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 7,807.36	$ 5,216.47	$ 2,236.29	**$ 15,260.12**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	33.8%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 2,214.77	$ 1,765.23	$ 592.52	**$ 4,572.51**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**4.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**28.00**	V = U * 7
W	Total mileage per week				**1,218.00**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 0.00**	Not assumed in Status Quo Rate Models
Z	Transportation costs per week				**$ 816.06**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 20,648.69**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$6,882.90**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$27,531.59**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$27,531.59**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$1,431,642.45**	**AH = AG * 52**

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 1B - Status Quo Rate Model - 24/7 On-Call - Dual-Clinician Dyad

Ref.	Description	Master's Level Degree Unlicensed (MHP)	Master's Level Degree Unlicensed (MHP)	Master's Level Degree Licensed (MHP)	Total	Notes
A	First shift workers	2.00	2.00	0.40		
B	Second shift workers	1.00	1.00	0.20		
C	Third shift workers	0.25	-	0.20		
D	Weekend first shift workers	1.00	1.00	0.20		
E	Weekend second shift workers	1.00	1.00	0.20		
F	Weekend third shift workers	0.25	-	0.20		
G	Total weekly hours	166.00	152.00	41.60		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	21.0%	21.0%	21.0%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	200.80	183.87	50.32		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 36.38	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	8%	0%	27%		
L	Total wages expense per week	$ 7,339.89	$ 6,689.85	$ 2,102.39		L = I * (J + K * Additional Hourly Pay for 3rd Shift Workers)
M	Holidays worked	10.00	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 7,807.36	$ 7,115.92	$ 2,236.29	**$ 17,159.57**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	28.4%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 2,214.77	$ 2,018.62	$ 592.52	**$ 4,825.90**	R = P * Q
S	Average mileage per trip				**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response				**3.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day				**4.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week				**28.00**	V = U * 7
W	Total mileage per week				**1,218.00**	W = S * T * V
X	Reimbursement per mile				**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs				**$ 0.00**	Not assumed in Status Quo Rate Models
Z	Transportation costs per week				**$ 816.06**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support				**$ 22,801.53**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage				25.0%	
AC	Administration / overhead / program support cost per week				**$7,600.51**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week				**$30,402.04**	AD = AA + AC
AE	Caseload efficiency				**100.0%**	No caseload efficiency factor
AF	Units per week				1.00	
AG	**Weekly Rate**				**$30,402.04**	**AG = AD / AE / AF**
AH	**Yearly Rate**				**$1,580,906.27**	**AH = AG * 52**

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 1B - Status Quo Rate Model - Limited Staffing - Clinician Response					
Ref.	**Description**	**Master's Level Degree Unlicensed (MHP)**	**Master's Level Degree Licensed (MHP)**	**Total**	**Notes**
A	First shift workers	1.00	0.20		
B	Second shift workers	1.00	0.20		
C	Third shift workers	-	-		
D	Weekend first shift workers	1.00	0.20		
E	Weekend second shift workers	1.00	0.20		
F	Weekend third shift workers	-	-		
G	Total weekly hours	112.00	22.40		G = {[(A + B + C) * 5] + [(D + E + F) * 2]} * 8
H	PTO/training/conference time adjustment factor	21.0%	21.0%		Based on separate PTO build. Reflects incremental training costs.
I	Adjusted total hours of time per week	135.48	27.10		J = G * (1 + H)
J	Hourly wage	$ 36.38	$ 41.24		Based on separate wage build
K	Percent of hours that are third shift	0%	0%		
L	Total wages expense per week	$ 4,929.36	$ 1,117.46		L = I * J
M	Holidays worked	10.00	10.00		10 holidays per year
N	Percent of non-holiday hours paid at time and a half	10%	10%		Informed through interested party engagements
O	Percent of total hours paid at time and a half	12.7%	12.7%		O = (365.25 * N + M) / 365.25
P	Total direct care wage adjusted for overtime and holidays per week	$ 5,243.31	$ 1,188.63	**$ 6,431.94**	P = L * (1 - O) + L * O * 1.5
Q	Employee related expense (ERE) percentage	28.4%	26.5%		Based on separate ERE build
R	Total ERE expense per week	$ 1,487.40	$ 314.94	**$ 1,802.34**	R = P * Q
S	Average mileage per trip			**14.50**	Statewide average mileage per trip, developed through GIS analysis
T	Trips per crisis response			**2.00**	To and from. Assumes dyad team members respond in separate vehicles half of the time.
U	Crisis responses per day			**2.00**	A crisis response is assumed per dyad available on weekdays
V	Crisis responses per week			**14.00**	V = U * 7
W	Total mileage per week			**406.00**	W = S * T * V
X	Reimbursement per mile			**$ 0.67**	Reflects gas, maintenance, and insurance costs for a personal vehicle
Y	Endorsed team-specific transportation and equipment costs			**$ 0.00**	Not assumed in Status Quo Rate Models
Z	Transportation costs per week			**$ 272.02**	Z = (W * X) + Y
AA	Subtotal before administration / overhead / program support			**$ 8,506.30**	AA = (P + R + Z)
AB	Administration / program support / overhead percentage			25.0%	
AC	Administration / overhead / program support cost per week			**$2,835.43**	AC = (AA * AB) / (1 - AB)
AD	Total cost per week			**$11,341.74**	AD = AA + AC
AE	Caseload efficiency			**100.0%**	No caseload efficiency factor
AF	Units per week			1.00	
AG	**Weekly Rate**			**$11,341.74**	**AG = AD / AE / AF**
AH	**Yearly Rate**			**$589,770.47**	**AH = AG * 52**

Appendix 2: Interested Party Engagement

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 2 - Interested Party Engagement
Workgroup Invited Participants
Mobile Crisis Response Providers
Cascade Mental Health
Catholic Community Services
DESC
Frontier Behavioral Health
Multicare
Olympic Health & Recovery Services
Quality Behavioral Health
YMCA of Greater Seattle
Behavioral Health Administrative Services Organizations
Thurston Mason Behavioral Health Administrative Service Organization

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 2 - Interested Party Engagement
BH-ASO Data Request Respondents
Carelon Behavioral Health
Greater Columbia Behavioral Health
Great Rivers Behavioral Health Administrative Services Organization
King County
North Sound Behavioral Health Administrative Services Organization
Spokane County
Thurston Mason Behavioral Health Administrative Service Organization

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 2 - Interested Party Engagement Workgroup Invited Participants	
Technical Workgroup	**BH-ASO Workgroup**
Adams County	Adams County
Carelon Behavioral Health	Carelon Behavioral Health
Cascade Mental Health	Great Rivers Behavioral Health Administrative Services Organization
Catholic Community Services	Greater Columbia Behavioral Health
Central Kitsap Fire and Rescue	King County
Columbia River Mental Health Services	Kitsap County
Columbia Wellness	North Sound Behavioral Health Administrative Services Organization
Compass Health	Office of Financial Management
Comprehensive Healthcare	Spokane County
Connections	Thurston Mason Behavioral Health Administrative Service Organization
DESC	Washington State Legislature
Discovery Behavioral Healthcare	
Everett	
Forks Community Hospital	
Frontier Behavioral Health	
Grant County	
Great Rivers Behavioral Health Administrative Services Organization	
Greater Columbia Behavioral Health	
King County	
Kitsap County	
Kitsap Mental Health Services	
Klickitat County	
Multicare	
North Sound Behavioral Health Administrative Services Organization	
Office of Financial Management	
Okanogan Behavioral Healthcare	
Palouse River Counseling	
Pend Oreille County	
Peninsula Behavioral Health	
Quality Behavioral Health	
Sea Mar Community Health Centers	
Seneca Family of Agencies	
Skagit Beahviroal Health	
Snohomish County	
South County Fire	
Spokane County	
Stevens County	
Thurston Mason Behavioral Health Administrative Service Organization	
Washington State Legislature	
Willapa Behavioral Health & Wellness	
YMCA of Greater Seattle	

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 2 - Interested Party Engagement
Mobile Crisis Response Survey Respondents
Cascade Mental Health
Catholic Community Services
Columbia Wellness
Comprehensive Healthcare
DESC
Everett
Frontier Behavioral Health
Grant County
Kitsap Mental Health Services
Klickitat County
Pend Oreille County
Quality Behavioral Health
Sea Mar Community Health Centers
Seneca Family of Agencies
South County Fire
YMCA of Greater Seattle

Note that the 19 completed mobile crisis surveys were submitted by the sixteen organizations above. Certain organizations completed multiple circumstances if they had presence in multiple BH-ASO regions.

