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CCBHC Financial Management and Sustainability Learning and Action Series, Session 4:

Capturing CCBHC Services/Visits

Wednesday, July 12th, 2023

2:30-4:00 pm E.T.

CCBHC-E National Training and Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Acknowledgements and Disclaimer

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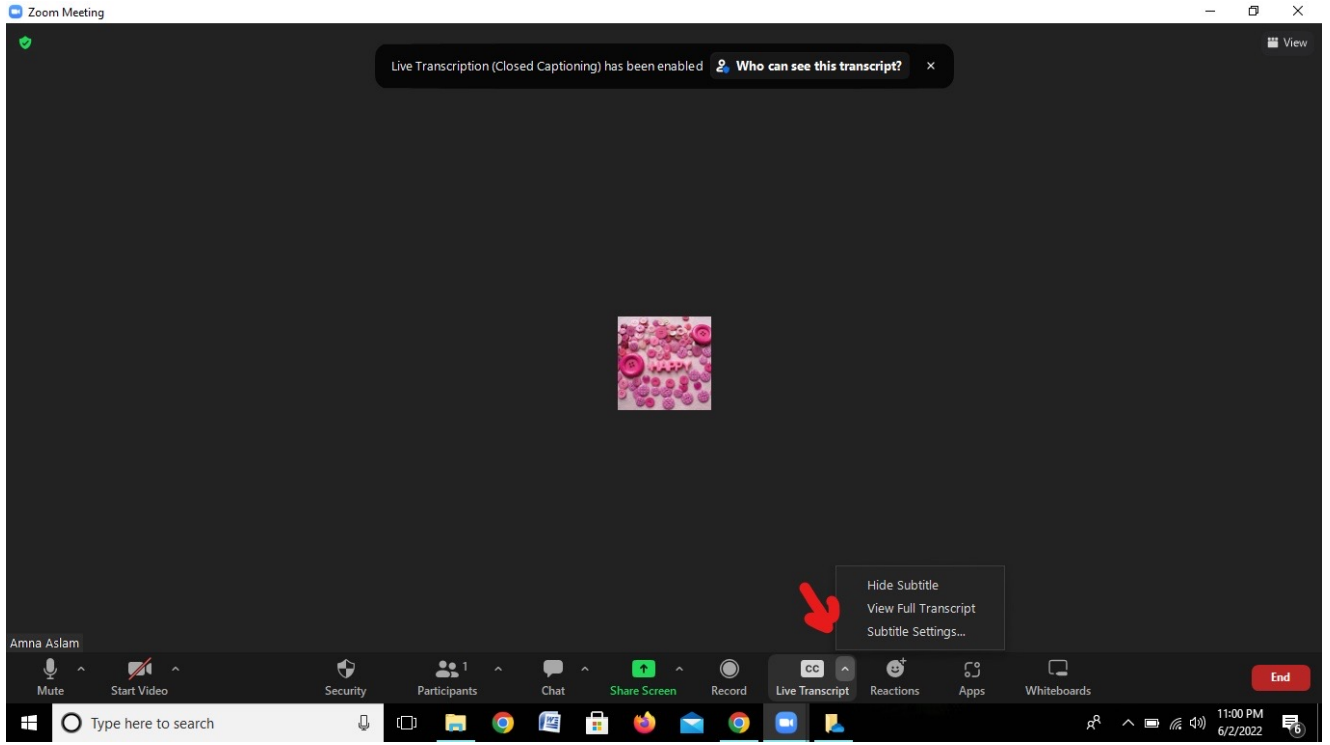

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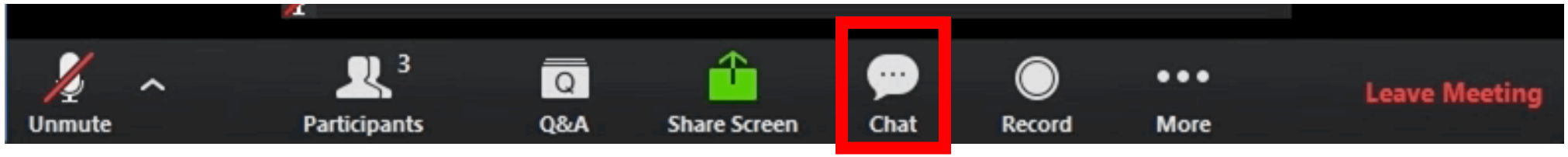
How to Ask a Question



Please share questions throughout today's session using the **Chat Box** on your Zoom toolbar.
We'll answer as many questions as we can throughout today's session.

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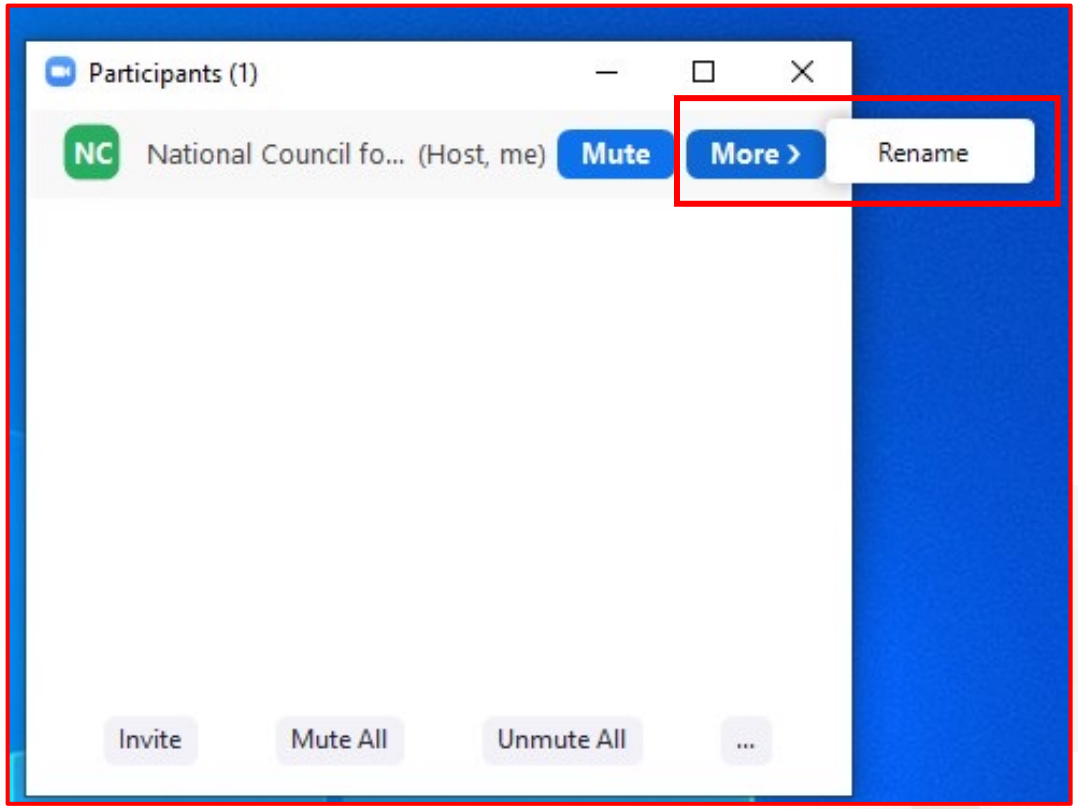
Name and Organization

- **Please join by video** if you are able!
- **Please rename yourself so your name includes your organization.**
  - *For example:*
    - Ritu Dhar, National Council
  - *To rename yourself:*
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
    - Click **Rename**
- If you are having any issues, please send a Zoom chat message to **Ritu Dhar, National Council**



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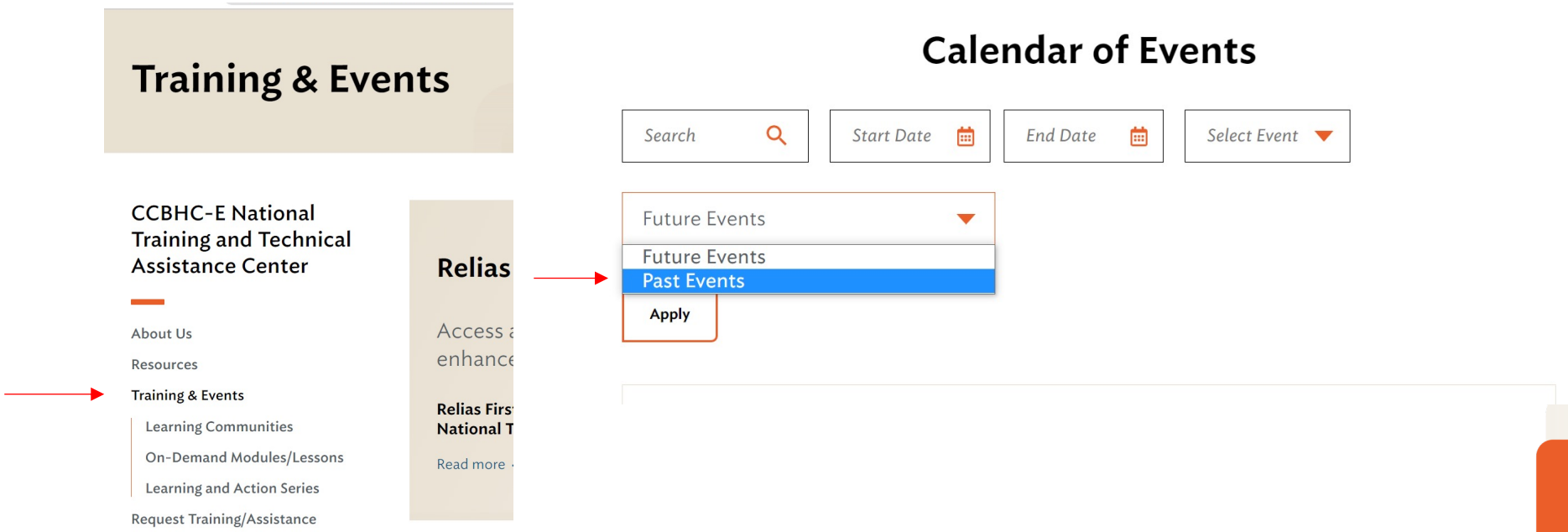
Today's Session: Slides and Recording

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.



