DECODING HEALTHCARE FINANCES: UNDERSTANDING COSTS AND INDIRECT ALLOCATION STRATEGIES, COST OF CARE PART 2

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

PRESENTED BY:
Suzanne Daub, LCSW
Chuck Weis, MBA, CPA

Wednesday,
March 13, 2024
12:30 pm – 1:30 pm ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $3,500,365, or 81 percent, of the project is financed with federal funds, and $810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

DHCF
Department of Health Care Finance

HMA

WHAT IS INTEGRATED CARE DC?

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

- 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?

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

- 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.

All content was created and delivered by HMA.

INTEGRATED CARE DC UPDATES

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

Are you receiving our Integrated Care DC Newsletters?

Check your inbox on the 1st Tuesday for the Monthly Newsletter.

Got ideas?

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

CONTINUING EDUCATION CREDITS

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

- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2022–09/22/2025. Social workers completing this course receive 1.0 continuing education credits.
- To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.
- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 02/01/2024 to 01/31/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.
- **If you would like to receive CE/CME credit, the online evaluation will need to be completed.**

  You will receive a link to the evaluation shortly after this webinar.
- Certificates of completion will be emailed within 10–12 business days of course completion.

All content was created and delivered by HMA.

PRESENTERS

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

Suzanne Daub, LCSW
Health Management Associates
Practice Site Coach/Subject Matter Expert
sdaub@healthmanagement.com

Chuck Weis
Health Management Associates
Subject Matter Expert
cweis@healthmanagement.com

Faculty	**Elizabeth Wolff, MD, MPA** **CME Reviewer**	**Muriel Kramer, LCSW, FNAP** **CE Reviewer**	**Suzanne Daub, LCSW** **Presenter**	**Chuck Weis** **Presenter**
Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A

All content has been developed and reviewed by Health Management Associates, Inc. (HMA).
HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

AGENDA

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

Decoding Healthcare Finances: Understanding Costs and Indirect Allocation Strategies, Cost of Care Part 2

- Welcome and Program Announcements
- Direct and Indirect Cost Components
- Indirect Cost Allocation Options
- Measuring Productivity; Billable and Non-billable Activities
- Link to Value-Based Care
- Review Interactive Model and Proforma
- Closing Remarks/Q&A

LEARNING OBJECTIVES

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

1. Explain expenses within direct and indirect Costs.
2. Illustrate the different indirect cost allocation methodologies and how choice of a methodology should be considered based upon the specific business circumstance.
3. Describe how to measure staff productivity considering both billable and non-billable activities.

Source: Michele Henderson on Unsplash

VALUE-BASED CARE AND VALUE-BASED PAYMENTS

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

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

delivered by HMA.

DIRECT COST COMPONENTS

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

Staff Salaries Considered within Direct Cost

Practitioners directly providing services

Allied Support Staff

- Nurses
- Medical Assistants
- Interpreters
- Case Managers
- Care Coordinators
- Community Support Workers

Fringe Benefits Components

- Federal Insurance Contributions Act (FICA)
- Health Insurance
- Workers Comp and Unemployment Insurance
- Pension
- Life and Disability Insurance

Direct assignment to FTE or application of an allocation methodology

OTHER NON-SALARY DIRECT COSTS

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

Supplies

Insurance

Other

INDIRECT COST COMPONENTS

INDIRECT COST FACILITY EXPENSES

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

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
- Housekeeping and Maintenance
- Building depreciation, equipment, and fixtures
- Other Facility Costs

INDIRECT COSTS: ADMINISTRATIVE EXPENSES

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

- Legal
- Accounting
- Telephone
- Insurance
- Depreciation on office equipment
- General Office Supplies

INDIRECT COST: ADMINISTRATIVE EXPENSES

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

Typical Other Administrative Expenses:

- Management salaries/benefits
- Payroll
- Personnel Management
- Purchasing
- Employee Relations

INDIRECT COST ALLOCATION, EXPLORING VARIOUS OPTIONS

OPTIONS FOR INDIRECT COST ALLOCATION

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

Option 1:	Option 2:
Federal Minimum (de minimis) rate of 10%	**Indirect Cost Rate specific to organization** • Applied for and then negotiated Federal rate

A Guide for Indirect Cost Rate Determination. U.S. Department of Labor Cost & Price Determination Division Office of Strategy & Administration/OSPE/OASAM, November 2023
https://www.dol.gov/sites/dolgov/files/OASAM/legacy/files/DCD-2-CFR-Guide.pdf

OPTIONS FOR INDIRECT COST ALLOCATION

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

Option 3:

Ratio of Direct Costs; Allocation based upon percent of Direct Program/Service Line Costs to Total Costs

- Total Costs would include all Direct Costs and Non-Reimbursable Costs but exclude Indirect Cost

Option 4:

Provider documented cost allocation method for select Indirect costs combined with Option #3.