Appendix 3: Team Staffing Approaches

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 3A - Endorsed Team Staffing Approaches

24/7 At-the-Ready

Shift	Clinician	Clinician or Peer	Supervisor
Weekday First	3	3	0.6
Weekday Second	2	2	0.4
Weekday Third	1	1	0.2
Weekend First	1	1	0.2
Weekend Second	1	1	0.2
Weekend Third	1	1	0.2
Total FTEs	8.8	8.8	1.8

24/7 On-Call

Shift	Clinician	Clinician or Peer	Supervisor
Weekday First	2	2	0.4
Weekday Second	1	1	0.2
Weekday Third	0.25	0.25	0.2
Weekend First	1	1	0.2
Weekend Second	1	1	0.2
Weekend Third	0.25	0.25	0.2
Total FTEs	5.1	5.1	1.3

Washington State Health Care Authority (HCA) HB1134 Mobile Crisis Response Appendix 3B - Status Quo Staffing Approaches			
24/7 At-the-Ready			
Shift	**Clinician**	**Clinician or Peer**	**Supervisor**
Weekday First	2	2	0.4
Weekday Second	2	2	0.4
Weekday Third	1	1	0.2
Weekend First	1	1	0.2
Weekend Second	1	1	0.2
Weekend Third	1	1	0.2
Total FTEs	7.5	7.5	1.5
24/7 On-Call			
Shift	**Clinician**	**Clinician or Peer**	**Supervisor**
Weekday First	2	2	0.4
Weekday Second	1	1	0.2
Weekday Third	0.25	0	0.2
Weekend First	1	1	0.2
Weekend Second	1	1	0.2
Weekend Third	0.25	0	0.2
Total FTEs	5.0	4.6	1.3
Limited Staffing			
Shift	**Clinician**	**Clinician or Peer**	**Supervisor**
Weekday First	1	0	0.2
Weekday Second	1	0	0.2
Weekday Third	0	0	0
Weekend First	1	0	0.2
Weekend Second	1	0	0.2
Weekend Third	0	0	0
Total FTEs	3.4	0.0	0.7

Appendix 4: Wages and Employee-Related Expenses

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 4 - Wages and Employee Related Expenses Development by Provider Group

		A	B	C	D	E	F	G	H	I	J	K
Provider Group	**Wage Percentile**	**Trended Wage**	**Annual Employee Salary**	**FICA**	**FUTA**	**SUI**	**Workers Comp**	**Insurance**	**Retirement**	**ERE per Employee**	**ERE Percentage**	**Annual Salary and ERE**
Notes			**A * 2080**	**A * 2080 * 7.65%**						**SUM(C through H)**	**I / B**	**B * (1 + J)**
Peer	62.5th Percentile	$ 26.67	$ 55,478	$ 3,440	420	749	727	10,686	2,752	**$ 18,773**	**33.8%**	**$ 74,251**
Master's Level Degree Unlicensed (MHP)	62.5th Percentile	$ 36.38	$ 75,679	$ 4,692	420	925	991	10,686	3,754	**$ 21,468**	**28.4%**	**$ 97,147**
Master's Level Degree Licensed (MHP)	75th Percentile	$ 41.24	$ 85,780	$ 5,318	420	925	1,124	10,686	4,255	**$ 22,728**	**26.5%**	**$ 108,508**

Note: Wage levels were refined from phase two comparison rate assumptions using the most recent publicly available data (e.g., May 2023 BLS data) and cost trending by 3.80% to the midpoint of calendar year 2025 (July 1, 2025)

Appendix 5: BH-ASO Reported Funding and Unidentified Organizational Dyad Staffing Approaches

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 5 - Projected CY 2025 Organizational Funding and Staffing

24/7 At-the-Ready Staffing Approach

Organization [A]	BH-ASO Funding [B]	Status Quo Staffing Approach Annual Cost [C]	Derived Number Of Teams [D] = [B] / [C]	Assumed FTEs Per Team [E]	Organizational FTEs [F] = [D] * [E]
Organization 1	$ 26,220,000	$ 2,311,535	11.3	16.5	187.2
Organization 2	13,750,000	2,311,535	5.9	16.5	98.1
Organization 3	10,580,000	2,311,535	4.6	16.5	75.5
Organization 4	8,980,000	2,311,535	3.9	16.5	64.1
Organization 5	6,050,000	2,311,535	2.6	16.5	43.2
Organization 6	5,930,000	2,311,535	2.6	16.5	42.3
Organization 7	5,570,000	2,311,535	2.4	16.5	39.8
Organization 8	5,220,000	2,311,535	2.3	16.5	37.3
Organization 9	3,760,000	2,311,535	1.6	16.5	26.8
Organization 10	3,700,000	2,311,535	1.6	16.5	26.4
Organization 11	3,440,000	2,311,535	1.5	16.5	24.6
Total	$ 93,200,000		40.3		665.3

24/7 On-Call Staffing Approach

Organization [A]	BH-ASO Funding [B]	Status Quo Staffing Approach Annual Cost [C]	Derived Number Of Teams [D] = [B] / [C]	Assumed FTEs Per Team [E]	Organizational FTEs [F] = [D] * [E]
Organization 12	$ 2,050,000	$ 1,528,782	1.3	10.9	14.6
Organization 13	1,910,000	1,528,782	1.2	10.9	13.6
Organization 14	1,790,000	1,528,782	1.2	10.9	12.7
Organization 15	1,790,000	1,528,782	1.2	10.9	12.7
Organization 16	1,620,000	1,528,782	1.1	10.9	11.5
Organization 17	1,250,000	1,528,782	0.8	10.9	8.9
Organization 18	1,230,000	1,528,782	0.8	10.9	8.7
Organization 19	1,210,000	1,528,782	0.8	10.9	8.6
Organization 20	1,060,000	1,528,782	0.7	10.9	7.5
Total	$ 13,910,000		9.1		98.9

Limited Staffing Approach

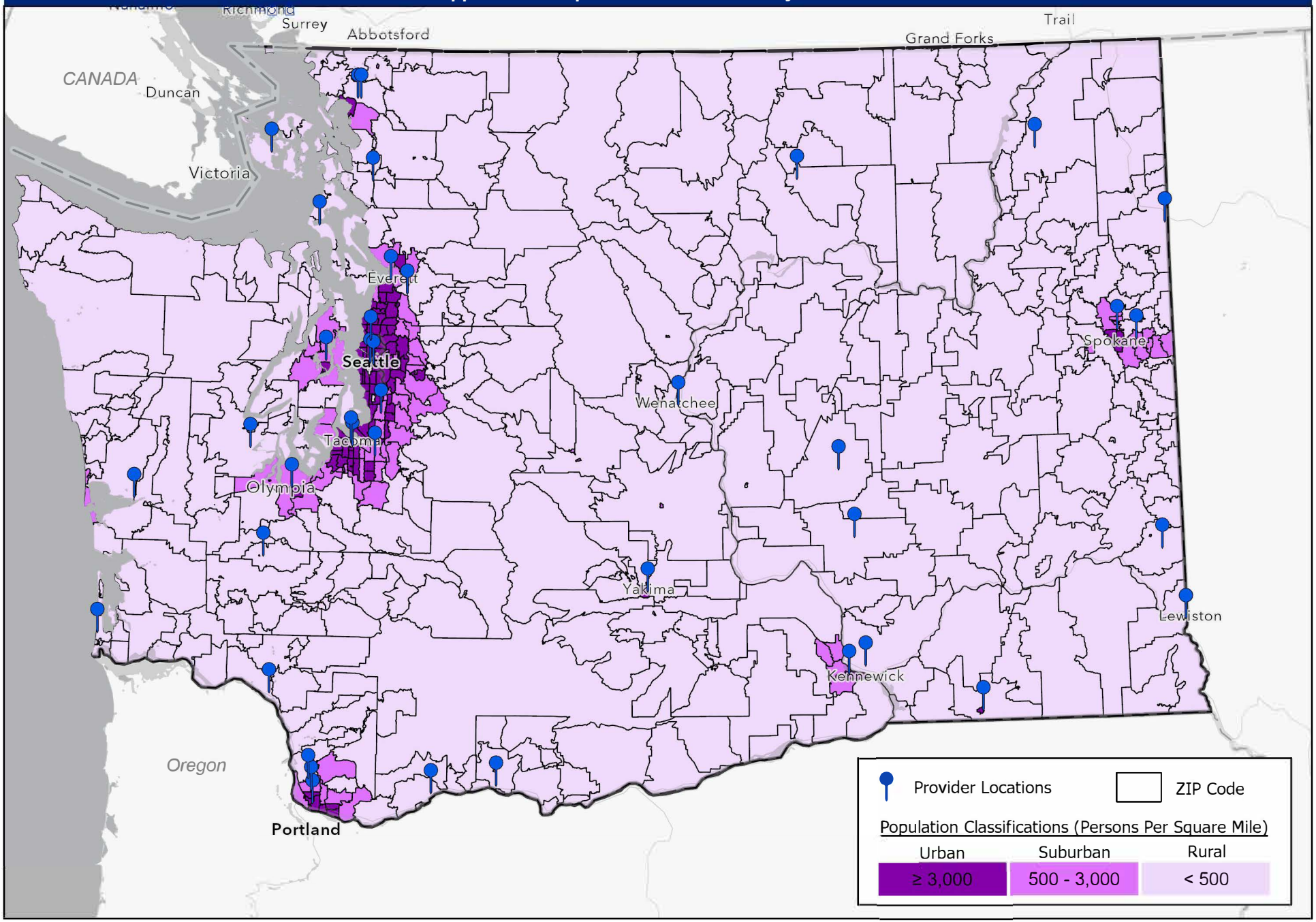
Organization [A]	BH-ASO Funding [B]	Status Quo Staffing Approach Annual Cost [C]	Derived Number Of Teams [D] = [B] / [C]	Assumed FTEs Per Team [E]	Organizational FTEs [F] = [D] * [E]
Organization 21	$ 1,020,000	$ 589,770	1.7	4.1	7.0
Organization 22	650,000	589,770	1.1	4.1	4.5
Organization 23	630,000	589,770	1.1	4.1	4.4
Organization 24	560,000	589,770	0.9	4.1	3.8
Organization 25	340,000	589,770	0.6	4.1	2.4
Organization 26	80,000	589,770	0.1	4.1	0.5
Organization 27	40,000	589,770	0.1	4.1	0.2
Total	$ 3,320,000		5.6		22.9

