Understanding Your Costs in an Evolving Payment Environment

Session 4: Focus on Behavioral Health: Utilizing Cost Data to Drive Programmatic Change

July 28, 2020

Dave Kleiber, Capital Link
Robert Urquhart, Consultant/ Retired CFO
Anya Eliassen, Interim CEO, CFO OCHN
Nicole Lawson, Dep Dir, COO, OCHN

the DELTA CENTER
for a thriving safety net

CAPITAL LINK

What We Have Discussed So Far…

- **Session 1:** Cost Allocation: Getting the Basics Right
- **Session 2:** Preparing Internal Systems for Gathering Cost Data
- **Session 3:** Understanding Your Costs in an Evolving Payment Environment

Step Back: It's Essential to Agree on Definitions

The definition of "Evolving Payment Environment" depends to some extent on where you sit: For the payers who typically drive the process, it means - one that produces improved healthcare outcomes while (their) costs/client are controlled.

If so, that will require 3 things:

1. We have to be able to define and measure the outcomes;
2. We have to know how to accurately calculate the costs per client (for whatever outcomes we produce); and
3. To stay in business, we need to get reimbursed enough to cover those costs.

CAPITAL LINK

the DELTA CENTER
for a thriving safety net

Step Back…and Re-Think

We all have to admit that there is pressure to contain costs (though it seems unfair to saddle behavioral health care with a drive to reduce costs when reimbursements have been so low historically….)

How do we respond to that?

1. Maintain focus on and fidelity to the Quadruple Aim;
2. Realize that though the total of all system costs needs to be controlled, that does not mean ALL costs need to be reduced. It is possible to spend more in some areas to save more money elsewhere – but we have to prove that connection to payers.
3. And that goes back to demonstrating measurable outcomes.

Playing Offense: Talk to Your Payers

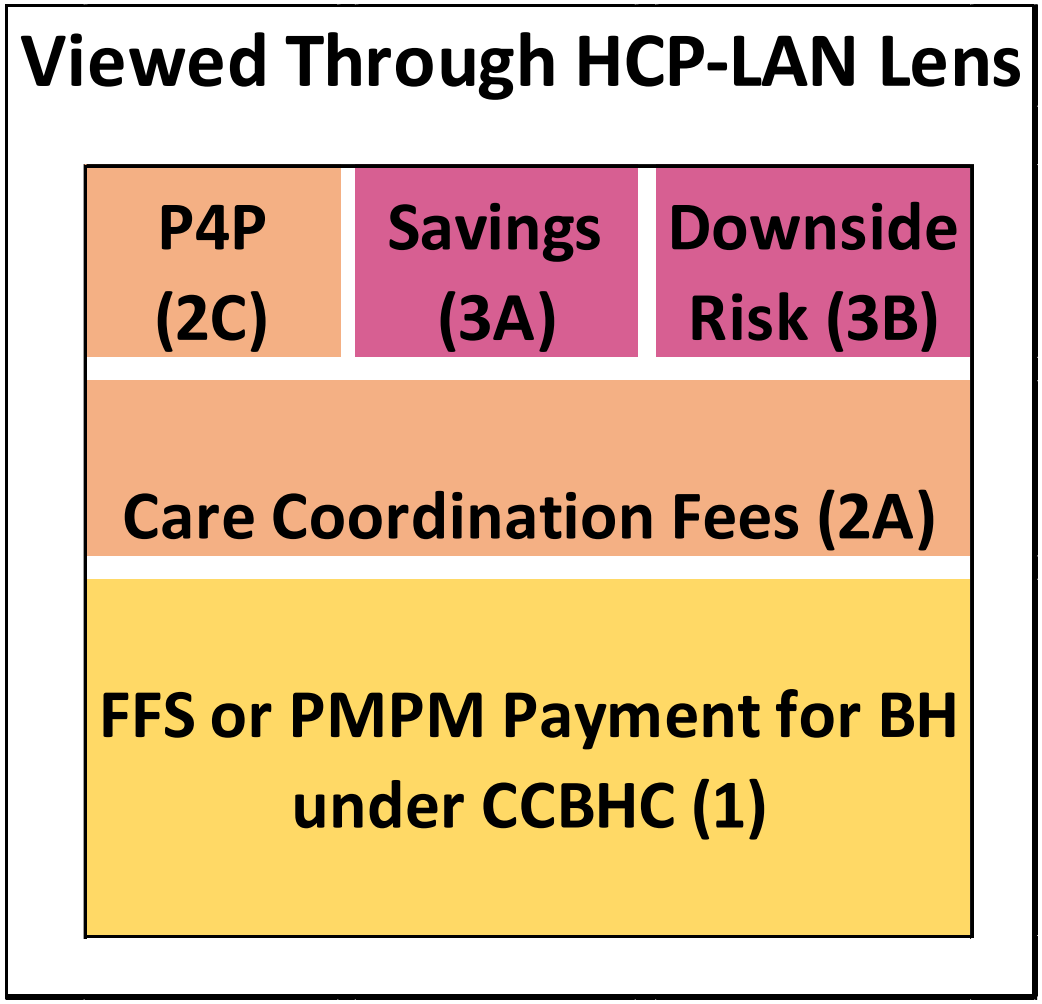
Three serious challenges arise for VBP networks that go **without** robust behavioral health process and outcome measures:

