ADMINISTRATIVE RULES
Fiscal Estimate & Economic Impact Analysis (EIA)

1. Type of estimate and analysis:
☒ Original ☐ Updated ☐ Corrected

2. Date:
July 8, 2025

3. Administrative Rule Chapter, Title and Clearinghouse Number (if assigned):
DHS 31, 105, and 107, Crisis urgent care and observation facilities.

4. Subject:
Certification of crisis urgent care and observation facilities, as required under s. 51.036, Stats.

5. Fund sources affected
☒ GPR ☒ FED ☐ PRO ☒ PRS ☐ SEG ☐ SEG-S

6. Chapter 20, stats., appropriations affected:
Section 20.435 (4) and (5) (ck), Stats.

7. Fiscal effect of implementing the rule:
☐ No fiscal effect ☐ Increase existing revenues ☒ Increase costs ☐ Decrease costs
☐ Indeterminate ☐ Decrease existing revenues ☒ Could absorb in agency's budget

8. The rule will impact the following:
☒ State's economy ☒ Specific businesses/sectors
☒ Local governmental units ☐ Public utility rate payers
☐ Small businesses (complete Attachment A if checked)

9. Estimate of implementation and compliance costs to businesses, local governmental units, and individuals, per s. 227.137 (3) (b) 1., Stats.:
Indeterminate.

10. Would implementation and compliance costs to businesses, local governmental units, and individuals be $10 million or more over any 2-year period, per s. 227.137 (3) (b) 2., Stats.?
☐ Yes ☒ No

11. Policy problem addressed by the rule:
Wisconsin currently faces a shortage of accessible, facility-based services for behavioral health crises. The suicide rate among Wisconsin residents increased by 38% from 2000 to 2022, and the number of unique individuals receiving crisis services has increased 71% from 2013 to 2021. Forty-four percent of Wisconsin adults do not have access to a crisis stabilization facility, 36% do not have access to 24/7 mobile crisis services, and 66% of county crisis programs report staffing shortages. Specific to emergency detentions, an analysis by the Department of Health Services' Office of Policy Initiatives and Budget found that Winnebago Mental Health Institute ("WMHI"), the state treatment facility under s. 51.15 (2), Stats., is serving as a default placement for individuals in crisis due to lack of more accessible, facility-based services. And while overall emergency detentions decreased 21% from 2013 to 2021, the number of emergency detentions at WMHI increased 133% over that same time. WMHI estimates that 38% of their admissions in 2023 were hospitalized for 72 hours or less. Based on a 2019 Wisconsin Department of Justice survey, the average officer time spent responding to a mental health incident—which includes transporting the individual to WMHI—is 9 hours.

In response to this crisis, the legislature passed 2023 Wis. Act 249, which created s. 51.036, Stats., relating to crisis urgent care and observation facilities ("CCFs"), which are a new type of facility intended to offer persons in crisis a "no-wrong door option" to receive immediate crisis intervention services. Per Act 249, the Department may grant CCF certifications to facilities that can accept crisis service referrals for adults and youth for both emergency detention and voluntary services. CCFs admit individuals to prevent, de-escalate, or treat an individual in crisis, and s. 51.036 (2) (c) 8. requires that the facilities be adequately staffed 24 hours a day, 7 days a week, with a multidisciplinary team that includes psychiatrists or psychiatric nurse practitioners, physician assistants, nurses, licensed clinicians who can perform assessments, peers with lived experience, and other appropriate staff.

Section 51.036 (4), Stats., requires that the Department promulgate rules establishing all of the following:

1. Procedures for administration and establishment of the grant program required under s. 51.036 (2), Stats.
2. Criteria for CCFs to match a portion of any grant awarded by the department under this section, as set forth under s. 51.036 (2) (c) 10., Stats.
3. Requirements for admitting, holding, and discharging individuals for purposes of emergency detention, consistent with s. 51.15, Stats.
4. Minimum security requirements for a CCF.
5. A target range for the number of beds in a CCF.
6. Policies to ensure that persons authorized to transport an individual for purposes of emergency detention have clear standards and procedures regarding when a CCF can accept an emergency detention, and how to determine which facility to take an individual to.
7. Policies realting to interfacility transfers, including including how such transfers should occur and who should be involved in such transfers.
8. Procedures to communicate bed availability in a CCF, and a process for determining where to take an individual in need of crisis services if a CCF lacks capacity to admit.
9. Policies for coordination between crisis urgent care and observation facilities certified under this section and other facilities that provide services similar to those provided by a CCF.
10. Procedures for coordinating continuity of care any patient treated at a CCF for a period of 5 or fewer days.
11. Policies and procedures for facilities that intend to admit both youth and adults, including requirements that youths be treated in a separate part of the facility from adults, policies to address youth-related treatment issues, including parental input, and staff training for youth-specific issues.
12. Establishment of appropriate staffing level requirements, including policies to ensure the availability of adequate in-person and on-site care.
13. Establishment of requirements to define the population to be served at a given crisis urgent care and observation facility, including establishment of any minimum age requirement.