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Today's Agenda

- Review of agenda, learning objectives, and presenters
- Discussion – Homework Assignment from Session #3
- Capturing CCBHC Services/Visits
  - Projecting Anticipated Revenue
  - Capturing Activities in the EHR
- Sustainability Revenue Options
  - Revenue Cycle Enhancement
  - CCBHC Medicaid Prospective Payment System (PPS)
  - Value-Based Payment Opportunities
- Financial/EHR System Requirements
- Homework Assignment for next Session
- Questions

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Learning Objectives

- Learn how to project future clients and services that will impact future potential revenue streams
- Understand CCBHC Medicaid Prospective Payment System (PPS) and value-based/alternative payment model rate-setting models and their impact on a Sustainability Plan
- Understand the future demands on billing systems and electronic health records, and evaluate the need to modify/replace existing systems

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Today's Presenters

Peter R. Epp, CPA
Partner,
Community Health – Practice Leader
CohnReznick LLP

Joanne McNamara, JD
Senior Manager,
Healthcare Consulting Services
CohnReznick LLP

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Capturing CCBHC Services/Visits

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Homework Assignment from Session #3

In Session #3, we discussed:

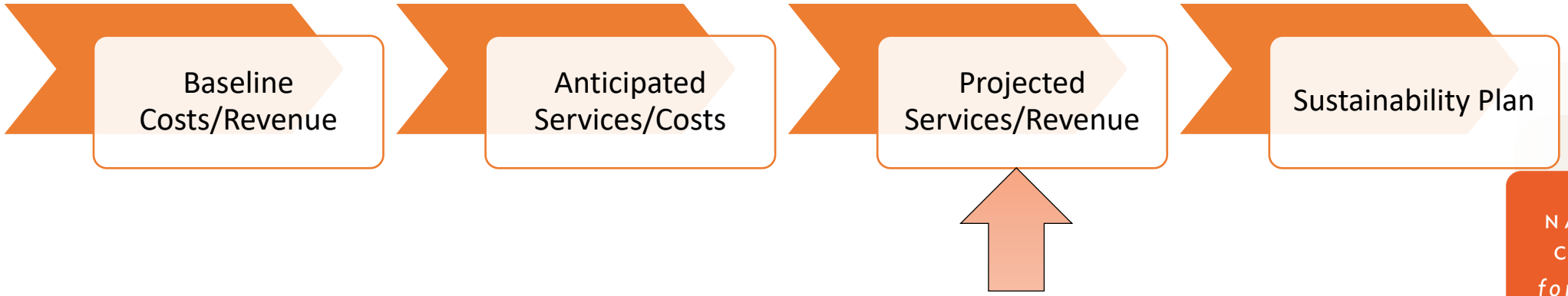
- Budgeting future demand for CCBHC services and its impact on Anticipated Costs and Revenue

Homework from the prior session:

- Have you developed a gap analysis of services that need to be implemented to become CCBHC compliant? Have you attempted to put a cost to these gaps? What difficulties have you experienced?
- In projecting anticipated costs, have you linked it to anticipated services to be provided? If not, what obstacles do you foresee?
- Do your anticipated costs include non-clinical services and infrastructure? Do you have any questions on what types of additional costs should be considered?
- Other concerns?

Review - Elements of a CCBHC Sustainability Plan

- An Executive Summary that describes, in narrative form, the elements of the Business Plan discussed in session #1
- It is recommended that the Sustainability Plan "narrative" be supported by a financial plan/projection covering the CCBHC "Total Budget" concept with the following components:
  - Summary revenue and expense projections
  - Client and services/volume budget



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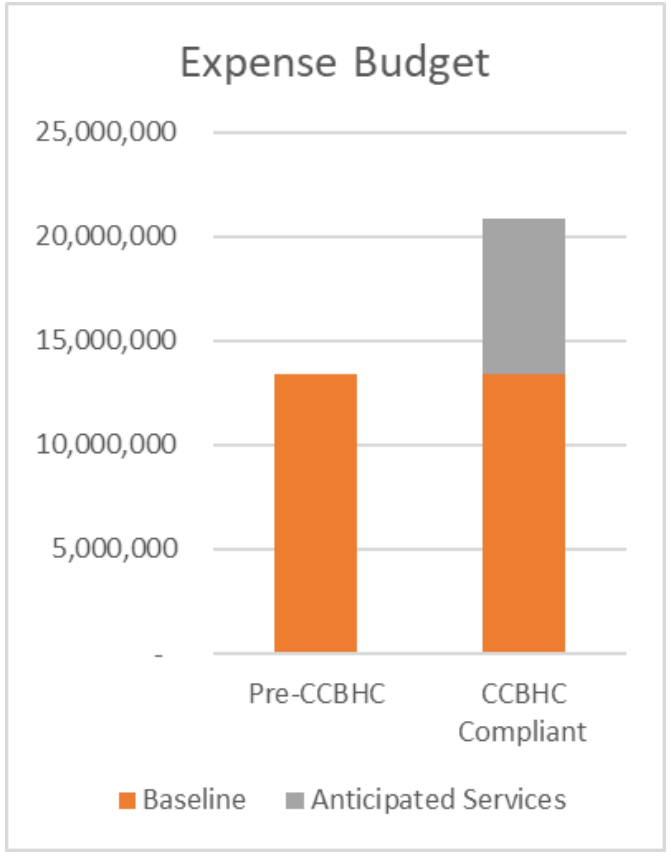
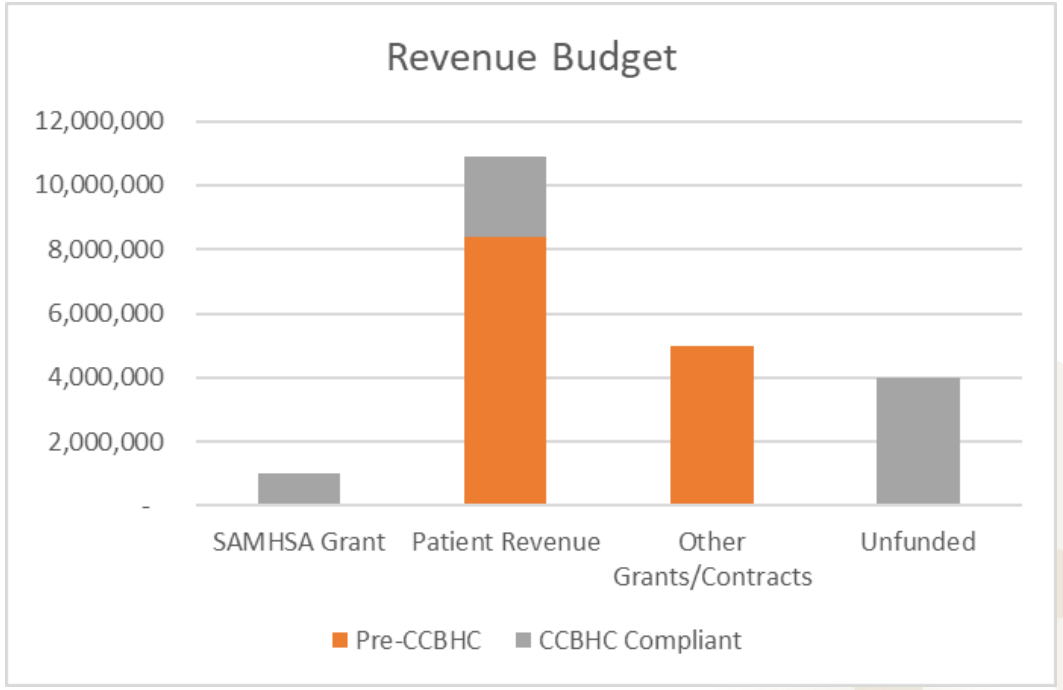
Developing the CCBHC "Total Budget"

Transitioning the current baseline revenue and expense profile to a fully compliant CCBHC under the "Total Budget" concept will create a need to identify alternative revenue streams to sustain the CCBHC program





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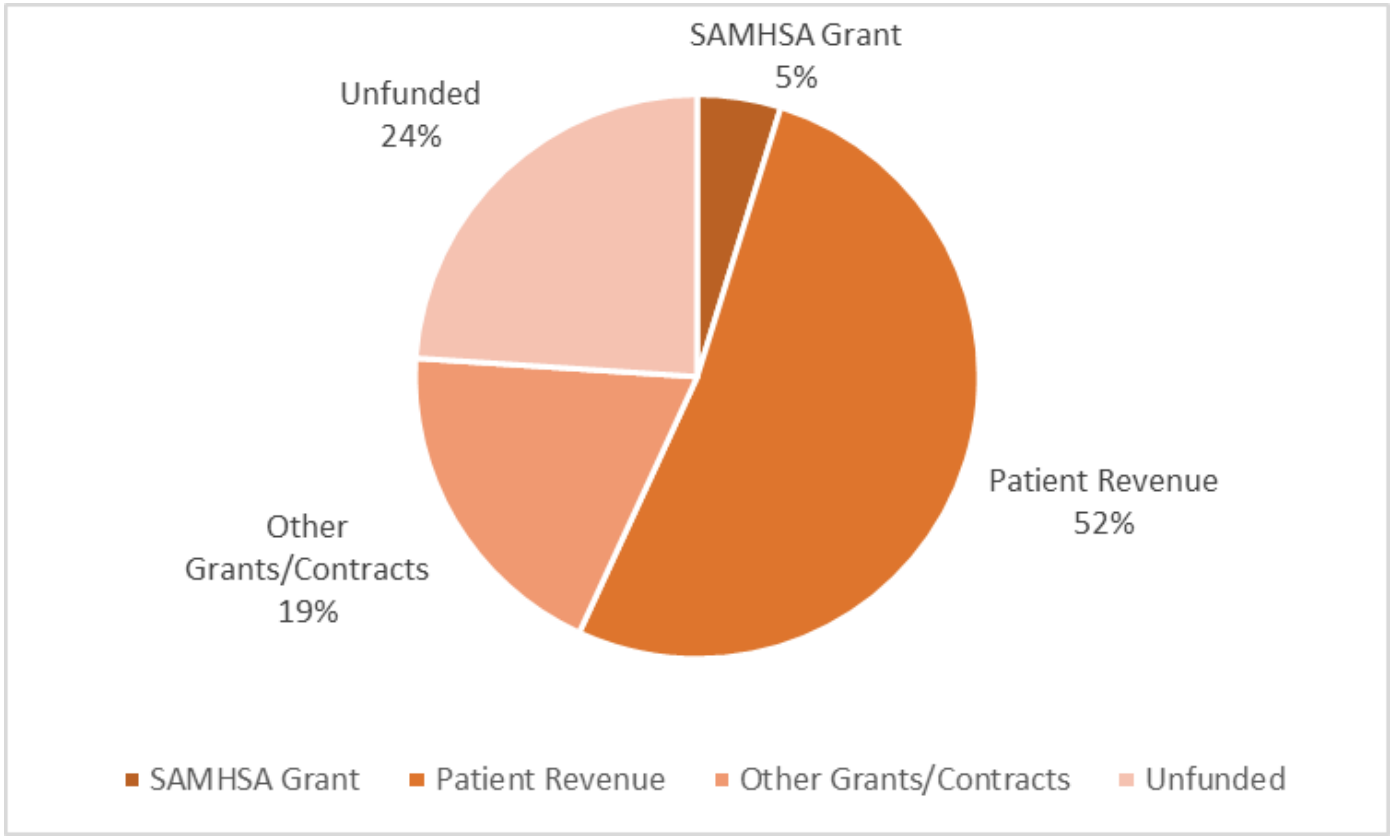
“Slicing-Up” The CCBHC Funding Pie

Revenue Budget – Identifying Current Funding Streams for the CCBHC Program (Example)



