Understanding Your Costs in an Evolving Payment Environment

Session 3: Focus on Behavioral Health: Cost Allocation Methodology for Value-Based Payment Systems

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What We Have Discussed So Far…

- **Session 1:** Cost Allocation: Getting the Basics Right
- **Session 2:** Preparing Internal Systems for Gathering Cost Data

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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 improved healthcare outcomes while total 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.

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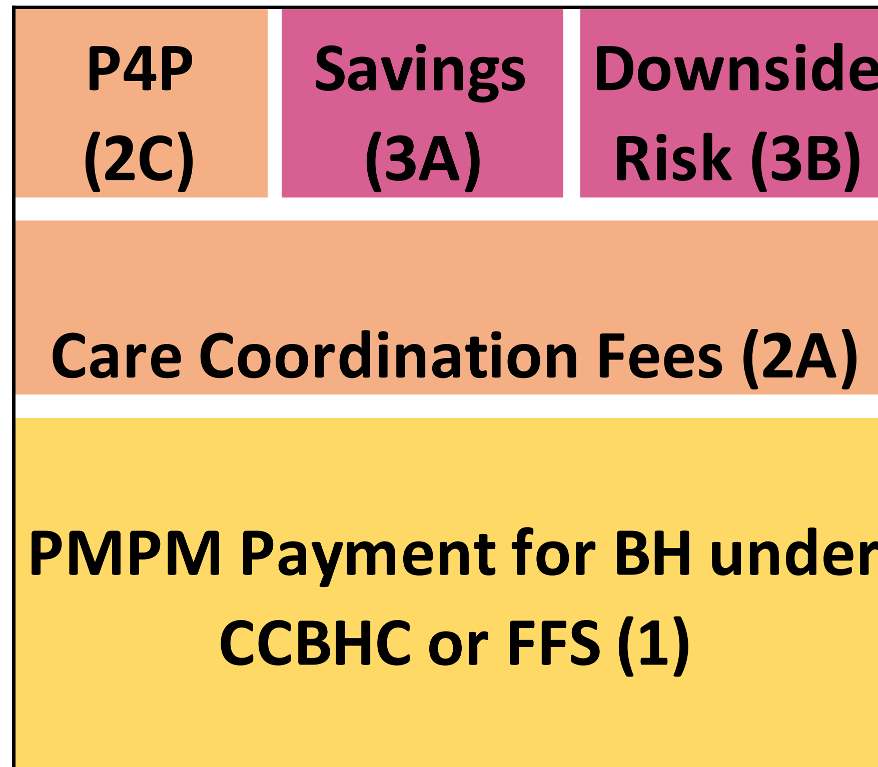
Payment Reform – Multi-Layered



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The Multi-Layered Model, unpublished paper, JSI

Session 3: Cost Allocation Methodology for Value-Based Payment Systems

Compared to a FFS reimbursement system, several new wrinkles are introduced here:

1. **What is a Value-based Payment System?**
   - The definition may depend on your perspective ($ cost or outcomes or both?)
2. **How do we achieve those outcomes?**
   - Stand-alone or integrated with primary care (bi-directional)
   - Develop Care Pathways
3. **How do we account for the costs of achieving those outcomes?**
   - Time Driven Activity-Based Costing

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What is a Value-Based Payment System?

Here's where it starts to get complicated…

A definition of "Value" in behavioral healthcare must be agreed upon and often it depends on where you sit in the chain of service:

"Value is defined in terms of the value equation health outcomes achieved per unit cost expended over the entire care delivery value chain."

Time-driven activity-based costing in health care: A systematic review of the literature George Keel, Health Policy; April 29, 2017

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So How Do We Define Outcomes?

Outcomes should align with the goals of treatment and be measurable.

Hopefully what the client wants as an outcome is at least close to what the provider thinks they can achieve.

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Where do Outcomes Fit in a Value-Based Payment System?

Since value depends on results, not inputs, value in behavioral health care should be measured by the **outcomes** achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge.

Adapted from "What is Value in Health Care" – Porter, NEJM; Dec 2010

Cost, the equation's denominator, refers to the total costs accrued by the CMHC to achieve the desired outcomes, not the cost of individual services.

