# Understanding Your Costs in an Evolving Payment Environment

## Session 4: Utilizing Cost Data to Drive Programmatic Change

Dave Kleiber, Capital Link
Robert Urquhart, Consultant/ Retired FQHC CFO

April 22, 2020

the DELTA CENTER
*for a thriving safety net*

CAPITAL LINK

# What We Have Discussed So Far…

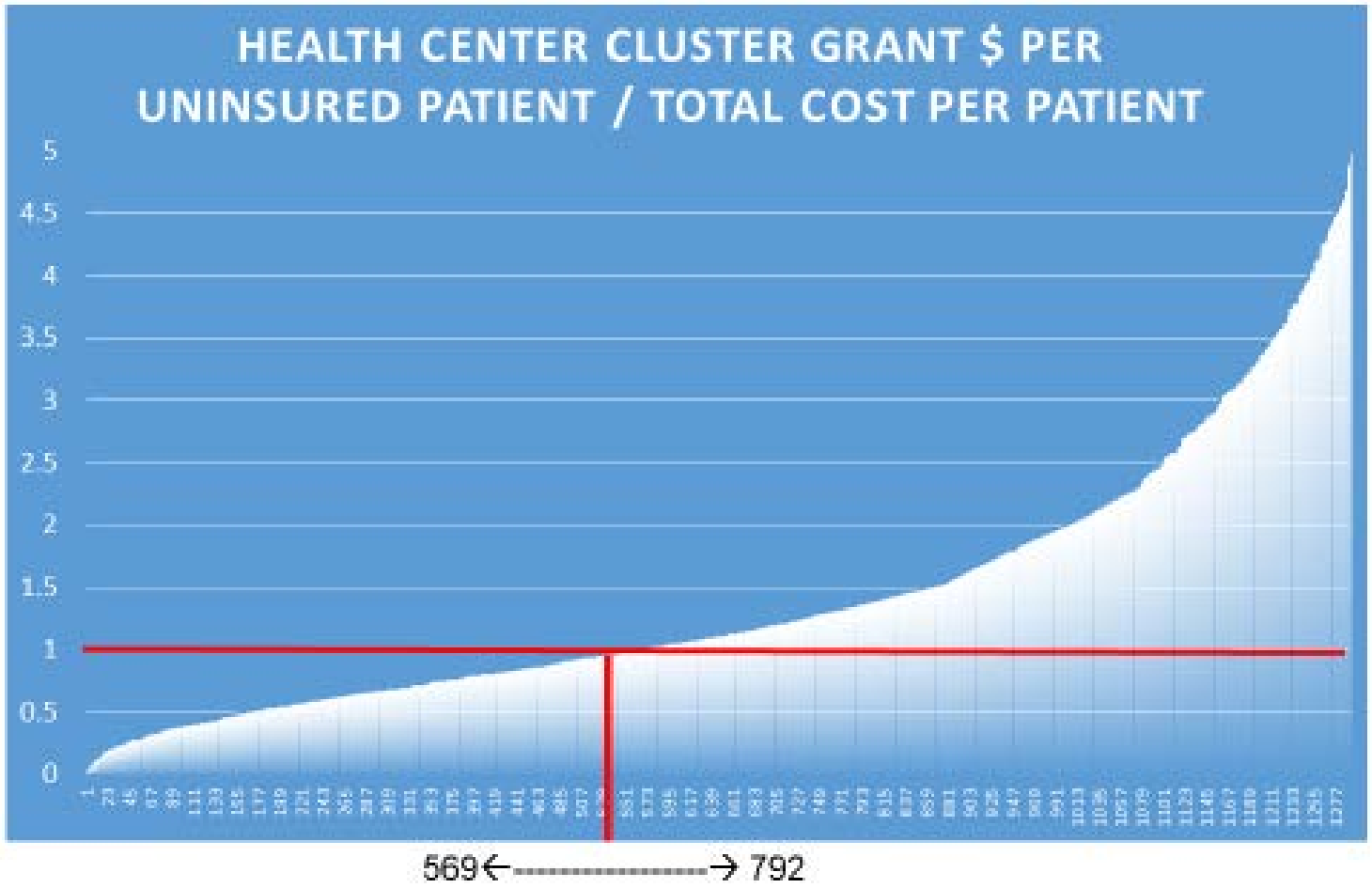
- **Session 1:** Cost Allocation: Getting the Basics Right
- **Session 2:** Preparing Internal Systems for Gathering Cost Data
- **Session 3:** Understanding Your Costs in an Evolving Payment Environment

# "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.
- 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 center 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.