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Projecting Revenue in the CCBHC "Total Budget"

- CCBHCs generally cover the costs of the CCBHC program through various revenue streams
  - Federal/state/local grants and contracts
  - Patient revenue (e.g., Medicaid, Medicare, commercial insurance, self-pay)
  - Other
- Projecting revenue for each revenue stream have different drivers
  - Grant and contracts – usually driven by past funding experiences and future, known funding opportunities
  - Patient revenue – based on 2 factors
    - Projected clients and services/visits
    - Services/visits split by payer and payer specific payment rates

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Anticipated/Budgeted Services & Revenue

- Anticipated activities may also generate anticipated revenue received to support the expanded CCBHC operations that are billable under today's payment models
- Projected services that were utilized to calculate anticipated costs for new service providers will form the basis for projecting anticipated revenue
    - Anticipated revenue may also incorporate new grant funding opportunities
- Projecting anticipated patient services revenue requires the following information:
    - Number of anticipated services (units of service)
    - Payer mix of services
    - Payment rates
- Payment rates may differ based on the unit of service included in the payment model
    - Fee-for-service revenue = # of service units × payment rate per service
    - Capitation revenue = # of clients/members served per month × payment rate PMPM

Projecting Revenue in the CCBHC "Total Budget"

Projecting Patient Revenue (Example):

1st Project services/visits based on projected clients (see Session #3)

Projected # of Clients	10,000
Average # of Services per Client per Year	8
Projected # of Services	80,000

2nd Project patient revenue based on the payer mix of visits and payer specific payment rates

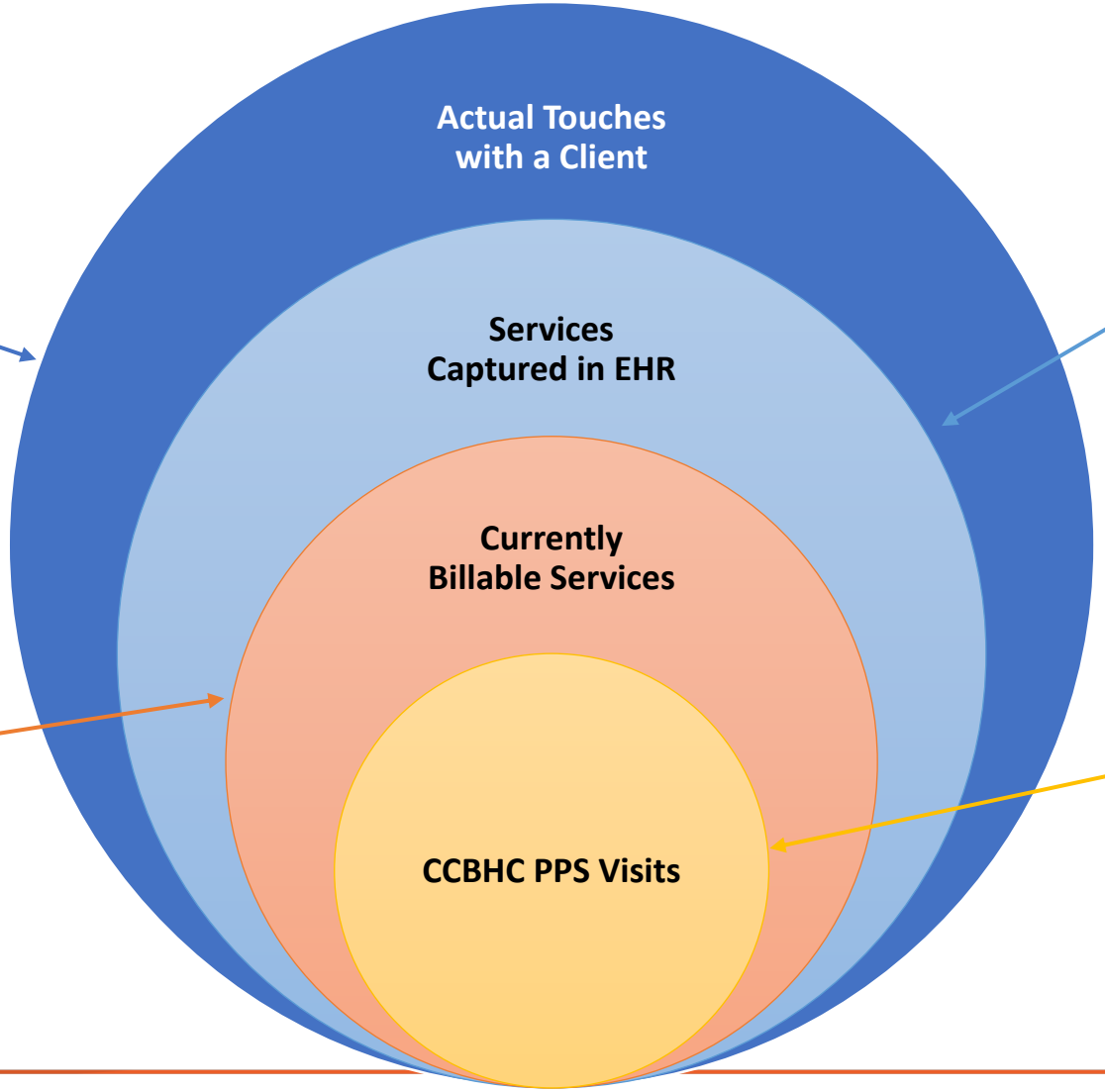
	Services/Visits	Payer %	Average Pymt. Rates	Revenue
Medicaid	64,000	80%	$150	$ 9,600,000
Other Third Parties	8,000	10%	$75	$ 600,000
Self-pay	8,000	10%	$50	$ 400,000
Total Patient Revenue	80,000	100%	$133	$ 10,600,000

Capturing Activities in the EHR

- Projecting patient revenue differs by payer based on units of service in the payment model
- EHR/Billing systems generally capture units of service required today to bill for services under existing contracts
    - Service hours – payment based on a multiple of 15-minute service increments
    - Per diem – a fixed rate for a specific period of time per client, billed on a per episode basis, not necessarily correlated to the number of services provided
        - Often per diem payment models require the submission of “shadow bills” – claims submitted for reporting purposes, not necessarily payment
    - Per client per month – a fixed payment per month when a client accesses “covered services”, regardless of the number of services provided in a given month
    - CCBHC PPS visit – payment on a daily or monthly visit basis, regardless of the number of services provided

Capturing Activities in the EHR for VBC

All meaningful touches with clients to support a VBP value proposition



Services entered in the EHR but in non-reportable fields

Current State: Capture and report services billable service units

Ability to report on current service level data consistent with CCBHC PPS definitions

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Sustaining the CCBHC Service Delivery Model

Sustaining the CCBHC service delivery model (or plugging the “unfunded” hole) can be accomplished through a combination of available alternatives:

- Improve the efficiency of the current revenue cycle
- New Base Compensation Models
  - Case Rates
  - Partial Capitation
  - Prospective Payment System (PPS)
- Care Management/Care Coordination fees
- Value Based Payment (VBP)/Value Based Care (VBC) and APMs
- Other program designations (e.g., Federally Qualified Health Center (FQHC))
- Partnerships with other community-based providers

Healthcare Revenue Cycle Efficiency

FRONT

Scheduling
Pre-Registration
Eligibility
Benefit Coverage
Estimates

MIDDLE

Registration
Documentation
Charge Capture
Coding
Pricing/Contracts
Claim Edit Review/Submission

BACK

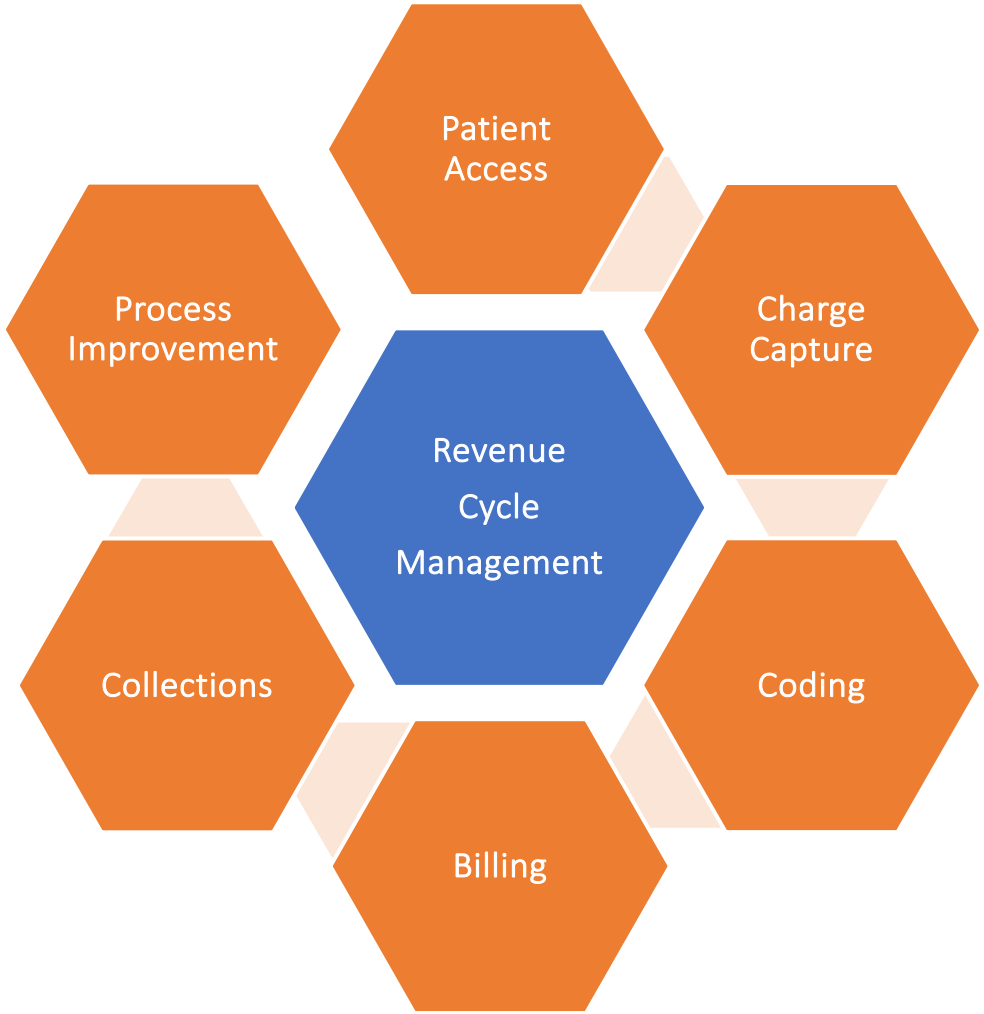
Bill Edit Review
Insurance Follow-up
Denials Review
Payment Posting
Patient Collection
Internal/External Audit