Note: 1. Funding amounts shown have been cost trended by 3.80% a year from BH-ASO data request reporting periods (typically CY 2023) to the midpoint of CY 2025.

2. 24/7 at-the-ready and 24/7 on-call team costs shown reflect a 35%/65% blend of the peer-clinician and dual-clinician dyad rates shared in Appendix 1B, respectively.

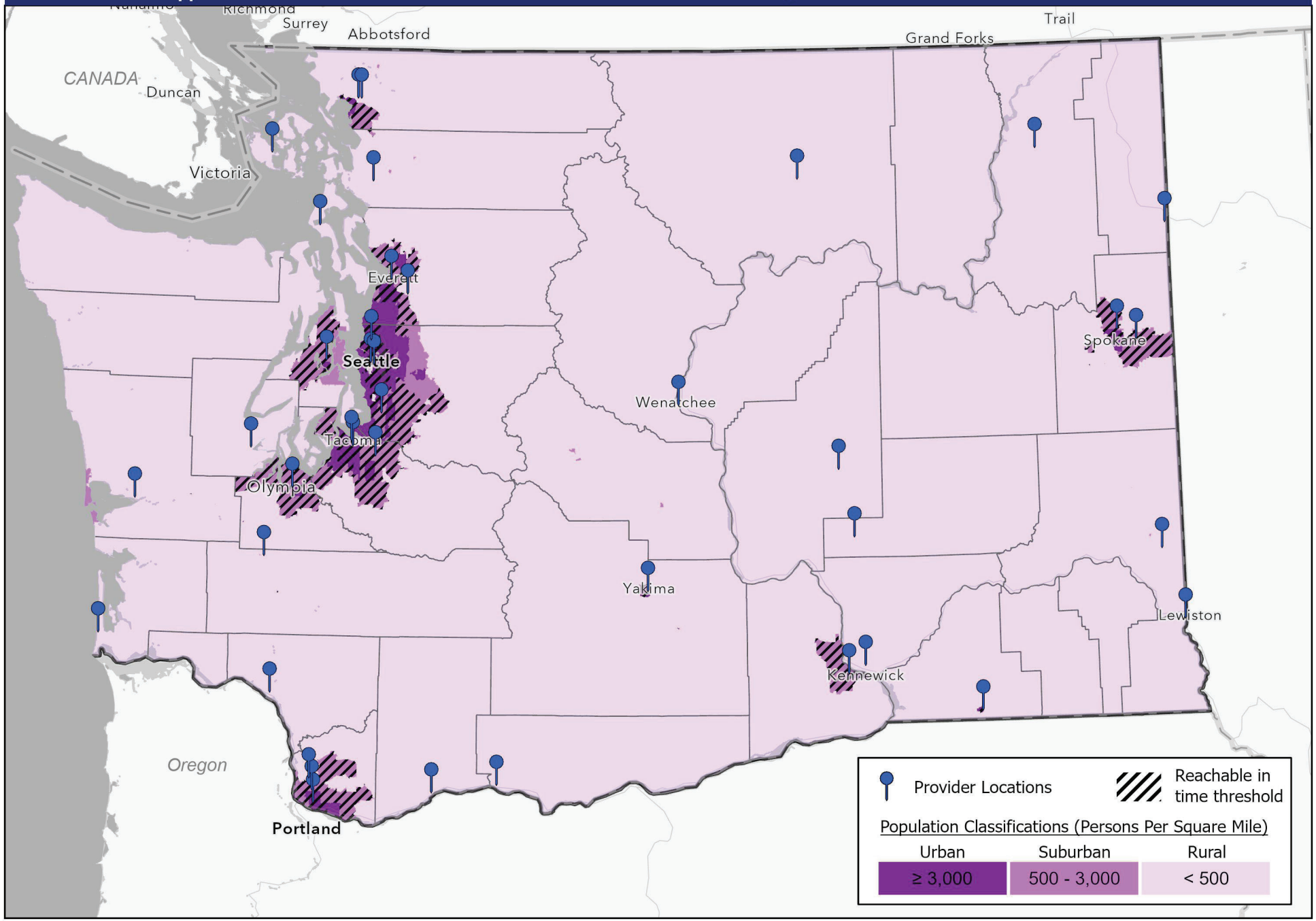
Appendix 6: Organization Assigned Population by ZIP Code

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 6 - Population Classification by ZIP Code