Act 249 also created ss. 51.036 (2) (a) and (4) and 49.45 (41) (d), Stats., which direct the department to submit a state plan amendment to the federal department of health and human services to obtain any necessary approval to provide reimbursement under Medical Assistance for services provided at a CCF.

The department proposes to create ch. DHS 31 to establish all of the requirements for certifying and operating CCFs in s. 51.036 (4), Stats., and to establish a grant program to "award grants to develop [CCFs.]" under s. 51.036 (2) and (4) (a), Stats. The proposed rules also establish requirements for certification and covered services in chs. DHS 105 and 107, respectively.

12. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments:

The department published a solicitation notice in the Administrative Register on April 21, 2025, seeking comments on the economic impact of the proposed rule. The Department also contacted the following to solicit public comment:

- County staff, advocates for people with mental health and substance use concerns, tribal nation staff, and others interested in DCTS work (10,111 email addresses)
- Wisconsin Crisis Intervention Network (including people who work in crisis services or are interested in crisis services (692 email addresses)
- Behavioral Health Providers who work at DHS 35 certified and DHS 75 certified clinics (4,378 email addresses)
- Peer Specialists (7,447 email addresses)
- 988 Suicide & Crisis Lifeline including people interested in 988 and broader crisis work (9,487 email addresses)
- DMS Medicaid Behavioral Health Services list (7,373 email addresses).

13. Identify the local governmental units that participated in the development of this EIA:

County human service departments were included in solicitation for public comment, and several members of the Wisconsin County Human Services Association were on the advisory committee appointed under s. 227.13, Stats.

14. Summary of rule's economic and fiscal impact on specific businesses, business sectors, public utility rate payers, local governmental units and the state's economy as a whole (include implementation and compliance costs expected to be incurred):

Consistent with the requirements in s. 51.036, Stats., the proposed rule intends to reduce strains placed on those entities currently providing crisis services, thereby enabling the state's mental health crisis system to operate more effectively. Currently, individuals experiencing a crisis may initially receive support through law enforcement, first responders, hospital emergency rooms, and county human service departments. These entities work to determine the best way to provide the care, treatment, and support the individuals need to address the crisis. With the introduction of CCFs as a facility-based treatment option, private and public inpatient mental health facilities will likely see a reduction in admissions and associated costs. The statute also requires that persons referred to a CCF do not need to meet the medical clearance requirement, and this is expected to result in less time spent by holding individuals in county jails, and less time spent by law enforcement and staff coordinating care for and transporting persons in crisis, thus lowering staffing costs. Certifying CCFs under the proposed rule will therefore positively impact county crisis programs and contracted providers, emergency departments, psychiatric inpatient units, county law enforcement, and county jails.

The proposed rule will also create new business opportunities for crisis service providers. Interested providers who are granted certification will have the opportunity to provide crisis services, which are traditionally operated by counties or county-contracted providers, in a setting that is external to a county-based program. Persons and families in crisis with urgent needs will have the option of accessing services at a CCF as an alternative to an emergency department or county services. In accordance with s. 51.036, Stats., CCFs providing services can seek reimbursement through MA, private insurance, or the county of financial responsibility.

It is estimated that establishing CCFs will not significantly increase in costs to the state mental health system as a whole. CCFs will serve individuals in need of emergency mental health services, and the state's mental health system is already responding to those needs in some manner. It is anticipated that CCFs will prove to be a more

cost-effective setting for individuals who are otherwise transported to WMHI or to private hospitals for emergency detention. Many individuals, especially those patients who do not have adequate access to community-based crisis services, are treated at WMHI, which had a daily rate of $1,596 in fiscal year 2025. The cost for a 72-hour adult emergency detention at private hospitals in calendar year 2024 was between nearly $7,000 and over $9,000. In addition, the Department anticipates cost savings related to the time spent by law enforcement transporting persons in crisis to WMHI, and time and costs associated with individuals being held in hospital emergency departments while waiting for facility-based behavioral health care.