- 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 the following: Square feet, Time studies, FTEs, Total Costs, Time spent, Number housed, Worker Day Logs
- Provider can also specifically assign indirect cost, e.g., via invoice, lease agreement

INDIRECT COST ALLOCATION, CONSIDERING SPECIFIC BUSINESS SITUATIONS

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

» **Indirect Cost Allocation**: How do specific business situations impact the methodology chosen and specificity of same?

- Situations to discuss
  - Establishing rates
    - CCBHC PPS 1 and PPS 2 rates
    - FQHC PPS rates initially, specific to change of scope, or use in rebasing
  - Entering or exiting a business line or program
  - Expanding an existing business line
  - Existing or new grants

USE OF INDIRECT COST ALLOCATION TOOL (1/2)

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

INTEGRATED CARE DC
PROVIDER COST DETERMINATION TOOL
INDIRECT COST ALLOCATION
EFFECTIVE 3/1/2024

	NOTES	OPTION 1	OPTION 2	OPTION 3	OPTION 4
			Entity or Federal	Ratio of Program/	HYBRID
	11 a-d	Federal	Determined	Business Lined	OPTION 3 +
		De Minimis	Indirect Cost	Direct Costs to	Directly Assigned
		Rate	Rate	Total Direct Costs	or Computed
					Indirect Cost Components
Indirect Cost Rate		**10.0%**	**15.0%**		
Direct Cost of Program/Business Line		$206,053	$206,053	$206,053	$206,053
Computation of Indirect Cost Allocation					
Total Direct Costs of the Organization		Not Applicable	Not Applicable	$2,100,000	$2,100,000
Total Indirect Costs of the Organization		Not Applicable	Not Applicable	$750,000	$750,000
Computed Total Indirect Cost Allocation		**$20,605**	**$30,908**	**$73,590**	**$76,919**
Ratio of Program/Business Line Indirect Cost to Direct Cost		**0.1**	**0.15**	**0.36**	**0.37**

USE OF INDIRECT COST ALLOCATION TOOL (2/2)

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

	NOTES	OPTION 1	OPTION 2	OPTION 3	OPTION 4
			Entity or Federal	Ratio of Program/	HYBRID
	11 a-d	Federal	Determined	Business Lined	OPTION 3 +
		De Minimis	Indirect Cost	Direct Costs to	Directly Assigned
		Rate	Rate	Total Direct Costs	or Computed
					Indirect Cost Components
Discreet Assignment using Measure or Direct Assignment		Not Applicable	Not Applicable	Not Applicable	
Facilties (lease expense/utilities) Cost					$125,000
Square Feet					
Total all facilities with Lease Expense					5000
Attributed to Program/Business Line					500
Lease Expense Assigned to Program					$12,500
Human Resouces (HR) Cost					$50,000
Full Time Equivalents (FTEs)					
FTEs					
Total all organization					12.5
Attributed to Program/Business Line					2.0
HR Expense Assigned to Program					$8,000
Remaining Costs (no discreet allocation)					$575,000
Direct Cost/Total Direct Cost x Indirect Cost					$56,419
Total Allocated					**$76,919**

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

Measuring Staff Productivity

Non-billable/Administrative activities

- Time to document patient visit
- Referrals to community-based resources
- Supervision by a Qualified Practitioner of staff

Billable activities

- Psychologist: published standards
- Community Support Worker: Time studies; internal created standard

