



988 Fiscal Planning Grant Research Project

Funding Options &
Cost Modeling Report



August 26, 2021



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988 Stakeholder Group – August 26th Meeting Presentation

1. State Legislation and Funding Options Research

2. Federal Guidance and National Funding Options Research

3. South Dakota 988 Cost Model and Five Year Pro Forma

4. Questions

State Legislation and Funding Research



Guidehouse conducted research on 988 efforts and legislation in 10 states.

Comparable States

- DBH and Guidehouse agreed to focus research on five comparable states including **Alaska, Montana, North Dakota, Nevada, and Utah.**
- Like South Dakota, most comparable states have one Lifeline call center (except for Montana, which has two).
- Guidehouse reviewed 988 initiative-related materials from comparable states, including 988 legislation, press releases, and stakeholder coalition materials (if available).

Additional States

- Guidehouse also reviewed 988 legislation from five other key states, including **Arizona, Idaho, Indiana, Virginia, and Washington.**
- These states are either model states in crisis services or have significant 988-related materials published online.

State Legislation and Funding Research

Guidehouse organized **funding approaches commonly outlined in 988 state legislation** into four categories:

State General
Funds & Other
Non-Fee
Approaches

988 End-User
Fees

1115 Medicaid
SMI / SED &
Demonstration
Waivers

Medicaid
Administrative
Claiming

State Legislation and Funding Research Summary

Overall, states are at varying stages in 988 design and implementation. While several states have signed 988-related legislation into law, other states have not yet introduced 988-related legislation.

For states which have already adopted a 988 funding approach, the approaches focus on state general funds and other non-fee funding options, end-user fees, and Medicaid reimbursement. Several reviewed states have not adopted a definitive 988 funding approach.

	Comparable States					Other States				
	AK*	MT*	ND*	NV*	UT*	AZ	ID	IN	VA*	WA*
Funding Approach										
State General Funds & Other Non-Fee Approaches**		X		X	X		X	X	X	X
End-User Fee		X		X			X		X	X
Medicaid Reimbursement					X					
To Be Determined	X		X		X	X				
Legislation Status										
None Introduced	X		X			X				
Unsuccessful		X								
Introduced							X			
Signed into Law				X	X			X	X	X

* As of 6/15/2021, legislature adjourned or in special session.¹

**Includes state general funds; gifts, grants, and donations; interest earnings; and investment income.

State General Funds & Other Non-Fee Approaches

988 legislation passed by states typically included **appropriations from state general funds; gifts, grants, and contributions;** and **investment earnings and interest.** 7 out of 10 reviewed states included one or all of these funding options in 988 legislation.

These approaches were often used in tandem with end-user fees and Medicaid-focused approaches, including waiver demonstrations and administrative claiming. However, the State of Indiana recently passed legislation that creates a 988 trust fund consisting of only general appropriations, federal funding, investment earnings, and other sources. ²

Reimbursement from commercial insurers is rare – some insurers fund their own hotlines for members.³ However, as more payers recognize behavioral health as a cost driver, opportunities for commercial payer reimbursement may emerge. ⁴

End-User Fees



What Is An End-User Fee?

- End-user fees are collected fees from mobile and landline communications subscribers.
- End-user fees are imposed across mobile communication services, IP-enabled voice services (VoIP), and landline telephone services in the state.
- Similar to 911 end-user fees, 988 end-user fees may differ according to subscription package (e.g., prepaid vs. contract mobile services).



Research Findings

End-user fees were the second most common funding approach. 5 out of 10 states (ID, MT, NV, VA, WA) proposed end-user fees as a funding approach in 988 legislation.

Typically, states will deposit funds generated from end-user fees in a trust fund to earn interest, invest funds, and add funds from other sources (e.g., state appropriations; grants; gifts and donations).

End-User Fees: State Spotlights

- Imposes a surcharge of \$0.10 /month/line for all access lines and \$0.10 /transaction for prepaid wireless services.
- Requires communications providers to collect and submit fees to the Department of Revenue via a quarterly return.
- Establishes a statewide 988 account for deposit of all fees received from communications providers. Monies in the fund are used to offset costs associated with 988 implementation, operation, improvement, and expansion. ⁵

Montana



- Imposes a surcharge on mobile communication services, IP-enabled voice services and landline telephone services not to exceed \$0.35 /month/line.
- Establishes a Crisis Response Account within the State General Fund. Surcharges are collected from telecommunication companies and providers and transferred to the Account.
- Funds the Crisis Response Account with other approaches, including gifts, grants, donations, interest, and investment earnings. ⁶

Nevada



End-User Fees: Comparing Fee Amounts – 988 vs. 911




Across most states, 911 end-user fees are a primary funding source for 911 services. The fee amount, distribution, and use vary by state. States also rely on other funding sources – some 911 program components are fully funded by fees, but there are no states that fund the entirety of their 911 system on 911 fees.

