NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

Prospective Payment System TA Series: Living Within the PPS Rate

April 28, 2025

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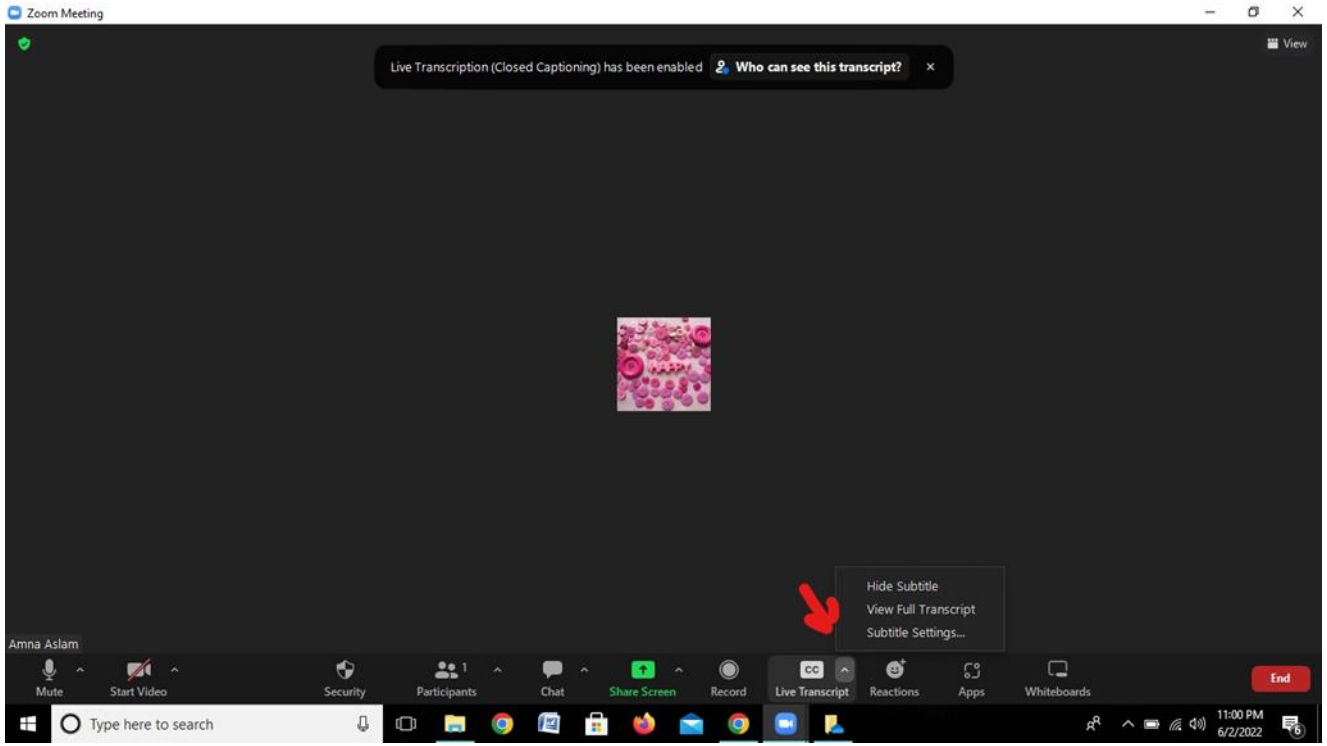

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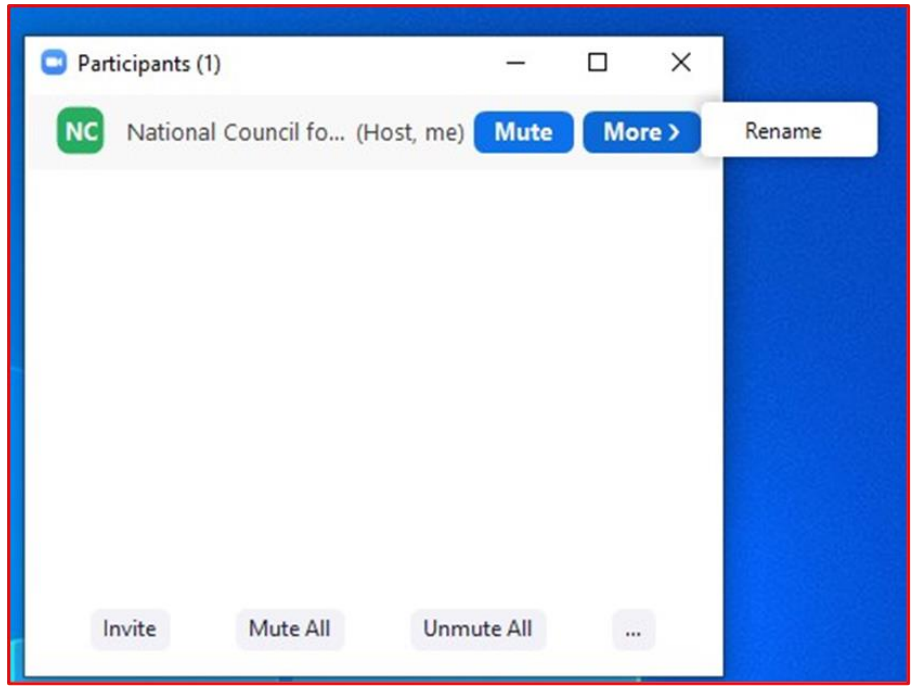

Today's Learning Objectives

- Understand how to manage the financial performance of the CCBHC program and how service delivery impacts finance and the PPS rate
- Learn how select Key Performance Indicators (KPIs) impact the financial performance of the CCBHC program
- Understand how to manage the KPIs and their impact on future rebasing of the PPS rates and sustainability

Today's Presenters

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Poll #1

- Do you produce monthly financial management reports for the CCBHC program analyzing the CCBHC cost per visit?
  - Yes
  - No

Overview

- Living Within the CCBHC PPS Rate
  - Refresher of CCBHC PPS rate fundamentals
  - Financial management reports to monitor CCBHC performance
  - Metrics that impact CCBHC financial performance
  - Key drivers of the CCBHC cost per visit (PPS Rate)
  - Concepts impacting future PPS rate rebasing
  - CCBHC sustainability planning
- Preview of Webinar #3
- Q&A

Basic PPS Rate Construct

- CCBHC Covered Services
- Anticipated "Budgeted" Costs
- Direct Costs & Allocated Overhead

Total "Allowable" CCBHC Costs *

Total CCBHC Visits *

= CCBHC PPS Rate

- Services Versus Billable Visits
- Daily vs. Monthly Visits
- Anticipated Visits

** For **ALL** clients!*

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

The CCBHC Medicaid PPS Dilemma

- A basic premise of the CCBHC PPS payment methodology is that the same level of service (and cost) is provided to clients regardless of the underlying payer
- Medicaid will pay for their share of the cost of services provided to Medicaid patients
  - Will other payers increase payment rates consistent with the CCBHC Medicaid PPS rate?
  - Who will subsidize the gap in the CCBHC cost for non-Medicaid payers?