# Why the Change to VBP Matters NOW

## 330 Grant Subsidy



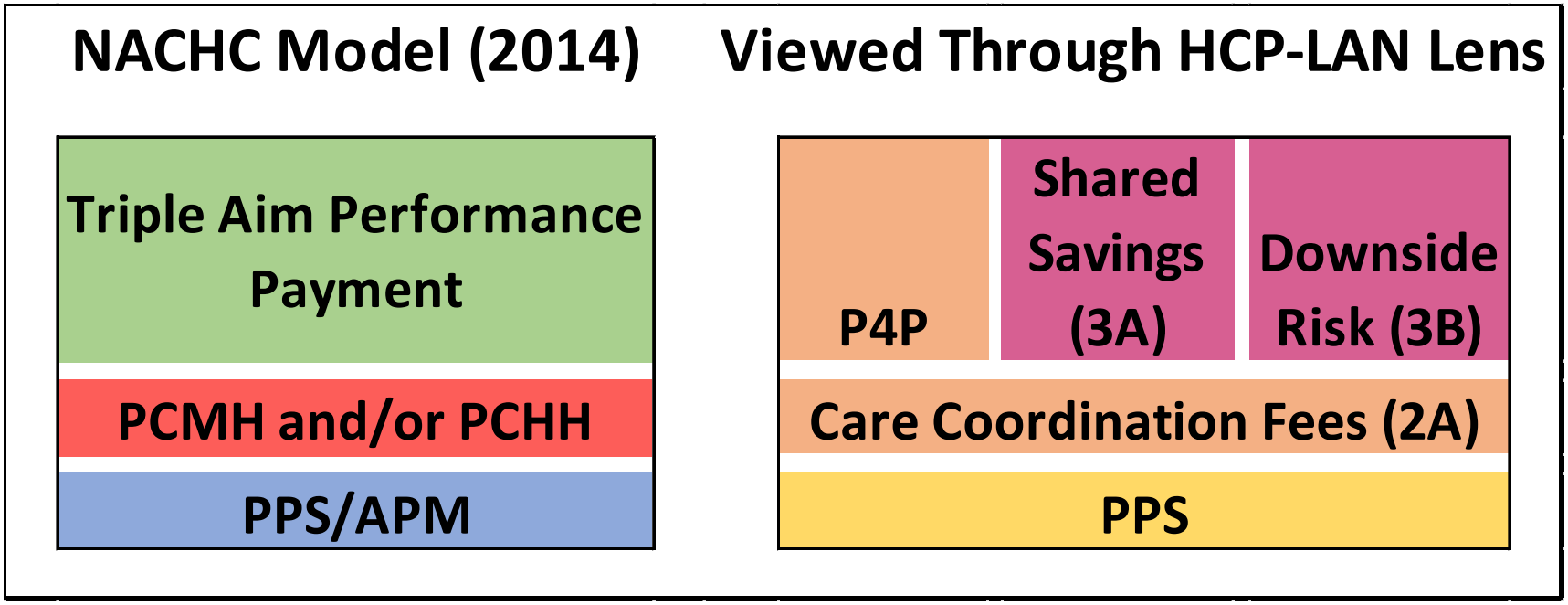
# Value-Based Payment Systems for CHCs - Today

| | |
|---|---|
| Payment for Performance on Triple Aim | **Layer 3** - includes shared savings with upside only or upside and downside risk (typically through Medicaid MCOs |
| Payment for Delivery System Transformation (PCMH) | **Layer 2** - includes partial capitation for care coordination or infrastructure development (example: investment in HIT) |
| Base Payment (PPS or APM) | **Layer 1** - base payment involves shifting from PPS to per member per month capitated payments for all primary care services |

**Health Centers and Payment Reform: A Primer, NACHC, authored by JSI**

# NACHC Model Aligns with Other Models

## *VBP for Primary Care: Multi-Layered*




**Health Centers and Payment Reform: A Primer, NACHC, authored by JSI**

# Flashback!

## (To Session 1 in this webinar series)

### Components of Cost Per Visit or Patient

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

- Provider cost
- Direct Support cost
- Direct Enabling cost
- Overhead cost
- Ancillary and Other cost

# "Time is Money"

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

- The **time** devoted to each patient (or group of patients) by these resources
- The **capacity cost** of each resource
- The **support costs** required for each patient-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 patient as a base
2. Stratify patients by intensity of needs
3. Identify clinical care pathways for groups of patients with similar needs
4. Identify unique costs of more intensive services

# Example – Costing Behavioral Health Care

For comparison purposes we will look at some actual FQHC results for its behavioral health department under three actual operating and payment scenarios.

