Franklin County Crisis Center Operating Budget Analysis: Final Report

PRESENTED TO

THE ALCOHOL, DRUG AND MENTAL HEALTH BOARD OF FRANKLIN COUNTY

DATE: AUGUST 31, 2020

HEALTH MANAGEMENT ASSOCIATES AND HEALTHCARE PERSPECTIVES

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Background

The Alcohol, Drug and Mental Health (ADAMH) Board of Franklin County issued a Request for Bids soliciting assistance services for a Franklin County Crisis Center Operating Budget Analysis. The requested services included working with the ADAMH Board of Franklin County and other representatives of the Steering Committee identified by ADAMH to meet the following objectives and develop the following deliverables. The Board engaged Health Management Associates (HMA) partnered with its subcontractor Healthcare Perspective (HCP) to work with the Board and representatives of the Steering Committee toward these objectives and deliverables.

Objective

To understand what optimizes revenue/expense ratios in terms of:

- Licensure, certification, accreditation options
- Service types, procedure codes, reimbursement rate options
- Staff types, credentials, training requirements, salaries, staff/patient ratio options

Deliverables

- Financial pro forma and SWOT analysis for identified business model options under Ohio's/Franklin County's current funding structures

Process and Artifacts

The project team met over the course of seven weeks. During the first four Project Team meetings and two subgroup meetings, the HMA/HCP team members presented information and analysis of options for the Franklin County Crisis Center and facilitated discussion toward preliminary decisions around which to develop the financial proforma. At Project Team meeting 5, the HMA/HCP team presented a draft Financial Proforma to orient the team to how the tool is built and how the preliminary decisions/assumptions are embedded in it. These meetings culminated in a final meeting of the Project Team during which they reviewed and discussed the final Financial Proforma, its inputs and resulting information, and future use; and the project's final report.

Week	Meetings	Focus	Artifacts
1	7/14 Project Team Meeting 1	-Project KickOff -Accreditation, Certification, and Licensure -Core Service Review	 Agenda_20200714_ FCCC_Steering Com  Franklin County Crisis Center Operat  FCCC_Meeting Minutes_20200714.c
2	7/21 Project Team Meeting 2	-Accreditation, Certification, and Licensure	 Agenda_20200721_ FCCC_Steering Com

			 CertLicenseAccredOptions_FranklinCo 0  FranklinCoCrisisCtr_ServicecrosswalkLic  FCCC_Meeting Minutes_20200721.c
3	7/28 Project Team Meeting 3	-Inpatient Psych v Crisis Stabilization Certification -Approach to determination of Service Array	 Agenda_20200728_FCCC_Steering Com  FrankCoCrisisCtr InptCrisisRes compa  FrCoCrisisCtr_ServicesDetailSUMMARY0  FCCC_Meeting Minutes_20200728.c
4	8/3 Services Subgroup 8/4 Services Subgroup	-Determination of Service Array	 FrCoCrisisCtr_ServicesDetailSUMMARY0
5	8/11 Project Team Meeting 4	-Debrief on OMHAS meeting re: CSU Certification and whether allows locked unit and involuntary admission -Determination of Average Encounter per revenue center	 Agenda_20200811_FCCC_Steering Com  FCCC_AverageEncounter_FeedbackTool  FCCC_AverageEncounter_FeedbackTool

			 FCCC_Meeting Minutes_20200811.c
6	8/18 Project Team Meeting 5	Review of Draft Proforma	 Agenda_20200818_ FCCC_Project Team M  Financial Estimates Franklin County 8-1  FCCC_Meeting Minutes_20200818.c
7	8/26 Project Team Meeting 6	Review final Proforma and Draft Final Report	 Agenda_20200831_ FCCC_Project Team M  FCCC OpBudAnal_Final R  Financial Estimates Franklin County 8-2  FCCC_Meeting Minutes_20200831.c

Accreditation, Certification, and Licensure Analysis and Decisions

At the 7/21 Team Meeting, the HMA/HCP team reviewed an analysis of Accreditation, Certification and Licensure options with the Project Team and facilitated discussion about options and requirements for the stated scope of the Franklin County Crisis Center. The documents reviewed with the team are embedded above.

Certification and Licensure

At the 7/21 Team meeting, there was initial concurrence of need for the following Certifications to support the Core Services outlined in the Request for Bids:

- General Services [5122-29-03]
- Crisis Intervention [5122-29-10]
- Peer Recovery [5122-29-15]
- Consultation [5122-29-19]

- SUD Case Management [5122-29-13]
- Community Psychiatric Supportive Treatment (CPST) [5122-29-17]
- OTP Level 1 - Opioid Treatment Program
    - Licensure requirements through
        - OMHAS - application, intent of location
        - SAMHSA
        - DEA
        - State Board of Pharmacy for a Terminal Distributor of Dangerous Drugs (TDDD) license

The TDDD license will be required irrespective of whether the Center ultimately includes an OTP. A Terminal Distributor of Dangerous Drugs (TDDD) is a person (individual, partnership, association, limited liability company, corporation or government agency) who is engaged in the sale of dangerous drugs at retail, or any person, other than a wholesale distributor or a pharmacist, who has possession, custody, or control of dangerous drugs for any purpose other than for that person's own use and consumption.