	Base Year			CCBHC Compliant		
	Medicaid	**Other**	**Total**	**Medicaid**	**Other**	**Total**
Visits	37,500	12,500	50,000	45,000	15,000	60,000
Payer Mix	*75%*	*25%*	*100%*	*75%*	*25%*	*100%*
Grants	750,000	750,000	1,500,000	0	1,500,000	1,500,000
Patient Revenue	5,625,000	937,500	6,562,500	11,250,000	1,125,000	12,375,000
Other	187,500	187,500	375,000	0	375,000	375,000
Total Revenue	6,562,500	1,875,000	8,437,500	11,250,000	3,000,000	14,250,000
Total Expenses	6,562,500	1,875,000	8,437,500	11,250,000	3,750,000	15,000,000
Surplus/(Loss)	0	0	0	0	(750,000)	(750,000)
"Per Visit" Metrics:						
Patient Revenue	$150.00	$75.00	$131.25	$250.00	$75.00	$206.25
Expenses	$175.00	$150.00	$168.75	$250.00	$250.00	$250.00

“Living Within the PPS Rate” - Managing CCBHC Operations

- CCBHC financial performance should be monitored on a monthly basis throughout the year
- Actual performance should be measured against budget (e.g., cost report)
  - Revenue and expense financial report
  - Revenue/cost per visit analyses
- Manage and monitor KPIs (Key Performance Indicators) against budget
- Future sustainability through analysis of current financial data
  - Assessment of future rebasing
  - Preparing for Value Based Payment and third party payer negotiations

Managing CCBHC Operating Performance

- When evaluating financial performance in the CCBHC PPS model, finances should be evaluated in total as compared to fluctuations in volume
- Financial analyses should therefore be performed on a per visit and per client basis
  - Compare actual vs. budget (e.g., cost report)

Statistics:		*19,000*	*1,250*
	Totals	**Per Visit**	**Per Client**
Operating Revenue:			
Patient Revenue, Net	$ 4,016,125	$211.38	$3,212.90
Grants and Contracts	1,000,000	$52.63	$800.00
TOTAL OPERATING REVENUE	**5,016,125**	**$264.01**	**$4,012.90**
Operating Expenses:			
CCBHC Staff Costs	3,021,000	$159.00	$2,416.80
Other Direct CCBHC Costs	1,007,000	$53.00	$805.60
Total CCBHC Direct Expenses	4,028,000	$212.00	$3,222.40
Indirect (Overhead) Expenses	1,007,000	$53.00	$805.60
TOTAL OPERATING EXPENSES	**5,035,000**	**$265.00**	**$4,028.00**
OPERATING SURPLUS/(LOSS)	**$ (18,875)**	**($0.99)**	**($15.10)**

Monitoring Patient Revenue

- Improving Financial Performance:
  - Although patient revenue is driven by visit volume, the proper balance of payer mix of visits, reimbursement rates and bad debt % must be managed

Patient Revenue:	Payer Mix	Daily Visits	Payment Rate	Patient Revenue
Medicaid	75%	14,250	$275.00	$ 3,918,750
Medicare	10%	1,900	$85.00	161,500
Commercial Insurance	10%	1,900	$65.00	123,500
Self-pay	5%	950	$25.00	23,750
Subtotal	100%	19,000	$222.50	4,227,500
Less: Bad Debt **(5%)**			($11.13)	(211,375)
Total Patient Revenue, Net			$211.38	$ 4,016,125

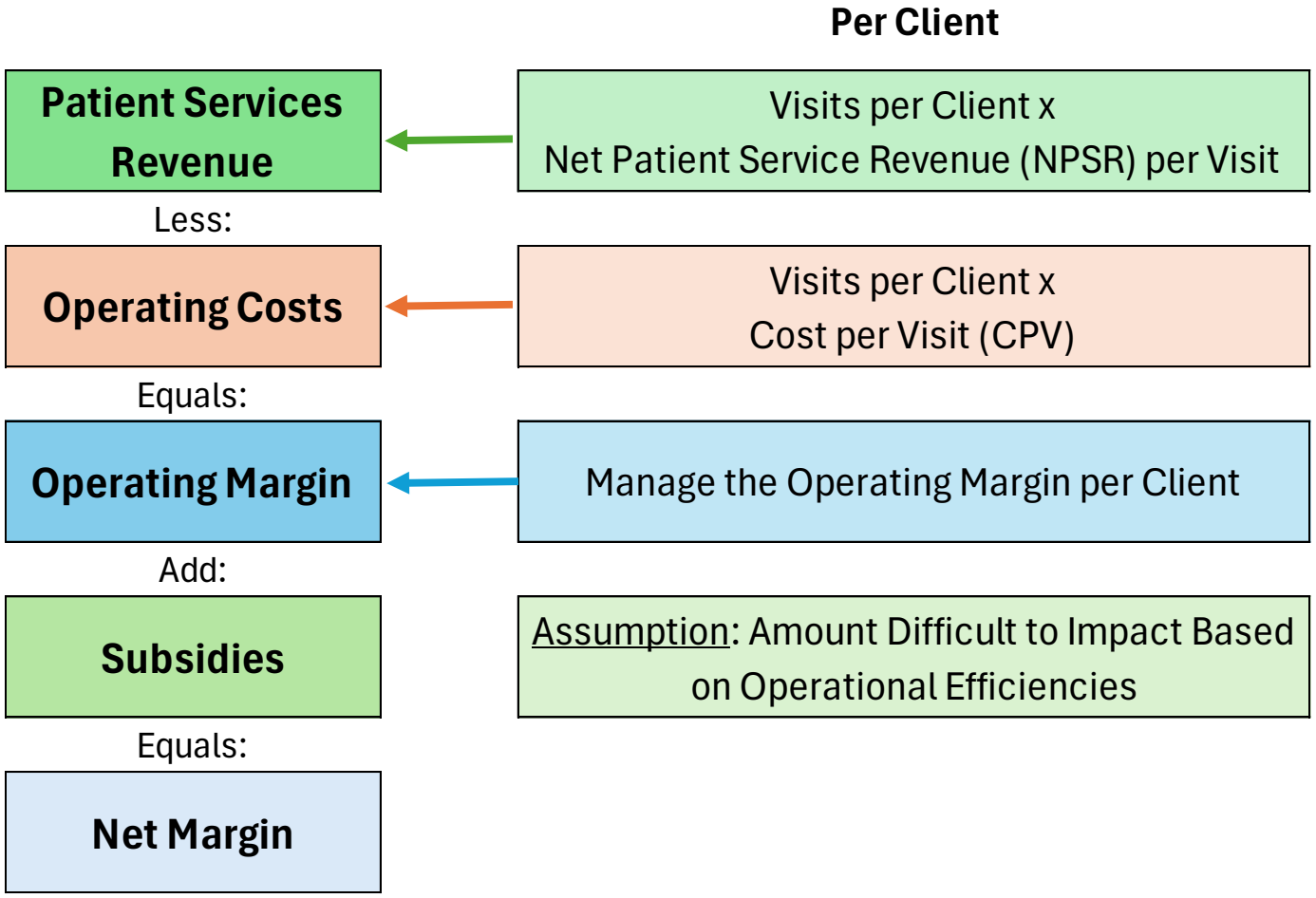
Monitoring Grant/Contract Revenue

- Improving Financial Performance:
  - Calculating the cost of uncompensated care versus funding/subsidies to support it must be evaluated/monitored