Key Operational Functions and Areas of Focus

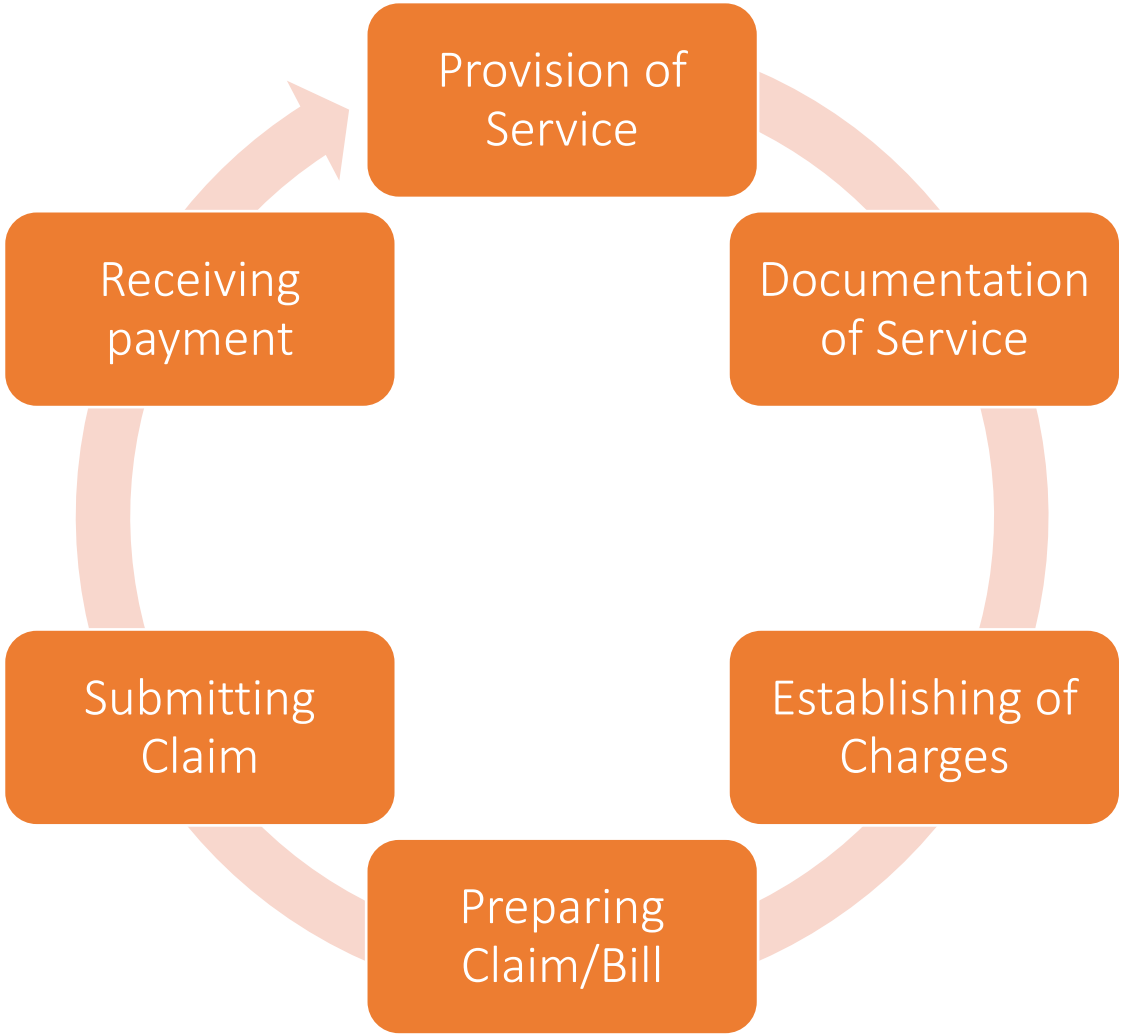
Healthcare Revenue Cycle Efficiency

- Sustaining positive revenue cycle performance requires an in-depth understanding of the front, middle and end operational functions.
- Moving toward sustainable success requires:
  - **Revenue integrity structured focused group/team** - Forming a separate revenue integrity department or group to serve as a hub for the overall revenue cycle department can help bring together disparate resources and standardize processes.
  - **Tangible, measurable performance indicators** - Standardized measurements and processes in place to continually monitor key performance metrics is vital to maintaining revenue cycle performance
  - **Clear and transparent communication** – Communicate revenue cycle performance regularly is essential for sustaining performance.
  - **Tech-enabled solutions to maintain preformation** - Seek technology solutions that automatically monitor, capture, and track performance initiatives so staff members can focus their valuable time and resources on fixing issues and improving performance.

Revenue Cycle Activities



Claim – Life Cycle



Sustaining the CCBHC Service Delivery Model

- When Value-Based Payment began, payers were concerned with moving payment from volume to value
- Patient/consumer advocates were successful in adding individuals being served to the center of the value equation
- The “silver lining” of the COVID pandemic has been a heightened concern with health equity for inclusion in value-based arrangements
- “Value-Based Payment” (VBP) has evolved to “Value-Based Care” (VBC)

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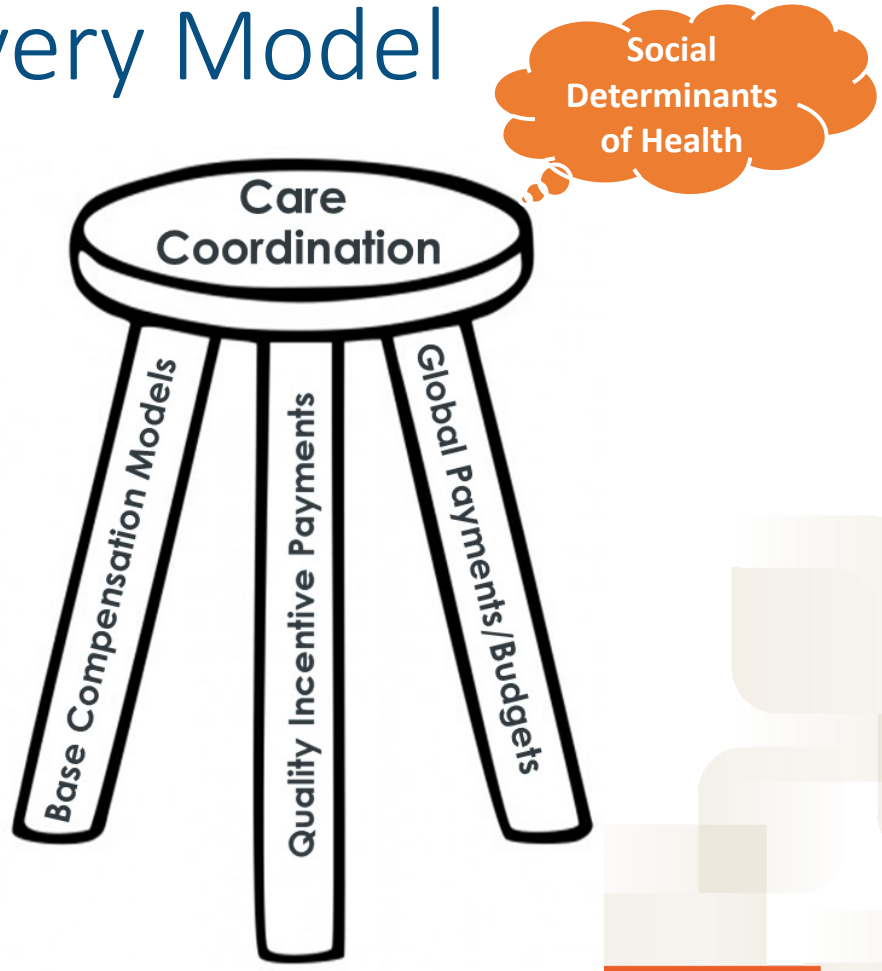
Sustaining the CCBHC Service Delivery Model

- VBP arrangements contain a hybrid of several different payment methodologies to incentivize and tie together desired behaviors
- The key components of VBP arrangements include:
  - Base Compensation Models
    - Fee-for-service
    - Partial capitation/case rates
  - Care Coordination Fee PMPM
  - Quality Incentive Payments
  - Global Payments/Budgets (Total Cost of Care)
    - Surplus-sharing/Risk-sharing
  - Support of Social Determinants of Health



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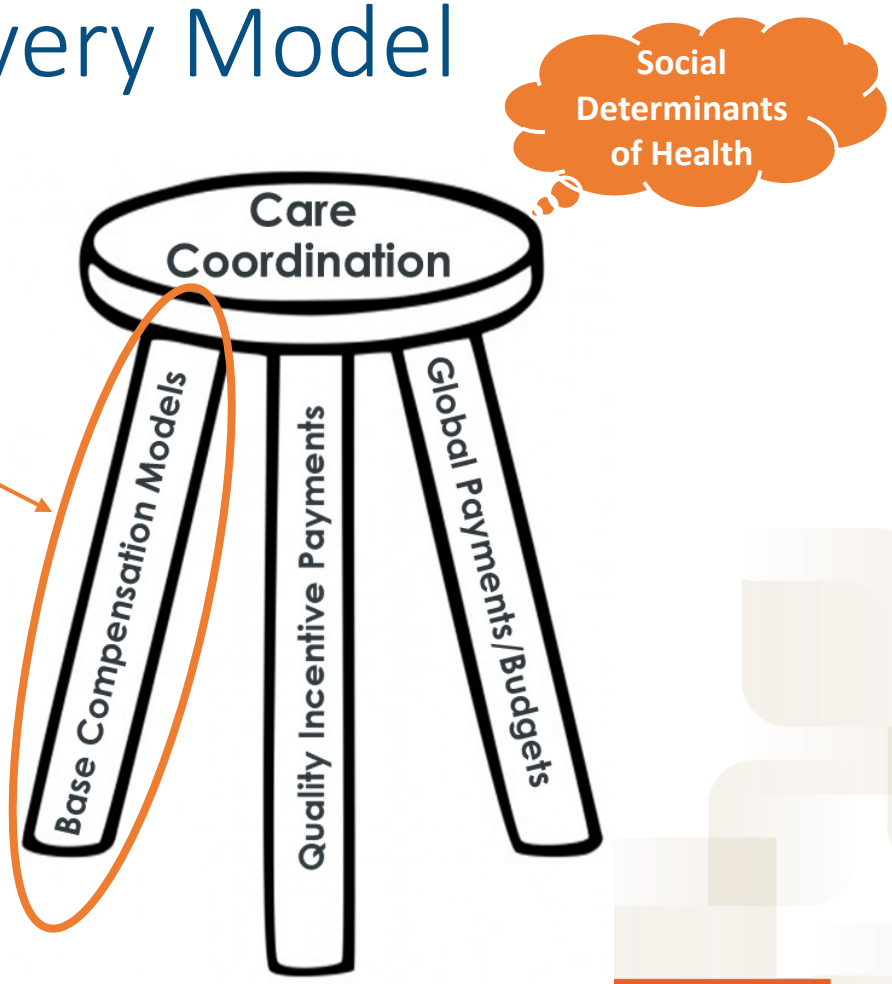
Sustaining the CCBHC Service Delivery Model

- **Base Compensation** acknowledges that providers must still be reimbursed for the provision of services
- Today, payers are developing new payment designs to cover services not covered in traditional payment models (e.g., Alternative Payment Models, or APMs)
  - Case Rates
  - Partial Capitation Arrangements
  - Prospective Payment System (PPS) Methodologies



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Sustaining the CCBHC Service Delivery Model

- Define alternative Base Compensation models
  - **Case Rates** – *a predetermined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a given defined episode of care for an individual over an agreed upon time period.**
  - **Partial Capitation** - a fixed amount of money per patient per unit of time paid in advance to a provider organization for the delivery of covered health care services in the agreement.
    - Capitation payments often very based on the actuarial class of a patient
  - **Prospective Payment System (PPS)** - PPS is a single, bundled rate for each qualifying patient visit for all covered services and supplies provided during the visit; the PPS rate is established using a base year, and trended annually for inflation and future changes in operations.

