DETERMINING COST OF PROVIDER CARE – A USEFUL BUSINESS MANAGEMENT TOOL

INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
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WHAT IS INTEGRATED CARE DC?

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- Integrated Care DC enhances Medicaid providers' capacity to deliver whole-person care for the physical, behavioral health, substance use disorder, and social needs of beneficiaries.
- The technical assistance program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH).

To improve care and outcomes, the program focuses on three practice transformation core competencies:

1. Deliver **patient-centered care** across the care continuum
2. Use **population health analytics** to address complex needs
3. Engage **leadership** to support person-centered, value-based care

WHY PARTICIPATE IN INTEGRATED CARE DC?

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- Integrated Care DC will help ensure you have the infrastructure, knowledge, and tools you need to deliver high-value care.
- Our coaching team includes primary care, psychiatric, addiction medicine, and behavioral health clinicians with deep expertise in integrated care models.
- Educational credit (CE/CME) is offered at no cost to attendees for live webinars.
- All DC Medicaid providers are eligible.

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AGENDA

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Determining Cost of Provider Care – A Useful Business Management Tool

- Welcome and Program Announcements
- Defining Cost
- Identification of Measurable Unit of Service(s)
- Computation of Cost per Unit of Service
- Use in Managing the Business
- Closing Remarks/Q&A

LEARNING OBJECTIVES

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1. Define and describe cost in terms of its components – Direct Costs (Variable) and Indirect Costs (Overhead)
2. Identify a measurable unit for rendered services via CPT code and Relative Value Unit
3. Describe how to obtain and quantify the reimbursement rate for each measurable unit
4. Describe how to calculate the Direct and Indirect Cost per measurable unit for comparison with the reimbursement rate
5. Discuss how to use cost of care information in business management

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POLL

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1. **Provider type**
   - Mental Health
   - Substance Use Disorder (SUD)
   - Federally Qualified Health Center (FQHC)
   - Other Primary Care
   - Care Management
2. **We have contracts with MCOs:** yes/no
3. **We have contracts with MCOs with quality incentives**: yes/no
4. **We bill entirely FFS**: yes/no
5. **We have determined cost per unit for a service.** yes/no
6. **What is your biggest fear for the transition to managed care (if you are a BH provider)?**

   Type this in the chat box!

DEFINITIONS OF TERMS IN COST DETERMINATION AND COMPARISON – SLIDE 1/4

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- **Direct Cost (Variable Cost):** Costs that can be identified specifically with a particular final cost objective.
- **Indirect Cost (Overhead):** Costs incurred for a common or joint purpose benefitting more than one cost objective.
- **Cost Allocation:** Plan or methodology used to assign Indirect Cost to Direct Cost
- **Current Procedural Terminology (CPT):** A medical code set used to report medical, surgical, and diagnostic procedures and services
  - Category I; most common CPT codes and describe most healthcare services and procedures performed by healthcare providers
    - Five-digit numeric code

SLIDE DEFINITIONS OF TERMS IN COST DETERMINATION AND COMPARISON – SLIDE 2/4

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- **Healthcare Common Procedure Coding System (HCPCS):** used in reporting to Medicare and Medicaid
  - Level I: Known as CPT-4 and used to report services and procedures performed by physicians and identical to CPT code
  - Level II are used to report medical supplies, equipment, and services not included in CPT Codes
    - Alphanumeric codes including "G", “H”, “J”, “K”, ”L”, and “T”
- **Modifier Codes:** Used to further identify services including type of provider
- **Qualified Practitioner for Mental Health & Rehabilitation Services (MHRS):** A behavioral health clinician appropriately licensed, certified, or registered in the District with Department of Health.

SLIDE DEFINITIONS OF TERMS IN COST DETERMINATION AND COMPARISON – SLIDE 3/4

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- **Relative Value Unit ("RVU"):** the base unit used by CMS Resource-Based Relative Value Scale (RBRVS) to value a certain procedure/service relative to all procedures/services. RVUs have the following three components:
  - **Work RVUs:** Cost of providers' direct care
  - **Practice Expense ("PE"):** Cost of the clinical and non-clinical labor and expenses of the practice
  - **Malpractice:** Cost of professional liability insurance