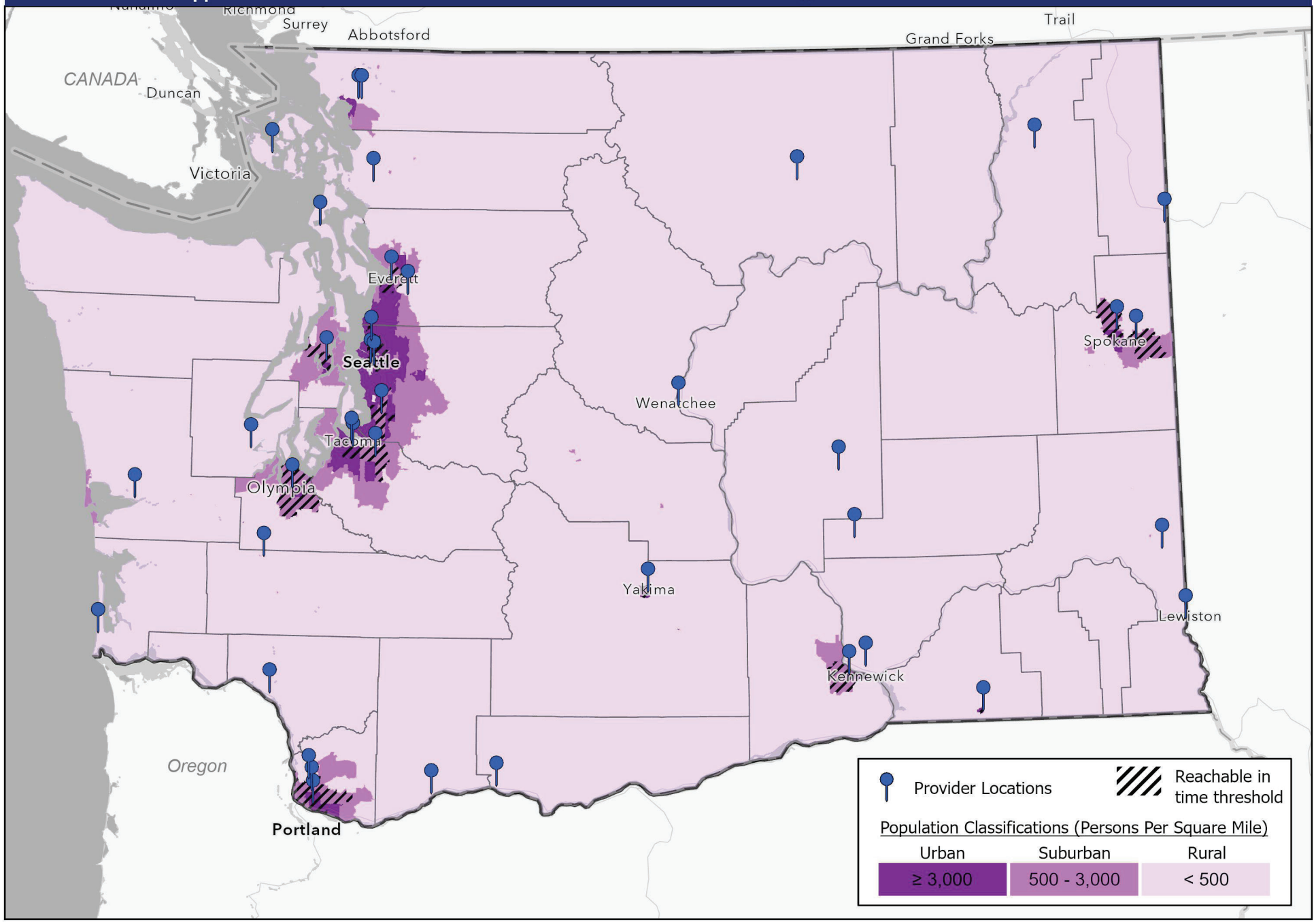


Appendix 7: Percentage of Responses Reachable Within Threshold by Organization

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 7A - ZIP Codes Reachable within Time Thresholds at Least 80% of the Time - 2025-2026 Time Thresholds



Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 7B - ZIP Codes Reachable within Time Thresholds at Least 80% of The Time - 2027+ Time Thresholds



Appendix 8: Detailed Funding Projections

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 8A - Low Cost Projection - Baseline Scenario - Costs in $ Millions

		Statewide Teams		Per Team Costs		Statewide Team Costs						Medicaid Costs			Non-Medicaid Costs
Team type	Calendar Year	Not Endorsed [A]	Endorsed [B]	Not Endorsed [C]	Endorsed [D]	Not Endorsed [E] = [A] * [C]	Endorsed [F] = [B] * [D]	Total [G] = [E] + [F]	Likelihood of Meeting Time Thresholds [H]	Performance Payments [I] = [F] * [H] * 2%	Total Costs [J] = [G] + [I]	FMAP [K]	Federal Portion [L] = [J] * 55% * [K]	State Portion [M] = [J] * 55% * (100% - [K])	[N] = [J] * 45%
24/7 at-the-ready	2025	36	6	$ 2.3	$ 2.7	$ 83.2	$ 16.4	$ 99.6	45%	$ 0.1	$ 99.8	86.3%	$ 47.2	$ 7.5	$ 45.0
24/7 on-call	2025	9	0	1.5	1.6	13.8	0.0	13.8	89%	0.0	13.8	86.3%	6.5	1.0	6.2
Limited staffing	2025	6	0	0.6	1.6	3.5	0.0	3.5	98%	0.0	3.5	86.3%	1.7	0.3	1.6
New MRRCTs	2025	0	0	0.0	2.7	0.0	0.0	0.0	45%	0.0	0.0	86.3%	0.0	0.0	0.0
New CBCTs	2025	0	0	0.0	1.6	0.0	0.0	0.0	89%	0.0	0.0	86.3%	0.0	0.0	0.0
Annual Composite/Total	**2025**	**51**	**6**	**$ 2.0**	**$ 2.7**	**$ 100.5**	**$ 16.4**	**$ 116.9**	**45%**	**$ 0.1**	**$ 117.1**	**86.3%**	**$ 55.4**	**$ 8.8**	**$ 52.9**
24/7 at-the-ready	2026	28	14	$ 2.4	$ 2.8	$ 67.2	$ 39.7	$ 106.9	45%	$ 0.4	$ 107.3	86.3%	$ 50.8	$ 8.1	$ 48.4
24/7 on-call	2026	8	1	1.6	1.7	12.7	1.7	14.4	89%	0.0	14.4	86.3%	6.8	1.1	6.5
Limited staffing	2026	6	0	0.6	1.7	3.7	0.0	3.7	98%	0.0	3.7	86.3%	1.7	0.3	1.7
New MRRCTs	2026	0	1	0.0	2.8	0.0	2.8	2.8	45%	0.0	2.9	86.3%	1.4	0.2	1.3
New CBCTs	2026	0	2	0.0	1.7	0.0	3.4	3.4	89%	0.1	3.4	86.3%	1.6	0.3	1.5
Annual Composite/Total	**2026**	**42**	**18**	**$ 2.0**	**$ 2.6**	**$ 83.6**	**$ 47.6**	**$ 131.1**	**52%**	**$ 0.5**	**$ 131.6**	**86.3%**	**$ 62.3**	**$ 9.9**	**$ 59.4**
24/7 at-the-ready	2027	20	22	$ 2.5	$ 2.9	$ 49.8	$ 64.8	$ 114.6	40%	$ 0.5	$ 115.1	68.7%	$ 43.4	$ 19.8	$ 52.0
24/7 on-call	2027	6	3	1.6	1.7	9.9	5.2	15.1	89%	0.1	15.2	68.7%	5.7	2.6	6.9
Limited staffing	2027	5	1	0.6	1.7	3.2	1.7	4.9	98%	0.0	5.0	68.7%	1.9	0.8	2.2
New MRRCTs	2027	0	2	0.0	2.9	0.0	5.9	5.9	40%	0.0	5.9	68.7%	2.2	1.0	2.7
New CBCTs	2027	0	4	0.0	1.7	0.0	7.0	7.0	89%	0.1	7.1	68.7%	2.7	1.2	3.2
Annual Composite/Total	**2027**	**31**	**32**	**$ 2.0**	**$ 2.6**	**$ 62.9**	**$ 84.6**	**$ 147.5**	**53%**	**$ 0.8**	**$ 148.3**	**68.7%**	**$ 55.9**	**$ 25.4**	**$ 67.0**
24/7 at-the-ready	2028	16	26	$ 2.6	$ 3.1	$ 41.4	$ 79.5	$ 120.8	40%	$ 0.6	$ 121.5	62.9%	$ 41.9	$ 24.7	$ 54.9
24/7 on-call	2028	5	4	1.7	1.8	8.5	7.2	15.8	89%	0.1	15.9	62.9%	5.5	3.2	7.2
Limited staffing	2028	4	2	0.7	1.8	2.6	3.6	6.3	98%	0.1	6.3	62.9%	2.2	1.3	2.9
New MRRCTs	2028	0	3	0.0	3.1	0.0	9.2	9.2	40%	0.1	9.2	62.9%	3.2	1.9	4.2
New CBCTs	2028	0	5	0.0	1.8	0.0	9.0	9.0	89%	0.2	9.2	62.9%	3.2	1.9	4.2
Annual Composite/Total	**2028**	**25**	**40**	**$ 2.1**	**$ 2.7**	**$ 52.6**	**$ 108.5**	**$ 161.1**	**54%**	**$ 1.1**	**$ 162.2**	**62.9%**	**$ 55.9**	**$ 33.0**	**$ 73.2**
Grand Total	**2025-2028**					**$ 299.5**	**$ 257.1**	**$ 556.6**		**$ 2.5**	**$ 559.1**		**$ 229.5**	**$ 77.2**	**$ 252.5**

Note: 24/7 at-the-ready and 24/7 on-call team costs shown reflect 35%/65% blends of the peer-clinician and dual-clinician dyad rates shared in Appendix 1A/1B.