There were several Core Services, as defined in the Request for Bids that required additional research and discussion: "Inpatient Services", and "Pharmacy".

"Inpatient Services"

The purpose of providing "Inpatient Services" at the Franklin County Crisis Center was stated by the Project Team members as having capacity to support individuals coming out of 23-hour observation who require continued care and cannot be referred to another community resource. The goal is to be able to provide service at the Center for anyone who cannot be referred out. The estimates provided are that there will be 6,300 individuals discharging from the Center's 23-hour observation that require continued care, of which 1,100 will be served at the Center and the other 5,200 will be referred out. The estimated average length of stay is 5 days.

The project team discussed two possible certification options for providing these services:

- Inpatient Psychiatric Services Provider
    - Licensure requirements through OMHAS - application, checklist, logs; State Board of Pharmacy
    - Registration requirements with ODH (bed registration), OH Medicaid, and CMS
- Residential [5122-29-09]
    - Licensure of Class One Residential needed for Crisis Stabilization Unit - application, 2 attachments, rules, checklist

At the 7/28 Project Team meeting, the HMA/HCP team presented a comparison of the two options (embedded above) and facilitated discussion about the two. The Project Team indicated that it was not prepared to make a final determination but wants to be able to present the options and pros and cons to the Steering Committee for final determination. For purposes of developing the Financial Proforma, a preliminary decision is needed.

The Project Team also initially indicated that their initial intention is to certify under only one of the options, not both.

The certification information for a Crisis Stabilization Unit in Ohio Administrative code that was discussed by the Team, and prior information from OMHAS to Jonathan Thomas and Jeff Klingler were inconsistent/confusing. It was unclear whether under a Residential certification, there could be a locked unit, or acceptance of involuntary admissions. Following these discussions, the Team agreed that Jonathan would pursue a discussion with his contacts at OMHAS to revisit the question. The results of that discussion clarified that:

1. A CSU can have a locked unit
2. A CSU cannot currently take involuntary admissions, though OMHAS understands the need. Under Inpatient Certification a unit could accept voluntary and involuntary admissions.
3. Beds cannot be dually certified as both Inpatient and Residential/CSU.

Some confusion remains about #2 above - the involuntary/voluntary status of admissions to a CSU. OMHAS rules do allow for admission of those under probate court orders so continued clarification with OMHAS staff should be pursued. Embedded here is a document showing excerpts from the OMHAS rules for Licensure for Residential Facilities (5122-30) under which CSUs are licensed.

OMHAS_CSU rulesclarification 08'

In addition to the comparison provided and reviewed at the 7/28 Project Team meeting, another significant difference between the two Certifications is the expected Level of Care (LOC). Certification as an Inpatient Psychiatric Services Provider requires admissions of individuals with an Inpatient LOC, whereas the LOC for admission to a Residential/CSU is an intermediate LOC. In order to serve *anyone* coming out of 23-hour observation, the Center would need both types of certification in order to not create an accreditation risk or a reimbursement risk.

At the 8/11 Project Team meeting, the Team discussed the outcomes of the meeting with OMHAS, the desire to be able to service both levels of care, and the accreditation and reimbursement risks. The conversation concluded with concurrence that the financial proforma should include the Center being certified as both an Inpatient Psychiatric Services Provider and Residential/Crisis Stabilization Unit. The total number of planned beds remains at 16 for the Center, and the Proforma assumes 10 CSU beds and 6 Inpatient beds. The staffing for these units can be the same so staffing costs are not duplicated based on having some beds licensed as CSU and some as IP. Sharing staff between both units is certainly possible as long as the acuity level of the patients allows that and the design of the facility provides a safe setting when staff move between units. However, the Level of Care for Inpatient is higher than CSU. The Proforma runs the staffing calculator for each of the units, but for IP only added services and with a higher acuity level. In addition, the staffing calculator is not calculating staff that the operator would need to meet all Inpatient requirements. Embedded here is comparison of CSU to Inpatient Requirements that was updated follow the initial presentation and conversation at the 7/28 Project Team meeting. The Inpatient requirements include services for which the staffing calculator and Proforma do not include and which based on the size of the IP until would be secured through contract, not employed staff. Examples include the requirement to have availability of a licensed dietician; and requirement to provide clergy or arrange for pastoral services from community.