SLIDE DEFINITIONS OF TERMS IN COST DETERMINATION AND COMPARISON – SLIDE 4/4

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- **Cost Report Template:** Capture of cost, units of service, allocation of indirect cost, and cost per unit calculation
  - Template can be used to define costs associated with
    - Defined Service(s)
    - Program(s)
  - Currently available Cost Report Templates
    - Federally Qualified Health Center (FQHC)
    - Certified Community Behavioral Health Clinic (CCBHC)

DIRECT COST– STAFF COSTS

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Costs for providers and allied support personnel for the **direct provision of patient care.** Allowable providers or support personnel may vary by service or within the same service:

Physicians

- Psychiatrists
- Family Physicians
- Obstetricians
- Pediatricians
- Internists

Extenders / Non Traditional/ Non Licensed

- Nurse Practitioners (Advanced Practice Registered Nurse)
- Physician Assistants
- Certified Nurse Midwives
- Licensed Independent Clinical Social Worker (LICSW)
- Psychologist
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)

Mental Health & Rehabilitation Services Additional Providers

- Peer Specialists (under the supervision of a qualified provider)
- Licensed Independent Social Worker
- Licensed Graduate Social Worker (LGSW)
- Psychology Associates
- Certified Addiction Counselors

Other Allied (Support) Personnel

- Nurses (allowed to provide screening and assessment)
- Medical Assistants
- Care Coordinators

DIRECT OTHER SALARY RELATED STAFF COSTS

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Other Salary related costs for providers or support personnel for the **direct provision of patient care** related to the identified program.

- Contracted Labor for the services
- Fringe Benefits
- Training and Education

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OTHER NON-SALARY DIRECT COSTS

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Non-Salary related costs for **providing clinical services**, which may include:

- Supplies
- Translation or interpretation services
- Transportation
- Depreciation on clinical equipment used to provide services
- Liability insurance
- Other costs incurred as a direct result of providing services

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INDIRECT COSTS – ADMINISTRATIVE COSTS

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Overhead **administrative** expenses include costs of **running the business**, such as:

- Legal
- Accounting
- Telephone
- Depreciation on office equipment
- General office supplies

- Typical other administrative costs:
  - Management salaries/benefits
  - Other Payroll; i.e., reception, clerical, coding, billing
  - Personnel Management
  - Purchasing
  - Employee Relations

INDIRECT COSTS – FACILITY COSTS

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Overhead **facility** costs are costs incurred by the program but **not directly attributable to providing clinical services.** Facility costs include:

- Rent
- Property insurance
- Mortgage, property tax, or loan interest
- Utilities
- Maintenance
- Depreciation on the building or furniture

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INDIRECT COST ALLOCATION TO DIRECT

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At the facility level, providers can elect to directly assign indirect costs to cost centers. To do this, allocations may be done through a mathematical measure including, but not limited to:

- Direct Allocation
- Square feet
- Dollar value
- FTEs
- Time spent
- Number housed
- Worker Day Logs
- Time Studies
- Direct Costs
- Total Costs

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Certified Community Behavioral Health Clinic (CCBHC) cost template allocates Indirect Cost on Direct Costs or allows a discreet allocation.

MEASURES OF SERVICES PROVIDED

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Services provided will be the denominator in determining the cost per unit of service.

- Identifiable units for the denominator can include:
  - **CPT Codes/ HCPC Codes;**
    - CPT; five-digit numeric; services and procedures by healthcare provider
    - HCPC; Alphanumeric
  - **Behavioral CPTs/HCPCs**
    - Mental Health & Rehabilitation Services (examples)
      - Counseling; H0004
      - Clinical Care Coordination; T1017
  - **Hours of service**
  - **Visits**
  - **Encounters;** G0467, G0470, T1015

COMPUTATION OF COST AND COST PER UNIT

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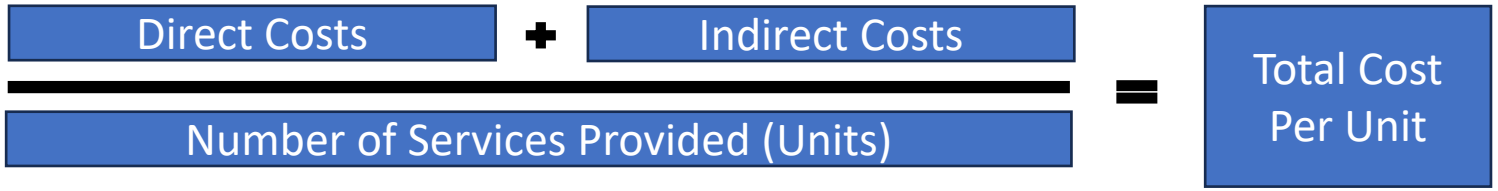