1) **There is little incentive for the network to support care specifically for behavioral health conditions (if they don't see the benefits);**

2) **It becomes difficult to justify what, if any, shared savings should be available to participating behavioral health providers (you have to help them make the connection!)** and

3) **There are no quality signals to alert the network when individuals may in fact be receiving substandard behavioral health care. (the system doesn't acknowledge when proper care is available so obviously it doesn't know when good care is lacking)**

Payment Reform – Multi-Layered



"Your Costs are Your Costs"

- Good cost accounting can identify which of your programs/operations are losing money and which others are effectively subsidizing those (which can be fine if that is a conscious decision!!).
- Often when only the big picture is available, management's solution is a broad stroke – reduce everyone's salary by 10% or cut FTEs by 5% across the all departments. That punishes all programs of the CMHC without knowing if in fact some programs are making money and should be exempt from cuts.
- Understanding your costs allows you to make strategic choices based on a clear understanding of the financial realities and associated mission tradeoffs.

Flashback!

(To Session 1 in this webinar series)

Components of Cost Per Visit or Client/Patient

All expenses at the organization can be classified into one of the following categories:

- Provider cost
- Direct Support cost
- Enabling cost
- Overhead cost

"Time is Money"

Cost depends on the **actual use of resources** involved in a client's care process (personnel, facilities, supplies):

- The **time** devoted to each client (or group of clients) by these resources
- The **capacity cost** of each resource
- The **support costs** required for each client-facing resource

Flashback!

(To Session 3 in this webinar series)

Approaches to Understanding Cost Associated with New Payment Models

1. Start with historic average cost per client as a base
2. Stratify clients by intensity of needs
3. Identify clinical care pathways for groups of clients with similar needs
4. Identify unique costs of more intensive services

Costing BH Care Pathways

We will look at
Assertive Community Treatment as an example of an effective care pathway and describe how to appropriately calculate its costs.

Assertive Community Treatment

Basics:

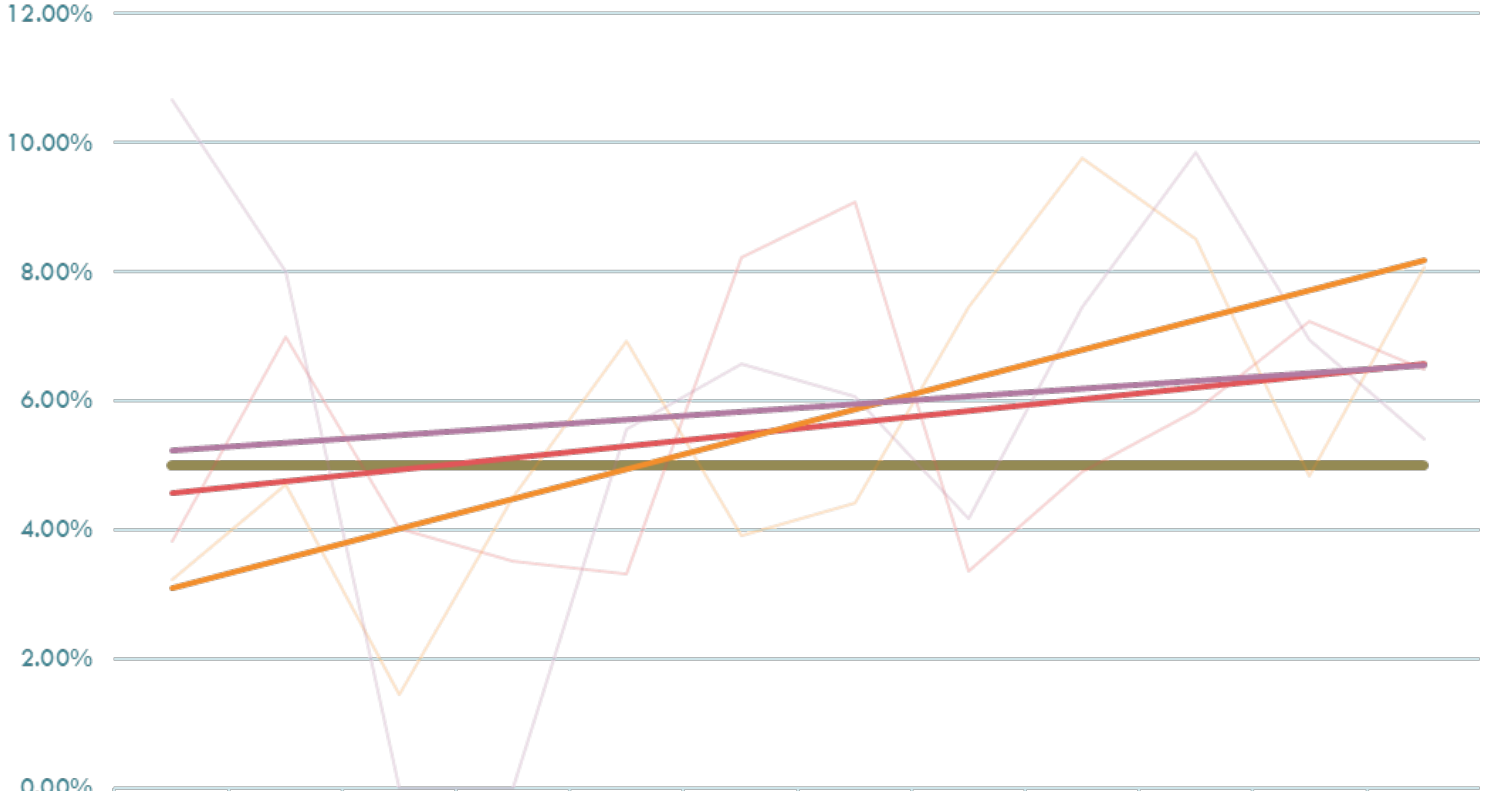
- Core Provider Agencies (CPA) receive monthly case rate-based ACT staff, costs, and caseloads
- Monitoring model fidelity, outcomes, and costs

Funding:

- Bundled Code based on team composition
- Ancillary services based on service groupings
- Enhanced Rates provided for Evidence-Based Practices