FCCC IP v CSU_20200817.xlsx

IMD Consideration

At the 8/18 Project Team meeting, Lynne Lyon provided feedback on the question of whether having more than 16 beds total, but no more than 16 of each CSU and Inpatient, would create the risk of being designated as an IMD. IMD is a Medicaid issue so it is not about certification. Without doing a full legal assessment on an entity's status and whether is meets all the conditions on IMD, however, ODM and OMHAS concluded that there is nothing that says you can separate beds when counting based on how they are certified. Anything over 16 beds would be at risk of being deemed an IMD.

Additional discussion included that the reimbursement risk related to being defined as an IMD is for Medicaid FFS, and only for Medicaid MCOs for stays longer than 15 days in a month. This is because for stays 15 days or less in a month, MCOs can pay for (and the state get FMAP) stays in an IMD. There is a 90% penetration rate of Managed Care enrollment in Ohio's Medicaid programs, and the current Center ALOS assumption is 5 days, so the risk of reimbursement issues is low. Lynne also indicated that under the SUD 1115 Waiver, Ohio is approved to provider SUD Residential in an IMD with no day limit but an ALOS of 30 days.

There was concurrence to stay with a total of 16 beds with a 10 (CSU)/6 (IP) split for the purposes of the Financial Proforma. However, this may be revisited later in the planning process for the Center.

Pharmacy

The Request for Bids specified pharmacy as a Core Service specifying the following with regard to the pharmacy service offering:

- Establish an automated medication dispensing system which increases safety and efficiency
- Enhance ability to accurately and quickly reconcile patient's home medications on admission to the Crisis Center's programming
- Provide common psychiatric drugs including long-acting injectables
- Increase accessibility to the walk-in clinic for patients with medication compliance issues
- Consider an on-site outpatient pharmacy to optimize medication compliance and reduce recidivism

The Center will require a TDDD license as mentioned above in any case, and associated DEA registration, but the extent of pharmacy services planned will drive the business type(s) of the TDDD license pursued. Given the array of services and other licensures anticipated:

- The Center will need to be licensed as a "Clinic" or "prescriber office" business type. This licensure is for a facility licensed as a terminal distributor of dangerous drugs in accordance with section 4729.54 of the Revised Code where a licensed prescriber or pharmacist serves as the responsible person on the license and drugs are possessed onsite for *administration or to personally furnish.* This business type does not include pharmacies or institutional facilities. And under this business type, quantities personally furnished to a patient are limited to a seventy-two-hour supply and quantities personally furnished to all patients shall not exceed two thousand five hundred dosage units in any thirty day period pursuant to

section 4729.291 of the Revised Code. This business type may be applicable to the following Center service lines: Walk-in Clinic including Medical Care Services and 23-hour observation.

- The Center will also need to be licensed as an Opioid Treatment Program in order to personally furnish buprenorphine and/or administer methadone.
- The Center will also need to be licensed as a "non-limited facility" to facilitate on-site administration, dispensing, or personally furnishing of dangerous drugs in the crisis stabilization unit.
- The Center may need to be licensed as "non-limited facility" or "unlimited facility" where a non-limited facility as described at OAC 4729:5-22 possesses drugs on-site for administration, dispensing, or personally furnishing.

The Project Team considered whether an on-site outpatient pharmacy would be in scope of the initial Center services and made a preliminary determination not to license as an on-site pharmacy. The Project Team discussion incorporated a report out from the SUD team that the preference is to connect individuals to ongoing care in the community rather than to establish the Center as a place for routine pharmacy fills and refills.

Accreditation

Accreditation by an acknowledged entity facilitates "deemed status". Deemed status essentially means "evidence of compliance". When the Ohio Department of Mental Health and Addiction Services (OMHAS) grants deemed status to an agency, it is accepting the agency's appropriate behavioral health accreditation as evidence of compliance with the state certification standards. OMHAS accepts accreditation from three bodies: The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation (COA) - for community providers. If an entity is an inpatient/hospital, the Department of Health (ODH) accepts accreditation from three bodies: TJC, Det Norske Veritas (DNV), and Healthcare Facilities Accreditation Program (HFAP). For inpatient psychiatric, OMHAS also requires accreditation from TJC, DNV or HFAP. Only TJC overlaps requirements of both Departments. The Project Team concurred that the preliminary determination for the Center is that it would pursue TJC accreditation.

Presumptive Eligibility Considerations

Ohio Medicaid allows Qualified Entities (QEs) to facilitate Medicaid Presumptive Eligibility determinations using ODMs Presumptive Eligibility and Deemed Eligibility Portal. Per Ohio Administrative Code 5160:1-1-01 defines a QE as (emphasis added):

> "Qualified entity" means the source of eligibility determinations for the presumptive eligibility program and is limited to the following:
>
> (a) A county department of job and family services (CDJFS); or
>
> (b) A hospital, the department of youth services (DYS), a federally qualified health center (FQHC) or a FQHC look-alike, that meet the requirements described in Chapter 5160-28 of the Administrative Code; or
>
> (c) A local health department, a women, infants, and children (WIC) clinic, ***or other entity as designated by the director***."