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 8A - Medium Cost Projection - Baseline Scenario - Costs in $ Millions

		Statewide Teams		Per Team Costs		Statewide Team Costs						Medicaid Costs			Non-Medicaid Costs
Team type	Calendar Year	Not Endorsed [A]	Endorsed [B]	Not Endorsed [C]	Endorsed [D]	Not Endorsed [E] = [A] * [C]	Endorsed [F] = [B] * [D]	Total [G] = [E] + [F]	Likelihood of Meeting Time Thresholds [H]	Performance Payments [I] = [F] * [H] * 2%	Total Costs [J] = [G] + [I]	FMAP [K]	Federal Portion [L] = [J] * 55% * [K]	State Portion [M] = [J] * 55% * (100% - [K])	[N] = [J] * 45%
24/7 at-the-ready	2025	21	21	$ 2.3	$ 2.7	$ 48.5	$ 57.4	$ 105.9	56%	$ 0.6	$ 106.6	86.3%	$ 50.4	$ 8.0	$ 48.1
24/7 on-call	2025	7	2	1.5	1.6	10.7	3.2	13.9	89%	0.1	14.0	86.3%	6.6	1.1	6.3
Limited staffing	2025	6	0	0.6	1.6	3.5	0.0	3.5	98%	0.0	3.5	86.3%	1.7	0.3	1.6
New MRRCTs	2025	0	0	0.0	2.7	0.0	0.0	0.0	56%	0.0	0.0	86.3%	0.0	0.0	0.0
New CBCTs	2025	0	0	0.0	1.6	0.0	0.0	0.0	89%	0.0	0.0	86.3%	0.0	0.0	0.0
Annual Composite/Total	**2025**	**34**	**23**	**$ 1.8**	**$ 2.6**	**$ 62.8**	**$ 60.6**	**$ 123.4**	**59%**	**$ 0.7**	**$ 124.1**	**86.3%**	**$ 58.7**	**$ 9.3**	**$ 56.0**
24/7 at-the-ready	2026	13	29	$ 2.4	$ 2.8	$ 31.2	$ 82.3	$ 113.5	56%	$ 0.9	$ 114.4	86.3%	$ 54.1	$ 8.6	$ 51.7
24/7 on-call	2026	5	4	1.6	1.7	7.9	6.7	14.6	89%	0.1	14.8	86.3%	7.0	1.1	6.7
Limited staffing	2026	5	1	0.6	1.7	3.1	1.7	4.7	98%	0.0	4.8	86.3%	2.3	0.4	2.2
New MRRCTs	2026	0	2	0.0	2.8	0.0	5.7	5.7	56%	0.1	5.7	86.3%	2.7	0.4	2.6
New CBCTs	2026	0	4	0.0	1.7	0.0	6.7	6.7	89%	0.1	6.8	86.3%	3.2	0.5	3.1
Annual Composite/Total	**2026**	**23**	**40**	**$ 1.8**	**$ 2.6**	**$ 42.2**	**$ 103.1**	**$ 145.2**	**64%**	**$ 1.3**	**$ 146.5**	**86.3%**	**$ 69.3**	**$ 11.0**	**$ 66.2**
24/7 at-the-ready	2027	9	33	$ 2.5	$ 2.9	$ 22.4	$ 97.2	$ 119.6	50%	$ 1.0	$ 120.6	68.7%	$ 45.4	$ 20.7	$ 54.4
24/7 on-call	2027	3	6	1.6	1.7	4.9	10.5	15.4	89%	0.2	15.6	68.7%	5.9	2.7	7.0
Limited staffing	2027	4	2	0.6	1.7	2.5	3.5	6.0	98%	0.1	6.1	68.7%	2.3	1.0	2.8
New MRRCTs	2027	0	4	0.0	2.9	0.0	11.8	11.8	50%	0.1	11.9	68.7%	4.5	2.0	5.4
New CBCTs	2027	0	7	0.0	1.7	0.0	12.2	12.2	89%	0.2	12.4	68.7%	4.7	2.1	5.6
Annual Composite/Total	**2027**	**16**	**52**	**$ 1.9**	**$ 2.6**	**$ 29.9**	**$ 135.1**	**$ 165.0**	**62%**	**$ 1.6**	**$ 166.5**	**68.7%**	**$ 62.8**	**$ 28.6**	**$ 75.2**
24/7 at-the-ready	2028	7	35	$ 2.6	$ 3.1	$ 18.1	$ 107.0	$ 125.1	50%	$ 1.1	$ 126.1	62.9%	$ 43.5	$ 25.7	$ 57.0
24/7 on-call	2028	2	7	1.7	1.8	3.4	12.7	16.1	89%	0.2	16.3	62.9%	5.6	3.3	7.4
Limited staffing	2028	3	3	0.7	1.8	2.0	5.4	7.4	98%	0.1	7.5	62.9%	2.6	1.5	3.4
New MRRCTs	2028	0	5	0.0	3.1	0.0	15.3	15.3	50%	0.2	15.4	62.9%	5.3	3.1	7.0
New CBCTs	2028	0	10	0.0	1.8	0.0	18.1	18.1	89%	0.3	18.4	62.9%	6.3	3.7	8.3
Annual Composite/Total	**2028**	**12**	**60**	**$ 2.0**	**$ 2.6**	**$ 23.5**	**$ 158.4**	**$ 181.9**	**64%**	**$ 1.9**	**$ 183.8**	**62.9%**	**$ 63.4**	**$ 37.4**	**$ 83.0**
Grand Total	**2025-2028**					**$ 158.4**	**$ 457.2**	**$ 615.6**		**$ 5.4**	**$ 621.0**		**$ 254.2**	**$ 86.4**	**$ 280.4**

Note: 24/7 at-the-ready and 24/7 on-call team costs shown reflect 35%/65% blends of the peer-clinician and dual-clinician dyad rates shared in Appendix 1A/1B.

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 8A - High Cost Projection - Baseline Scenario - Costs in $ Millions