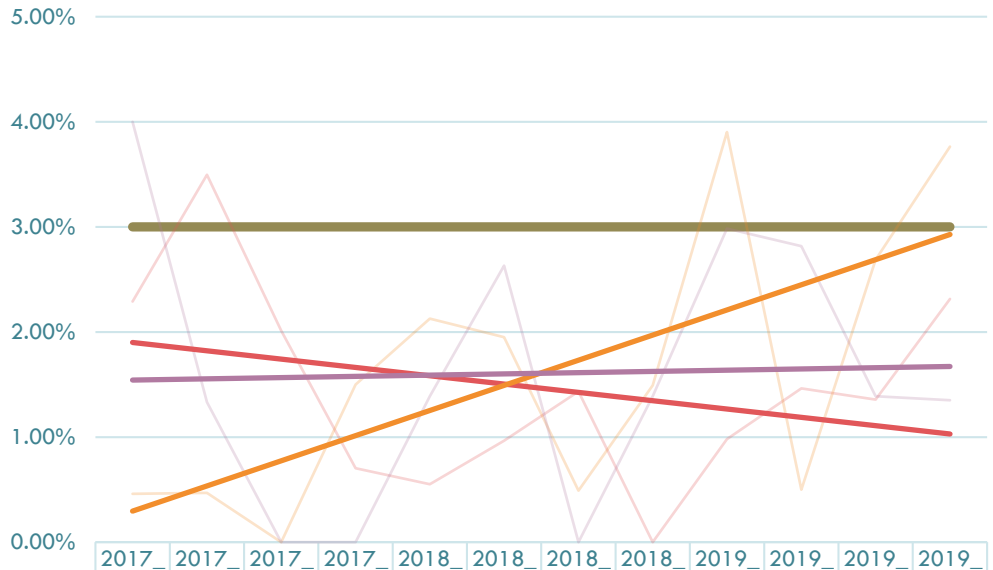
Source: Using outcomes-based payment for behavioral health services: Lessons learned from Oakland Community Health Network's experience; OCHN - Presented By: Anya Eliassen, MBA, Nicole M. Lawson, PhD

Assertive Community Treatment: Inpatient Admissions

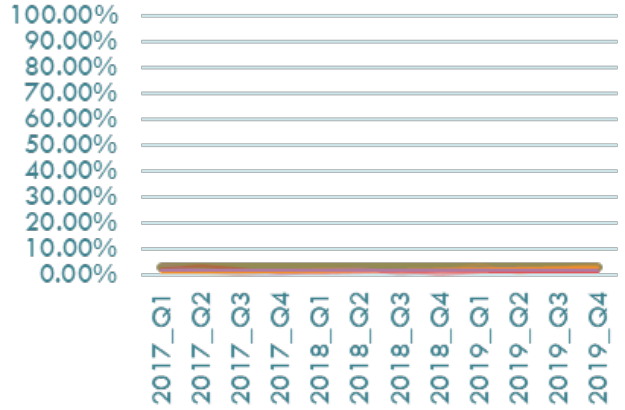


	2017_Q1	2017_Q2	2017_Q3	2017_Q4	2018_Q1	2018_Q2	2018_Q3	2018_Q4	2019_Q1	2019_Q2	2019_Q3	2019_Q4
INCENTIVE	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Provider A	3.817%	6.993%	4.027%	3.521%	3.315%	8.213%	9.091%	3.349%	4.902%	5.854%	7.240%	6.481%
Provider B	3.226%	4.695%	1.435%	4.500%	6.915%	3.902%	4.412%	7.463%	9.756%	8.500%	4.839%	8.065%
Provider C	10.667%	8.000%	0.000%	0.000%	5.556%	6.579%	6.061%	4.167%	7.463%	9.859%	6.944%	5.405%