The Center may be able to register as a QE based on an Inpatient Certification and registration of beds with the Ohio Department of Health. This may limit the patients for which the Center can facilitate the determination. Alternately, and recommended, the ADAMH Board may consider engaging ODM to seek approval to register as a QE as an "other entity as designated by the director."

Service Types, Procedure Codes, Reimbursement Rate Options

Determination of Service Array at The Center

The HMA/HCP Team prepared and presented a project artifact at the 7/28 Project Team Meeting that outlined the specific service options and Medicaid reimbursement that could be included based on the information provided by the Project Team, both the high level services and specific services billing. The Project Team agreed to establish a subgroup to meet to review the service array and narrow it to reflect those services specifically expected to be available at the Center. The subgroup met twice and refined the service array to be available at the Center. The Excel Sheet embedded above for the 8/3 and 8/4 subgroup meetings documents the results of those meetings and the preliminary agreement on the array of services.

Determination of Reimbursement per Encounter

In order to convert services and reimbursements into inputs for the Financial Proforma, the HMA/HCP team requested that the Project Team complete an exercise to identify the services and units of service that would be included in an average encounter for each of the Center's revenue centers. The HMA/HCP team included a "strawman" against which the Project Team members could propose modifications. There were no proposed modifications prior to the 8/11 meeting, but during the meeting, Project Team members proposed modifications. The tool provided to solicit feedback and the results of modifications agreed to in the 8/11 Project Team meeting are embedded above.

The HMA/HCP Team used these average encounters to determine specific billing per average encounter to include in the Financial Proforma. In addition to the services and units of services agreed by the Project Team, other inputs to the Financial Proforma regarding reimbursement include the following.

Encounters

The ADAMH Board provided estimated encounters the Steering Committee and its various strategic workgroups had landed on as of 7/17/2020.

Intake, Assessment, and Triage
The Center is expected to have a total of 37,333 total encounter a year, all of which are expected to go through initial Intake, Assessment, and Triage irrespective of how they arrive at the Center. No ALOS estimate was factored for Intake, Assessment, and Triage. Space planning for this service included 3,000 square feet, and 10 private units.
Walk-In Clinic
Of the 37,333 total encounters, 9,333 are expected to be seen at the Walk-In Clinic. The average LOS at the Walk-In Clinic was expected to be 4 hours. Space planning for this service included 1,500 square feet, and 5 private units.
23-hour Observation
The remaining portion of total encounters, 28,000 annually, was expected to be served in a 23-hour Observation Unit. The average ALOS for this unit was 23 hours. Space planning for this service included 11.000 square feet, 80 recliners with some in private rooms (number to be determined).

"Inpatient Services"
6,300 individuals coming out of 23-hour Observation are expected to require "inpatient care", however, the expectation is that a majority of these individuals will be referred out of the Center and admitted to other inpatient or crisis stabilization units in the community. Initially, no specific encounter or ALOS estimates were included. Space planning for this service included 10,000 square feet, and 16 rooms. Based on the planned physical capacity at the Center, Project Team members subsequently determined that the Center would serve 1,100 of those needing "inpatient" admission following 23-hour Observation, with a 5-day ALOS. Note: "Inpatient" is in quotes because of ongoing discussion about potentially wanting to meet both inpatient and intermediate (residential/crisis stabilization unit) levels of care. The Financial Proforma includes assumption of 10 CSU beds and 6 inpatient beds.
Medical Care Services
The initial information received indicated that an estimated 2,800 Medical Care Service encounters with a 6-hour ALOS, and an additional 1,400 medical clearances with a 2-hour ALOS. Space planning for this service included 3,800 square feet and 5 exam rooms. Discussion about these estimates clarified that the Medical Care Services encounters are a subset of the Walk-In Clinic Encounters, so approximately 2,800 of the 9,333 Walk-In Clinic encounters will require medical care. In determining average encounters for the Walk-In Clinic, there are three acuity levels that address the level of medical services anticipated. The team discussed Medical Services when determining the service array and average encounter, the result that is currently reflected in the Proforma is limited to medical services that would be billed under E&M codes, and the staffing assessment calculator includes those encounters, so the staff capacity is accounted for. The staffing calculator is coming up with a number of staff by category and those categories are not granular. For example, a Provider could be an ambulatory doctor or a psychiatrist. In discussion about the Medical Service, it was envisioned as urgent or immediate care to avoid referring to the emergency room as much as possible. The thinking on what the full range of medical services to achieve this may evolve. For example, the space for medical services was limited to five exam rooms. There was no indication of space for a lab or radiology suite. These services and associated required space, staff, equipment, and associated billing may evolve in ongoing planning.
Pharmacy
No pharmacy utilization estimates were provided. Space planning for this service included 1,000 square feet.
SUD Services
4,900 encounters at the Center were estimated to require SUD detox services, however the information indicated that only some individuals of the total may be appropriate to receive such services (e.g., MAT induction) on-site at the Center. There was no separate space planned for SUD services, rather there was planned integrated square footage.
Linkage Services
No utilization estimates were provided. Through discussion, there was clarification that linkage services were expected to be provided by on-site community providers for whom the Center would provide space. Space planning for this service included 2,000 square feet.
Family Support Services
No utilization estimates were provided. Space planning for this service included 500 square feet.