		Statewide Teams		Per Team Costs		Statewide Team Costs						Medicaid Costs			Non-Medicaid Costs
Team type	Calendar Year	Not Endorsed [A]	Endorsed [B]	Not Endorsed [C]	Endorsed [D]	Not Endorsed [E] = [A] * [C]	Endorsed [F] = [B] * [D]	Total [G] = [E] + [F]	Likelihood of Meeting Time Thresholds [H]	Performance Payments [I] = [F] * [H] * 2%	Total Costs [J] = [G] + [I]	FMAP [K]	Federal Portion [L] = [J] * 55% * [K]	State Portion [M] = [J] * 55% * (100% - [K])	[N] = [J] * 45%
24/7 at-the-ready	2025	17	25	$ 2.3	$ 2.7	$ 39.3	$ 68.3	$ 107.6	60%	$ 0.8	$ 108.4	86.3%	$ 51.3	$ 8.2	$ 49.0
24/7 on-call	2025	5	4	1.5	1.6	7.6	6.5	14.1	89%	0.1	14.2	86.3%	6.7	1.1	6.4
Limited staffing	2025	5	1	0.6	1.6	2.9	1.6	4.6	98%	0.0	4.6	86.3%	2.2	0.3	2.1
New MRRCTs	2025	0	0	0.0	2.7	0.0	0.0	0.0	60%	0.0	0.0	86.3%	0.0	0.0	0.0
New CBCTs	2025	0	0	0.0	1.6	0.0	0.0	0.0	89%	0.0	0.0	86.3%	0.0	0.0	0.0
Annual Composite/Total	**2025**	**27**	**30**	**$ 1.8**	**$ 2.5**	**$ 49.9**	**$ 76.4**	**$ 126.3**	**65%**	**$ 1.0**	**$ 127.3**	**86.3%**	**$ 60.2**	**$ 9.6**	**$ 57.5**
24/7 at-the-ready	2026	9	33	$ 2.4	$ 2.8	$ 21.6	$ 93.6	$ 115.2	60%	$ 1.1	$ 116.3	86.3%	$ 55.1	$ 8.7	$ 52.5
24/7 on-call	2026	3	6	1.6	1.7	4.8	10.1	14.8	89%	0.2	15.0	86.3%	7.1	1.1	6.8
Limited staffing	2026	4	2	0.6	1.7	2.4	3.4	5.8	98%	0.1	5.9	86.3%	2.8	0.4	2.7
New MRRCTs	2026	0	3	0.0	2.8	0.0	8.5	8.5	60%	0.1	8.6	86.3%	4.1	0.6	3.9
New CBCTs	2026	0	5	0.0	1.7	0.0	8.4	8.4	89%	0.1	8.5	86.3%	4.0	0.6	3.9
Annual Composite/Total	**2026**	**16**	**49**	**$ 1.8**	**$ 2.5**	**$ 28.8**	**$ 123.9**	**$ 152.8**	**68%**	**$ 1.6**	**$ 154.4**	**86.3%**	**$ 73.1**	**$ 11.6**	**$ 69.7**
24/7 at-the-ready	2027	5	37	$ 2.5	$ 2.9	$ 12.5	$ 109.0	$ 121.4	60%	$ 1.3	$ 122.7	68.7%	$ 46.2	$ 21.1	$ 55.4
24/7 on-call	2027	1	8	1.6	1.7	1.6	13.9	15.6	89%	0.2	15.8	68.7%	6.0	2.7	7.1
Limited staffing	2027	3	3	0.6	1.7	1.9	5.2	7.1	98%	0.1	7.2	68.7%	2.7	1.2	3.3
New MRRCTs	2027	0	6	0.0	2.9	0.0	17.7	17.7	60%	0.2	17.9	68.7%	6.7	3.1	8.1
New CBCTs	2027	0	10	0.0	1.7	0.0	17.4	17.4	89%	0.3	17.7	68.7%	6.7	3.0	8.0
Annual Composite/Total	**2027**	**9**	**64**	**$ 1.8**	**$ 2.6**	**$ 16.0**	**$ 163.2**	**$ 179.2**	**70%**	**$ 2.2**	**$ 181.4**	**68.7%**	**$ 68.4**	**$ 31.1**	**$ 81.9**
24/7 at-the-ready	2028	3	39	$ 2.6	$ 3.1	$ 7.8	$ 119.2	$ 127.0	60%	$ 1.4	$ 128.4	62.9%	$ 44.3	$ 26.2	$ 58.0
24/7 on-call	2028	1	8	1.7	1.8	1.7	14.5	16.2	89%	0.3	16.4	62.9%	5.7	3.3	7.4
Limited staffing	2028	2	4	0.7	1.8	1.3	7.2	8.6	98%	0.1	8.7	62.9%	3.0	1.8	3.9
New MRRCTs	2028	0	8	0.0	3.1	0.0	24.5	24.5	60%	0.3	24.7	62.9%	8.5	5.0	11.2
New CBCTs	2028	0	15	0.0	1.8	0.0	27.1	27.1	89%	0.5	27.6	62.9%	9.5	5.6	12.5
Annual Composite/Total	**2028**	**6**	**74**	**$ 1.8**	**$ 2.6**	**$ 10.8**	**$ 192.5**	**$ 203.3**	**71%**	**$ 2.6**	**$ 205.9**	**62.9%**	**$ 71.0**	**$ 41.9**	**$ 93.0**
Grand Total	**2025-2028**					**$ 105.5**	**$ 556.1**	**$ 661.5**		**$ 7.4**	**$ 668.9**		**$ 272.6**	**$ 94.2**	**$ 302.0**

Note: 24/7 at-the-ready and 24/7 on-call team costs shown reflect 35%/65% blends of the peer-clinician and dual-clinician dyad rates shared in Appendix 1A/1B.

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 8B - Low Cost Projection - Enhanced Scenario - Costs in $ Millions

		Statewide Teams		Per Team Costs		Statewide Team Costs						Medicaid Costs			Non-Medicaid Costs
Team type	Calendar Year	Not Endorsed [A]	Endorsed [B]	Not Endorsed [C]	Endorsed [D]	Not Endorsed [E] = [A] * [C]	Endorsed [F] = [B] * [D]	Total [G] = [E] + [F]	Likelihood of Meeting Time Thresholds [H]	Performance Payments [I] = [F] * [H] * 4%	Total Costs [J] = [G] + [I]	FMAP [K]	Federal Portion [L] = [J] * 55% * [K]	State Portion [M] = [J] * 55% * (100% - [K])	[N] = [J] * 45%
At-the-ready	2025	36	6	$ 2.3	$ 2.9	$ 83.2	$ 17.2	$ 100.4	45%	$ 0.3	$ 100.7	86.3%	$ 47.7	$ 7.6	$ 45.5
On-call	2025	9	0	1.5	1.7	13.8	0.0	13.8	89%	0.0	13.8	86.3%	6.5	1.0	6.2
Limited staffing	2025	6	0	0.6	1.7	3.5	0.0	3.5	98%	0.0	3.5	86.3%	1.7	0.3	1.6
New MRRCTs	2025	0	0	0.0	2.9	0.0	0.0	0.0	45%	0.0	0.0	86.3%	0.0	0.0	0.0
New CBCTs	2025	0	0	0.0	1.7	0.0	0.0	0.0	89%	0.0	0.0	86.3%	0.0	0.0	0.0
Annual Composite/Total	**2025**	**51**	**6**	**$ 2.0**	**$ 2.9**	**$ 100.5**	**$ 17.2**	**$ 117.7**	**45%**	**$ 0.3**	**$ 118.0**	**86.3%**	**$ 55.9**	**$ 8.9**	**$ 53.3**
At-the-ready	2026	28	14	$ 2.4	$ 3.0	$ 67.2	$ 41.7	$ 108.9	45%	$ 0.7	$ 109.6	86.3%	$ 51.9	$ 8.2	$ 49.5
On-call	2026	8	1	1.6	1.8	12.7	1.8	14.5	89%	0.1	14.5	86.3%	6.9	1.1	6.6
Limited staffing	2026	6	0	0.6	1.8	3.7	0.0	3.7	98%	0.0	3.7	86.3%	1.7	0.3	1.7
New MRRCTs	2026	0	1	0.0	3.0	0.0	3.0	3.0	45%	0.1	3.0	86.3%	1.4	0.2	1.4
New CBCTs	2026	0	2	0.0	1.8	0.0	3.5	3.5	89%	0.1	3.7	86.3%	1.7	0.3	1.6
Annual Composite/Total	**2026**	**42**	**18**	**$ 2.0**	**$ 2.8**	**$ 83.6**	**$ 50.0**	**$ 133.5**	**52%**	**$ 1.0**	**$ 134.5**	**86.3%**	**$ 63.7**	**$ 10.1**	**$ 60.7**
At-the-ready	2027	20	22	$ 2.5	$ 3.1	$ 49.8	$ 68.0	$ 117.8	40%	$ 1.1	$ 118.9	68.7%	$ 44.8	$ 20.4	$ 53.7
On-call	2027	6	3	1.6	1.8	9.9	5.5	15.4	89%	0.2	15.6	68.7%	5.9	2.7	7.0
Limited staffing	2027	5	1	0.6	1.8	3.2	1.8	5.0	98%	0.1	5.1	68.7%	1.9	0.9	2.3
New MRRCTs	2027	0	2	0.0	3.1	0.0	6.2	6.2	40%	0.1	6.3	68.7%	2.4	1.1	2.8
New CBCTs	2027	0	4	0.0	1.8	0.0	7.3	7.3	89%	0.3	7.6	68.7%	2.9	1.3	3.4
Annual Composite/Total	**2027**	**31**	**32**	**$ 2.0**	**$ 2.8**	**$ 62.9**	**$ 88.8**	**$ 151.7**	**53%**	**$ 1.7**	**$ 153.4**	**68.7%**	**$ 57.8**	**$ 26.3**	**$ 69.3**
At-the-ready	2028	16	26	$ 2.6	$ 3.2	$ 41.4	$ 83.4	$ 124.8	40%	$ 1.3	$ 126.1	62.9%	$ 43.5	$ 25.7	$ 57.0
On-call	2028	5	4	1.7	1.9	8.5	7.6	16.1	89%	0.3	16.4	62.9%	5.7	3.3	7.4
Limited staffing	2028	4	2	0.7	1.9	2.6	3.8	6.4	98%	0.1	6.6	62.9%	2.3	1.3	3.0
New MRRCTs	2028	0	3	0.0	3.2	0.0	9.6	9.6	40%	0.2	9.8	62.9%	3.4	2.0	4.4
New CBCTs	2028	0	5	0.0	1.9	0.0	9.5	9.5	89%	0.3	9.8	62.9%	3.4	2.0	4.4
Annual Composite/Total	**2028**	**25**	**40**	**$ 2.1**	**$ 2.8**	**$ 52.6**	**$ 114.0**	**$ 166.5**	**54%**	**$ 2.2**	**$ 168.8**	**62.9%**	**$ 58.2**	**$ 34.4**	**$ 76.2**
Grand Total	**2025-2028**					**$ 299.5**	**$ 270.0**	**$ 569.5**		**$ 5.3**	**$ 574.7**		**$ 235.5**	**$ 79.7**	**$ 259.5**

Note: 24/7 at-the-ready and 24/7 on-call team costs shown reflect 35%/65% blends of the peer-clinician and dual-clinician dyad rates shared in Appendix 1A/1B.