	Payment Rate	Cost Per Visit	Net Margin Per Visit	Visits	Net Margin
Medicare	$85.00	$265.00	($180.00)	1,900	(342,000)
Commercial Insurance	$65.00	$265.00	($200.00)	1,900	(380,000)
Self-pay	$25.00	$265.00	($240.00)	950	(228,000)
Subtotal				4,750	(950,000)
Grants and Contracts					1,000,000
Unfunded Care					**$ 50,000**

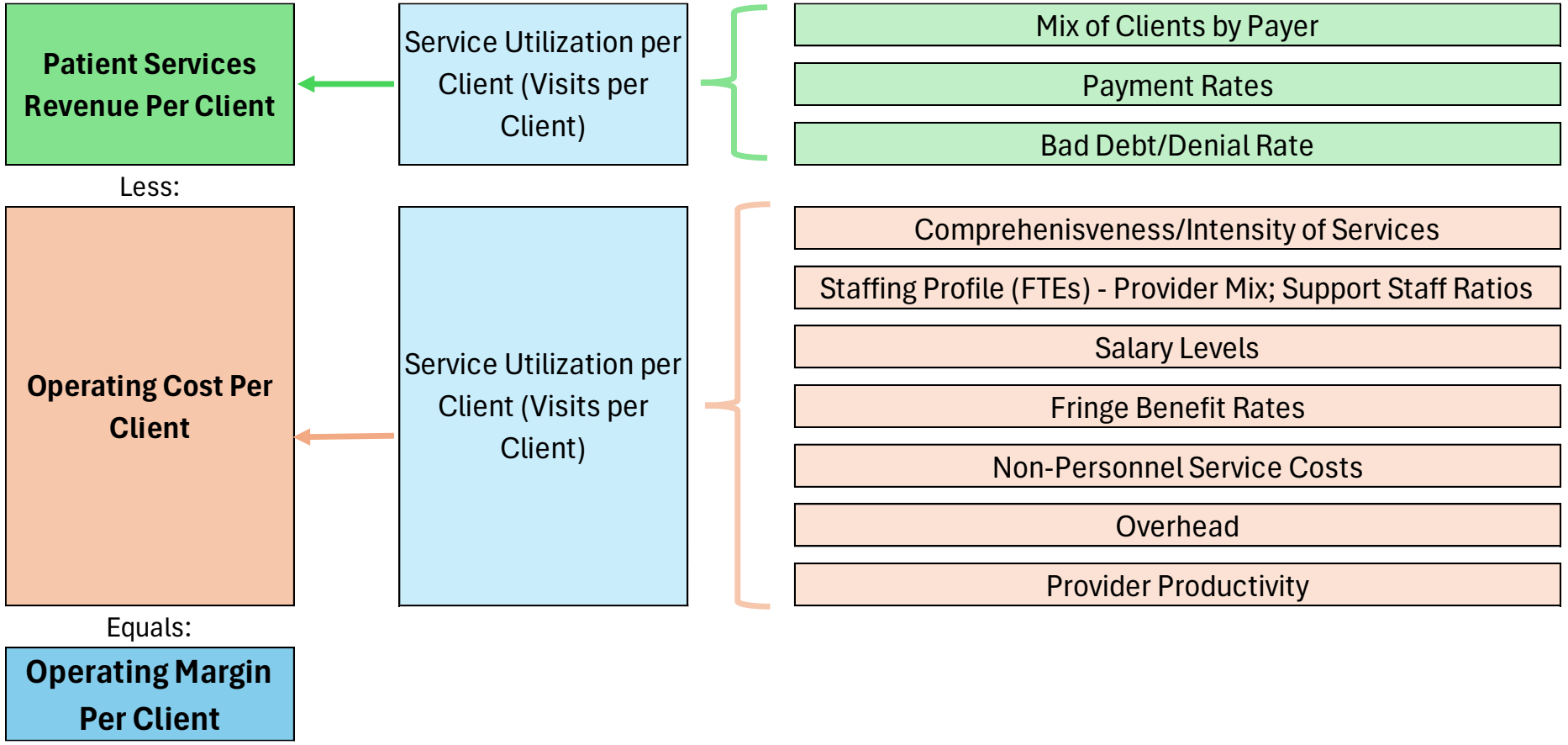
A New Lens – Drivers of CCBHC Performance

- Manage the Operating Margin on a Per Client Basis!



A New Lens – Drivers of CCBHC Performance

- Drivers of the Operating Margin Per Client



Patient Revenue Generation – PPS-1 Versus PPS-2

- Both revenue streams are driven by the **number of clients** seen
- Rates of payment are subject to negotiation
- CCBHCs should manage **service utilization**
  - PPS-2 rates are set based on historic **service utilization** patterns

PPS-1 (Daily Visit)		PPS-2 (Monthly Visit)	
Payment Rate per Daily Visit	$275	Payment Rate per Monthly Visit	$348
Multiplied by:		Multiplied by:	
Service Utilization: # of Services per Client per Year	15.20	12 Months per Year	12
Equals:		Equals:	
Patient Revenue per Client per Year	$4,180	Patient Revenue per Client per Year	$4,180
Muliplied by:		Multiplied by:	
# of Clients	938	# of Clients	938
Equals:		Equals:	
Total Annual Patient Revenue	**$3,918,750**	Total Annual Patient Revenue	**$3,918,750**

Driver of Operating Expenses

- Operating expenses are driven by the same metrics in both the PPS-1 an PPS-2 payment models
- Similar to revenue generation, the **number of clients** and **service utilization** drive operating expenses
- In both models, operating expenses are driven by the **cost per visit**

Operating Expenses:

PPS-1 and PPS-2	
Operating Cost per Visit	$265
Multiplied by:	
Service Utilization: # of Services per Client per Year	15.20
Equals:	
Operating Cost per Client per Year	$4,028
Muliplied by:	
# of Clients	938
Equals:	
Total Annual Operating Expense	**$3,776,250**