These encounter estimates were provided as the best available starting point and have been used with appropriate modification based on discussion to develop the Financial Proforma. A limitation of the Financial Proforma is that the estimated encounters are under ongoing review. ADAMH Board Project Team members have indicated that it is likely that revised estimates will decrease the number of 23-hour Observation encounters and increase the number of Walk-In Clinic encounters. Other potential changes to estimated encounters include if the Steering Committee determines to have more than a combined 16 beds across the inpatient and crisis stabilization units as a result of feedback from OMHAS that doing so does not jeopardize reimbursement related to the IMD exclusion.

Payer Mix

The Project Team provided the following anticipated payer mix for the Center.

Estimated Payer Mix for the Center	
Commercial	5%
Medicaid (includes FFS and MCO)	65%
Medicare (includes Medi-Medi)	15%
Uninsured (includes covered by ADAMH)	15%

Regarding the 15% uninsured, currently NetCare bills for, and ADAMH pays for services delivered to the uninsured, so ADAMH Board is currently the payer for the uninsured. Technically, ADAMH will only pay for services for people with income under 400% FPL, but per ADAMH, there has never been an issue with someone over 400% needing payment as uninsured. Another important factor about the uninsured rate is that it assumes the Center will be a Qualified Entity and able to facilitate Medicaid Presumptive Eligibility determinations such that a patient who arrives uninsured would be able to be billed out as Medicaid. Removal of a QE and Presumptive Eligibility assumption would increase the uninsured rate considerably.

In the Financial Proforma, all rates being used are Medicaid rates. A limitation of the analysis relative to the uninsured is that it does not assume ADAMH reimbursement rates for the uninsured, rather, it treats the amounts not able to be billed and reimbursed by a payer other than ADAMH as unbillable. Another limitation of the analysis is that it underestimates reimbursements from commercial payers and Medicare whose rates are generally higher than Medicaid.

Primary Diagnosis

While many individuals served by the Center will have dual MH and SUD diagnosis, the HMA/HCP team requested a breakdown by primary diagnosis. The primary MH vs. SUD split reported for 2018 and used for the Steering Committee's volume assumptions was 65% MH and 35% SUD. The team also determined that no special SUD staff would be needed. Staff should be able to treat all patients.

In some cases in the Proforma, rather than apply a 65/35 split, because the corollary service have the same reimbursement, we have just priced the encounter to include the service/unit. In other cases, such as for Peer Services which are only reimbursed by Medicaid for SUD, the Proforma assumes that only 35% of the otherwise billable Peer Services will be reimbursed.

New v. Established Patient

The HMA/HCP team requested a breakdown of estimated new verses established patient.

ADAMH estimated that in a given year roughly 35% of encounters will be a second+ encounter for an individual; and that 65% of annual encounters will be the only encounter that year for a given person.

By CPT definition, a new patient is one who has not received services from the same provider or a provider at the same practice with the same specialty in last 3 years.

The issue of new verses established patient comes into play for some E&M codes for which there is a higher reimbursement rate for a new patient. For the purposes of the Proforma, it uses the established patient codes/rates currently, and does not try to make an assumption about how many of the total encounters are for new patients. A subset of Project Team members discussed which to use or whether to try to make an assumption about the percent of new verses established and decided to use the established patient rate to be more conservative, and avoid trying to introduce a new assumption based on imperfect data.

Reimbursement Rates and Procedure Codes

As mentioned, the Proforma uses all Medicaid reimbursement rates and procedure codes. The rates are from the August 2019 Behavioral Health Coding Workbook FINAL as published by the Ohio Department of Medicaid and the Ohio Department of Mental Health and Addiction services.

The amount used in the Proforma as the DRG reimbursement rate for the 6 Inpatient beds and associated encounters is an average of all DRG rates across all acuities for Central Ohio Psychiatric. There is a reference tab in the Proforma that shows the full range.

The Proforma includes staffing for Intake, Assessment and Triage, but does not make any reimbursement or encounter assumptions. The Proforma assumes that billable services will be provided once an individual has been triaged to either the Walk-In Clinic, or 23-Hour Observation unit.