Assertive Community Treatment: Inpatient Readmissions



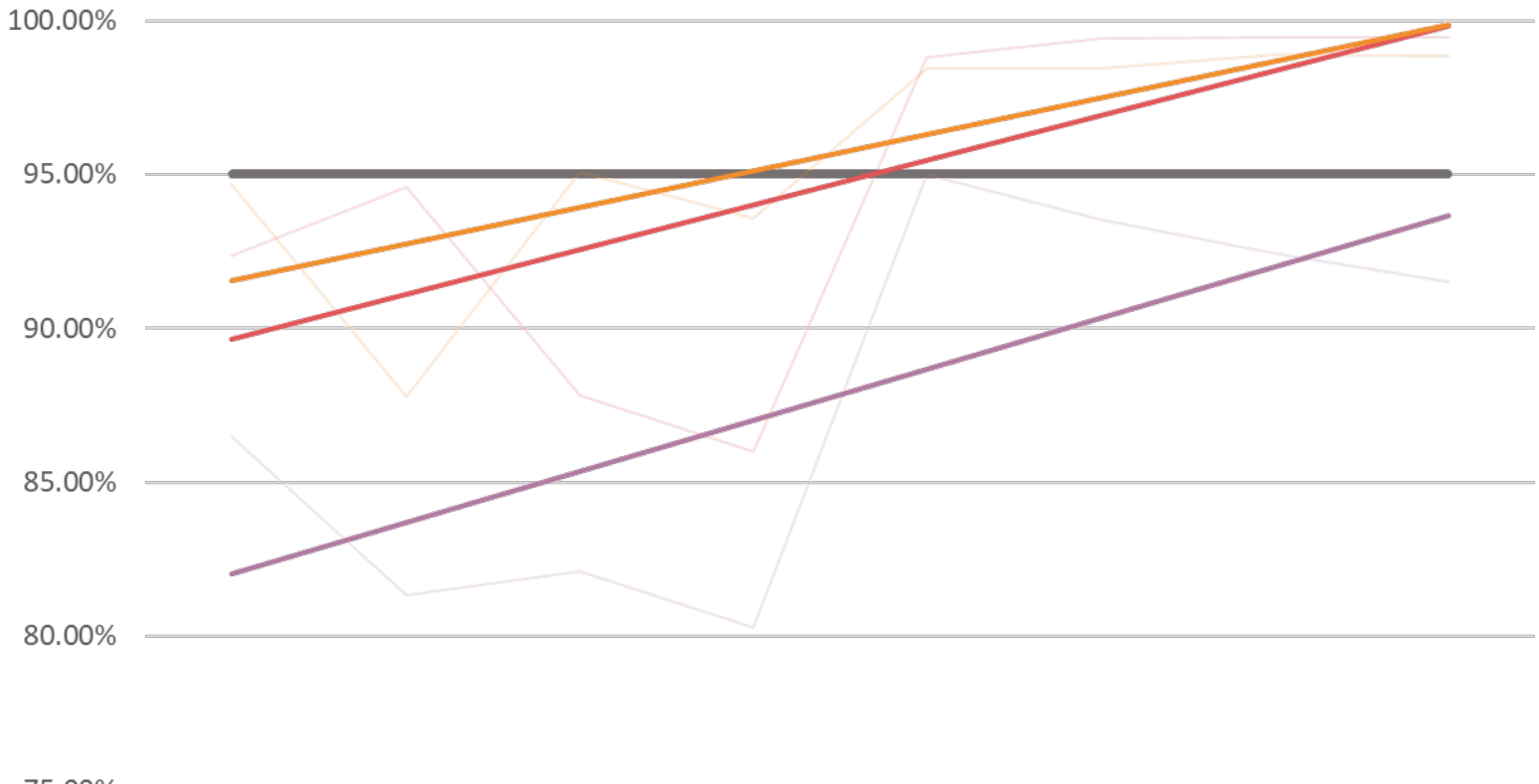
	2017_Q1	2017_Q2	2017_Q3	2017_Q4	2018_Q1	2018_Q2	2018_Q3	2018_Q4	2019_Q1	2019_Q2	2019_Q3	2019_Q4
INCENTIVE	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Provider A	2.29%	3.50%	2.01%	0.70%	0.55%	0.97%	1.44%	0.00%	0.98%	1.46%	1.36%	2.31%
Provider B	0.46%	0.47%	0.00%	1.50%	2.13%	1.95%	0.49%	1.49%	3.90%	0.50%	2.69%	3.76%
Provider C	4.00%	1.33%	0.00%	0.00%	1.39%	2.63%	0.00%	1.39%	2.99%	2.82%	1.39%	1.35%