Evaluating Medicaid Performance – Evaluation of PPS Rates

- By analyzing cost on a per visit and per client (per month), CCBHCs can compare actual performance versus current PPS-1/PPS-2 payment rates
  - For PPS-2, divide the annual cost per client by 12 months

Medicaid		14,250	938
	Totals	**Per Visit**	**Per Client**
Total Annual Patient Revenue	$3,918,750	$275.00	$4,180.00
Less:			
Total Annual Operating Expense	$3,776,250	$265.00	$4,028.00
Equals:			
Operating Margin	$142,500	$10.00	$152.00
PPS-1/2 Rate in Excess of Current Cost		*$10.00*	*$12.67*

Drivers of Service Utilization

- Services provided to a client in a given year is often driven by the treatment plan developed and scheduling
- A shift in the client mix will have an impact on the overall service utilization (and totals services/visits) of the CCBHC

Baseline:

	General Population	High Acuity Adults	High Acuity Children	Total
Number of Clients	500	250	500	1,250
Client Mix	40%	20%	40%	100%
Average Service Utilization	3.80	15.20	26.60	15.20
Number of Services	1,900	3,800	13,300	19,000

Shift in Client Mix:

	General Population	High Acuity Adults	High Acuity Children	Total
Number of Clients	250	375	625.0	1,250
Client Mix	*20%*	*30%*	*50%*	*100%*
Average Service Utilization	3.80	15.20	26.60	*18.62*
Number of Services	*950*	*5,700*	*16,625*	*23,275*

Evaluating Performance – PPS-1 Versus PPS-2 Payment Models

- Cost per visit and the other drivers of cost (to be discussed) are of equal importance under both payment models as operating cost is driven by volume
- From a patient revenue perspective, clients and service utilization are important to monitor under both payment models

Operating Metric	PPS-1 (Daily Visit)	PPS-2 (Monthly Visit)
Number of Clients	Increase/decrease in clients will generate a corresponding impact on revenue	Increase/decrease in clients will generate a corresponding impact on revenue
Service Utilization per Client	Increase/decrease in service utilization will have a corresponding impact on revenue *Note: Assumes ratio of services to visits is unchanged*	No impact on revenue *unless there are different PPS-2 rates per population* *Note: Costs increase/decrease as cost is driven by services provided*

CCBHC Operations – Key Concepts

- Outreach efforts drive clients
- Clients and utilization patterns drive visits
- Clients/Visits drive operating revenue and expenses
- Manage client mix
- Clinical productivity levels impact clients/visits (supply versus demand)
- Reimbursement rates and payer mix drive patient revenue
- Improve revenue cycle efficiencies and minimize bad debt
- Measure uncompensated care versus grants/contracts
- Negotiate third party payer rates – Value Based Payment
- Cost per visit drive operating expenses

Poll #2

- Do you produce monthly financial management reports of the Key Performance Indicators (KPIs) that impact the CCBHC cost per visit?
  - Yes
  - No

Key Drivers of the Cost per Visit

- Key drivers of the all-inclusive cost per visit, and the operational workflows that impact them:
  1. Clinician productivity (services per FTE)
  2. Service-to-visit conversion ratio
  3. Service utilization & impact of special populations
     - Needs assessment → clients to be served → services & visits → staffing requirements
  4. Staffing profile (e.g., support staff ratios)
  5. Other drivers of the cost per visit

- Related metrics reviewed and monitored by State Medicaid agencies

1. Clinician Productivity (Services per FTE)

- Clinician productivity impacts:
  - Current revenue
  - Future PPS rate

- There is a direct relationship between clinician productivity and current revenue.
  - As productivity increases, revenue increases (because there are more services, and therefore more billable visits).

- There is an inverse relationship between clinician productivity and the future PPS rate.
  - As productivity increases, the service and billable visit counts increase. As the visit count increases, the PPS rate decreases *(assuming costs do not change).*
  - This will **not impact the current PPS rate**, but it will impact the future PPS rate after rebasing.

1. Clinician Productivity (Services per FTE)

Impact of productivity on current revenue and future PPS-1 rate (when rebased)*:

	PPS-1 (Daily Rate) – 12 Month Information		
	CLINIC A	CLINIC B	CLINIC C
Initial CCBHC Cost Report			
Allowable CCBHC Costs	$ 100,000	$ 100,000	$ 100,000
Total CCBHC Visits	1,000	1,000	1,000
PPS Rate (for Year 1)	**$ 100**	**$ 100**	**$ 100**
Year 1 Operations			
PPS Rate (based on initial cost report)	$ 100	$ 100	$ 100
Productivity change scenario	***Productivity flat***	***Productivity increase***	***Productivity decrease***
Total CCBHC Visits	1,000	1,500	500
Medicaid Payer Mix	90%	90%	90%
Medicaid Visits	900	1,350	450
Year 1 Medicaid PPS Revenue	**$ 90,000**	**$ 135,000**	**$ 45,000**
PPS Rate Rebase (based on Year 1 Operations)			
Allowable CCBHC Costs	$ 100,000	$ 100,000	$ 100,000
Total CCBHC Visits	1,000	1,500	500
PPS Rate (for Year 2)	**$ 100**	**$ 67**	**$ 200**

**Assuming all else is equal (costs, service utilization, etc.)*

1. Clinician Productivity (Services per FTE)

Impact of productivity on current revenue and future PPS-2 rate (when rebased)*:

	PPS-2 (Monthly Rate) – 12 Month Information		
	CLINIC A	CLINIC B	CLINIC C
Initial CCBHC Cost Report			
Allowable CCBHC Costs	$ 100,000	$ 100,000	$ 100,000
Total CCBHC Visits	100	100	100
PPS Rate (for Year 1)	**$ 1,000**	**$ 1,000**	**$ 1,000**
Year 1 Operations			
PPS Rate (based on initial cost report)	$ 1,000	$ 1,000	$ 1,000
Productivity change scenario	***Productivity flat***	***Productivity increase***	***Productivity decrease***
Total CCBHC Visits	100	150	50
Medicaid Payer Mix	90%	90%	90%
Medicaid Visits	90	135	45
Year 1 Medicaid PPS Revenue	**$ 90,000**	**$ 135,000**	**$ 45,000**
PPS Rate Rebase (based on Year 1 Operations)			
Allowable CCBHC Costs	$ 100,000	$ 100,000	$ 100,000
Total CCBHC Visits	100	150	50
PPS Rate (for Year 2)	**$ 1,000**	**$ 667**	**$ 2,000**

**Assuming all else is equal (costs, service utilization, etc.)*

1. Clinician Productivity (Services per FTE)

An increase in productivity allows CCBHCs to:

- Serve more clients
  - Provide more services
    - Generate more billable visits