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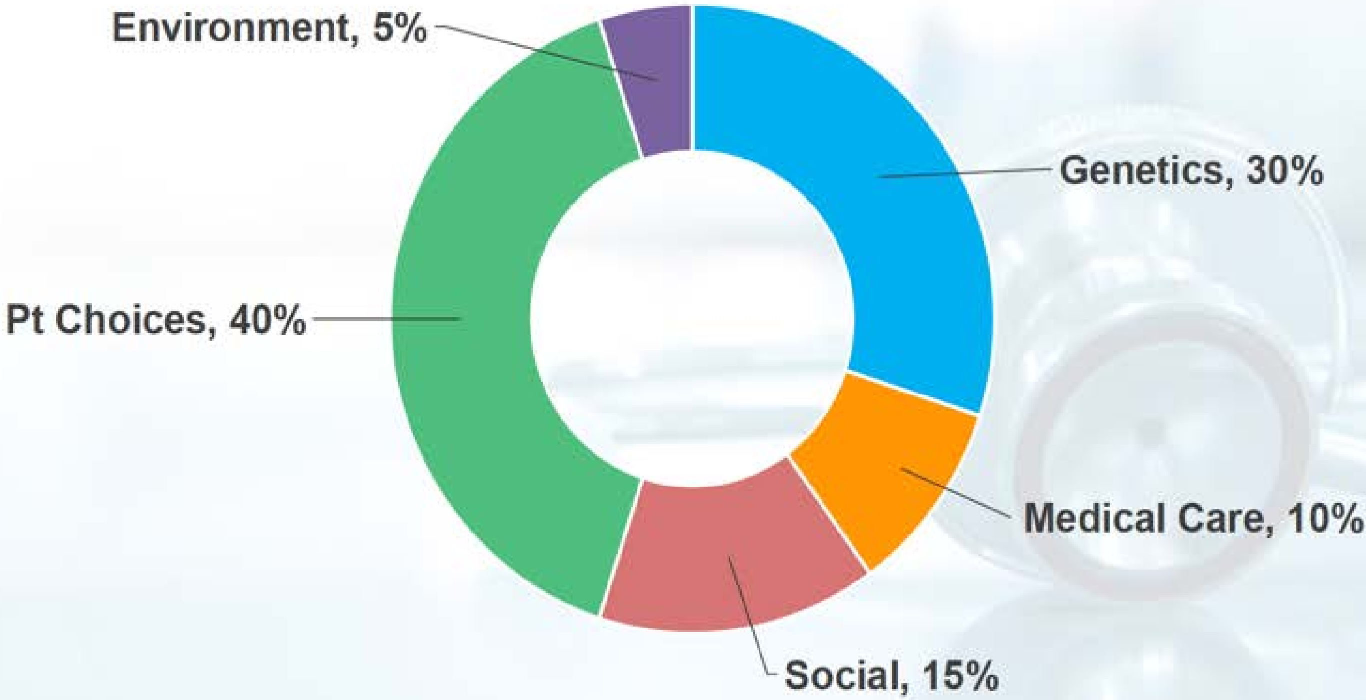
Achieving Outcomes - What Determines Health



Social Determinants of Health: Tools to Leverage Today's Data Imperative

Health Catalyst Editors January 4, 2019

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But you know the old saying…

"You can't manage what you can't measure" and in the quest to get adequately paid for behavioral health interventions, that may be the key issue….

..There are gaps in the evidence base to support mental health quality measurement outcomes that are most meaningful to:

- consumers
- specific populations, such as children
- experienced in populations, such as anxiety disorders

and even for evidence-based psychotherapies, quality measures may not fully capture whether they were delivered adequately (fidelity issues)

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World Psychiatry. 2018 Feb; **Measuring and improving the quality of mental health care: a global perspective**

Example of Measures - CCBHC

1. Follow-up After Hospitalization for Mental Illness (adults)
2. Follow-up After Hospitalization for Mental Illness (child/adol.)
3. Adherence to Antipsychotics for Individuals with Schizophrenia
4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
5. Adult Major Depressive Disorder: Suicide Risk Assessment
6. Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
7. Follow-up Care for Children Prescribed ADHD Medication
8. Screening for Clinical Depression and Follow-up Plan
9. Antidepressant Medication Management
10. Plan All-cause Readmission Rate
11. Depression Remission at 12 Months-Adults

Red font indicates HEDIS measures

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Client Reported Outcomes

- Research has shown that clients' and providers' perceptions of outcomes differ, and taking into consideration what are known as client-reported outcomes—essentially client's views of their health status—can lead to more effective interventions.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports exist for medical interactions but Behavioral Health-focused survey questions are still in development.

With survey standardization, client surveys may be integrated into the payment system

Adapted from United Hospital Fund, NY https://uhfnyc.org/initiatives/PROPC-NY/

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Beyond Useful Measures: Common Data

- Mental health providers often use separate electronic health record systems from their general medical provider counterparts, or do not have access to these systems at all.
- Behavioral health and primary care differ in their clinical language, classifications, codes, data reporting requirements and regulations.
- But the primary differences between every practice's EHR requirements rest in the type of data they use.