Total Direct Cost:

- Salary Cost of Provider plus
- Salary Cost of Provider Support (Allied Personnel) plus
- Fringe Benefits for all Providers and Provider Support plus
- Other non-salary direct costs

Indirect Cost

- Allocation of administrative and facilities costs

Number of services provided (units) for specified period

- **Visits/Encounters**
- **CPTs**
- **Hours (Total or scheduled for services)**
- **RVUs**

PAYER REIMBURSEMENT PER UNIT

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Medicare; By Relative Value Unit (RVU)	Established RVU by CPT multiplied by geographically adjusted Conversion Factor (2024 base of $32.7375)
Medicaid	DC Medicaid Fee Schedule by CPT or HCPCS code ▪ Specific Modifier codes may be added
Commercial	Negotiated Fee Schedule by CPT or HCPCS

MANAGING THE BUSINESS

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- Use of CPT codes to generate time or RVUs
  - Allows for management of staff productivity
    - Time billed versus time incurred
  - Ability to benchmark to external source, i.e., MGMA
- Compare Provider reimbursement per unit to cost per unit
  - Determines whether service is financially sustainable
  - Allows for analytics to be performed on service components of cost that are the key financial drivers
    - Salaries/fringes
    - Support costs
    - Other Direct costs
    - Indirect Costs
  - Informs negotiation of payer rates and payer contracting with emphasis on Managed Care
  - Provides better understanding of the financial impact in use of certain provider types to perform services:
    - Physician versus advanced practice clinician
    - Qualified Provider or a provider under the supervision of a Qualified Provider

MANAGING THE BUSINESS

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- **Is this an existing, added business line, or incremental expansion of service to the overall business?**
- Incremental Unit of existing service line
  - Consider in the financial evaluation that the Indirect Cost allocation may be small versus a "fully loaded" indirect cost assignment
- Existing or new service line
- Need to add supporting infrastructure
  - Information Technology
  - Facilities
  - Administrative support

EVALUATING EXISTING SERVICES OR PLANNING FOR NEW SERVICE MODELS WITH UNDERSTANDING OF THE FINACIAL IMPLICATIONS TO THE BUSINESS

MODIFY EXISTING AND DEVELOP NEW MODELS OF CARE (MOC)

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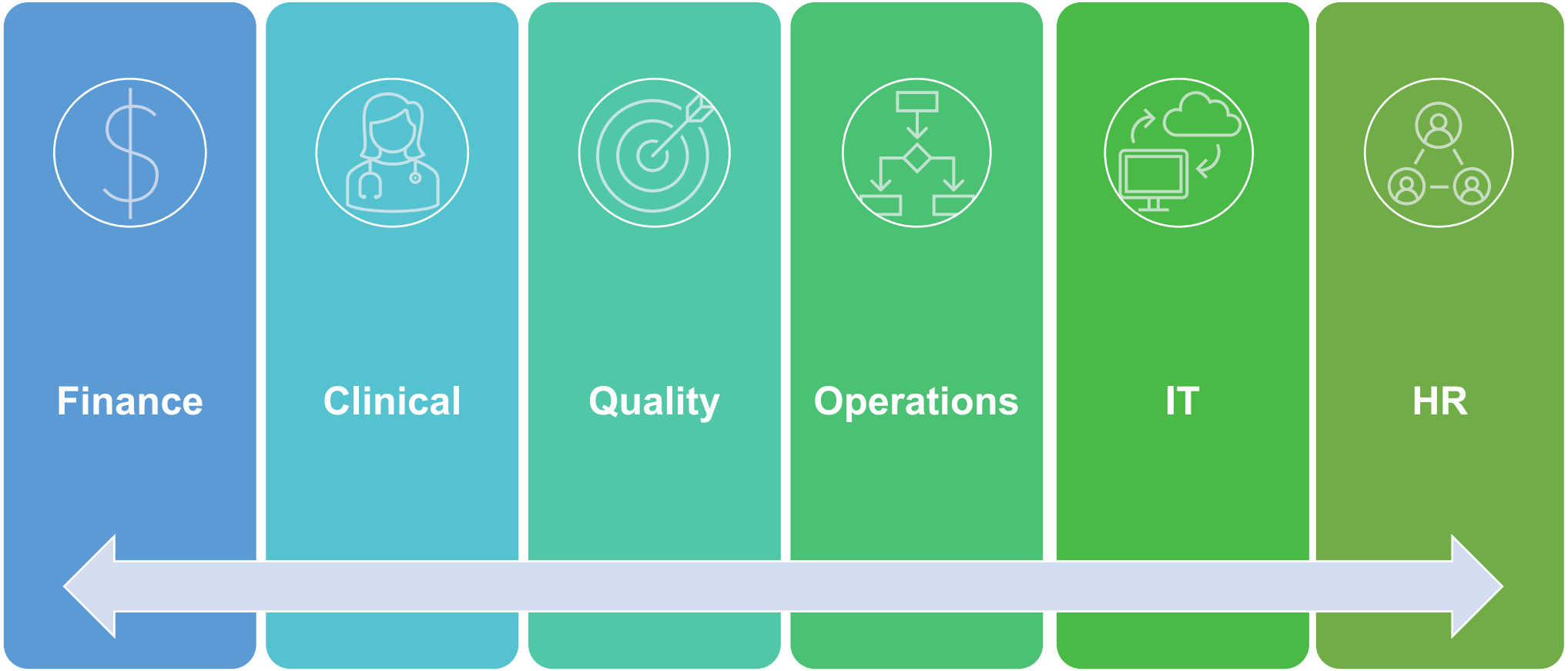