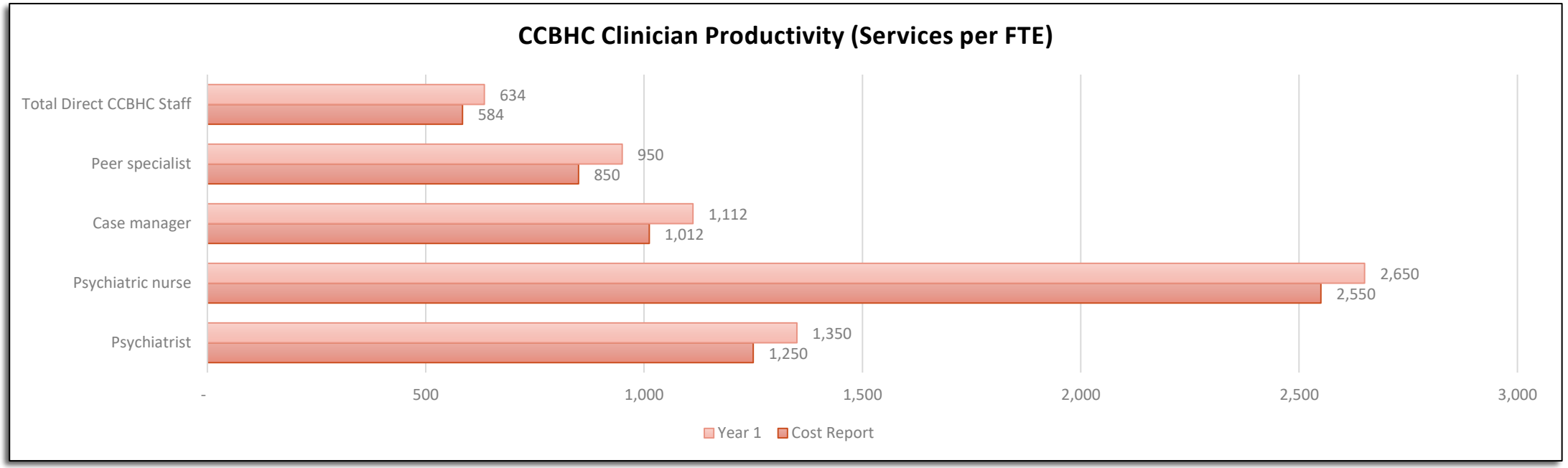
Although intuitive, this logic is important for CCBHCs operating in the PPS-2 environment, where billing is limited to 1 qualifying CCBHC service **per client per month**.

If the productivity increase is attributed to providing more services to the **same clients during the same month**, there is **no increase in revenue**!

For PPS-1 CCBHCs, it is more flexible given the ability to bill daily (vs. monthly under PPS-2).

1. Clinician Productivity (Services per FTE)

Monitoring clinician productivity:



You may also monitor the Visits per FTE productivity, but if there are multiple qualifying services provided during the same visit (PPS-1 day or PPS-2 month), which clinician gets the visit?:

The clinician treating the primary diagnosis/reason for the visit, "gets the visit." This may skew the productivity metrics, so keep this in mind when analyzing and comparing the results.

2. Service-to-Visit Conversion Ratio

The service-to-visit conversion ratio shows what % of your CCBHC services convert into a CCBHC visit.

Example:

20,000 CCBHC services *(PPS rate triggering services + non-triggering services)*

- 1,000 non-triggering CCBHC services

19,000 PPS rate triggering CCBHC services

- 1,000 same-client same-day (or month) services

18,000 CCBHC visits

$$\frac{18{,}000\ CCBHC\ Visits}{20{,}000\ CCBHC\ Services} = 90\%$$ **service-to-visit conversion**

2. Service-to-Visit Conversion Ratio

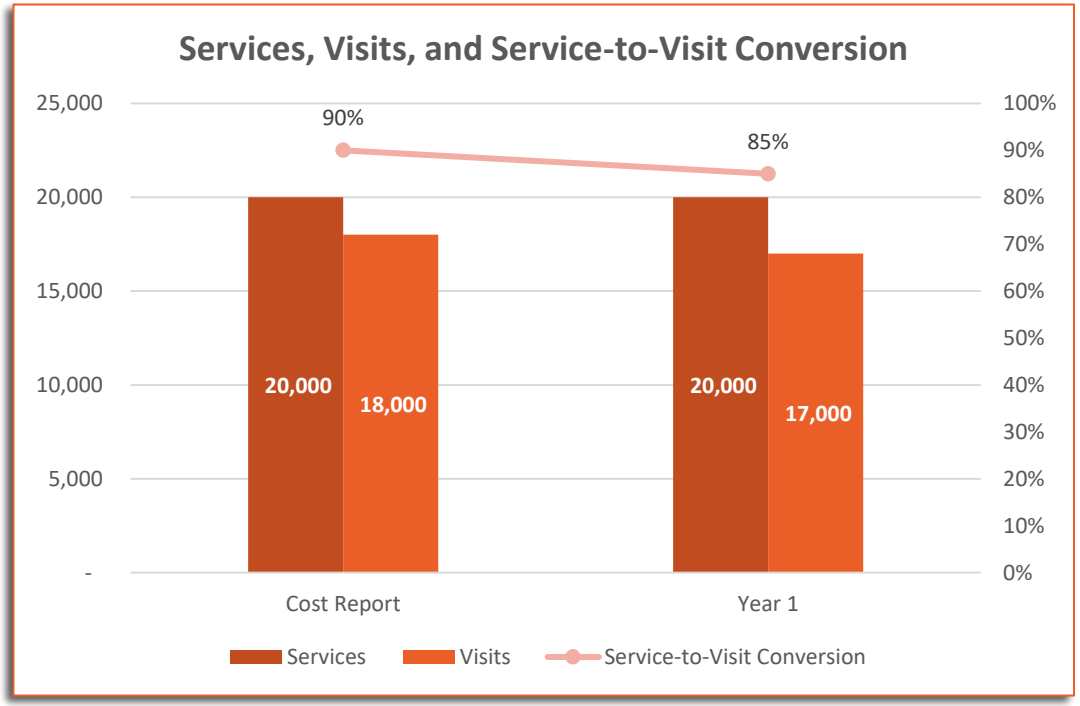
$$\frac{18{,}000\ CCBHC\ Visits}{20{,}000\ CCBHC\ Services} = 90\%\ \text{service-to-visit conversion}$$