*Source: "Case Rate Toolkit" – National Council for Mental Wellbeing

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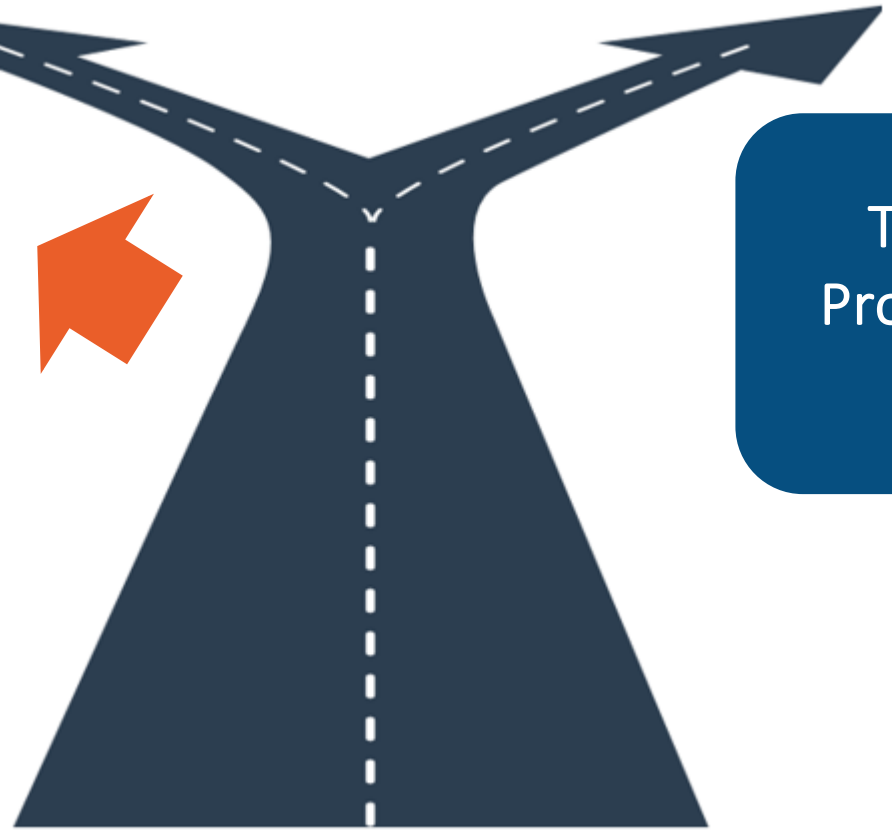
Options for Sustainability

Transitioning CCBHC Program into the PPS Rate Model



Transitioning CCBHC Program to Value-Based Payment Approach

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CCBHC – Conceptual Financing Framework

- **Holy Grail = PPS rate to cover the cost of the CCBHC bundle of services for Medicaid beneficiaries ***
- Understand the CCBHC PPS reimbursement model
- Transitioning to the PPS payment model
  - Develop the costs of the CCBHC "Total Budget"
  - Understand current revenue streams supporting the CCBHC program
  - Consider other revenue opportunities (e.g., Alternative Payment Models)
- Data elements required to successfully transition to the CCBHC PPS payment model

* Note: CCBHC Medicaid PPS reimbursement is only available to states participating in the federal demonstration program or have implemented the payment models through a State Plan Amendment/Waiver

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CCBHCs Operating Under the PPS Reimbursement Model Are…

A Unique Provider Type

Must Provide the CCBHC Core Bundle of Services

Bundled Payment Model Covering the CCBHC Core Services

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CCBHC Rate Options

- CMS offers states the option of using either Certified Clinic Prospective Payment System (CC PPS-1) or CC PPS Alternative (CC PPS-2).
- PPS Methodology will depend on the state's selection
- CMS recently issued proposed guidance on expanding these options

Rate Element	CC PPS-1	CC PPS-2
Base rate	Daily rate	Monthly rate
Payments for services provided to clinic users with certain conditions[1]	NA	Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations
Update factor for demonstration year 2	Medicare Economic Index (MEI)[2] or rebasing	MEI or rebasing
Outlier payments	NA	Reimbursement for portion of participant cost in excess of threshold
Quality bonus payment	Optional bonus payment for CCBHCs that meet state-defined and CMS approved quality measures	Bonus payment for CCBHCs that meet state-defined and CMS approved quality measures

Source: SAMHSA 2016 PPS Guidance to Clinics and States, https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf#page=94
1- The state will develop monthly PPS rates that vary according to users' clinical conditions and will define how PPS rates could vary
2- CMS Medicare Program Rates and Statistics, Market Basket Data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData

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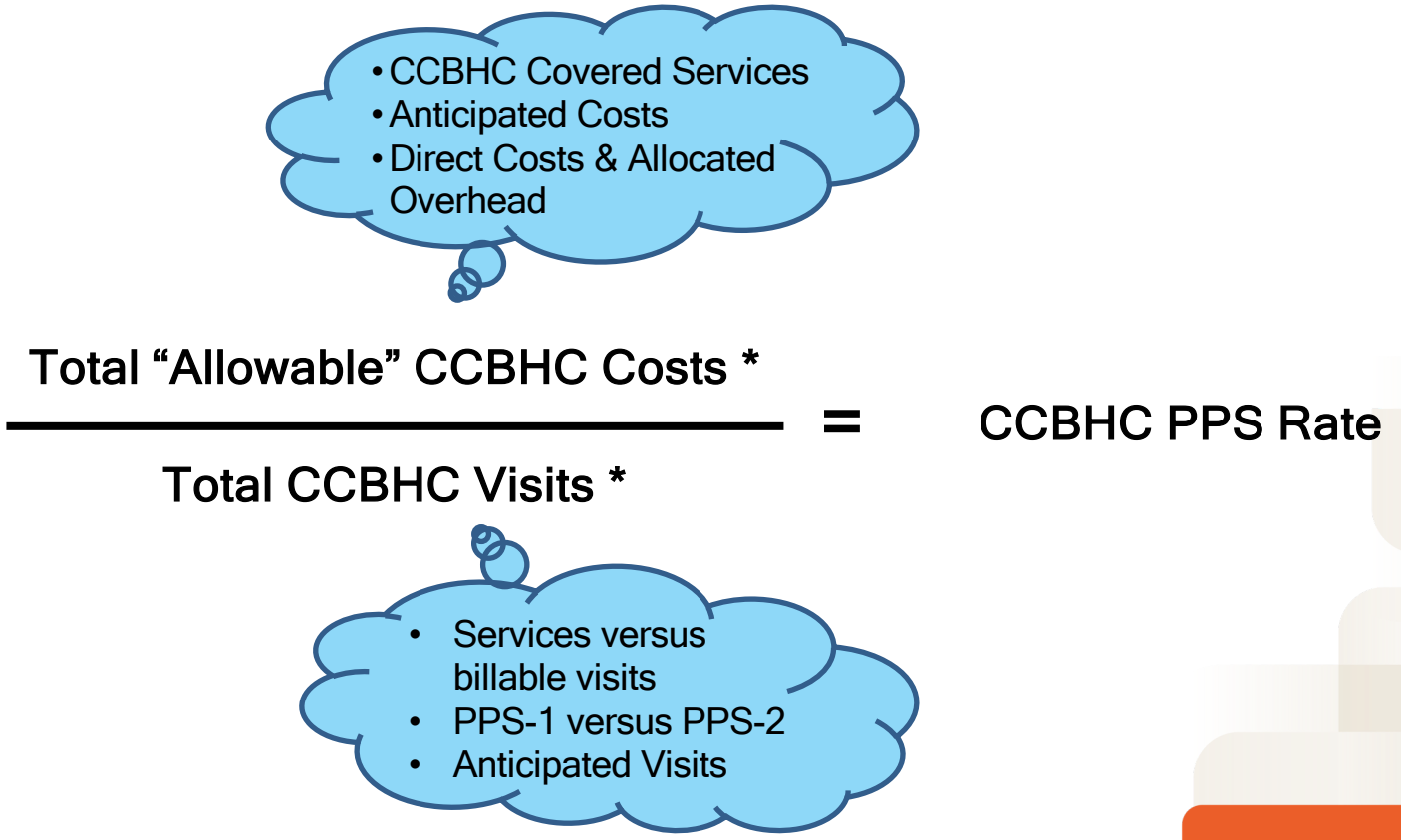
Basic PPS Rate Construct

- CCBHCs may be able to sustain the CCBHC service model through a Medicaid PPS payment methodology approved through a:
  - Expansion of sites in a Demonstration state
  - State Plan Amendment (SPA)
  - Medicaid waiver approved by CMS



**** For ALL clients; utilizing base year defined by State and CCBHC regulations***

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PPS Payment Model Fundamentals

All-Inclusive Rate (AIR) Equation

$$\frac{\text{Total “Allowable” CCBHC Costs}}{\text{Total CCBHC Visits}} = \text{CCBHC PPS Rate}$$

Description	Number of Visits Option A	Option B
Total Allowable Costs	$10,000,000	$10,000,000
Threshold visits	55,000	40,000
Projected CCBHC Medicaid Rate	**$181.82**	**$250.00**
Medicaid Payer Mix	90%	90%
Number of Medicaid Visits	49,500	36,000
Medicaid CCBHC Revenue	**$9,000,000**	**$9,000,000**
% of Allowable Costs Reimbursed	*90%*	*90%*

AIR Reimbursement Fundamentals

Impact of Payer Mix

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Defining Allowable Costs

1st Understand CCBHC Covered Services*

- Review CCBHC core required services

2nd Compare Existing Services Versus CCBHC Covered Services to Identify Gaps*

- How will gaps be covered – internal staff/resources versus an outside organization

3rd Calculate Direct CCBHC Service Costs

- Direct CCBHC service costs – personnel/other then personnel services
- CCBHC Program Administration
- Anticipated Costs

4th Allocate Overhead Costs (Agency Wide)

- Overhead costs that benefit both CCBHC and non-CCBHC services – to be allocated