COMPONENTS FOR NEW MODELS OF CARE (MOC)

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Finance

- **Payment**
- **Payer Mix**
- Risk Management
- Incentive Structures
- Costs i.e., Staff

Clinical

- Evidence Based Practices (EBPs)
- Measurement based care
- Care Management

Quality

- Benchmarks
- Performance metrics
- Plan Do Study Act (PDSA) Cycles
- Assess intervention effectiveness and related costs
- Identify disparities in quality/equity

MODIFY EXISTING AND DEVELOP NEW MODELS OF CARE (MOC)

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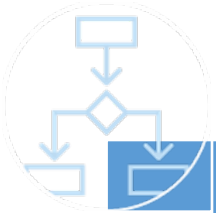

Operations

- Policies & Procedures
- Workflows
- Partnership Agreements
- Regulatory Compliance

IT

- Technology Investment
- Information Management
- Data Sharing
- Data Reporting

HR

- Recruiting
- Refiguring
- Onboarding
- Performance Management
- Training

PAYER REIMBURSEMENT TO COST PER UNIT COMPARISON

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Contribution Margin

- Payer Reimbursement less Direct Cost per unit
- Profitability of each incremental unit of service

Bottom Line

- Payer Reimbursement less Direct Cost plus Indirect Cost

Understanding the Key Financial Drivers

- Volume
  - Productivity and impact of same, i.e., no show rates
- Payer Rates
- Provider and other staff rates of pay and fringe benefits
- Other non-salary costs

PROVIDER CASE EXAMPLE

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- Midsized outpatient behavioral health provider that is certified as a MHRS provider for consumers in the District.
- Your team has been effectively managing care and reducing repeat inpatient stays related to BH conditions for individuals with serious mental illness.
- One of the MCOs in the District has approached your leadership to enter into a contract for enhanced transition planning services.
- Your organization has identified this as a priority area. In order meet the additional outpatient demand, your organization needs to add one additional psychologist and care coordinator.
- This MCO is offering an aligned incentive under the Value Based Payment Pay for Performance Program (P4P) for meeting certain quality/outcome metrics.

TOOL TO COMPUTE COST OF PROVIDER CARE AND RELATED REIMBURSEMENT

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Live Demonstration

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PROVIDER COST DETERMINATION TOOL
FINANCIAL EVALUATION
EFFECTIVE 12/1/2023

				SOURCES AND COMMENTS
Volume:		Benchmark	Benchmark	
Visits	1200	1132	1410	MGMA Median and 75th Percentile for 2022
Work RVUs	3103	2815	3363	MGMA Median and 75th Percentile for 2022
Productive Hours	1290	1800	1800	Full time equivalent productive hours
Payer Mix				
Medicaid	55.0%			
Medicare	15.0%			
Commercial	25.0%			
Self Pay/Charity	5.0%			
Total	100.0%			
Full Time Equivalents	1.00			
Net Patient Revenue	$164,353	$188,868	$234,296	MGMA Median and 75th Percentile for 2022
Other Operating Revenue	$0			Examples: Grants and Value Based Payments
Total Operating Revenue	$164,353			
Direct Costs				
Provider Salary	$108,000			
Provider Fringe	$27,000			
Other Salary Related Cost	$0			
Total Provider Salary Cost	$135,000	$122,301	$145,697	MGMA Median and 75th Percentile for 2022