Although it is difficult to estimate exact cost savings as a result of the proposed rules, a study in Arizona, which operates a facility similar to a CCF, estimated that its facility produced $37 million in cost savings on emergency departments and freed up law enforcement time and salary equivalent to 37 full-time officers, as reported in the 2025 Behavioral Health True Cost Report. The study also found that having more accessible alternative to inpatient care Arizona resulted in a 40% reduction in overall behavioral health care expenses.

Under both Act 249 and the proposed rule, entities voluntarily seek certification to operate a CCF. No local government agency, business, or any other organization is mandated to operate as a CCF. The largest operating expenditure for a CCF will be staffing costs to comply with statutory requirements that it provide services on a 24/7 basis through an interdisciplinary team that includes, as needed, psychiatrists or psychiatric nurse practitioners, physician assistants, nurses, peers, and other staff as appropriate. Facilities will also incur costs for medical supplies and equipment, food, building operations, and other categories. The Department estimates that operating expenditures for one CCF with an average daily census of 15 patients would total approximately $6.2 million annually. Of this amount, $5.4 million relates to salary and fringe costs to staff the Act 249-mandated 24/7 operation.

The proposed rule will allow CCF providers to bill Medicaid for services provided to individuals in crisis. The Department intends to set Medicaid rates at a level that covers the costs of serving Medicaid patients at the facility. In addition to Medicaid, CCFs would be able to bill other parties who have financial responsibility for patients they serve, such as counties of financial responsibility and private insurance. Act 249 also directs the Department to administer a grant program for CCFs. The most recent biennial budget, 2025 Wis. Act 15, included $10,000,000 in the Joint Finance Committee's program supplements appropriation to fund grants for CCFs. Accordingly, each CCF will incur operating expenditures inherent to any business or entity providing mental health services, but these costs stem largely from Act 249 requirements that the facility operate on a 24/7 basis with a multi-disciplinary clinical team and other specific requirements in Section 51.036 (4), Stats. At the same time, Act 249 establishes revenue streams and potential for grants for a CCF to support these operating expenses.

Each CCF will need a physical space to operate in. Because CCFs are a new type of facility for Wisconsin and cannot be established until the proposed rules take effect, the actual costs in this respect are indeterminate. The rule requires the CCF facilities to meet specific building code requirements. Some providers may choose to lease space that meets the rule's requirements, while other providers may own an existing facility or construct a new facility to provide these services. Under either a leased space or owned space model, it is anticipated that the provider can recover these building costs through the billing mechanisms described above. The provider could bill annual lease costs or annual depreciation costs for an owned building through standard allowable cost guidelines.

Interested entities will incur costs to seek and maintain certification, and to prepare grant applications. The application process will entail the Department posting a grant funding opportunity, receiving applications for the grant, reviewing applications, and awarding grant funds and certification to a recipient. The Department estimates

that applicants will spend approximately $15,000 to research, draft, and submit certification and grant applications. Certification fees are expected to be $1,000. The Department expects it will expend at least $15,000 on the administrative costs to review an application in accordance with the proposed rules, and those costs can be absorbed by its existing budget. It is unclear how many applicants are anticipated, but the overall fiscal impact of administering this program during the duration will be minimal.

In conclusion, the economic impact of the proposed can be summarized as follows:

- Establishing CCFs will not result in excess costs to the state mental health system, as they will provide a more cost-effective setting for individuals in need of crisis services.
- CCFs will incur operating expenses as part of providing services. The majority of these expenses will consist of staffing costs stemming from statutory requirements to provide services on a 24/7 basis through a multidisciplinary clinical team. At the same time, Act 249 and this rule establishes funding and billing mechanisms to support those expenses.

15. Benefits of implementing the rule and alternative(s) to implementing the rule:

The benefits of implementing the rule are more accessible, 24/7 crisis services available to people when then need them. CCFs will help to supplement existing county-based crisis services and will provide an alternative to emergency departments and inpatient facilities. Benefits include the ability for providers, independent of a county, to provide facility-based crisis services that can be reimbursed under Medicaid.

There are no reasonable alternatives to the proposed rulemaking. The Wisconsin Legislature has explicitly directed the department to promulgate rules for the certification of CCFs. If the proposed rules are not implemented, the Department cannot certify CCFs and the status quo for crisis services will continue.

16. Long-range implications of implementing the rule:

The proposed rule changes will provide an additional provider for persons in crisis, and quicker access to services for community partners assisting in the facilitation of care for persons in crisis. This will ultimately improve the state's mental health crisis system by allowing it to function more efficiently. The long-range implication of expanded access to crisis services may result in county crisis programs, contracted agencies, emergency departments, and inpatient psychiatric units seeing fewer admissions into their programs and facilities. An additional long-range implication may include decreased wait time law enforcement assisting with the care coordination and transportation needs of individuals in crisis.