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Grouping Patients to Simplify Costing

For behavioral health care, value should be measured for defined client/patient groups with similar needs, such as:

- Assertive Community Treatment
- First Episode Psychosis

Primary Care – Behavioral Health Bi-directional Integration

Creating a close collaboration between specialist mental health services and primary physical health services. Care for **depression** (for instance), must integrate:

- **case management which has support/input from both a senior mental health professional and a PCP;**
- **patient education;**
- **psychological and pharmacological interventions/medication management; and**
- **long-term coordination of care and follow-up**

Value (both outcomes and cost) should be measured for all this care, rather than for a single specialist or intervention.

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Utilizing Care Pathways

A Care Pathway is a protocol based/standardized set of clinical & administrative work flow process steps that staff engage in to assist a consumer with a social determinant, behavioral and/or physical health need.

A care pathway operationalizes care management components into replicable, measurable work flow steps, including:

- Consumer engagement
- Screening, assessment & stepped evidence-based treatment with clearly defined treat-to-target parameters
- Interdisciplinary team-based care which employs population health management techniques
- Ongoing quality improvement to assess effectiveness & efficiency of the pathway

A Path to Value: Strategies for Developing Care Pathways; Care Transitions Network Dec. 2018. The National Council

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Care Pathway Example

Care Pathway

Screening & Assessment	Level of Engagement	Level of Service Criteria/Cost	Service Bundle	Length of Care/ Time to Tx	Target Parameters
Adult Male, 25yrs old Substance Addicted (nicotine) Depressed High Blood Pressure Unemployed Homeless	Maintenance/ Relapse Prevention	Low Intensity/$	Medication Cog. Beh. Therapy Smoking Cessation Care Management Supported Employment Assistance Housing Assistance	Low Intensity 0-9 Months	Smoking Cessation or Reduction BP w/in Normal Range PHQ-9 Score <10 Appt's Kept No Hosp. & ED Use Employment Housing Satisfaction
	Action	Moderate Intensity/$$		Moderate Intensity 9-18 Months	
	Preparation				
	Precontemplation & Contemplation	High Intensity/$$$		High Intensity 18 -28 Months	

From: National Council presentation: Jeff Capobianco, PhD, Senior Consultant: A Path to Value: Strategies for Developing Care Pathways December 13, 2018

Principles of Measuring the Cost of Care

1. Cost is the **actual expenses for client care**, not the **charges** billed or collected.
2. Optimally, cost would be measured around the **client.**
3. Cost should be aggregated over the **full cycle of care for the client's condition leading to desired outcomes,** not for departments, services, or line items.
4. 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

Measure Outcomes & Cost for Every Patient Institute For Strategy & Competitiveness, Harvard University

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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 care pathways for groups of clients with similar needs
4. Identify unique costs of more intensive services

Seven Steps to Creating a Costing System

- **Step 1.** **Select the clinical condition.** Typically chronic conditions that are best addressed in a coordinated way and should be broadly defined to include common complications and both mental health and physical comorbidities.
- **Step 2.** **Define the care delivery value chain (Clinical Pathway).** This step involves charting the activities that occur and their locations over the entire cycle of care, and helps identify required measures and ways to inform and engage clients and achieve outcomes.
- **Step 3** **Develop process maps for each activity in client care delivery** include all relevant resources required for each process step.

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Seven Steps to Estimate Total Costs

(Optional - For the High Achievers)

- **Step 4. Obtain time estimates for each process**
  - Standard times estimated by experts could be used for common, short, and inexpensive activities
  - Actual times should be measured for integrated care interventions, where observations would be the preferred approach

Seven Steps to Estimate Total Costs

•Step 5. **Estimate the cost of supplying client care resources**

Flashback!

(To Session 1 in this webinar series)

Components of Cost Per Visit or client

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

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

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Seven Steps to Estimate Total Costs

- **Step 6. Estimate the capacity of each resource and calculate the capacity cost rate**

Obtain the practical capacity for all primary resources – the annual or monthly time available for client-related work. Calculate the Capacity Cost Rate (CCR) as the cost of a resource divided by its practical capacity over a given time period. The most common procedure is to group resources into resource pools and develop CCRs for each pool.

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Seven Steps to Estimate Total Costs

- **Step 7. Calculate the total cost of client care**

Sum the cost of each activity to obtain the cost of a process (or alternatively, multiply the CCR of each resource by its duration of use in each activity). The cost of each process is summed to generate the cost of a complete cycle of care for clients with the given condition.