988 user fee amounts varied across states. **Proposed 988 user fees are substantially lower than most 911 user fees:**

State	Proposed 988 User Fee	911 User Fee ¹⁰
Idaho ⁷	<ul style="list-style-type: none"> Amount not specified, but may not exceed 911 user fee 	<ul style="list-style-type: none"> \$1.25 monthly fee maximum
Montana ⁵	<ul style="list-style-type: none"> \$0.10 monthly fee, per line \$0.10 fee per transaction (prepaid wireless only) 	<ul style="list-style-type: none"> \$1.00 monthly fee
Nevada ⁶	<ul style="list-style-type: none"> \$0.35 monthly fee maximum, per line 	<ul style="list-style-type: none"> Varies by jurisdiction
South Dakota	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> \$1.25 monthly fee 2% Point of Sale (prepaid wireless only)
Virginia ⁸	<ul style="list-style-type: none"> \$0.12 monthly fee, per line \$0.08 fee per transaction (prepaid wireless only) 	<ul style="list-style-type: none"> \$0.82 monthly fee, per line \$0.55 fee per transaction (prepaid wireless only)
Washington ⁹	<ul style="list-style-type: none"> \$0.24 monthly fee, per line (through 12/31/2022) \$0.40 monthly fee, per line (after 1/1/2023) 	<ul style="list-style-type: none"> \$0.95 combined statewide and county fee

Medicaid Reimbursement: State Examples

States have used innovative methods to capture Medicaid matching funds as reimbursement for crisis call services, including for 988 implementation and operations.

988 example	 <p>Under recently passed 988 legislation, the Utah Department of Human Services will pursue a waiver or State Plan Amendment to enable reimbursement for 988 services delivered to Medicaid beneficiaries. ¹¹</p>
Current crisis line examples	 <p>The Arizona Health Care Cost Containment System (AHCCCS) reimburses crisis call center services as a form of telephonic case management. The service must be delivered to Medicaid beneficiaries or those who are eligible to enroll in Medicaid. ¹²</p>
	 <p>New Mexico's Behavioral Health Services Division was able to secure Medicaid reimbursement for calls to the state's crisis line. Half of all callers self-identified as being enrolled in Medicaid; enabling New Mexico to attain a 50 percent match on half of the callers, resulting in 25 percent of the call center's costs being subsidized by Medicaid. ³</p>

Federal Guidance and National Funding Research

Beyond state legislation on 988, Guidehouse reviewed relevant federal guidance, national publications, and other academic sources for 988-related funding options. **There are several more potential funding approaches to explore for supporting 988 implementation efforts.** Options include, but are not limited to the following:

Medicaid
Technology
Claiming

American
Rescue Plan
State and Local
Recovery Funds

SAMHSA Mental
Health & SA
Block Grant

Medicaid
Managed Care

Commercial
Insurers

Potential Funding Approaches

Short Term	American Rescue Plan State and Local Recovery Funds	South Dakota could allocate some portion of its \$980 million in State Recovery Funds and \$120 million in capital project funds, as well as coordinate and leverage county and municipal Local Recovery Funds for 988 implementation. U.S. Treasury Guidance of 5/10/21 supports use of funds for crisis hotlines and services.
	SAMHSA Mental Health & SUD Block Grants	South Dakota could consider allocating a portion of its Supplemental FY 21 MHBG and SABG awards (under ARPA) of \$3.08 million and \$4.89 million to 988 implementation.
Long Term	1115 Medicaid Demonstration Waivers	States may seek federal Medicaid reimbursement for behavioral health services, including crisis services. Waiver opportunities include SMI/SED IMD waivers, as well as broader delivery system transformation waivers. States may seek new payment models under these waivers, including bundled payment for crisis services with enhanced federal reimbursement.
	Medicaid Administrative and System Claiming	States may leverage federal reimbursement (generally at 50 percent FFP) for administering case management or wraparound crisis services to Medicaid populations. In addition, states should consider submitting APDs (advanced planning documents) to CMS for 75 percent and 90 percent reimbursement for Medicaid system buildouts for 988.
	988 End-User Fees	FCC 988 Final Report and Order permits states to impose fees on communication access lines (e.g., landline, mobile, VoIP) to support 988 implementation and operation.
Longer Term	State General Funds & Other Non-Fee Funding	States may utilize state general funds, gifts, grants, investment income, to support 988 implementation and operations.
	Managed Care & Commercial Insurer Assessment	In the longer term, states can leverage managed care contracts for delivery and payment of crisis services. States can require MCOs to help administer the 988 system, contract with any willing crisis provider, and cover 988 system costs. States should also consider how to leverage contribution from commercial insurers.