** These steps must be performed through a multi-disciplinary effort of the clinical, operational and financial teams!*

Defining Billable Visits

1st Start with all services (touches) between CCBHC staff and clients

2nd Remove non-CCBHC billable services

- No-shows and void claims
- Non-billable CCBHC providers
- Non-billable CCBHC procedures (CPT codes)

3rd PPS-1 Daily Visits

- Remove duplicate billable services per client per day to arrive at one “Daily Visit” per patient

4th PPS-2 Monthly Visits (if applicable)

- Starting with Daily Visits, remove multiple daily visits to arrive at one “Monthly Visit” per patient

CCBHC PPS Rate Reimbursement Analysis

- Financial success under a PPS All-Inclusive rate model is driven by:
  - Cost per visit
  - Payer mix of visits

	Number of Visits	
Description	**Option A**	**Option B**
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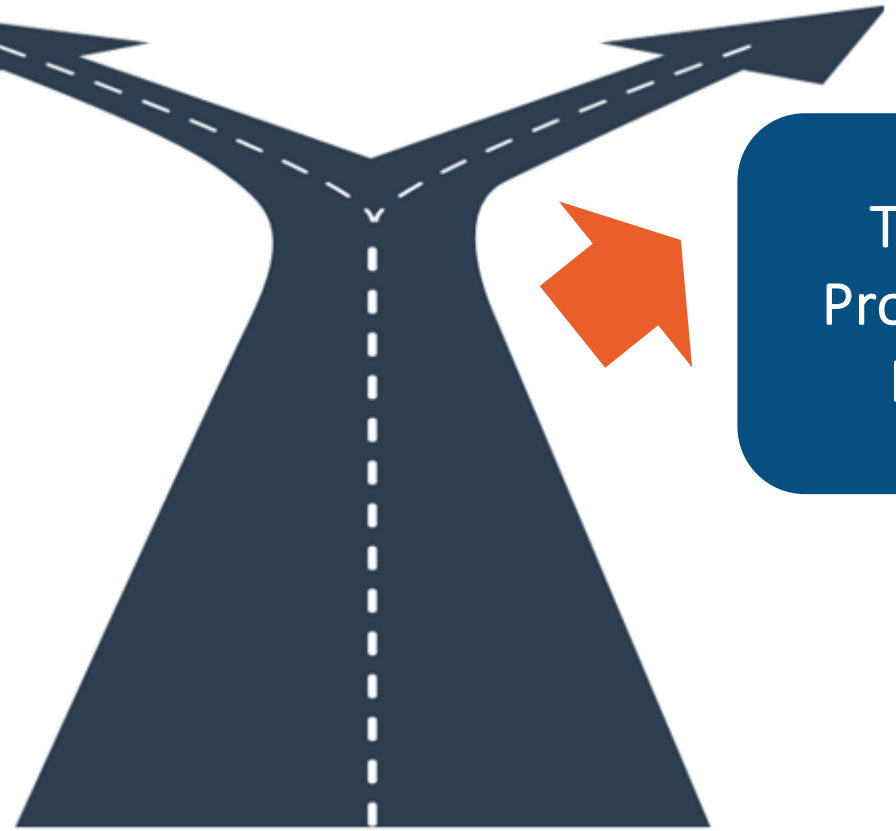
Options for Sustainability

Transitioning CCBHC Program into the PPS Rate Model



Transitioning CCBHC Program to Value-Based Payment Approach

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VBP Arrangement – Current/Future Considerations

Current State	Future State
Advantage: Payers are currently receptive to VBP arrangements that impact Behavioral Health. Payers understand that new payment models are needed to incentivize delivery of quality services that address behavioral health needs and improve outcomes and are receptive to VBP contracting opportunities. ***Obstacle: Many current VBP arrangements are driven by attribution.*** Attribution is predominately driven by assignment of patients to a contracting entity based on assignment to primary care provider.	***Opportunity: Payer market is ready to embrace an innovative service delivery and payment model.*** There is opportunity for entities to develop and market new service packages and payment arrangements but requires development of an ROI (return on investment) to entice payers. ***Challenge: Movement to an attribution model maybe be needed that incorporates assignment to a contracting entity based on care managers.*** This VBP model will increase opportunity for behavioral health providers.

Sustaining the CCBHC Service Delivery Model

- What revenue sources will support CCBHC services?

CCBHC Scope of Services	*Funded Today*			*Future Funding Model*			
	Traditional FFS Reimbursement	*CCBHC Grant Funding*	*Other Grant/Contract Funding*	*Base Compensation*	*"New" Base Compensation*	*Care Management Fee*	*Enabling / Social Drivers of Health (SDOH)*
Core Services							
24/7 Crisis Services			✓		✓		
Screening, Assessment, and Diagnosis	✓			✓			
Person-Centered Treatment Planning, including Risk/Crisis Planning	✓			✓			
Outpatient Mental Health and Substance Use Services	✓			✓			
Outpatient Primary Care Screening and Monitoring	✓			✓			
Targeted Case Management Services		✓				✓	
Psychiatric Rehabilitation Services		✓			✓		
Peer Supports, Peer Counseling, and Family/Caregiver Supports		✓					✓
BH care for members of the Armed Forces and Veterans	✓			✓			
Additional Components							
Care Coordination		✓				✓	
Quality Improvement/Reporting		✓				✓	
Payment Model				**FFS or Capitation (PMPM) $**		**PMPM $**	**FFS vs. PMPM**

- *Understanding total costs is critical for preparing for sustainability – whether through future PPS rate, APM, or other payment arrangement – to manage and track financial performance*

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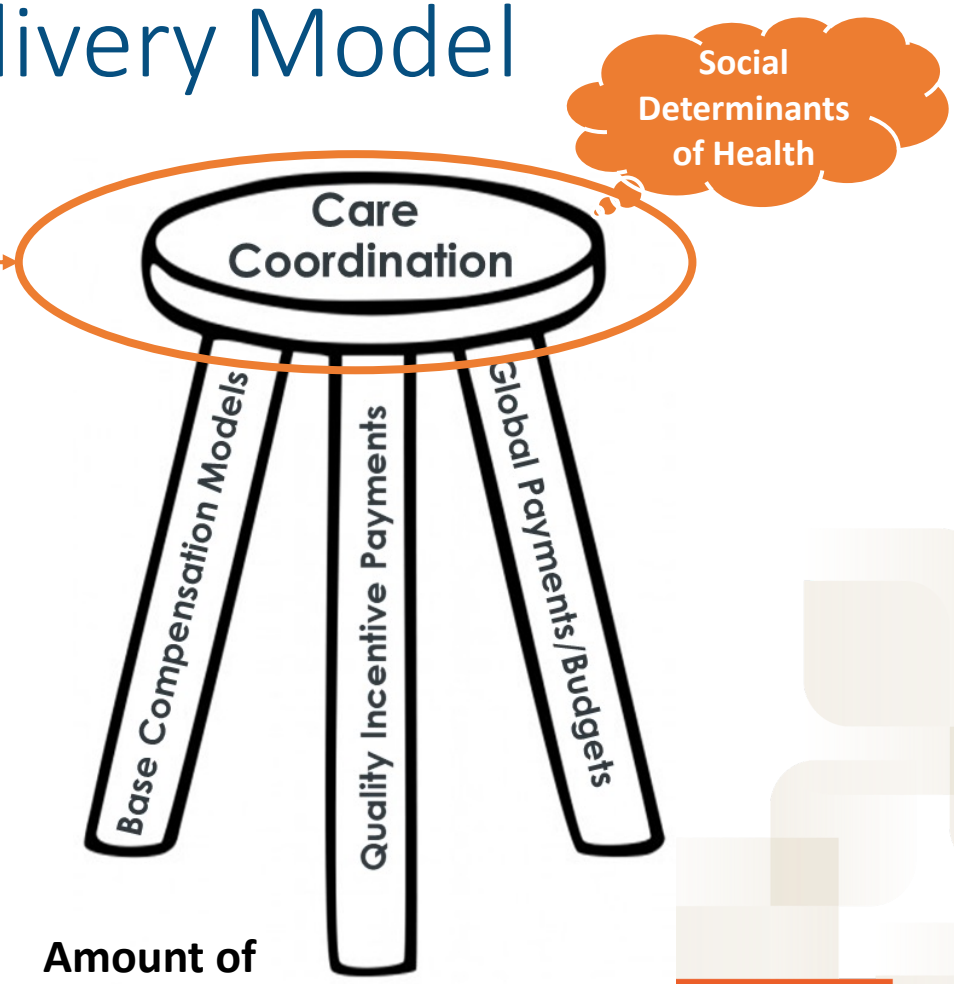
Sustaining the CCBHC Service Delivery Model

- **Care Coordination/Management Fees** acknowledge that providers must coordinate services with other providers in the delivery system to improve health outcomes and reduce the total healthcare expenditure
- Today, payers are reimbursing for care coordination/management services under a per fixed per member per month (PMPM) basis



# of Attributed Members	×	Rate PMPM	=	Amount of Payment
5,000 Members		$ 5.00 PMPM		$ 25,000

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VBP/APM Opportunities

- Opportunities exist to negotiate reimbursement for some of the "unfunded" CCBHC services and activities
  - *Often providers pursue innovative payment models as a group (e.g., IPAs) or through state behavioral health associations*
- Third party payers (e.g., Medicaid, commercial insurance) have acknowledged the need to adequately reimburse providers for behavioral health services
- Before a PPS is available in your state or with non-Medicaid payers, behavioral health providers should leverage the nationally-recognized CCBHC program into the development of new Alternative Payment Models (APMs)
  - *Quality incentive payments*
  - *Reimbursement of care management/coordination services and quality programs through a care management fee paid on a per member per month (PMPM) basis (e.g., health homes)*
  - *Creation of bundled case rates – "a predetermined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a given defined episode of care for an individual over an agreed upon time period.**

**Source: "Case Rate Toolkit" – National Council for Mental Wellbeing*

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Explanation of VBP Services and Cost Pools