Reimbursement Issues

Over the course of the project, the Project Team identified multiple reimbursement issues that impact the Center. These are summarized below:

- Medicaid only reimburses Peer for SUD, not for MH
- Nobody pays for room and board. For CSU right now ADAMH is paying codes that include room and board. Medicaid pays only general services and crisis intervention services

Staff Types, Credentials, Training Requirements, Salaries, Staff/Patient Ratio Options

Staffing Types and Ratios

The ADAMH Board shared a staffing calculator with HMA/HCP that RI International shared with the ADAMH Board for the purpose of helping with planning for the Center. The calculator is not for public distribution. The calculator is used in the Financial Proforma, and this document should, therefore, not be distributed publicly with the Calculator tabs. The calculator is not solely focused on crisis stabilization centers and has not been formally adopted by the Steering Committee. We are using it for the Proforma as representative of best practice as informed by RI International.

The staffing calculator is embedded in the Financial Proforma and includes a staffing calculator and ratio for each of the Intake/Assessment/Triage, Walk-In Clinic, 23-hour Observation, the Crisis Stabilization Unit, and the IP Unit. The proforma assumes there will be shared staffing between the IP and CSU beds. However, IP is a higher level of care and includes some specific staffing requirements:

- Must have a minimum nursing to patient ratio of 1:4 as an overall average in any four-week period with the exception of night hours when patients are sleeping
- Must have an experienced RN directing/supervising nursing services
- Two nursing staff must be present at all times
- Must have an RN on site 24/7
- Must have at least one licensed social worker during the day
- Must have at least one qualified rehabilitation therapist during the day.

The staffing for a Class One Facility/CSU is much vaguer. A nurse is required but the number is not specified, rather required to meet the needs of the residents in providing the general MH services.

In the Proforma, the staffing calculator is run separately for CSU and Inpatient, though there is an assumption that CSU and IP are sharing staffing. For IP it is only looking at added discrete services from a medical perspective and uses the highest intensity service level.

Ultimately, the Center operator will bring its own staffing model including staff types, ratios, and shifts. And the building design, layout, and Center flow will influence the ultimate staffing needs. For the purposes of the Proforma, it assumes a 40-hour work week for individual. The Center is open 24/7 which is 168 Hours. 4 shifts of 40= 160 hours, so there is an 8-hour gap.

Staff Credentials

The staff categories in the table below are the categories in the Proforma. The range of credentials for each category is noted, along with credentials and services from the BH Redesign Medicaid services/rates table. The services are aligned with those used in the Proforma. No specific SUD credentials were used as that can limit what services can be provided.

Proforma Staff Category	Credentials	Services that can be provided/billed
Provider (doctor, prescriber, APN)	MD/DO, CNS, CNP, PA (there are a few services where the MD rate is slightly higher than for the others)	E&M, psychotherapy, group, crisis intervention, family counseling, SUD Case Management, CPST, CPST group, TBS, TBS/crisis, TBS group, injections
Nursing Staff	RN, LPN (rates are typically higher for RNs than for LPNs)	E&M (5 min. only), MH & SUD nursing services, TBS/crisis (RN only), MH nursing group (RN only), injections
Clinician (licensed social worker)	PSY, LISW, LIMFT, LPCC; LPC, LSW, LMFT (PSY rates are higher for some services)	psychotherapy, group, crisis intervention, family counseling, SUD Case Management, CPST,

		CPST group, TBS, TBS/crisis, TBS group
Milieu Specialist (unlicensed clinician w/BA or MA, psych tech, PCA)	Min. Qual – AA degree in psychology, counseling or social work and one year of experience (some places may accept a HS diploma with one year experience) Preferred Qual – BA in psychology, counseling or social work (fits the BA/MA w/general supervision and the paraprofessional QMH & CM Specialist categories for Ohio depending on degree & experience) (rates vary by degree)	Depending on degree and supervision: Psychotherapy, group, crisis intervention, family counseling (not QMH); SUD Case Management (CM Specialist only), CPST, CPST group, TBS, TBS/crisis, TBS group (All TBS - min. 3 yrs exp or BA/MA)
PEER	Must have lived recovery experience and be trained and certified as peer specialist Ohio has and requires the certification. No specific educational qualifications.	SUD peer recovery, SUD peer recovery group

Training Requirements

The financial impact of training requirements is not reflected in the Financial Proforma since it does not include indirect costs at this point in time. The ultimate cost impact will vary depending on the selected operator's existing capacity and programming. This section identifies Ohio Administrative Code sections that include training requirements applicable to the scope of the Center. In the initial Financial Proforma, there is a 30% load on salaries with an assumption that some portion of that 30% supports staff license maintenance benefits.

OAC Citation
5122-14 Licensing of Psychiatric Hospitals and Units
5122-26 Policies and Procedures for the Operation of Mental Health Services Agencies
5122-29 Requirements and Procedures for Mental Health Services Provided by Agencies
5122-30 Licensing of Residential Facilities

Salaries

The Ohio Council of Behavioral Health and Family Services Providers periodically conducts a Compensation & Benefits Survey and publishes a report prepared by Blue & Co., LLC detailing:

- Employee Benefits & Human Resource Practices
- Employee Turnover
- Compensation of Line Personnel
- Compensation of Management & Supervisory Personnel
- Profile of Survey Respondents

For purposes of the Proforma, we have used information from the 2018 Compensation & Benefits Survey Report informed by information provided by hospital participants at the 8/18 meeting during review of the draft Proforma. The salary amounts included in the Financial Proforma are conservative and represent the higher end of the ranges reviewed.