Then we will look at one of those scenarios vs. a center's stand-alone medical department results (no integrated BH).

Finally we take a look at how a well integrated practice might take advantage of value-based payments resulting from achieving negotiated outcomes that effectively make the "sum greater than the parts."

# Example: Behavioral Health Dept. - Staffing

| Position | Hrs Per Week | Rate Per Hour | Annual Total | FTE | Hrs Per Week | Annual Total |
|---|---|---|---|---|---|---|
| Clinical | | | | | | |
| Clinical Psychiatrist | 5 | $ 96 | $ 24,960 | 0.12 | 20 | $ 99,840 |
| Clinical Psychiatrist | 8 | $ 111 | $ 46,176 | 0.20 | 20 | $ 115,440 |
| Pyschiatrist | 40 | $ 106 | $ 220,480 | 1.00 | 80 | $ 440,960 |
| Pyschiatrist | 8 | $ 143 | $ 59,488 | 0.20 | 15 | $ 111,540 |
| Psychiatric NP | 40 | $ 41 | $ 85,280 | 1.00 | 80 | $ 170,560 |
| | | | | | | |
| Non Clinical | | | | | | |
| Behavioral Scientist | 3 | $ 54 | $ 8,424 | 0.07 | 10 | $ 28,080 |
| Behavioral Scientist | 3 | $ 54 | $ 8,424 | 0.07 | 10 | $ 28,080 |
| Associate Director | 24 | $ 45 | $ 55,536 | 0.60 | 40 | $ 92,560 |
| | | | | | | |
| Support | | | | | | |
| Community HW | 40 | $ 18 | $ 36,400 | 1.00 | 60 | $ 54,600 |
| Senior MA | 35 | $ 16 | $ 28,210 | 0.87 | 60 | $ 48,360 |
| MA | 40 | $ 14 | $ 29,952 | 1.00 | 60 | $ 44,928 |
| | | | | | | |
| Total Salaries/FTE | | | $ 603,330 | 6.13 | | $ 1,234,948 |
| | | | | | | |
| Fringe Benefits @ 18% | | | $ 108,599 | | | $ 222,291 |
| | | | | | | |
| Total Personnel Costs | | | $ 711,929 | | | $ 1,457,239 |

# Example: Behavioral Health Dept. - Revenue

| Position | Hrs Per Week | Weeks | Annual | PPH | Visits | RPV | PSR |
|---|---|---|---|---|---|---|---|
| Clinical | | | | | | | |
| Clinical Pyschiatrist | 8.0 | 52 | 416 | 1.25 | 520 | $ 80 | $ 41,600 |
| Clinical Pyschiatrist | 4.0 | 52 | 208 | 1.25 | 260 | $ 80 | $ 20,800 |
| Pyschiatrist | 32.0 | 52 | 1,664 | 1.25 | 2,080 | $ 65 | $ 135,200 |
| Pyschiatrist | 40.0 | 52 | 2,080 | 1.25 | 2,600 | $ 65 | $ 169,000 |
| Psychiatric NP | 32.0 | 52 | 1,664 | 1.25 | 2,080 | $ 65 | $ 135,200 |
| Pyschologist | 32.0 | 52 | 1,664 | 1.25 | 1,040 | $ 65 | $ 67,600 |
| | | | | | | | |
| Non Clinical | | | - | | | | |
| Behavioral Scientist | 3.0 | 48 | 144 | - | N/A | $ - | $ - |
| Behavioral Scientist | 3.0 | 48 | 144 | - | N/A | $ - | $ - |
| Assoc Dir/Psychologist | 4.0 | 48 | 192 | 1.25 | 120 | $ 65 | $ 7,800 |
| | | | | | | | |
| Support | | | | | | | |
| Community Health Worker | 40.0 | | | | | | |
| Senior MA | 35.0 | | | N/A | | | |
| MA | 40.0 | | | | | | |
| | | | | | | | |
| | | | | | 8,700 | | $ 577,200 |
| | | | | | | | |
| RPV | | | | | | | $ 66 |