CAPITAL LINK

the DELTA CENTER
for a thriving safety net

Assertive Community Treatment: Healthcare Coordination



	2018_Q1	2018_Q2	2018_Q3	2018_Q4	2019_Q1	2019_Q2	2019_Q3	2019_Q4
INCENTIVE	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Provider A	92.361%	94.578%	87.805%	86.000%	98.824%	99.429%	99.471%	99.462%
Provider B	94.681%	87.778%	95.098%	93.564%	98.429%	98.438%	98.870%	98.844%
Provider C	86.486%	81.333%	82.090%	80.282%	95.000%	93.548%	92.424%	91.525%

Costing the Program

	Vacation weeks	CME (weeks)	Net FT weeks available per year	Working Days	Working Hours per Day	Daily Availability Adjustment Factor
Psychiatrist	5	3	44	220	7	70%
Nurse	2	1	49	245	7	90%
SUD Counselor	2	1	49	245	7	80%
Case Manager	2	1	49	245	7	90%
Team Leader	3	1	48	240	7	90%
Cert. Peer Spec.	2	1	49	245	7	90%
Care Coordinator	2	0	50	250	7	90%
Total						

Costing the Program

	Minutes available per day	Minutes available per year	Annual Total Salary	Fringe @ 25%	Total Compensation
Psychiatrist	294	64,680	$ 220,000	$ 55,000	$ 275,000
Nurse	378	92,610	$ 65,000	$ 16,250	$ 81,250
SUD Counselor	336	82,320	$ 50,000	$ 12,500	$ 62,500
Case Manager	378	92,610	$ 50,000	$ 12,500	$ 62,500
Team Leader	378	90,720	$ 62,000	$ 15,500	$ 77,500
Cert. Peer Spec.	378	92,610	$ 38,500	$ 9,625	$ 48,125
Care Coordinator	378	94,500	$ 35,000	$ 8,750	$ 43,750
Total					

Costing the Program

	Avg. Time per Interaction (min)	Interaction Capacity per year	Cost per minute	Cost per Interaction	Interactions per Year per Client	Total Program Cost per Participant
Psychiatrist	15	4,312	$ 4.25	$ 63.78	12	$ 765.31
Nurse	10	9,261	$ 0.88	$ 8.77	12	$ 105.28
SUD Counselor	40	2,058	$ 0.76	$ 30.37	12	$ 364.43
Case Manager	40	2,315	$ 0.67	$ 26.99	24	$ 647.88
Team Leader	40	2,268	$ 0.85	$ 34.17	6	$ 205.03
Cert. Peer Spec.	60	1,544	$ 0.52	$ 31.18	24	$ 748.30
Care Coordinator	30	3,150	$ 0.46	$ 13.89	12	$ 166.67
Total Personnel						$ 3,002.89
					Overhead @ 45%	$ 1,351.30
					Total Cost	$ 4,354.19
					PMPM Equivalent	**$ 362.85**

CAPITAL LINK

the DELTA CENTER
for a thriving safety net

Using Data to Support VBP Negotiations

Understanding the true costs of services will help inform decisions during rate negotiations, and will give you the flexibility to quickly establish a cost for new services that may be of interest to the MCO/State Medicaid agency.

- Patient Attribution
- Performance Improvement Projects (PIPs)
- Leverage Medicaid Managed Care Health Plan & ACO Innovations
- Social Risk Adjustment

Review and update your Charge Master. Does it include the full cost of providing services? This is especially important for Evaluation and Mgt., Early Childhood Intervention and other services where negotiated rates may not cover your full costs. The Charge Master should not be set at Medicaid FFS, Medicare FFS or contracted rates unless these rates cover the full cost of service.