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 8B - Medium Cost Projection - Enhanced Scenario - Costs in $ Millions

		Statewide Teams		Per Team Costs		Statewide Team Costs						Medicaid Costs			Non-Medicaid Costs
Team type	Calendar Year	Not Endorsed [A]	Endorsed [B]	Not Endorsed [C]	Endorsed [D]	Not Endorsed [E] = [A] * [C]	Endorsed [F] = [B] * [D]	Total [G] = [E] + [F]	Likelihood of Meeting Time Thresholds [H]	Performance Payments [I] = [F] * [H] * 4%	Total Costs [J] = [G] + [I]	FMAP [K]	Federal Portion [L] = [J] * 55% * [K]	State Portion [M] = [J] * 55% * (100% - [K])	[N] = [J] * 45%
At-the-ready	2025	21	21	$ 2.3	$ 2.9	$ 48.5	$ 60.3	$ 108.8	56%	$ 1.4	$ 110.2	86.3%	$ 52.1	$ 8.3	$ 49.7
On-call	2025	7	2	1.5	1.7	10.7	3.4	14.1	89%	0.1	14.2	86.3%	6.7	1.1	6.4
Limited staffing	2025	6	0	0.6	1.7	3.5	0.0	3.5	98%	0.0	3.5	86.3%	1.7	0.3	1.6
New MRRCTs	2025	0	0	0.0	2.9	0.0	0.0	0.0	56%	0.0	0.0	86.3%	0.0	0.0	0.0
New CBCTs	2025	0	0	0.0	1.7	0.0	0.0	0.0	89%	0.0	0.0	86.3%	0.0	0.0	0.0
Annual Composite/Total	**2025**	**34**	**23**	**$ 1.8**	**$ 2.8**	**$ 62.8**	**$ 63.7**	**$ 126.4**	**59%**	**$ 1.5**	**$ 127.9**	**86.3%**	**$ 60.5**	**$ 9.6**	**$ 57.8**
At-the-ready	2026	13	29	$ 2.4	$ 3.0	$ 31.2	$ 86.4	$ 117.6	56%	$ 1.9	$ 119.5	86.3%	$ 56.6	$ 9.0	$ 54.0
On-call	2026	5	4	1.6	1.8	7.9	7.0	15.0	89%	0.3	15.2	86.3%	7.2	1.1	6.9
Limited staffing	2026	5	1	0.6	1.8	3.1	1.8	4.8	98%	0.1	4.9	86.3%	2.3	0.4	2.2
New MRRCTs	2026	0	2	0.0	3.0	0.0	6.0	6.0	56%	0.1	6.1	86.3%	2.9	0.5	2.8
New CBCTs	2026	0	4	0.0	1.8	0.0	7.0	7.0	89%	0.3	7.3	86.3%	3.5	0.5	3.3
Annual Composite/Total	**2026**	**23**	**40**	**$ 1.8**	**$ 2.7**	**$ 42.2**	**$ 108.2**	**$ 150.4**	**64%**	**$ 2.6**	**$ 153.0**	**86.3%**	**$ 72.4**	**$ 11.5**	**$ 69.1**
At-the-ready	2027	9	33	$ 2.5	$ 3.1	$ 22.4	$ 102.0	$ 124.5	50%	$ 2.0	$ 126.5	68.7%	$ 47.7	$ 21.7	$ 57.1
On-call	2027	3	6	1.6	1.8	4.9	11.0	15.9	89%	0.4	16.3	68.7%	6.1	2.8	7.4
Limited staffing	2027	4	2	0.6	1.8	2.5	3.7	6.2	98%	0.1	6.3	68.7%	2.4	1.1	2.9
New MRRCTs	2027	0	4	0.0	3.1	0.0	12.4	12.4	50%	0.2	12.6	68.7%	4.8	2.2	5.7
New CBCTs	2027	0	7	0.0	1.8	0.0	12.8	12.8	89%	0.5	13.3	68.7%	5.0	2.3	6.0
Annual Composite/Total	**2027**	**16**	**52**	**$ 1.9**	**$ 2.7**	**$ 29.9**	**$ 141.8**	**$ 171.7**	**62%**	**$ 3.3**	**$ 175.0**	**68.7%**	**$ 66.0**	**$ 30.0**	**$ 79.0**
At-the-ready	2028	7	35	$ 2.6	$ 3.2	$ 18.1	$ 112.3	$ 130.4	50%	$ 2.2	$ 132.7	62.9%	$ 45.7	$ 27.0	$ 59.9
On-call	2028	2	7	1.7	1.9	3.4	13.3	16.7	89%	0.5	17.2	62.9%	5.9	3.5	7.8
Limited staffing	2028	3	3	0.7	1.9	2.0	5.7	7.7	98%	0.2	7.9	62.9%	2.7	1.6	3.6
New MRRCTs	2028	0	5	0.0	3.2	0.0	16.0	16.0	50%	0.3	16.4	62.9%	5.6	3.3	7.4
New CBCTs	2028	0	10	0.0	1.9	0.0	19.0	19.0	89%	0.7	19.7	62.9%	6.8	4.0	8.9
Annual Composite/Total	**2028**	**12**	**60**	**$ 2.0**	**$ 2.8**	**$ 23.5**	**$ 166.4**	**$ 189.8**	**64%**	**$ 3.9**	**$ 193.8**	**62.9%**	**$ 66.8**	**$ 39.5**	**$ 87.5**
Grand Total	**2025-2028**					**$ 158.4**	**$ 480.1**	**$ 638.4**		**$ 11.3**	**$ 649.8**		**$ 265.7**	**$ 90.6**	**$ 293.4**

Note: 24/7 at-the-ready and 24/7 on-call team costs shown reflect 35%/65% blends of the peer-clinician and dual-clinician dyad rates shared in Appendix 1A/1B.

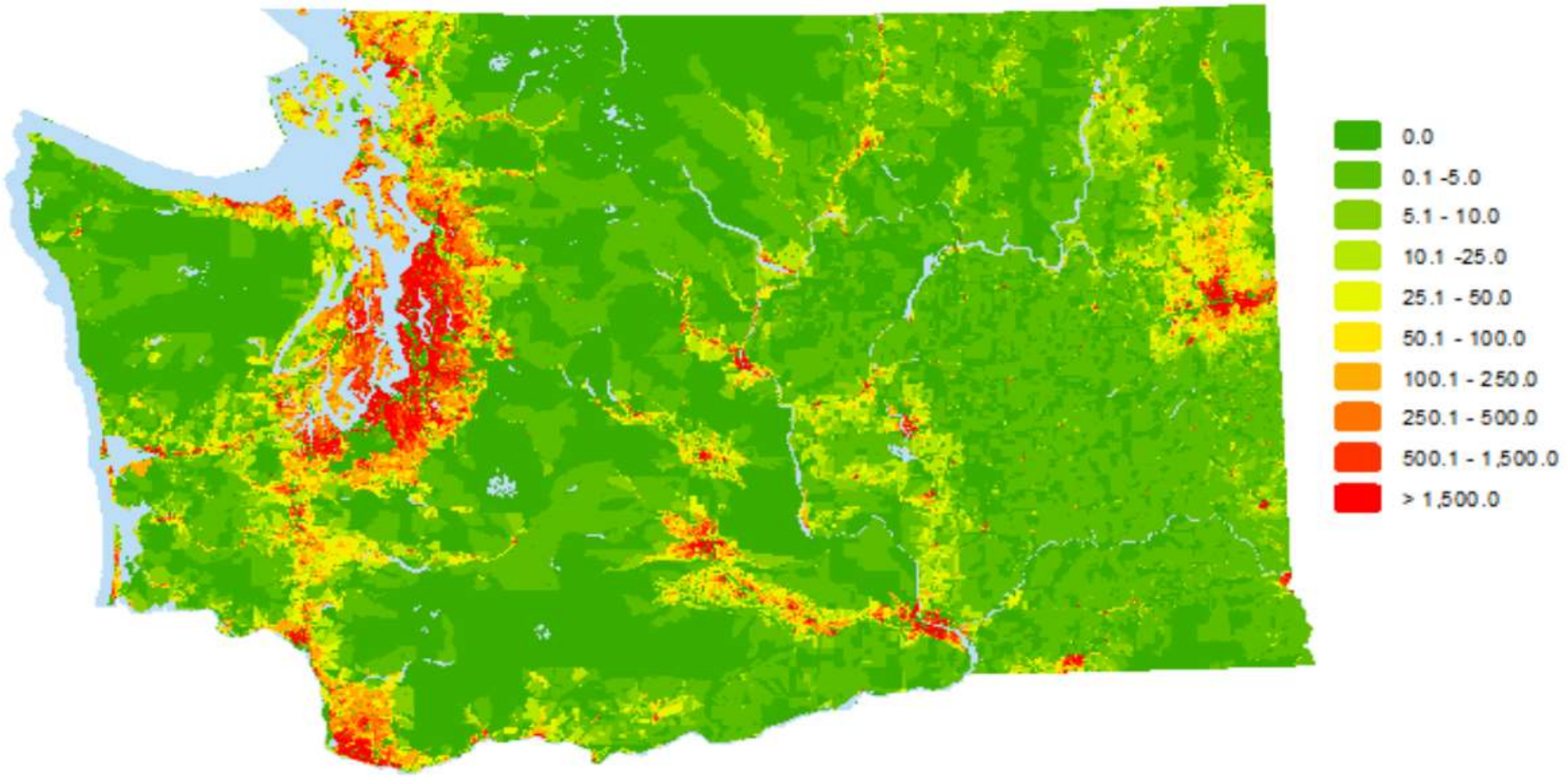
Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Appendix 8B - High Cost Projection - Enhanced Scenario - Costs in $ Millions