# Behavioral Health Dept. – Operating Revenue

| Scenarios assume: | No PFP | 100% PFP | 50% PFP |
|---|---|---|---|
| | **Scenario 1** | **Scenario 2** | **Scenario 3** |
| **Patient Visits** | | | |
| Total Visits | 8,700 | 17,400 | 8,700 |
| Total Patients | 5,742 | 9,500 | 5,742 |
| | | | |
| **Revenue and Expenses** | | | |
| **Operating Revenue** | | | |
| Patient Service Revenue | $ 577,200 | $ 1,154,400 | $ 577,200 |
| PFP/Outcomes Revenue | - | 100,000 | 50,000 |
| Net Patient Service Revenue | $ 577,200 | $ 1,254,400 | $ 627,200 |
| Grant and Contract Revenue | $ 5,000 | $ 5,000 | $ 5,000 |
| Other Revenue | - | - | - |
| Pharmacy Revenue | | | |
| **Total Operating Revenue** | $ 582,200 | $ 1,259,400 | $ 632,200 |
| **Revenue Per Visit** | $ 67 | $ 72 | $ 73 |

# Behavioral Health Dept. – Net Income

| Operating Expenses | Scenario 1 | Scenario 2 | Scenario 3 |
|---|---|---|---|
| Salaries | $ 603,330 | $ 1,234,948 | $ 603,330 |
| Fringe Benefits | 108,599 | 222,291 | 108,599 |
| **Personnel Costs per Visit** | **$ 81.83** | **$ 83.75** | **$ 81.83** |
| Supplies | 5,700 | 10,200 | 5,700 |
| Sub-Contracts - Patient Service | 55,000 | 20,000 | 55,000 |
| Other Purchased Services | 8,400 | 8,400 | 8,400 |
| Travel and Training | 10,250 | 10,250 | 10,250 |
| **Direct Support Costs per Visit** | **$ 9.12** | **$ 2.81** | **$ 9.12** |
| **Total Operating Expenses** | $ 791,279 | $ 1,506,089 | $ 791,279 |
| **Subtotal Before Allocations** | $ (209,079) | $ (246,689) | $ (159,079) |
| **Allocated Administrative Overhead** | $ 212,945 | $ 212,945 | $ 212,945 |
| **Overhead Costs per Visit** | **$ 24.48** # | **$ 12.24** # | **$ 24.48** |
| **Total Expenses Per Visit** | $ 115 | $ 99 | $ 115 |
| **Net Surplus/(Deficit)** | $ (422,024) | $ (459,634) | $ (372,024) |
| **Net Surplus/(Deficit) Per Visit** | $ (49) | $ (26) | $ (43) |

# Example – Costing Behavioral Health Care

Scenario 1: Up-side Only Behavioral Health VBP

- Outcome targets are all BH measures
- Upside is fairly modest

Scenario 2: Medical-Only VPB

- Medical outcomes targets only
- No BH program

Scenario 3: Integrated Medical / BH VBP

- Rewards tied to BH and medical outcomes
- "Add on" for care coordination for an attributed population with a variety of chronic diseases and mental health co-morbidities
- Base PM/PM rate; "At Risk Threshold" set at 50%:

  - If < 50% of this group meets the specific health parameters, the center owes the plan $250/patient under 50%
  - At 50% - nothing owed but no incentive / reward payment
  - > 50% and the center earns $500 per patient over the 50% threshold

# Capacity Cost Analysis - Staffing

| | Vacation weeks | CME (weeks) | Net FT weeks available per year | Working Days | Working Hours per Day | Daily Availability Adjustment Factor | Minutes available per day | Minutes available per year | Annual Total Comp. |
|---|---|---|---|---|---|---|---|---|---|
| FP Physician | 5 | 3 | 44 | 220 | 7 | 80% | 336 | 73,920 | $ 160,000 |
| Internist | 5 | 2 | 45 | 225 | 7 | 80% | 336 | 75,600 | $ 85,000 |
| Nurse Practitioner | 3 | 1 | 48 | 240 | 7 | 85% | 357 | 85,680 | $ 55,000 |
| Nurse | 2 | 0 | 50 | 250 | 7 | 90% | 378 | 94,500 | $ 65,000 |
| Medical Assistant | 2 | 0 | 50 | 250 | 7 | 90% | 378 | 94,500 | $ 35,000 |
| Psychiatrist | 5 | 3 | 44 | 220 | 7 | 80% | 336 | 73,920 | $ 230,000 |
| Psychologist | 3 | 2 | 47 | 235 | 7 | 85% | 357 | 83,895 | $ 90,000 |
| Therapist | 2 | 1 | 49 | 245 | 7 | 90% | 378 | 92,610 | $ 60,000 |
| LCSW | 2 | 0 | 50 | 250 | 7 | 90% | 378 | 94,500 | $ 50,000 |
| Behaviorist | 2 | 0 | 50 | 250 | 7 | 90% | 378 | 94,500 | $ 50,000 |
| Care Coordinator | 2 | 0 | 50 | 250 | 7 | 90% | 378 | 94,500 | $ 35,000 |
| Case Manager | 2 | 0 | 50 | 250 | 7 | 90% | 378 | 94,500 | $ 35,000 |
| SUD Counselor | 2 | 0 | 50 | 250 | 7 | 85% | 357 | 89,250 | $ 45,000 |