Financial Proforma Overview, Strengths and Weaknesses

Overview

The Financial Proforma is an Excel file with multiple tabs facilitating different necessary aspects. In reverse order as presented in the file:

Reference Tabs

1. APR DRGs. This tab excerpts DRG information for Central Ohio Psych to illustrate the range of DRG payments to a facility.
2. E&M Code Times. This tab provides E&M code time and information on codes used for new verses established patients.
3. Coding Workbook. This tab excerpts coding information from the Behavioral Health Coding Workbook, (final as of August 1, 2019), as published by ODM and OMHAS.
4. Staff Roles. This tab lists the staffing types that are calculated by the staffing calculator and the role(s) each may play.

Staffing Calculator Tabs

5. Staffing Ratio INP. This tab provides the staffing ratios for Inpatient services, and the estimated staff needed per shift for the Inpatient beds
6. Staffing Calculator INP. This tab accepts utilization and acuity assumptions that are used to calculate the estimated staff needed per shift for the Inpatient beds.
7. Staffing Ratio CSU. This tab provides the staffing ratios for CSU services, and the estimated staff needed per shift for the CSU beds
8. Staffing Calculator CSU. This tab accepts utilization and acuity assumptions that are used to calculate the estimated staff needed per shift for the CSU beds.
9. Staffing Ratio 23 hour. This tab provides the staffing ratios for 23-hour observation services, and the estimated staff needed per shift for the 23-hour Observation unit(s).
10. Staffing Calculator 23 hour. This tab accepts utilization and acuity assumptions that are used to calculate the estimated staff needed per shift for the 23-hour observation unit(s).
11. Staffing Ratio Crisis. This tab provides the staffing ratios for Walk-In Clinic services, and the estimated staff needed per shift for the Walk-In Clinic.
12. Staffing Calculator Crisis. This tab accepts utilization and acuity assumptions that are used to calculate the estimated staff needed per shift for the Walk-In Clinic.
13. Staffing Ratio IAT. This tab provides the staffing ratios for Intake, Assessment and Triage services, and the estimated staff needed per shift for Intake, Assessment and Triage at the Center.
14. Staffing Calculator 23 IAT. This tab accepts utilization and acuity assumptions that are used to calculate the estimated staff needed per shift for Intake, Assessment and Triage.
15. Staffing Summary. This tab pulls information from the various staffing calculator pages and applies assumptions such as salary, salary load, shift, swing shift to arrive at an annual staff cost.

Encounter Cost Estimation

16. CSU Scenario. This tab includes the service array agreed to be provided at the Center in the CSU, and designates for 2 scenarios (the second of which is more conservative than the encounter defined by the Project Team), an estimated average encounter including billing codes, reimbursement rates, units of service and other details.
17. 23 Hour Obs Scenario. This tab includes the service array agreed to be provided at the Center in the 23 Hour Observation unit(s), and designates for 2 scenarios (the second of which is more conservative than the encounter defined by the Project Team), an estimated average encounter including billing codes, reimbursement rates, units of service and other details.
18. Walkin Clinic Scenarios. This tab includes the service array agreed to be provided at the Center in the Walk-In Clinic, and designates for 3 scenarios (Low at 10% frequency, Medium at 70% frequency, and High at 20% frequency) an estimated average encounter including billing codes, reimbursement rates, units of service and other details.

Encounter and Service Array

19. Service Summary by Area. This tab accepts entry of utilization data such as number of encounters, length of stay, number of beds/chairs/rooms for each of four Service Areas: Intake, Assessment, and Triage; Walk-In Clinic; CSU; Inpatient. The configurable fields in this tab flow to calculation on other pages.

Margin Estimation

20. Margin Estimate 2. This tab pulls in the staffing costs calculated elsewhere in the Excel, and the billing based on the defined encounters and estimated encounter volumes elsewhere in the Excel, applies assumptions such a percent uninsured to offset expected revenue to compare staffing costs to expected reimbursement.
21. Margin Estimate 1. This tab pulls in the staffing costs calculated elsewhere in the Excel, and the billing based on the defined encounters and estimated encounter volumes elsewhere in the Excel, applies assumptions such a percent uninsured to offset expected revenue to compare staffing costs to expected reimbursement.

The Margin Estimate 1 uses the average encounters and associated mix of acuity for each revenue center which reflects the Project Team inputs and decisions. The Margin Estimate 2 uses the same data with the exception that it assumes only half of encounters will include E&M codes. This is a more conservative assessment and provides a comparison point.