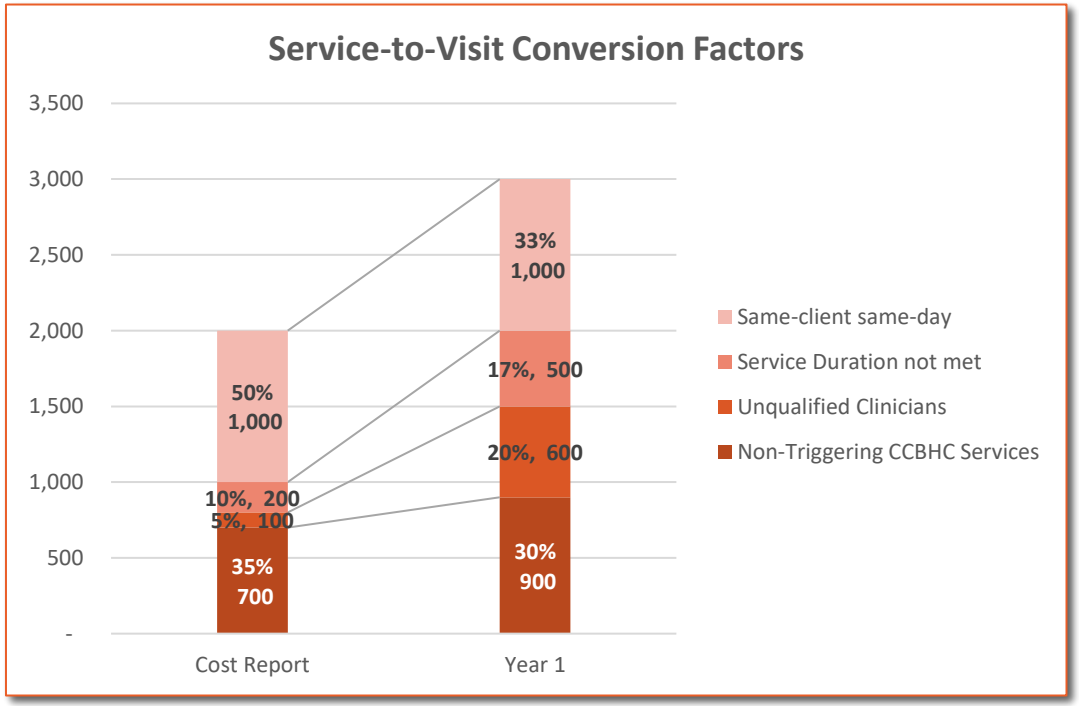
- 90% of all CCBHC services converted into a CCBHC visit.

- Underlying factors impacting this conversion:
  - CCBHC services that do not trigger the PPS rate *(non-triggering CCBHC services)*
  - Same-client same-day (or month) services
  - Unqualified clinicians *(based on State guidelines)*
  - Service duration qualification not met *(based on State guidelines)*
  - Anything else that would prevent a service from receiving a PPS rate payment

2. Service-to-Visit Conversion Ratio

Monitor the service-to-visit conversion % at the total level, and monitor the underlying factors:





Thought: Do your service-to-visit conversion ratios differ by client population/condition?

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2. Service-to-Visit Conversion Ratio

Change from 90% service-to-visit (S2V) conversion in one year to…

$$\frac{17{,}000\ CCBHC\ Visits}{20{,}000\ CCBHC\ Services} = 85\%$$

- What happens if the S2V ratio decreases?
  - Same amount of services but less visits (e.g., more services bundled into the same visit; more non-billable clinician services; etc.)
  - Lower current Medicaid PPS Revenue
  - Higher future PPS Rate

$$95\% = \frac{19{,}000\ CCBHC\ Visits}{20{,}000\ CCBHC\ Services}$$

- What happens if the S2V ratio increases?
  - Same amount of services but more visits
  - Higher current Medicaid PPS Revenue
  - Lower future PPS Rate

3. Service Utilization & Impact of Special Populations

Service utilization is a client driven metric, that estimates the average number of services per client.

Example:

1,875 CCBHC services (per month)

1,000 CCBHC clients (per month)

$$\frac{1{,}875\ CCBHC\ Services}{1{,}000\ CCBHC\ Clients} = \mathbf{1.88}\ \textbf{Services per Client (per month)}$$

3. Service Utilization & Impact of Special Populations

The service utilization will differ by client population/condition/level of care:

- General population
- Adults with a mental health diagnosis
- Youth with mental health diagnosis
- Adult substance use disorder
- Youth substance use disorder
- Adult co-occurring disorder
- Youth co-occurring disorder
- Etc.

E.g., a youth client with substance use disorder is likely to receive more services per client than a member of the general population.

3. Service Utilization & Impact of Special Populations

Your needs assessment should inform, and align with, your expected client mix.

Monitor the service utilization and client mix over time, to see if there are changes:

Client Population / Condition	Avg. Services per Month	Cost Report	Year 1
GP	1.50 (18/year)	70% →	10%
Adult w/ MHD	2.00 (24/year)	5%	5%
Youth w/ MHD	2.50 (30/year)	5%	5%
Adult SUD	2.50 (30/year)	5% →	20%
Youth SUD	3.00 (36/year)	5% →	15%
Adult COD	3.00 (36/year)	5% →	30%
Youth COD	3.50 (42/year)	5% →	15%

A shift in client mix such as the one shown here, would impact the overall service utilization. Assuming the **total number of clients served remains the same**, but the **number of services each client utilizes per month increases**, you may need to adjust your operations to accommodate the shift (e.g., hire additional clinicians to provide the additional services).

CCBHCs operating in the PPS-2 environment must monitor service utilization very carefully, since billing is limited to once per month per client, regardless of how many services are utilized by those clients (cont.).

3. Service Utilization & Impact of Special Populations

PPS-2: Change in Service Utilization Example

Month 1	*Month 2*
• 500 **General Population** clients	• 500 **General Population** clients
• **1.50** avg. services per client per month	• **2.50** avg. services per client per month
• $1,000 PPS-2 rate	• $1,000 PPS-2 rate
• 500 clients x 1.50 services per client = **750 services**	• 500 clients x 2.50 services per client = **1,250 services**
• 500 clients x $1,000 rate = **$500,000 revenue (to cover 750 services)**	• 500 visits x $1,000 rate = **$500,000 revenue (to cover 1,250 services)**
	• *Operational adjustments to accommodate the additional services? (cont.)*

3. Service Utilization & Impact of Special Populations

Under PPS-2, *assuming no change in total number of clients from month to month*:

A change in client service demand may increase (or decrease) the average service utilization (services per client). Since the total number of clients is not changing, **total revenue will not change (more services rendered does not equal more revenue).**

The average service utilization will drive the number of services, which will **impact staffing requirements to accommodate the additional (or reduced) service demands**.

Staffing requirements must be managed with a revenue source that is "fixed" in this example (fixed to the client count, rather than the service/visit count).

Under PPS-2, the **financial risk** for fluctuations in service volume/utilization is shifted from the payers, to the providers.