Costing Care of BH Client with Chronic Diabetes

Assume a future where your CMHC is negotiating to be under a shared-risk Value-Based Reimbursement Plan

A payer has identified a group of your BH clients with chronic Type 2 diabetes. This example shows three scenarios:

1. FFS – medical care only (for base case analysis)
2. You are paid on a PMPM basis +a grant for Care Coordination and working with an internal or external Primary Care Provider (PCP).
3. You are participating with this PCP in a VBP and given a set of measurable clinical targets. Under this plan you are paid a base PM/PM rate, and the “At Risk Threshold” is set at 50%, meaning:

- If less than 50% of this group meets the specific health parameters, you owe the plan $250/patient under 50%
- At 50% - nothing owed but no incentive / reward payment
- Over 50% and your center earns $1,000 per patient over the 50% threshold

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Example – Costing Care of BH Client with Chronic Diabetes

	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	3	44	220	7	80%	336	73,920	$ 185,000
Nurse Practitioner	3	2	47	235	7	80%	336	78,960	$ 95,000
Nurse	2	1	49	245	7	90%	378	92,610	$ 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	$ 220,000
Psychologist	3	2	47	235	7	80%	336	78,960	$ 77,000
Therapist/BHC	2	2	48	240	7	80%	336	80,640	$ 65,000
SUD Counselor	2	1	49	245	7	80%	336	82,320	$ 50,000
Case Manager	2	1	49	245	7	90%	378	92,610	$ 50,000
Care Coordinator	2	0	50	250	7	90%	378	94,500	$ 35,000

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Example – Costing Care of Client with MI and Chronic Diabetes

	Avg. time in attendance during visit	Visits per year	Cost per minute	Cost per Visit	FFS no BH	PMPM w/BH	PMPM + VBP
FP Physician	20	3,696	$ 2.16	$ 43.29	$ 43.29	$ 43.29	$ 43.29
Internist	20	3,696	$ 2.50	$ 50.05			
Nurse Practitioner	30	2,632	$ 1.20	$ 36.09			
Nurse	10	9,261	$ 0.70	$ 7.02	$ 7.02	$ 7.02	$ 7.02
Medical Assistant	15	6,300	$ 0.37	$ 5.56	$ 5.56	$ 5.56	$ 5.56
Psychiatrist	15	4,928	$ 2.98	$ 44.64		$ 44.64	44.64
Psychologist	30	2,632	$ 0.98	$ 29.26			
Therapist/BHC	20	4,032	$ 0.81	$ 16.12		$ 16.12	16.12
SUD Counselor	40	2,058	$ 0.61	$ 24.30			
Case Manager	40	2,315	$ 0.54	$ 21.60			
Care Coordinator	30	3,150	$ 0.37	$ 11.11		11.11	11.11
Total					$ 55.86	$ 127.74	$ 127.74

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Example – Costing Care of Client with MI and Chronic Diabetes

Income Statement Comparison

Total Visits - Medical	4,000
Total Visits - Behavioral Health	10,000
Total Unique Clients/Patients	1,000

Revenue	**FFS/Visit**	**FFS Visits per YR.**	**FFS Revenue**	**PMPM**	**PMPM Visits**		**PMPM + VBP**	**PMPM + VBP Visits**	**PMPM + VBP Revenue**
Medical	$ 100.00	4.0	$ 400.00	$ 36.00		$ 432.00	$ 36.00		$ 432.00
Behavioral Health			$ -	$ 50.00		$ 600.00	$ 50.00		$ 600.00
Care Coordination Grant Support				$100,000 per year					
Total Revenue			$ 400,000			$ 1,132,000			$ 1,132,000
Operating Expenses									
Personnel Costs - Medical			223,457			223,480			223,480
Personnel Costs - BH						718,700			718,700
			223,457			942,180			942,180
Overhead			$ 150,000			$ 200,000			$ 200,000
Total Operating Expenses			$ 373,457			$ 1,142,180			$ 1,142,180
Net Operating Profit			$ 26,543			$ (10,180)			$ (10,180)
Value-Based Payment			$ -			$ -		30%	$ (50,000)
% of Patients meeting Outcome Expectations =								50%	$ -
Third Party Patient Costs								70%	$ 200,000
($5000 * % of patients)		15%	**$ 750,000**		10.0%	**$ 500,000**		2.0%	**$ 100,000**

Session 4: Utilizing Cost Data to Drive Programmatic Change

As the final webinar of this four-part series, we will review the key take-aways from the first three presentations and apply these concepts to several scenarios in which behavioral health providers are seeking to understand their costs in an evolving reimbursement environment.

We will focus on how to model costs related to these scenarios and emphasize the use of this information for decision-making and guiding programmatic change.

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Thank you

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

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