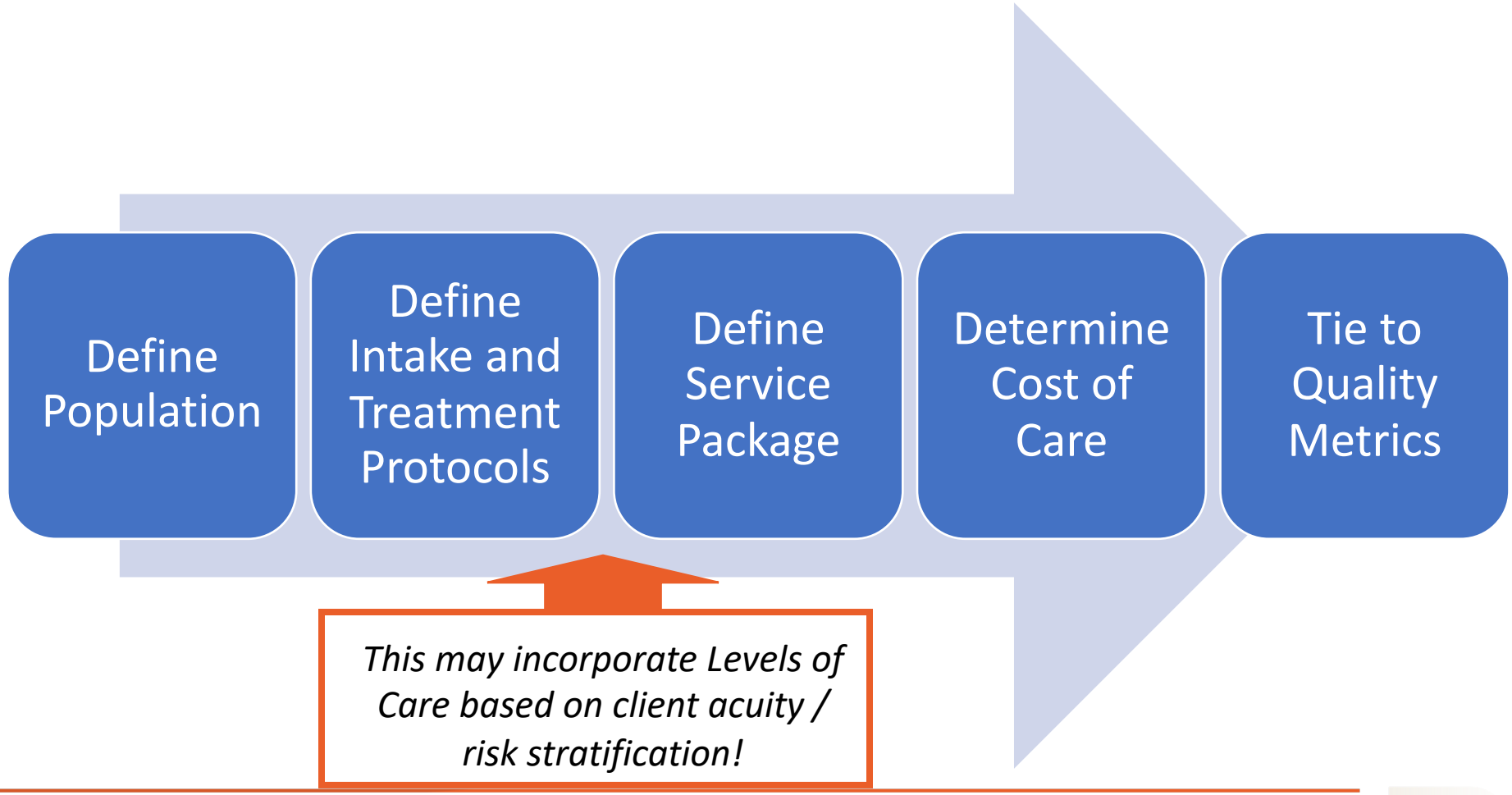
- To negotiate payment rates in VBP arrangements, CCBHCs need to understand their services, costs and utilization of services at a more detailed level
- CCBHCs need to evaluate several different cost per units of service by allocating costs into the following 4 VBP cost pools
  - Base Compensation - expenses for services traditionally reimbursed by payers for the delivery of services utilizing CPT codes
  - Care Management – care management/coordination services provided by non-billable direct program staff as well as an allocation of billable provider time plus technology
  - Quality Improvement – staff and technology dedicated to improving quality metrics
  - “Enabling” Services – expenses not covered by other payment rates that are incurred to improve patient outcomes and reduce the “Total Cost of Care”

Mapping Services to VBP

	TODAY			FUTURE UNDER VBP ?			
	Traditional FFS Reimbursement	Health Home Services	CCBHC	Base Compensation	New Base Compensation	Care Management Fee	"Enabling" Services
CCBHC Scope of Services (Core Services):							
24/7 Crisis Services							
Behavioral Health Screening, Assessment and Diagnosis							
Person-Centered and Family-Center Treatment Planning							
Outpatient Mental Health and Substance Use Services							
Outpatient Clinic Primary Care Screening and Monitoring							
Targeted Case Management Services							
Psychiatric Rehabilitation Services							
Peer Supports, Peer Counseling and Family/Caregiver Supports							
Intensive Community-Based Mental Health Services to Members of the Armed Forces and Veterans							
CCBHC Supportive Services:							
Care Coordination							
Quality Improvement/Reporting							
FUTURE PAYMENT MODEL?				**FFS versus Capitation (PMPM)**		**PMPM**	**FFS vs. PMPM**

Question: Which CCBHC services will you continue and package under a VBP Model?

Considerations in Packaging VBP Arrangement



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Create VBP Components for Costing Approach

Example: Costing out Health Home type service package for members with highest behavioral health needs based on qualifying diagnosis codes:

	UNDER VBP			
	Base Compensation	Care Management Fee	Quality Improvement	"Enabling" Services
Sample Service Package Components				
Medication Management				
Outpatient MH Services				
Targeted Case Management				
Peer Supports/Wellness Coach				
Supportive Services				
Care Coordination				
Quality Improvement/Reporting				
	FFS or Capitation	PMPM	PMPM	PMPM

- Based on service package components, elements may be split across several compensation cost pools, each of which need to be costed out separately

VBP Costing Components - Personnel

May need to consider separating by Level of Care/Acuity!

		High Acuity	*Moderate*	*Low Acuity*	Other Time Required per Acuity Level - Hours per Month			
Service Components	***Provider***	**Service Frequency**	**Service Frequency**	**Service Frequency**	**Administrative Time**	**Referral/Partner Coordination**	**Travel Time**	**Other**
Medication Management	PNP	1x per month			2.0			
Outpatient Therapy	LCSW	2x per month	1x per month	1x per month	2.0			
Case Management	Case Manager	4x per month			8.0	8.0	12.0	4.0
Peer/Wellness Coach	Peer/Wellness Coach	1x per month	1x per month		8.0	8.0	12.0	4.0
Care Coordination	Care Coordinator	1x per month	1x per month	1x per month	8.0	8.0		4.0

- **Building the Service Package – the "secret sauce" for improving outcomes and reducing Total Cost of Care:**
  - Who provides the service?
  - How often will they see the client (and does it differ based on Level of Care)?
  - What additional time is required by staff members
    - E.g., Internal Team Meetings/Supervision, Administrative Time, Referral/Partner Coordination, Travel Time, Other (Quality Reporting/Management), etc.

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VBP Costing Components - Personnel

May need to consider separating by Level of Care/Acuity!

	Total FTE	Total Cost	UNDER VBP			
			Base Compensation	Care Management Fee	Quality Improvement	"Enabling" Services
Sample Service Package Components						
Medication Management - PNP	0.50	$ 57,500	$ 51,750		$ 5,750	
Outpatient MH Services - LCSW	36.00	$ 1,260,000	$ 1,260,000			
Targeted Case Management - CM	9.50	$ 283,224		$ 283,224		
Peer Supports/Wellness Coach - Peer	30.00	$ 928,533				$ 928,533
Supportive Services						
Care Coordination - CC	10.00	$ 328,107		$ 328,107		
Quality Improvement/Reporting	1.50	$ 119,224		$ 23,845	$ 95,379	
TOTAL			$ 1,311,750	$ 635,176	$ 101,129	$ 928,533
Fringe @ 20%			*$ 262,350*	*$ 127,035*	*$ 20,226*	*$ 185,707*

- Based on the service delivery model and the non-direct services time allocation, personnel costs will be allocated into the various VBP Cost Component buckets
- Fringe benefits will be allocated based on salary expense allocations

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VBP Costing Components – Direct Non-Personnel

	Total Annual Cost	Allocation Method	UNDER VBP							
			Base Compensation		Care Management Fee		Quality Improvement		"Enabling" Services	
Sample Service Package Costs			%	Expense	%	Expense	%	Expense	%	Expense
Professional Liability Insurance	$ 52,500	Per Clinical FTE	100%	$ 52,500	0%	$ -	0%	$ -	0%	$ -
Equipment	$ 55,000	Per Direct FTE	19%	$ 10,450	46%	$ 25,300	0%	$ -	35%	$ 19,250
Travel and Transportation	$ 60,000	Per Direct FTE	19%	$ 11,400	46%	$ 27,600	0%	$ -	35%	$ 21,000
Consumable Supplies	$ 12,000	Direct	45%	$ 5,400	25%	$ 3,000	0%	$ -	30%	$ 3,600
Communication Expense	$ 65,000	Per Direct FTE	19%	$ 12,350	46%	$ 29,900	0%	$ -	35%	$ 22,750
Computer Hardware/Software	$ 1,500	Per Direct FTE	19%	$ 285	46%	$ 690	0%	$ -	35%	$ 525
Facility Costs	$ 165,000	Per Sq.Ft	30%	$ 49,500	30%	$ 49,500	10%	$ 16,500	30%	$ 49,500
Shared Services	$ 750,000	Per Expense %	44%	$ 330,000	21%	$ 157,500	4%	$ 30,000	31%	$ 232,500
				$ 471,885		$ 293,490		$ 46,500		$ 349,125

- Non-Personnel (Other than Personnel Costs or OTPS Costs) related to service delivery will also need to be added to each of the VBP cost pools
- Determine an allocation methodology for each type of cost category

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VBP Costing Components – Indirect Costs

	Total Annual Cost	UNDER VBP			
		Base Compensation	Care Management	Quality Improvement	"Enabling" Services
Sample Service Package Costs					
Total Salary Costs	$ 2,976,588	$ 1,311,750	$ 635,176	$ 101,129	$ 928,533
Total Fringe Costs	$ 595,318	$ 262,350	$ 127,035	$ 20,226	$ 185,707
Total Other Direct Costs	$ 1,161,000	$ 471,885	$ 293,490	$ 46,500	$ 349,125
TOTAL Direct Expenses	$ 4,732,906	$ 2,045,985	$ 1,055,701	$ 167,855	$ 1,463,365
Indirect Costs - Allocated					
Indirect Rate @ 15%	$ 709,936	$ 306,898	$ 158,355	$ 25,178	$ 219,505
TOTAL COST		$ 4,398,868	$ 2,269,757	$ 360,888	$ 3,146,234

- Finally, allocate indirect expenses to each VBP cost by utilizing the organization's indirect cost rate
- With total costs calculated across each VBP cost pool, you will then be ready to determine a cost per unit of service for use in VBP negotiations

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VBP Costing Components – Cost per Unit

	UNDER VBP			
	Base Compensation	Care Management	Quality Improvement	"Enabling" Services
TOTAL COST	$ 4,398,868	$ 2,269,757	$ 360,888	$ 3,146,234
CPT Codable Visits	70,250			
Average Cost/Visit	**$ 62.62**			
Average Utilization/Client @ 1.5 services per month		18	18	18
Average Number of Clients		3,903	3,903	3,903
Estimated # of Member Months		46,833	46,833	46,833
Average Cost PMPM		$ 48.46	$ 7.71	$ 67.18
			$ 56.17	
Non-utilizers at 10%		434	434	434
Estimated number of members		4,336	4,336	4,336
Estimated number of Member Months		52,037	52,037	52,037
Average Cost PMPM		$ 43.62	$ 6.94	$ 60.46
			$ 50.55	

- Divide each cost pool by the specific unit of service to be used for payment from third party payers to determine your cost per unit of service for use in VBP negotiations

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VBP Costing Components – Cost per Unit

	UNDER VBP			
	Base Compensation	Care Management	Quality Improvement	"Enabling" Services
TOTAL COST	$ 4,398,868	$ 2,269,757	$ 360,888	$ 3,146,234
CPT Codable Visits	70,250			
Average Cost/Visit	**$ 62.62**			
Average Utilization/Client @ 1.5 services per month		18	18	18
Average Number of Clients		3,903	3,903	3,903
Estimated # of Member Months		46,833	46,833	46,833
Average Cost PMPM		$ 48.46	$ 7.71	$ 67.18
			$ 56.17	
Non-utilizers at 10%		434	434	434
Estimated number of members		4,336	4,336	4,336
Estimated number of Member Months		52,037	52,037	52,037
Average Cost PMPM		$ 43.62	$ 6.94	$ 60.46
			$ 50.55	

Reminder: these can be risk-adjusted based on Level of Care needs / acuity scores of clients!