BENEFITS OF VALUE-BASED CARE AND VALUE-BASED PAYMENTS

Value-based care is a delivery model in which providers, including hospitals and providers, are paid based on health outcomes.*

Value-based payments (VBP) are intended to support the delivery of evidence-based, person-centered, efficient care that contributes to improved quality and positive health outcomes at an appropriate cost.**

Patients	Providers	Payers	Suppliers	Society
Lower costs and better outcomes	Higher patient satisfaction rates and more effective care	Stronger cost controls and reduced risks	Alignment of prices with patient outcomes	Reduced health care spending and better overall health

The future of health care will be determined by payers and patients looking for the best value and rewarding providers who can deliver better outcomes.

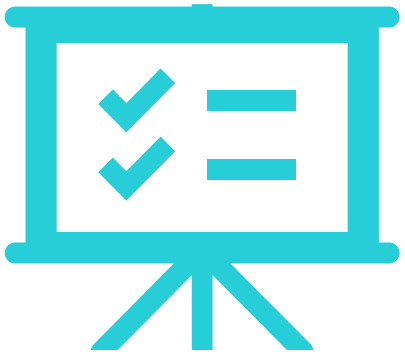
*NEJM Catalyst-Innovations in Health Care Delivery Jan 2017 "What is Value-Based Healthcare?" available at https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558
**OHA-CCO VBP Roadmap September 2019 available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf

IMPORTANT CONSIDERATIONS FOR VBP & UNDERSTANDING COSTS

Investments, infrastructure, & governance models

Long-term planning

Clinical transformation



Clear and consistent standards and benchmarks

Capacity to utilize/analyze data in real time

Q&A

RESOURCES

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Official Forms

- *CCBHC Cost Report.* Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/downloads/ccbhc-cost-report.xlsx
- *FQHC Form 224-2014*. Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/fqhc-224-2014-form
- CCBHC Cost Report Instructions. Centers for Medicare & Medicaid Services. https://www.hhs.gov/guidance/document/ccbhc-cost-report-instructions

RESOURCES

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Definitions

- *OMB CIRCULAR A-87 (REVISED 05/10/04).* Section C, “Basic Guidelines” (Pg. 8). Office of Management and Budget. https://northmiamifl.gov/DocumentCenter/View/4323/OMB-Circular-A-87-PDF
- *OMB Circular A-87, 2 CFR 225 - Cost Principles for State, Local and Indian Tribal Governments.* Office of Management and Budget. https://www.govinfo.gov/app/details/CFR-2012-title2-vol1/CFR-2012-title2-vol1-part225
- *42 CFR §413. Principles of Reasonable Cost Reimbursement.* Centers for Medicare & Medicaid Services. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413
- *45 CFR §75. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.* Centers for Medicare & Medicaid Services. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75

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Medicaid Fee Schedule

- *Interactive Fee Schedule*. DC Medicaid. https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleInquiry
- *Fee Schedule Download.* DC Medicaid. https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload

REFERENCES

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- Breslau, J., et al. (Sept 2022). Preliminary Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration. U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/preliminary-cost-quality-findings-national-evaluation-certified-community-behavioral-health-clinic
- What are Relative Value Units (RVUs)? (June 2022). American Academy of Professional Coders. https://www.aapc.com/resources/what-are-relative-value-units-rvus

WRAP UP AND NEXT STEPS

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- Please complete the online evaluation! **If you would like to receive CE or CME credit, the evaluation will need to be completed.** You will receive a link to the evaluation shortly after this webinar.
- The webinar recording will be available within a few days at: www.integratedcaredc.com/learning
- **Upcoming Webinar:**
  - *Supporting Practice Leaders Navigating Unfamiliar Waters – Leadership Through Change Part 1,* Wednesday, December 6, 2023, 12:30 pm ET
- For more information about Integrated Care DC, please visit: www.integratedcaredc.com

INTEGRATED CARE DC UPDATES

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Are you receiving our Integrated Care DC Newsletters?

Check your inbox on the 1st and 3rd Tuesday for the Monthly Newsletter and the Mid-Month Update.

Got ideas?

Take this short survey to share suggestions and requests for trainings.
www.integratedcaredc.com/survey