Cost Modeling Assumptions

Call Volume



Guidehouse developed cost models for 988 implementation for two call volume scenarios:

Scenario 1:

- Assumes current inbound NSPL call volumes (~3600 annually) increase by 2/3 in Year 1.
- For outbound calls, chat, and text, the model assumes 1/2 of the Vibrant projected amounts for Year 1.
- For Years 2-5, volume projections were trended upward using percentage increases based on Vibrant's Growth Model for Projected Contact Volume (low scenario).

Scenario 2:

- Assumes current inbound NSPL call volumes (~3600 annually) increase by 100% in Year 1.
- For outbound calls, chat, and text, the model assumes 2/3 of the Vibrant projected amounts for Year 1.
- For Years 2-5, volume projections were trended upward using percentage increases based on Vibrant's Growth Model for Projected Contact Volume (medium scenario).

Guidehouse has developed its 988 cost model based on several sources, including information from the existing South Dakota Helpline Center, Vibrant Emotional Health, other state data, and from behavioral health crisis experts. Guidehouse's cost model identifies both initial first year costs and includes a five-year pro forma that:

- Projects staffing estimates
- Uses appropriate salaries per position type
- Projects dedicated and shared resources
- Accounts for the blended nature of the Helpline Center

Cost Modeling Assumptions

Other Considerations

Guidehouse informed staffing estimates and salaries based on call volume/contact information obtained from the South Dakota Helpline Center and Vibrant Emotional Health, as well as 911 information obtained from the State.

The Guidehouse cost model assumes that initially and over the first five years the new 988 Suicide Prevention Line (as part of the Helpline Center) would operate out of a single, physical office, without remote workers. Our model also reflects the Helpline Center's plan to relocate to a larger office space to accommodate staff increases.

The Guidehouse cost model reflects all fixed and variable costs necessary to operate as a suicide prevention call center. It does not include the costs of mental health services.

Call volume will be impacted by a number of factors, including public awareness, marketing, and the range of services call centers can draw upon for referral. The Guidehouse cost model, as a result, incorporated two scenarios of call volume (e.g., low, medium volume projections), trended upward using percentages informed by Vibrant's Growth Model for Projected Contact Volume and information from the Helpline Center.

Scenario 1 – Low Volume Projection

Summary

Scenario 1 assumes current inbound NSPL call volumes (~3600 annually) increase by 2/3 in Year 1. For outbound calls, chat, and text, the model assumes 1/2 of the Vibrant projected amounts for Year 1. For Years 2-5, volume projections were trended upward using percentage increases based on Vibrant's growth model (low scenario).

Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Volume Projections	9,250	13,875	15,417	18,500	20,042	
Inbound calls	6,000	9,000	10,000	12,000	13,000	
Outbound calls	200	300	333	400	433	
Chat	2,800	4,200	4,667	5,600	6,067	
Text	250	375	417	500	542	

Labor Expenses Subtotal	\$1,053,984.89	\$ 1,138,567.24	\$ 1,226,111.28	\$1,316,701.67	\$1,488,297.55	\$ 6,223,662.63
Facility and Equipment Expenses Subtotal	\$ 138,745.00	\$ 32,084.10	\$ 32,725.78	\$ 33,380.30	\$ 36,840.58	\$ 273,775.76
Other Operational Expenses Subtotal	\$ 47,500.00	\$ 37,500.00	\$ 27,500.00	\$ 22,500.00	\$ 22,500.00	\$ 157,500.00
Total Overall	\$1,240,229.89	\$ 1,208,151.34	\$ 1,286,337.06	\$1,372,581.96	\$1,547,638.13	\$ 6,654,938.38

*The FCC initial order required only phone connectivity to 988; subsequent FCC dockets are proposing to add text and chat.