Strengths and Weaknesses

Strengths

The strengths of the Financial Proforma include that it has been designed to provide the ability for future use by the ADAMH Board and Steering Committee to:

- Update evolving assumptions about the Center such as encounters, services, and space (beds, chairs, rooms)
- Run scenarios to test the impact of reimbursement changes
- Integrate new data points such as indirect costs as they are identified and refined into the margin analysis

The Financial Proforma is an Excel file with no cells or formulas protected. Users familiar with Excel can see the calculations under understand how data points flow through those calculations to result in answers.

Weaknesses

The fundamental weakness of the Financial Proforma is that it uses a set of assumptions about a variety of things, all or most of which will not play out exactly as assumed or estimated. Many of the assumptions and estimates provided, discussed, and agreed to by the Project Team are preliminary decisions agreed because of the need for a value/answer for the Financial Proforma; and in reality continue to be under discussion, and are likely to change/evolve as the planning for the Center progresses. Examples include:

- **Encounter Estimates.** The Project Team expects that based on new information currently being collected and analyzed, the estimated encounters for the Center will change possibly resulting in more Walk-In Clinic encounters, and fewer 23 Hour Observation encounters among other changes. These changes will impact staffing and reimbursement calculations in the Proforma and have implications for building design and clinic flow considerations that are outside of this project's scope, but intrinsically connected in terms of how these variables affect one another.
- **Average Length of Stay (ALOS).** For each encounter type, there is an ALOS assumption. These ALOS assumptions may not reflect the ultimate reality of the Center, an in particular there has been discussion about the 23 Hour Observation unit for which the Proforma currently uses a 23-hour ALOS, though current NetCare experience is less. Changes to the ALOS in the Proforma will impact staffing and reimbursement calculations in the Proforma.
- **Average Encounter Services and Billing.** The Project Team completed an exercise to identify for each revenue center what the average actual services, and units of services would be for a given encounter (each of which has an assumed ALOS). The encounters designed by the Project Team reflect units of service per encounter that are higher than those provided by NetCare in an equivalent encounter today. To mitigate the possibility that the Project Team's average encounter over estimated units of services, for 23 Hour Observation and the CSU we introduced a conservative encounter alternative, which is used for 50% of those encounters. Irrespective of this mitigation, the services and billings for any of the scenarios my not play out in reality at the Center. At the 8/18 Project Team meeting, Jonathan made a plea for productivity information/assumption even if they come after the close of the Operating Budget Analysis project. He wants to be able to assess whether the assumed staff ratios and volume of service delivery are realistic in terms of staff productivity and make modifications in the Proforma as indicated.

In addition to these examples, the Proforma includes additional estimates and assumptions, many of which are documented in this report and all of which can be identified in the tool itself. The ADAMH Board will be able to modify these assumptions as refined estimates and assumptions are decided or become available. Irrespective of changes to the estimates and assumptions in the Proforma, the Center Operator will ultimately drive or influence many variables in the Proforma such that the cost and reimbursement outcomes of the actual Center will vary from even the best estimate or assumption. As example, the Proforma integrates the IR Staffing Calculator that uses the Crisis Now model for staffing as a recommended best practice. The Center Operator may have a different staffing model that meets

certification and accreditation standards and changes the cost profile of staffing; and the physical design of the Clinic will influence staffing needs and productivity.

A person's journey through the Center may take them through multiple revenue Centers on the same day. Many codes cannot be billed twice in a day. Because the Proforma assess each Revenue Center separately, there is a risk that it is capturing double billing. The Proforma mitigates this risk in several ways:

- There is no revenue assumption to Intake, Assessment and Triage.
- Of the total estimated annual encounters to the Center, the assumption is that some go to Walk-In Clinic and others go to 23 Hour Observation.
    - The Walk-In Clinic encounters are not assumed to go to 23 Hour Observation, rather resolve to discharge
    - A subset of the 23 Hour Observation encounters (1,100) are assumed to go to either the CSU or Inpatient bed. This set of 1,100 is the limit of risk where the Proforma may include billing in both 23 Hour Observation and the CSU that would not be allowed as duplicate.

Another weakness of the Proforma as it stands is that it only accounts for services and reimbursement and line staff costs. The original vision of the Proforma was that it would calculate the assumed operating margin, assumed to be a deficit. Early in the project, it became clear that it was premature to attempt to integrate indirect costs into the Proforma. The Proforma is designed in such a way that a user can integrate indirect cost information (whether that be specific, a general load, a load per square feet, or other methodology) into the Proforma to complete this more comprehensive assessment of operating margin.

A final weakness of note, or rather risk, is related to the intentional configurability of the Proforma Tool. Because it is highly configurable and has no locked fields, it would be easy for a user to inadvertently change something and not remember to save as a new file name and document changes from the baseline, or designate the version as a modeling scenario rather than an agreed change to baseline. HMA/HCP recommends that the ADAMH Board implement strict configuration management protocols for this file so that they can always be confident that they have the then current baseline version with agreed estimates and assumptions.