17. Comparison with approaches taken by the federal government:

Federally qualified health care centers can provide mental health services and may provide crisis support however, they function differently than a CCF as they are an outpatient level of care and unable to provide facility-based observation and stabilization support.

Although a small number of clinics in Wisconsin are operating under the Substance Abuse and Mental Health Services Administration ("SAMHSA"), Certified Community Behavioral Health Clinics ("CCBHCs") grant program, neither CMS nor SAMHSA provide actual certification. CCBHCs are designed to provide a comprehensive array of behavioral health and substance use services, including crisis intervention services. CCBHCs and CCFs are different in that CCFs are very specific to crisis needs, services, and interventions while CCBHCs serve a broader array of outpatient and rehabilitative services not required of CCFs. Additionally, CCFs are required to serve involuntary individuals in a secured setting while CCBHCs are not.

18. Comparison with approaches taken in neighboring states (Illinois, Iowa, Michigan, and Minnesota):

Illinois: Illinois certifies triage centers and crisis stabilization units through Ill. Admin. Code tit. 77 p. 380. Under section 380.300 of these rules, "triage centers shall provide an immediate assessment of consumers who present in psychiatric distress, as an alternative to emergency room treatment or hospitalization, and shall connect the consumer with community-based services and treatment when considered necessary". Under section 380.310 of these rules, crisis stabilization units "shall provide safety, structure and the support necessary, including peer support, to help a consumer to stabilize a psychiatric episode". Triage centers are similar in that they are intended to provide immediate assessment of clients in crisis as an alternative to an emergency room or hospitalization and provide connections and referrals to other community-based treatment services. Triage centers are different in that they do not accept law enforcement referrals or involuntary admissions and have a maximum length of stay of 23 hours. Crisis stabilization units are like CCFs in that they are intended to assist in stabilizing persons with acute psychiatric symptoms. Crisis stabilization units are different from CCFs in that they do not accept involuntary persons and have a maximum length of stay of 21 days.

Iowa: Iowa certifies crisis stabilization residential services through Iowa Admin. Code r. 441-24.39 (225C). Under these rules, crisis stabilization residential services are short-term services provided in facility-based settings of no more than 16 beds. The goal of these facilities is to stabilize and reintegrate the individual back into the community. Crisis stabilization residential services are similar in that the intended length of stay is less than five days. Crisis stabilization residential services are different from CCFs because that they do not admit involuntary individuals.

Michigan: Michigan certifies crisis stabilization units under their mental health code, specifically Mich. Admin. Code r. 330.1971. Under these rules, crisis stabilization units are crisis receiving and stabilization facilities that provide an alternative to emergency departments for individuals who can be stabilized typically within several hours but in no longer than 72 hours. Crisis stabilization units are like CCFs in that they accept all referrals and do not require medical clearance prior to admission, having the capacity to carry out limited medical evaluative functions. Crisis stabilization units are different from CCFs in that services may be provided for a period of up to 72 hours, after which the individual must be provided with the clinically appropriate level of care.

Minnesota: Minnesota licenses residential crisis stabilization facilities under Minn. Stat. s. 245I.23. The statutes regulate "residential crisis stabilization that provides structure and support to adult clients in a community living environment when a client has experienced a mental health crisis and needs short term services to ensure that the client can safely return to the client's home or precrisis living environment with additional services and supports identified in the client's crisis assessment". These facilities are like CCFs in that facilities can choose to operate involuntary programs. These facilities are different from CCFs because involuntary programs are not required, and they can only accept adult clients.

19. Contact name and phone number:

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This document can be made available in alternate formats to individuals with disabilities upon request.

ADMINISTRATIVE RULES
EIA Attachment A: Proposed Rule Impact on Small Businesses

1. Summary of rule's economic and fiscal impact on small businesses (separately for each small business sector, include implementation and compliance costs expected to be incurred):

2. Summary of the data sources used to measure the rule's impact on small businesses:

3. Did the agency consider the following methods to reduce the impact of the rule on small businesses?

☐ Less Stringent Compliance or Reporting Requirements
☐ Less stringent schedules or deadlines for compliance or reporting
☐ Consolidation or simplification of reporting requirements
☐ Establishment of performance standards in lieu of design or operational standards
☐ Exemption of Small Businesses from some or all requirements
☐ Other, describe:

4. Description of the methods incorporated into the rule that will reduce its impact on small businesses:

5. Description of the rule's enforcement provisions:

6. Did the agency prepare a cost-benefit analysis?

☐ Yes (if checked, attach to this EIA) ☐ No