Scenario 2 – Medium Volume Projection

Summary

Scenario 2 assumes current inbound NSPL call volumes (~3600 annually) increase by 100% in Year 1. For outbound calls, chat, and text, the model assumes 2/3 of the Vibrant projected amounts for Year 1. For Years 2-5, volume projections were trended upward using percentage increases based on Vibrant’s growth model (medium scenario).

Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Volume Projections	11,533	17,941	23,067	26,911	30,756	
Inbound calls	7,200	11,200	14,400	16,800	19,200	
Outbound calls	267	415	533	622	711	
Chat	3,733	5,807	7,467	8,711	9,956	
Text	333	519	667	778	889	

Labor Expenses Subtotal	\$1,116,242.39	\$ 1,202,069.89	\$ 1,355,656.69	\$1,580,974.29	\$1,960,024.20	\$ 7,214,967.45
Facility and Equipment Expenses Subtotal	\$ 141,325.00	\$ 32,084.10	\$ 35,410.01	\$ 38,856.13	\$ 45,218.60	\$ 292,893.85
Other Operational Expenses Subtotal	\$ 47,500.00	\$ 37,500.00	\$ 27,500.00	\$ 22,500.00	\$ 22,500.00	\$ 157,500.00
Total Overall	\$1,305,067.39	\$ 1,271,653.99	\$ 1,418,566.70	\$1,642,330.42	\$2,027,742.80	\$ 7,665,361.30

*The FCC initial order required only phone connectivity to 988; subsequent FCC dockets are proposing to add text and chat.

Comparison: Low vs. Medium Volume Scenarios

Scenario 1 – Low Volume

Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Volume Projections	9,250	13,875	15,417	18,500	20,042	
Staffing Projections* - Mental Health Counselor FTEs	5	6	7	8	9	
Staffing Projections* - Supervisor FTEs	2	2	2	2	3	
Labor Expenses Subtotal	\$1,053,984.89	\$ 1,138,567.24	\$ 1,226,111.28	\$1,316,701.67	\$1,488,297.55	\$ 6,223,662.63
Facility and Equipment Expenses Subtotal	\$ 138,745.00	\$ 32,084.10	\$ 32,725.78	\$ 33,380.30	\$ 36,840.58	\$ 273,775.76
Other Operational Expenses Subtotal	\$ 47,500.00	\$ 37,500.00	\$ 27,500.00	\$ 22,500.00	\$ 22,500.00	\$ 157,500.00
Total Overall	\$1,240,229.89	\$ 1,208,151.34	\$ 1,286,337.06	\$1,372,581.96	\$1,547,638.13	\$ 6,654,938.38

Scenario 2 – Medium Volume

Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total Volume Projections	11,533	17,941	23,067	26,911	30,756	
Staffing Projections* - Mental Health Counselor FTEs	6	7	9	12	16	
Staffing Projections* - Supervisor FTEs	2	2	2	2	3	
Labor Expenses Subtotal	\$1,116,242.39	\$ 1,202,069.89	\$ 1,355,656.69	\$1,580,974.29	\$1,960,024.20	\$ 7,214,967.45
Facility and Equipment Expenses Subtotal	\$ 141,325.00	\$ 32,084.10	\$ 35,410.01	\$ 38,856.13	\$ 45,218.60	\$ 292,893.85
Other Operational Expenses Subtotal	\$ 47,500.00	\$ 37,500.00	\$ 27,500.00	\$ 22,500.00	\$ 22,500.00	\$ 157,500.00
Total Overall	\$1,305,067.39	\$ 1,271,653.99	\$ 1,418,566.70	\$1,642,330.42	\$2,027,742.80	\$ 7,665,361.30

*This slide only identifies select staffing roles. See detailed Cost Models for all staffing positions and FTEs.

Observations for 988 Implementation

Most states are still in the planning stages for 988 implementation. South Dakota is positioned to take advantage of information and approaches in other states as they move forward.

The Federal Communications Commission (FCC) is presently considering expanding 988 requirements to include text and chat for call centers. Guidehouse took these additions into account in modeling costs.