CAPITAL LINK



the DELTA CENTER
for a thriving safety net

# Example: Capacity Cost Analysis – BH Only

| | Avg. time in attendance during visit | Visits per year | Cost per minute | Cost per Visit | Scenario Costing |
|---|---|---|---|---|---|
| FP Physician | 35 | 2,112 | $ 2.16 | $ 75.76 | |
| Internist | 30 | 2,520 | $ 1.12 | $ 33.73 | |
| Nurse Practitioner | 45 | 1,904 | $ 0.64 | $ 28.89 | |
| Nurse | 15 | 6,300 | $ 0.69 | $ 10.32 | |
| Medical Assistant | 35 | 2,700 | $ 0.37 | $ 12.96 | |
| Psychiatrist | 15 | 4,928 | $ 2.98 | $ 44.64 | $ 44.64 |
| Psychologist | 20 | 4,195 | $ 0.92 | $ 18.36 | |
| Therapist | 20 | 4,631 | $ 0.65 | $ 12.96 | $ 12.96 |
| LCSW | 20 | 4,725 | $ 0.53 | $ 10.58 | |
| Behaviorist | 30 | 3,150 | $ 0.53 | $ 15.87 | |
| Care Coordinator | 15 | 6,300 | $ 0.37 | $ 5.56 | $ 5.56 |
| Case Manager | 30 | 3,150 | $ 0.37 | $ 11.11 | $ 11.11 |
| SUD Counselor | 15 | 5,950 | $ 0.50 | $ 7.56 | $ 7.56 |
| Total | | | | | $ 81.83 |

# Example: Capacity Cost Analysis - Integrated

| | Avg. time in attendance during visit | Visits per year | Cost per minute | Cost per Visit | Scenario Costing |
|---|---|---|---|---|---|
| FP Physician | 35 | 2,112 | $ 2.16 | $ 75.76 | $ 75.76 |
| Internist | 30 | 2,520 | $ 1.12 | $ 33.73 | |
| Nurse Practitioner | 45 | 1,904 | $ 0.64 | $ 28.89 | |
| Nurse | 15 | 6,300 | $ 0.69 | $ 10.32 | $ 10.32 |
| Medical Assistant | 35 | 2,700 | $ 0.37 | $ 12.96 | $ 12.96 |
| Psychiatrist | 15 | 4,928 | $ 2.98 | $ 44.64 | $ 44.64 |
| Psychologist | 20 | 4,195 | $ 0.92 | $ 18.36 | |
| Therapist | 20 | 4,631 | $ 0.65 | $ 12.96 | $ 12.96 |
| LCSW | 20 | 4,725 | $ 0.53 | $ 10.58 | |
| Behaviorist | 30 | 3,150 | $ 0.53 | $ 15.87 | |
| Care Coordinator | 15 | 6,300 | $ 0.37 | $ 5.56 | $ 5.56 |
| Case Manager | 30 | 3,150 | $ 0.37 | $ 11.11 | $ 11.11 |
| SUD Counselor | 15 | 5,950 | $ 0.50 | $ 7.56 | $ 7.56 |
| Total | | | | | $ 180.87 |

CAPITAL LINK



the DELTA CENTER
for a thriving safety net

# Example: Capacity Cost Analysis - Integrated

| Scenario assumes: | 50% PFP | 50% PFP | 85% PFP |
|---|---|---|---|
| **Patient Visits** | **BH only** | **Med only** | **Integrated** |
| Total Visits | 8,700 | 8,700 | 17,400 |
| Total Patients | 5,742 | 5,742 | 5,742 |
| | | | |
| **Revenue and Expenses** | | | |
| **Operating Revenue** | | | |
| Patient Service Revenue - BH | $ 577,200 | | |
| Patient Revenue - Medical | | 1,305,000 | |
| Net Patient Service Revenue | $ 577,200 | $ 1,305,000 | 1,882,200 |
| Grant and Contract Revenue | $ 5,000 | 10,000 | 15,000 |
| Other Revenue | - | | - |
| Pharmacy Revenue | | | |
| **Total Operating Revenue** | $ 582,200 | $ 1,315,000 | $ 1,897,200 |
| **Revenue Per Visit** | $ 67 | $ 151 | $ 109 |