		Statewide Teams		Per Team Costs		Statewide Team Costs						Medicaid Costs			Non-Medicaid Costs
Team type	Calendar Year	Not Endorsed [A]	Endorsed [B]	Not Endorsed [C]	Endorsed [D]	Not Endorsed [E] = [A] * [C]	Endorsed [F] = [B] * [D]	Total [G] = [E] + [F]	Likelihood of Meeting Time Thresholds [H]	Performance Payments [I] = [F] * [H] * 4%	Total Costs [J] = [G] + [I]	FMAP [K]	Federal Portion [L] = [J] * 55% * [K]	State Portion [M] = [J] * 55% * (100% - [K])	[N] = [J] * 45%
At-the-ready	2025	17	25	$ 2.3	$ 2.9	$ 39.3	$ 71.7	$ 111.0	60%	$ 1.7	$ 112.8	86.3%	$ 53.4	$ 8.5	$ 50.9
On-call	2025	5	4	1.5	1.7	7.6	6.8	14.4	89%	0.2	14.7	86.3%	6.9	1.1	6.6
Limited staffing	2025	5	1	0.6	1.7	2.9	1.7	4.6	98%	0.1	4.7	86.3%	2.2	0.4	2.1
New MRRCTs	2025	0	0	0.0	1.7	0.0	0.0	0.0	60%	0.0	0.0	86.3%	0.0	0.0	0.0
New CBCTs	2025	0	0	0.0	1.7	0.0	0.0	0.0	89%	0.0	0.0	86.3%	0.0	0.0	0.0
Annual Composite/Total	**2025**	**27**	**30**	**$ 1.8**	**$ 2.7**	**$ 49.9**	**$ 80.2**	**$ 130.1**	**65%**	**$ 2.0**	**$ 132.2**	**86.3%**	**$ 62.5**	**$ 9.9**	**$ 59.7**
At-the-ready	2026	9	33	$ 2.4	$ 3.0	$ 21.6	$ 98.3	$ 119.9	60%	$ 2.4	$ 122.3	86.3%	$ 57.9	$ 9.2	$ 55.2
On-call	2026	3	6	1.6	1.8	4.8	10.6	15.3	89%	0.4	15.7	86.3%	7.4	1.2	7.1
Limited staffing	2026	4	2	0.6	1.8	2.4	3.5	6.0	98%	0.1	6.1	86.3%	2.9	0.5	2.8
New MRRCTs	2026	0	3	0.0	3.0	0.0	8.9	8.9	60%	0.2	9.2	86.3%	4.3	0.7	4.1
New CBCTs	2026	0	5	0.0	1.8	0.0	8.8	8.8	89%	0.3	9.1	86.3%	4.3	0.7	4.1
Annual Composite/Total	**2026**	**16**	**49**	**$ 1.8**	**$ 2.7**	**$ 28.8**	**$ 130.1**	**$ 158.9**	**68%**	**$ 3.4**	**$ 162.4**	**86.3%**	**$ 76.8**	**$ 12.2**	**$ 73.3**
At-the-ready	2027	5	37	$ 2.5	$ 3.1	$ 12.5	$ 114.4	$ 126.9	60%	$ 2.7	$ 129.6	68.7%	$ 48.8	$ 22.2	$ 58.5
On-call	2027	1	8	1.6	1.8	1.6	14.6	16.3	89%	0.5	16.8	68.7%	6.3	2.9	7.6
Limited staffing	2027	3	3	0.6	1.8	1.9	5.5	7.4	98%	0.2	7.6	68.7%	2.9	1.3	3.4
New MRRCTs	2027	0	6	0.0	3.1	0.0	18.6	18.6	60%	0.4	19.0	68.7%	7.2	3.3	8.6
New CBCTs	2027	0	10	0.0	1.8	0.0	18.3	18.3	89%	0.7	18.9	68.7%	7.1	3.3	8.6
Annual Composite/Total	**2027**	**9**	**64**	**$ 1.8**	**$ 2.7**	**$ 16.0**	**$ 171.4**	**$ 187.4**	**70%**	**$ 4.6**	**$ 192.0**	**68.7%**	**$ 72.3**	**$ 32.9**	**$ 86.7**
At-the-ready	2028	3	39	$ 2.6	$ 3.2	$ 7.8	$ 125.2	$ 132.9	60%	$ 3.0	$ 135.9	62.9%	$ 46.9	$ 27.7	$ 61.4
On-call	2028	1	8	1.7	1.9	1.7	15.2	16.9	89%	0.5	17.4	62.9%	6.0	3.6	7.9
Limited staffing	2028	2	4	0.7	1.9	1.3	7.6	8.9	98%	0.3	9.2	62.9%	3.2	1.9	4.2
New MRRCTs	2028	0	8	0.0	3.2	0.0	25.7	25.7	60%	0.6	26.3	62.9%	9.1	5.4	11.9
New CBCTs	2028	0	15	0.0	1.9	0.0	28.5	28.5	89%	1.0	29.5	62.9%	10.2	6.0	13.3
Annual Composite/Total	**2028**	**6**	**74**	**$ 1.8**	**$ 2.7**	**$ 10.8**	**$ 202.1**	**$ 212.9**	**71%**	**$ 5.5**	**$ 218.4**	**62.9%**	**$ 75.3**	**$ 44.5**	**$ 98.6**
Grand Total	**2025-2028**					**$ 105.5**	**$ 583.9**	**$ 689.3**		**$ 15.5**	**$ 704.8**		**$ 287.0**	**$ 99.6**	**$ 318.3**

Note: 24/7 at-the-ready and 24/7 on-call team costs shown reflect 35%/65% blends of the peer-clinician and dual-clinician dyad rates shared in Appendix 1A/1B.

Reference A: Washington’s Office of Financial Management (OFM) Population Density Map

Washington State Health Care Authority (HCA)
HB1134 Mobile Crisis Response
Reference A - Washington Office of Financial Management Documentation - Population Density by Census Block



Notes: 1. This reference document can be found on the following website:
https://ofm.wa.gov/washington-data-research/population-demographics/decennial-census/census-2010/census-2010-maps/population-density-census-block-2010
2. Population density amounts shown are based on the 2010 U.S. Decennial Census

LIMITATIONS

The information contained in this report, including the appendices, has been prepared for HCA. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

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The assumptions documented within this report were developed in conjunction between HCA, Milliman, interested parties. They build upon the results of previous comparison rate projects. Additionally, Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purposes and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The information in this report has relied extensively on data provided by HCA, interested parties, and national data sources. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The responsible actuaries for this report, Jeremy Cunningham, Davis Burge, and Jacob Epperly, are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis for this presentation.

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