3. Service Utilization & Impact of Special Populations

PPS-2: Shift in Client Mix Example

Month 1	General Population	High Acuity	Combined (Average)
Number of Clients	1,000	1,500	2,500
Client Mix	**40%**	**60%**	100%
PPS-2 Rate	$1,000	$1,500	$1,300
Revenue	$1,000,000	$2,250,000	$3,250,000

Month 2	General Population	High Acuity	Combined (Average)
Number of Clients	1,500	1,000	2,500
Client Mix	**60%**	**40%**	100%
PPS-2 Rate	$1,000	$1,500	**$1,200**
Revenue	$1,500,000	$1,500,000	**$3,000,000**

From Month 1 to Month 2, there is a decrease in revenue due to a shift in client mix (more General Population clients which are less complex and have a lower cost per visit). Monitor fluctuations to see if shifts in client mix are persistent/seasonal, as these shifts can lead to revenue implications.

Operational workflows may need to adjust for changes in service demand and service utilization.

3. Service Utilization & Impact of Special Populations

PPS-1: Change in Service Utilization Example

Month 1	*Month 2*
• 500 **General Population** clients	• 500 **General Population** clients
• ~~**1.50** avg. services per client per month~~	• ~~**2.50** avg. services per client per month~~
• $100 PPS-1 rate	• $100 PPS-1 rate

Avg. services per client ***per month*** in the ***PPS-1 environment*** is ***not as useful*** as in the PPS-2 environment

PPS-1 CCBHC's ability to manage changing service utilizations is more flexible than **PPS-2 CCBHC's**

(**Daily billing** vs. **Monthly billing**)

PPS-1 clinics should monitor the **average number of services per daily visit**

3. Service Utilization & Impact of Special Populations

In monitoring service utilization and client mix, ensure you have the proper staff to meet your community's needs in the present, and in the future. Client populations/conditions with high service utilization may require additional staff resources and specialties, to fully meet the client's individual needs.

Projecting next year's service volume should not be a generic x% increase year over year… it should be aligned with your community needs assessment, and factor in the nuances of:

- New services that are being added (if applicable), and the intensity of the services
- New staff, considering their ramp-up time and non-clinical time
- A client mix that aligns with your community

4. Staffing Profile

- Typically, direct CCBHC personnel costs (salaries/wages, payroll taxes, and benefits) are the largest expense incurred by CCBHCs.
- Direct CCBHC personnel can be categorized as follows:
  - Clinicians *(service and visit generating staff)*
  - Support or program administrative staff *(non-service and non-visit generating staff)*
  - Mixed *(e.g., clinicians in supervisory roles)*
- Clinician costs may have a direct or inverse relationship with the PPS rate:
  - Highly productive and efficient clinicians may contribute to a lower cost per visit.
  - Less productive or more specialized clinicians may contribute to a higher cost per visit.
- Mixed staff costs will likely have a direct relationship with the PPS rate.
- **Support staff costs will always have a direct relationship with the PPS rate (cont.).**

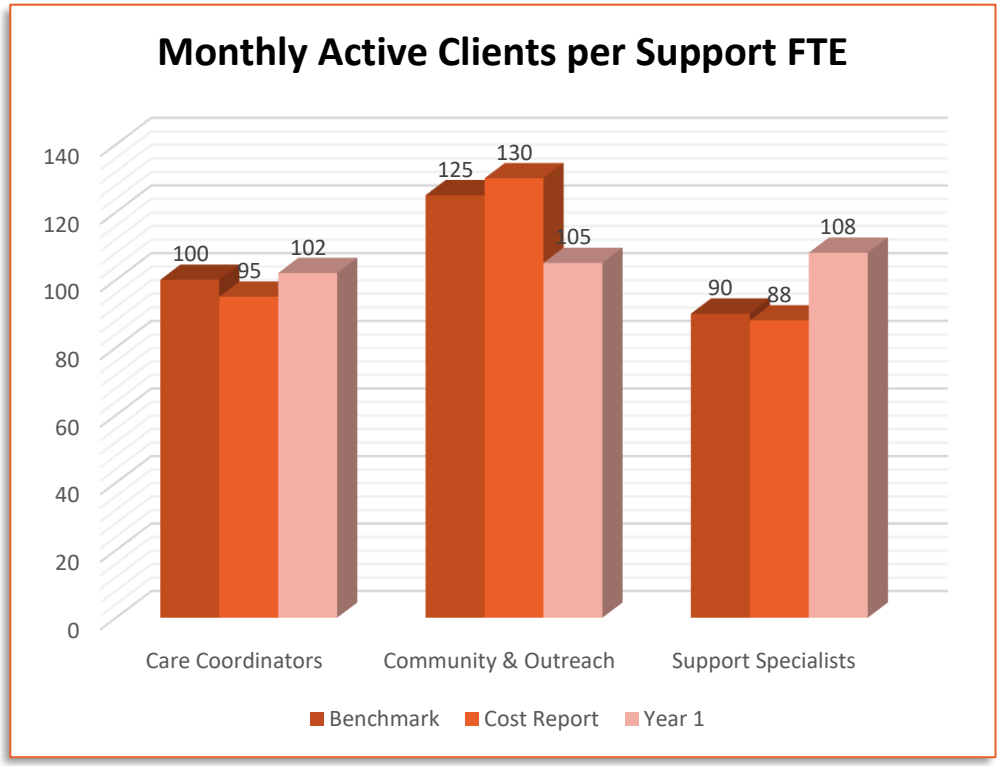
4. Staffing Profile

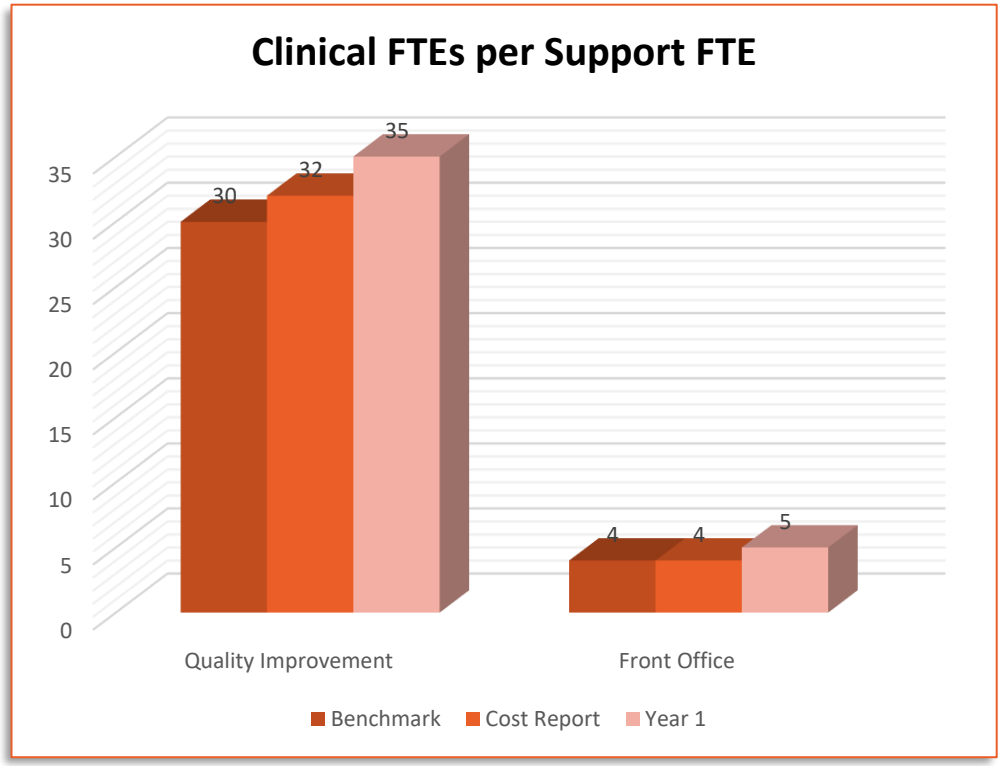
- **Support staff costs will always have a direct relationship with the PPS rate.** The more support staff FTEs (full time equivalents) → higher the costs → the higher the cost per visit and PPS rate.
- State Medicaid agencies highly scrutinize direct CCBHC support staff. Direct CCBHC support staff and program administrative staff should be both:
  - Supported by your needs assessment
  - Justified as a necessary and reasonable cost to serve your clients and community
- Classify your non-service rendering support and program admin staff into categories:

  - Care Coordinators
  - Program Admin
  - Community & Outreach
  - Enrollment Specialists
  - Quality Improvement
  - Support Specialists
  - Mental Health Technicians
  - Front Office
  - CCBHC Reporting

4. Staffing Profile

Monitor your support staff ratios *(in relation to clients or clinical FTEs)*:





5. Other Drivers of the Cost per Visit

CCBHC Direct Costs:

- Staff compensation levels (cost per FTE)
- Benefits offering to staff
- Provider mix ratio: utilization of higher-cost staff (Psychiatrists vs. LCSWs)
- Staff resources vs. independent contractor (1099 employee) resources
- Clinician time spent on non-billable or administrative activities (e.g., documentation)
- No-show rates
- Wait times (wait time to get an appointment, wait time during an appointment)
- Non-personnel costs (e.g., rent, program supplies, transportation costs)

Don’t forget about overhead or general & administrative costs allocated to the CCBHC

Common Metrics Reviewed by State Medicaid Agencies (from the CCBHC Cost Report)

- Support staff ratios (non-service producing staff FTEs to clinician FTEs)
- Productivity levels (services per FTE), by clinician type (CCBHC Cost Report lines 1-17)
- Total service utilization (services per visit)
- Average compensation levels
- Indirect cost rates

Note: Each State may track other metrics, with other data sources. The above are common metrics that can be calculated from the CCBHC Cost Report.

PART 1A - CCBHC STAFF SERVICES			
	Description	Number of Full-Time Equivalent (FTE) Staff	Total Number of Services Provided for CCBHC Services
		1	2
1	Psychiatrist		
2	Psychiatric nurse		
3	Child psychiatrist		
4	Adolescent psychiatrist		
5	Substance abuse specialist		
6	Case manager		
7	Recovery coach		
8	Peer specialist		
9	Family support specialist		
10	Licensed clinical social worker		
11	Licensed mental health counselor		
12	Mental health professional (trained and credentialed for psychological testing)		
13	Licensed marriage and family therapist		
14	Occupational therapist		
15	Interpreters or linguistic counselor		
16	General practice (performing CCBHC services)		
17	Subtotal other staff services (specify details in Comments tab)		
18	Subtotal staff services (sum of lines 1-17)	0.0	0

It’s A Wrap!

- KPIs of managing financial performance of the CCBHC program
  - Manage revenue by monitoring per visit and per client amounts
  - Manage expense by monitoring the cost per visit
  - Forecast/Project the impact of current year performance on future rates

Metric:	Revenue Impact	Expense Impact
Payer Mix	√	
Bad Debt Rate	√	
Payment Rates	√	
# of Clients	√	√
# of Visits	√	√
Service Utilization	√	√
Client Mix	√	√
Productivity	√	√
S2V Ratio		√
Staff Profile		√
Other Expenses		√

3-Year CCBHC Financial Forecasting

Objective: Prepare 3-year financial projections to assist with evaluating sustainability of the CCBHC program, project growth and PPS re-basing at the end of DY2

- Prepare a 3-year revenue and expense projection of the CCBHC program
  - Link client utilization/staffing to the CCBHC needs assessment
  - Addition of new sites and/or services
- Approach:
  - Establish most current base year
  - Re-evaluate Anticipated Costs and the timing over the 3-year period
  - Develop revenue projections
  - Forecast re-based PPS rate in DY3 based on DY1

3-Year CCBHC Financial Forecasting

- Considerations
  - Initial effective date of CCBHC billing
  - Rate periods
  - Reporting periods
  - Effective date of re-based PPS rate

Preview of Webinar #3

Learning Objectives:

- How to develop financial management reports to monitor the CCBHC KPIs and manage financial performance
- Best practices in forecasting future rebasing of the PPS rate.
- Review of operational workflows that impact the KPIs and CCBHC financial performance.

Questions & Discussion

Next Session

Financial Reporting and Management in a PPS Environment

May 27, 10:30–12 p.m. ET

Engage in hands-on training on the required financial reporting systems for managing a CCBHC PPS rate and identifying its differences from grant funding.

Serious Mental Illness Training and Technical Assistance Center (SMI TTAC) Upcoming Events

- **Case to Care Management for Those Experiencing Health Challenges and Serious Mental Illness**
  April 29, 2 p.m. ET
  The session will focus on how attendees can incorporate the principles and components of a care management approach into their work and strengthen their skills to support people with SMI through health behavior change.
- **Co-occurring SMI and SUD Learning Series Session 1: Pharmacological Management of Alcohol Use Disorder in Individuals with Bipolar and Schizophrenia Spectrum Disorders**
  April 30, 3 p.m. ET
  This session will focus on effective, evidence-based ways for clinicians to manage these co-occurring conditions and deliver quality care to their patients.
- **Leveraging the Lived Experience of People with Serious Mental Illness Learning Collaborative**
  Learning collaborative sessions will take place Tuesdays in June: June 3, 10, 17 and 24, from 1-2 PM ET. Applications are open now through May 6, 11:59 PM ET | **Apply here**!

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CCBHC Success Center News and Events Subscription Link: https://www.thenationalcouncil.org/program/ccbhc-success-center/implementation-support/#subscribe-form.

Questions? Contact us at: CCBHC@TheNationalCouncil.org

Visit our Success Center website at: https://www.thenationalcouncil.org/program/ccbhc-success-center/

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Your feedback is important to us!

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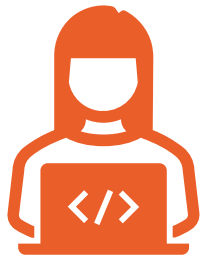
You may also scan the QR code (below) to fill out the survey!



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