CAPITAL LINK



the DELTA CENTER
for a thriving safety net

# Example: Capacity Cost Analysis - Integrated

| Operating Expenses | BH only | Med only | Integrated |
|---|---|---|---|
| Salaries | $ 603,330 | 970,239 | 1,573,569 |
| Fringe Benefits | 108,599 | 174,643 | 283,242 |
| **Personnel Costs per Visit** | **$ 81.83** | **$ 131.60** | **$ 106.71** |
| Supplies | 5,700 | 69,600 | 75,300 |
| Sub-Contracts - Patient Service | 55,000 | 75,000 | 130,000 |
| Other Purchased Services | 8,400 | 13,000 | 21,400 |
| Travel and Training | 10,250 | 15,000 | 25,250 |
| **Direct Support Costs per Visit** | **$ 9.12** | **$ 19.84** | **$ 14.48** |
| **Total Operating Expenses** | $ 791,279 | $ 1,317,482 | $ 2,108,761 |
| **Subtotal Before Allocations** | $ (209,079) | $ (2,482) | $ (211,561) |
| **Allocated Administrative Overhead** | $ 212,945 | $ 212,945 | $ 425,890 |
| **Overhead Costs per Visit** | **$ 24.48** | **$ 24.48** | **$ 24.48** |
| **Total Expenses Per Visit** | $ 115 | $ 176 | $ 146 |
| **Net Surplus/(Deficit)** | $ (422,024) | $ (215,427) | $ (637,451) |
| **Net Surplus/(Deficit) Per Visit** | $ (49) | $ (25) | $ (37) |
| **Shared Saving Payment** | **$ -** | **$ -** | **$ 1,004,850** |
| **Total Surplus/(Deficit)** | **$ (422,024)** | **$ (215,427)** | **$ 367,399** |

CAPITAL LINK



the DELTA CENTER
for a thriving safety net

# Empirical data: Impact of CHW's

Integration of CHWs into the iCMP (Integrated Care Management Program) is yielding positive results, both when the CHW functions as the lead and as part of the care team. When comparing the difference in six months post-program outcomes to six months pre-program outcomes:

When the CHW functions as a lead, results include a:

$664 larger PMPM reduction in total medical expense and an 11 percent larger reduction in ED visits compared to the control group.

When the CHW functions as a part of the care team, results include a:

$635 larger PMPM increase in total medical expense. However, patients with a CHW team member had a 28 percent larger reduction in ED visits, and an 11 percent larger decrease in office no-show rates compared to the control group.

**Integration of Community Health Workers Improves Care Management Effectiveness**
Health Catalyst December 4, 2018

# 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.

- 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 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 with high variation and those that can be improved by evidence based practices.

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

# Not all Negotiations are External

Costing at the patient or activity-based level can make your clinical 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. Clinical teams need to value the goal of improved "efficiency" as much as finance does or nothing will change.

And clinical 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.

# The Latest From CMS

## Medicare "Primary Care First"

Primary Care First is a set of voluntary five-year payment options that reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.
PCF is based on the underlying principles of the existing CPC+ model design:

- prioritizing the doctor-patient relationship;
- enhancing care for patients with complex chronic needs and high need,
- seriously ill patients,
- reducing administrative burden, and
- focusing financial rewards on improved health outcomes.

# CMS – Medicare Primary Care First

## In Primary Care First:

Measures include:

- a patient experience of care survey,
- controlling high blood pressure,
- diabetes hemoglobin A1c poor control,
- colorectal cancer screening, and
- advance care planning.

# CMS – Medicare Primary Care First

A population-based payment to provide more flexibility in the provision of patient care along with a flat primary care visit fee;

and

a performance based adjustment providing an upside of up to 50% of revenue as well as a small downside (10% of revenue) incentive to reduce costs and improve quality, assessed and paid quarterly.

# Recommendations for Negotiating with Payers

- **Measures –** Can you help the MCO with access and quality metrics? It is extremely helpful to have supporting data.
- **Integration** --. Service integration 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 health care.

# 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


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

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

# Funding Statement

*Support for this webinar was provided by the Robert Wood Johnson Foundation (RWJF). The views expressed here do not necessarily reflect the views of the 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