Projected initial costs for the implementation of a dedicated call center capability for 988 suicide prevention response are in the range of \$1.2 million for the initial year and approximately \$6.6 million for the first five years (using the low volume projection) is consistent with anticipated costs by the existing Helpline Center.

Contact volume (phone, text and chat) is likely to be influenced by a number of factors – (1) the amount of marketing and public awareness at the federal, state, and local level; (2) the performance of the call center in terms of timely answered calls and ability to quickly connect callers to needed services; and (3) the public's perception that the new 988 Helpline is a success.

Available and trained workforce to support 988 will be a critical component. 24/7 operation requires over 21 shifts per week. The work is demanding and at times difficult. Guidehouse's projected salaries reflect the investment in a specialized workforce.

Projection of costs associated with upgrading legacy telephone switches was not possible at this time due to lack of information by legacy telephone companies and their customers.

Questions?



Contact

Jeffrey Meyers

Director, Healthcare

jmeyers@guidehouse.com

Veronica Ross-Cuevas

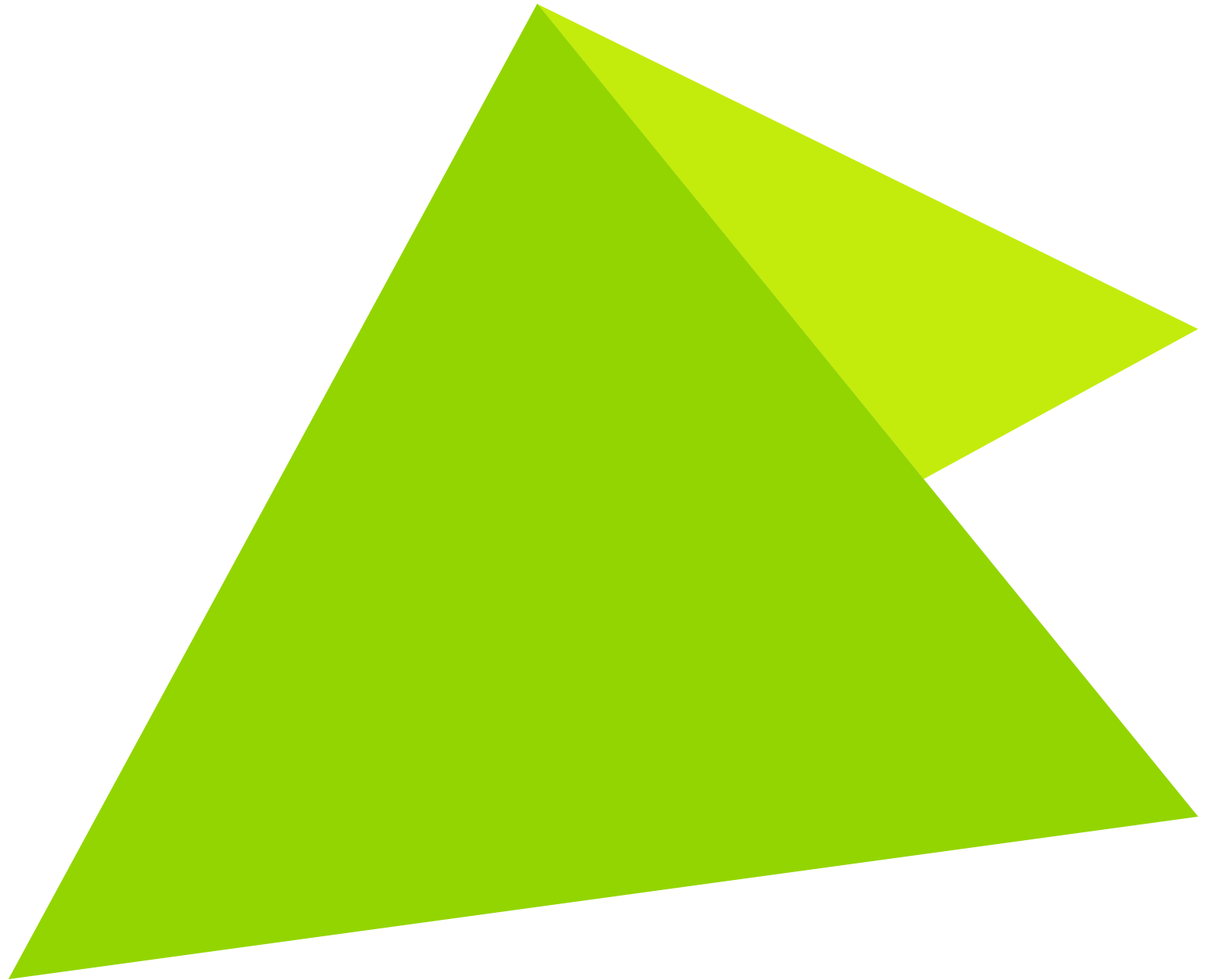
Managing Consultant, Healthcare

veronica.ross.cuevas@guidehouse.com

Peter Joyce

Senior Consultant, Healthcare

peter.joyce@guidehouse.com





HEALTH
MANAGEMENT
ASSOCIATES

South Dakota: Psychiatric Bed Board

August 26, 2021



AGENDA

PROJECT OVERVIEW

APPROACH

INTERVIEWS

FINDINGS

RECOMMENDATION

PROJECT OVERVIEW

- + **Research the Current Landscape of Electronic Behavioral Health Registries**
 - + Identify four other States
 - + Develop and Use a State Interview Protocol
- + **Obtain Additional Information from Platform Vendors**
 - + Build from Existing Vendor List
 - + Update information
- + **Elicit Requirements from Stakeholders**
 - + Develop and use a Stakeholder Interview Protocol
 - + Develop a comprehensive requirements document
- + **Write and Submit a Final Report**