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Sustainability and VBP: Tying to Value

- CCBHC Demo period is a testing ground for proving impact that service package has on quality metrics
- How does the service package improve patient outcomes and drive down Total Cost of Care (TCOC)?
- ***Sample Quality Metrics:***
  - 7 and 30- day psychiatric hospital readmission rates
  - Antidepressant medication management
  - Adherence to antipsychotic medications for individuals with schizophrenia
  - Controlling high blood pressure
  - Diabetes screening for people with schizophrenia or bipolar disorder
  - Follow-up after hospitalization for mental illness within 7 and 30 days- within 7 days

Care Management + Quality	$	56.17	*PMPM*
"Enabling" Services	$	67.18	*PMPM*
	$	**123.35**	

=

Cost Savings and Quality Metrics!

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Data Required for Transition to CCBHC PPS

- **Development of the CCBHC "Total Budget"**
  - Ability to develop CCBHC gaps and Anticipated revenue opportunities
  - Review the current revenue cycle for opportunities to enhance reimbursement
- **Capture all contacts with clients**
  - Capture contacts with clients by direct care staff **including currently non-billable services and activities**
    - Upgrade EHR and practice management systems to capture AND report on these services
- **Review all systems to ensure capability to support/manage CCBHC operations**
  - Accounting systems
  - EHR and practice management (billing) system(s)

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Homework Assignment for Session #5

The first section of Session #5 will be a discussion with participants on what was learned during this session and comments on building anticipated CCBHC ca Sustainability Plan. Please review these questions and be prepared to discuss next time:

- Is your electronic health record/billing system able to capture the services and billing required for transition to CCBHC?
- What are your plans for generating additional revenue sources to sustain the CCBHC program?
- What are your plans to enhance your EHR/billing system for transition to CCBHC?

Coming up:

Session 1: Sustainability Overview	**Session 2:** Understanding Baseline Operations	**Session 3:** Evaluating "Anticipated" Costs	**Session 4:** Capturing CCBHC Services/Visits	**Session 5:** Pulling All the Elements Together
• Overview of CCBHC Sustainability Planning • Framework for development of total budget and total revenue concepts • Overview of approaches to sustain CCBHC operations	• Identification of baseline (current) services and allocation between CCBHC and non-CCBHC programs • Review of data capture systems and discussion of modifications to existing systems to support data capture	• Framework for evaluating costs for new or expanded services • Approaches for projecting need for services based on identified gaps, utilization patterns, and staffing requirements	• Translating visits and utilization to costing units and identifying impact on financial management systems • Linkage of utilization to various payment models and impact to sustainability planning	• Review of foundational elements across sessions to project costs and evaluate approaches to sustainability planning • Process for monitoring and updating sustainability plans

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Questions?

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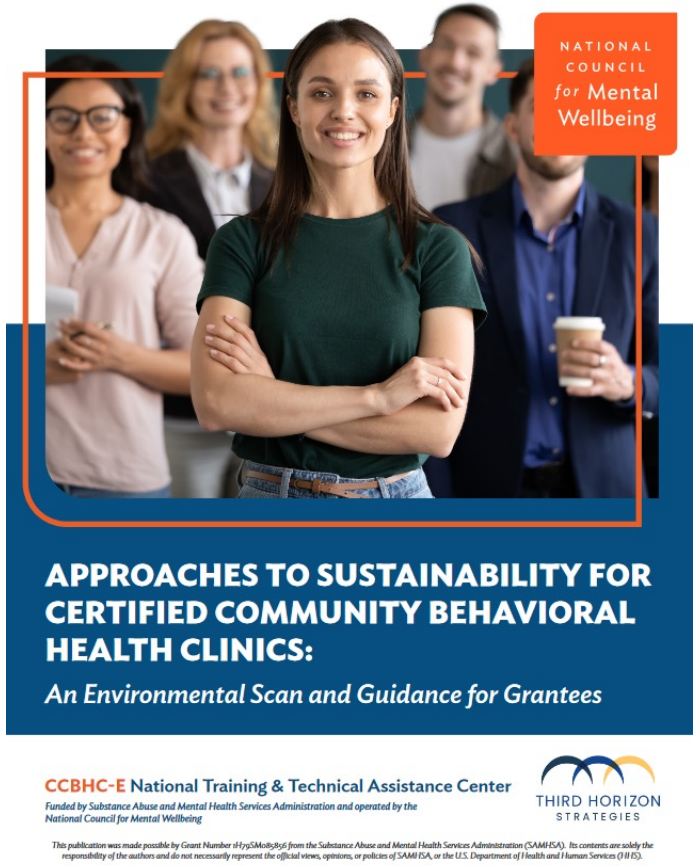
Additional Resources



[Approaches to Sustainability for CCBHCs: Guidance for Grantees]

This resource identifies strategies being utilized by CCBHC grantees to achieve sustainable funding for model implementation.

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Upcoming Events

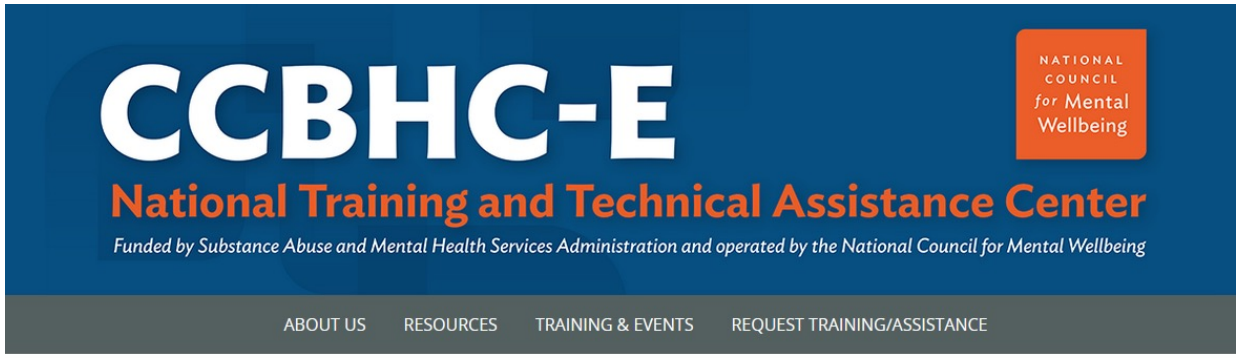
Financial Management and Sustainability (May-August 2023)

- **Session Five:** Pulling It All Together – August 2, 2:30-4 p.m. ET. Understand the different approaches of sustaining the CCBHC program and learn the elements and structure for pulling together a sustainability plan.

Population Health Management Learning Series (June-August 2023)

- The CCBHC-E NTTAC is hosting a three session Learning and Action series focused on Population Health Management. Building on foundational concepts covered in the Optimizing Data Series, this series will expand and advance on effective population health management approaches and strategies to drive clinical care decisions focusing on topics including risk stratification to identify gaps in care, continuous quality improvement to identify and address health disparities and using advance data analytics assess patient needs and support.
  - **Session Two:** Risk Stratification – July 27, 3-4:30 p.m. ET.
  - **Session Three:** Preventative Health Care and Predictive Data Analytics – August 24, 3-4:30 p.m. ET.

CCBHC-E TTA Center Website



Access our ever-growing resource library, upcoming trainings and events, and request for individualized support.

[CCBHC-E National Training and Technical Assistance Center]

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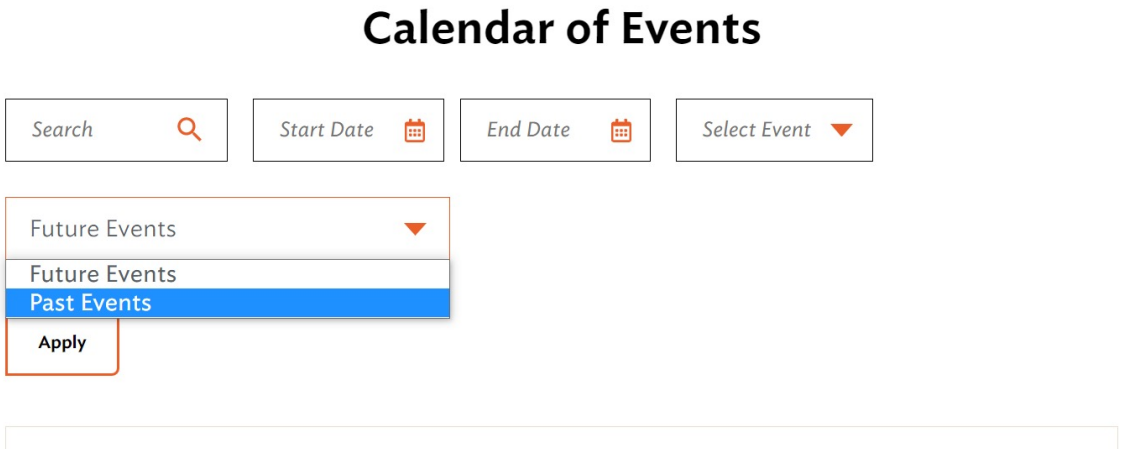
Thank You!

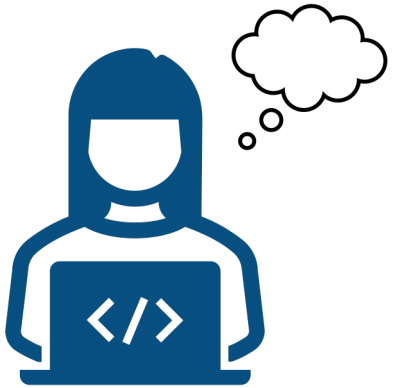
Thank you for attending today's event.

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.



Your feedback is important to us!

Please complete the brief event survey that will open in a new browser window at the end of this meeting. Your input helps us improve our support offerings and meet our SAMHSA data metrics.



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