VBP Negotiations

Three concepts payers must address when collaborating with providers.

Concept 1: Clinical Measurement and Metrics

When payers and providers collaborate on risk-based contracts, they must agree up-front on metrics—what they plan to measure and what their improvement targets are. Though these metrics will require refinement over time, they are needed from the outset as a baseline.

3 Best Practices for Payer-Provider Collaboration to Improve Patient Care
https://www.healthcatalyst.com/challenge-payer-provider-collaboration

VBP Negotiations

Concept 2: Payer-Provider Transparency

Payers and providers need a plan for ensuring transparency. How behavioural health providers and others are performing against targeted measures must be made available to many stakeholders. This availability helps ensure that targets are hit consistently and that everyone gets paid appropriately in a value-based system.

VBP Negotiations

Concept 3: Clinical Improvement

Once payers and providers have aggregated data they can visualize trends and jointly establish informed objectives for their population. Providers and payers will benefit most by targeting areas/populations with high costs, high variability in costs, and those that can be improved by evidence based practices.

Note: Many of these areas/populations will require a multi-year approach to attain the level of improvement needed

Not all Negotiations are External

Costing at the client or activity-based level can make your provider teams feel like you are putting them under a microscope.

In using costing as a management tool it is important that all affected internal parties are on board. Provider teams need to value the goal of improved "efficiency" as much as finance does or nothing will change.

And provider teams will not miss it if "overhead" is a large flat number that seems to be impervious to the same intense scrutiny. To the extent possible, management has to be willing to undergo the same scrutiny of its operations and related costs.

Recommendations for Negotiating with Payers

- **Measures –** Can you help the MCO/Network with access and quality metrics? It is extremely helpful to have supporting data.
- **Integration –** Service integration (bi-directional) becomes increasingly important when moving from low to high risk VBP models.
- **Money –** Describe how your Center can help improve efficiency and reduce costs *(both in-house AND at other providers like hospitals – that's where the big system impacts occur)*
- **Innovation –** Describe how your Center uses technology, best practices, or other innovative approaches to improve behavioral and overall client health care.

VBP in CCBHC's

CCBHC:

This demonstration program may be considered a P4P model depending on the payment methodology implemented by each state.

CCBHC quality measures include a range of measurable outcomes:

- access-related measures (e.g., time to initial evaluation),
- process measures (e.g., documentation of current medications in medical records),
- outcome measures (e.g., death by suicide) and
- measures addressing social determinants of health (e.g., housing status).

BEHAVIORAL HEALTH PROVIDER PARTICIPATION IN MEDICAID VALUE-BASED PAYMENT MODELS: AN ENVIRONMENTAL SCAN AND POLICY CONSIDERATIONS; The National Council September 2019

Thank You!

Contact Capital Link:

Allison Coleman
Chief Executive Officer
acoleman@caplink.org

Jonathan Chapman
Chief Project Officer
Tel: 970-833-8513
jchapman@caplink.org

Dave Kleiber, MBA
Project Consultant
Email: dkleiber@caplink.org

CAPITAL LINK

Visit us Online: **www.caplink.org**

Robert Urquhart
Consultant, Retired FQHC CFO
Email: rurquhart1733@gmail.com

Anya Eliassen
Interim CEO, CFO OCHN
eliassena@oaklandchn.org

Nicole Lawson
Dep Dir, COO, OCHN
lawsonn@oaklandchn.org

For more information on the Delta Center
please visit the website: deltacenter.jsi.com

Robert Wood Johnson Foundation

NATIONAL ASSOCIATION OF Community Health Centers

MENTAL HEALTH FIRST AID NATIONAL COUNCIL FOR BEHAVIORAL HEALTH Healthy Minds. Strong Communities.

the DELTA CENTER for a thriving safety net