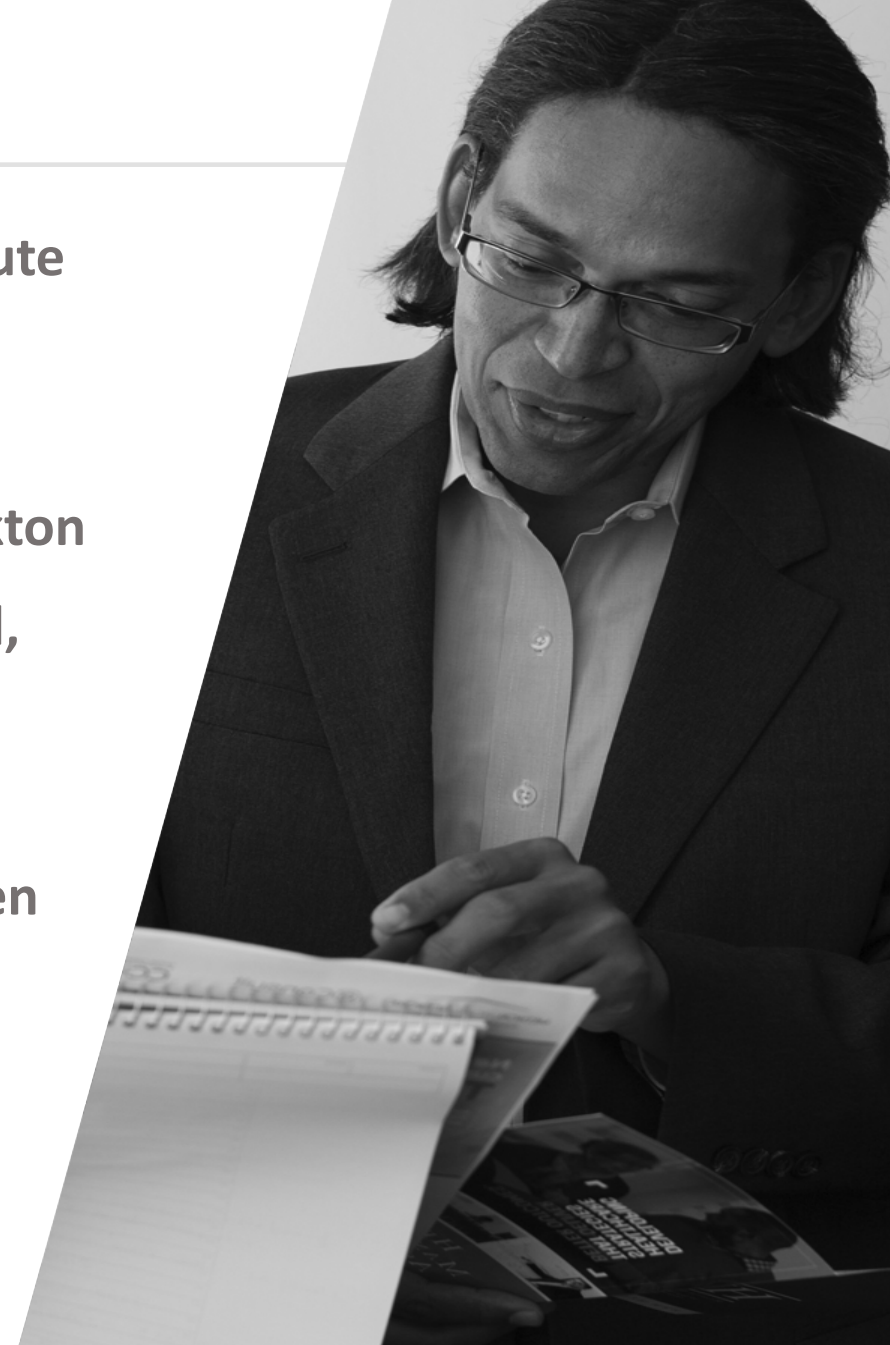




- + Interview South Dakota Stakeholders
- + Interview States
- + Collect Information from Vendors
- + Review/Discuss Findings

STAKEHOLDER INTERVIEWS

- + The Helpline Center
- + South Eastern Behavioral Healthcare
- + Capital Area Counseling Services
- + Avera, Sioux Falls
- + Monument Health
- + National Alliance on Mental Illness South Dakota (NAMI SD)
- + Face IT TOGETHER
- + Dakota Counseling Institute
- + Lewis & Clark Behavioral Health Services
- + Avera Sacred Heart, Yankton
- + Avera St. Mary's Hospital, Pierre
- + Human Services Center
- + Avera St. Luke's, Aberdeen
- + Volunteers of America, Dakotas
- + Behavior Management System



■ KEY FINDINGS: REQUIREMENTS FROM STAKEHOLDERS

+ Stakeholder with Capacity

- + Ideal: real-time updates linked to existing capacity management systems; otherwise, quick and easy to update
- + Open to key stakeholders (ER, CMHCs, Mobile Crisis Units, etc.) but not the general public
- + No bed guarantees—not all beds are the same
- + Not a substitute for formal intake/assessment process

+ Stakeholders Seeking Capacity

- + Streamline finding beds—particularly adolescent beds during the school year
- + Expand to other services (ARFs, SUD beds/resources, Mobile Crisis)

+ Alignment with 211/988

- + Access vs integration



STATE REQUIREMENTS



- + Easily managed access controls
 - + Administrators that update capacity
 - + Users that seek capacity
- + Real- or near-real-time
- + Secure information
- + Robust reporting
 - + frequency of updates and utilization
 - + Downloadable/exportable data
 - + Aligned with access requirements
- + Scalable to address future needs
- + Low cost to purchase/configure
- + Low cost to maintain/sustain

STATES

- + **Colorado:**
 - + Juvare, but in the midst of an RFP process
- + **Iowa:**
 - + Five Points/CareMatch
- + **Vermont:**
 - + MN Mental Health Access

VENDORS

- + **Appriss:**
 - + OpenBeds
- + **Five Points:**
 - + CareMatch
- + **Netsmart**
 - + MyAvatar™
- + **Vermont E-Bed Board**



BH Bed Registry High Level Requirements

Note: order does not connote priority.

Capability expectation

FUNCTIONAL REQUIRMENTS	
1	Display open bed availability by selected categories, traits, or parameters for IP psych and crisis beds at multiple locations across SD
2	Display beds that are open but in process of being filled
3	Display beds that are becoming available via anticipated discharges
4	Provide data for viewing 24/7/365
5	Enable bed availability entry multiple times daily (e.g., as beds open, 8 hours)
6	Real-time system recalculation and display of updated information with display of last update time
SECURITY AND INFORMATION PROTECTION	
22	Require user account and password to enter, update, report on data
23	Permission to view, enter, update data, run reports, etc. granted based on role
24	Assignment of User Accounts and permission sets can be managed by DBH
25	Allow for different public vs. private information display
26	If hosted, all data must be available to the State on demand in a standard usable format for queries and reporting.
PERFORMANCE REQUIREMENTS	
27	Be reliable in operation, access, and availability (limited system downtime)
28	The system must be able to accommodate simultaneous users (for both availability update and viewing) at multiple institutions without noticeable degradation in response time
29	The application causes no negative impact on network performance at user sites
30	The front-end application must be able to be run in standard current browser versions
31	No client software installation is required
TRAINING, DOCUMENTATION, AND SUPPORT	
32	Initial training provided for administrators and end-users sufficient to enable them to use and maintain the system productively
33	Develop training and documentation to ensure uniform use across all facilities
34	User and administrative documentation is provided
BUSINESS FUNCTIONS	
35	Integrate with providers delivering crisis mobile, stabilization, or respite services, as well as align with the longer-term vision for the 988 call line
36	Explore ways to integrate with existing EMRs/Systems and single-sign on (SSO) access and real-time updates
37	Accessible by other stakeholders and end users, such as judicial service, first responders, police, and others who require the system as an available services resource locator and for coordination of care
38	Explore integration with the state PDMP program
39	Integrate with the State HIE
40	Integrate with the State's social health information exchange ecosystem to support interoperable and social drivers of health (SDOH) closed loop referrals and decision support across the State.

■ CONCEPTUAL FRAMEWORK

- + **Scenario 1: State Developed Solution with Minimal Functionality**
 - + Built by the South Dakota Bureau of Information and Telecommunications (BIT)
 - + “Bare bones” minimal functionality
- + **Scenario 2: Vendor Developed Solution with Phased Implementation**
 - + Implement minimal functionality in the first phase (e.g., a bed registry)
 - + Build functionality in set phases
 - + May require a procurement process, which will add time and cost to the solution.
- + **Scenario 3: Vendor Developed Solution “Big Bang”**
 - + Like Scenario 2 with all business requirements in one phase.
 - + Shorter time frame overall, but requires “pre-knowledge” of all capabilities

■ APPROACH PROs/CONs

Scenario	Pros	Cons
State Developed Solution	<ul style="list-style-type: none"> ▪ Low cost ▪ Would not require an RFP 	<ul style="list-style-type: none"> ▪ Limited functionality ▪ Limited BIT bandwidth; may not be able to build out quickly ▪ Limited functionality with lack of ability to evolve
Vendor Solution – Phased Implementation	<ul style="list-style-type: none"> ▪ Enables State to quickly implement working registry and build out features over time ▪ Enables State to fund system over time ▪ Allows State to further define requirements over time ▪ State can leverage vendor solutions/features built for other states ▪ Proven solution 	<ul style="list-style-type: none"> ▪ Higher cost ▪ May require RFP process ▪ May present uncertain funding landscape in the future
Vendor Solution – “Big Bang”	<ul style="list-style-type: none"> ▪ Enables State to have all features in shortened timeframe ▪ Allows State to fund system in one increment ▪ State can leverage vendor solutions/features built for other states ▪ Proven solution 	<ul style="list-style-type: none"> ▪ Highest cost ▪ May require RFP process ▪ May result in solution that is more robust/complicated than necessary, including payment for features that are not used

RECOMMENDATIONS: VENDOR SOLUTION WITH PHASED APPROACH

Phase One:

- + Strong stakeholder buy-in
- + Streamline psych bed capacity
- + Early Wins:
 - + Take over the SUD capacity spreadsheet
 - + Appropriate Regional Facilities (when live)

Phase Two+:

- + Service Coverage:
 - + Crisis Services
 - + Peer and support services
 - + Other Psychiatric Services
 - + Other SUD services
- + Capability Expansion
 - + Facilitate referrals/assessment reviews



- + **Grow capabilities with interest**
 - + Building a bed board capability will take time to be fully adopted
 - + Stakeholders need to feel comfortable
- + **System should be able to grow with SD's Needs**
 - + Starting small may not yield significant efficiencies to start, but the value of a system will grow over time as it becomes the go-to resources for BH capacity in the State
- + **Future Alignments**
 - + As the State's Health IT capabilities change—interoperability with EHRs, etc.—longer-term expansion opportunities



QUESTIONS?

HEALTH MANAGEMENT ASSOCIATES

Our People



120 North Washington Square
Suite 705
Lansing, MI 48933

Telephone: (212) 519-7514
dbergman@healthmanagement.com



David Bergman



Lee Repasch



Anh Pham

HEALTH MANAGEMENT ASSOCIATES

CONTACT ME



DAVID M. BERGMAN

Principal

1133 Avenue of the Americas
Suite 620
New York, NY 10036

212.519.7514
dbergman@healthmanagement.com
www.healthmanagement.com

HEALTH MANAGEMENT ASSOCIATES