UMBRELLA THERAPEUTIC SERVICES

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

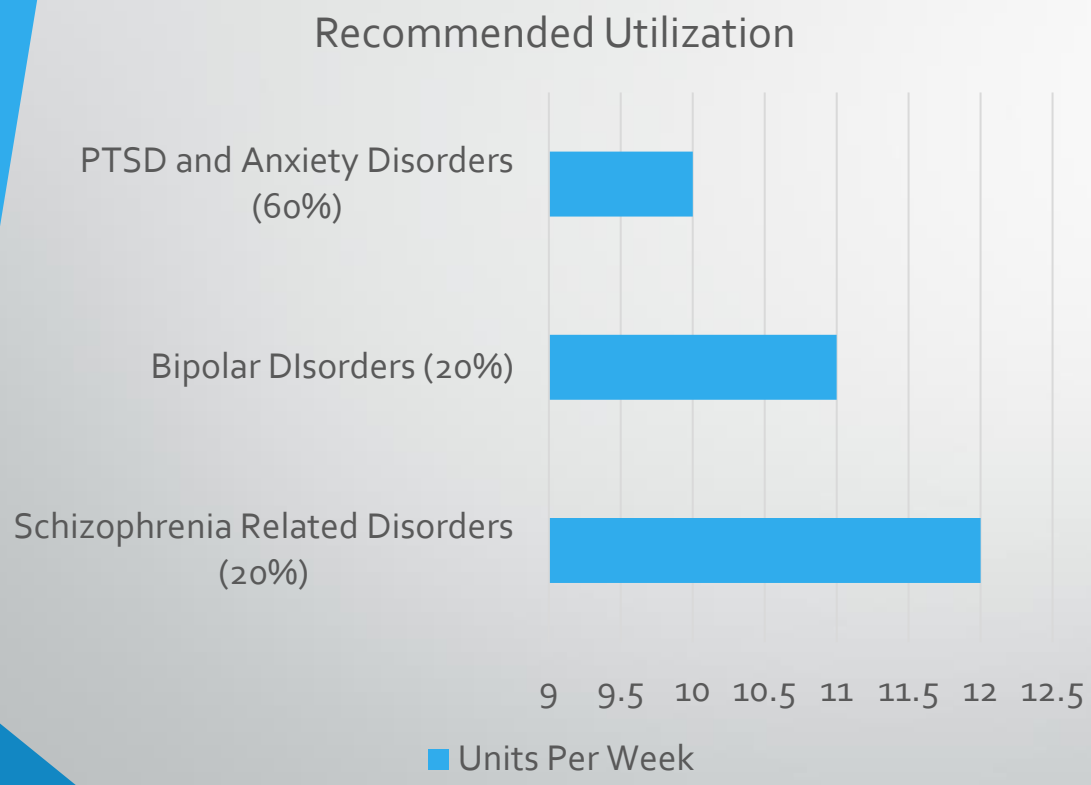
Wes Jones, DBA, MBA, MSM, MSW
Chief Executive Officer

Kena Bryant
Chief Operating Officer

Community Support Worker Time Study

An Integrated Analysis of Operational Effectiveness

Diagnostic Categories and CSW Visitation Schedules



- Schizophrenia Related Disorders (20% consumer base):
  - Recommended Utilization:
    - 3 visits/week by CSWs, 1 hour (4 units)/session.
    - Max 288 Units Per Episode (12 Units Per Week - 24 weeks)
  - DLA-20 Integration: Monthly assessments for support adjustments
- Bipolar Disorders (20% consumer demographic):
  - Recommended Utilization:
  - 2.8 visits/week, 1-hour (4 units)/session.
    - Max 288 Units Per Episode (11 Units Per Week - 26 Weeks)
  - DLA-20 Integration: Adjust visit frequencies based on daily living skills and stability.
- PTSD and Anxiety Disorders (60% consumer base):
  - Recommended Utilization:
    - 2.5 CSW visits/week, 1 hour (4 units) each.
    - Max 288 Units Per Episode (10 Units Per Week – 29 Weeks)
  - DLA-20 Integration: Regular evaluations to tailor support levels.

Methodology with DLA Consideration

Methodology with DLA-20 Consideration:

- Initial Assessment: Baseline DLA-20 assessment for new consumers.
- Diagnosis and Treatment Plan Integration: Align DLA-20 results with diagnostic categories and treatment plans.
- Continuous Re-assessment: Periodic DLA-20 reassessments to adjust visitation schedule and support intensity.
- Emergency Adjustments: Flexibility for modifying support allocations based on emergencies or significant changes in DLA-20 assessments.

Benefits of DLA-20 Integration:

- Offers nuanced and effective support.
- Links community support to functional abilities and recovery progress.
- Aligns with evidence-based practices for personalized and efficient care.

Compensation Structure

$34 average base rate

Medically necessary community support services

$5 per hour premium added

Two Individual supervisions per month

Two Group supervisions per month

Time allocated for completing CSW notes

Attendance at monthly all-staff meetings

Annual and quarterly trainings

$39 Total Hourly Compensation

TIME STUDY RESULTS

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

INTEGRATED CARE DC	
UMBRELLA THERAPEUTIC SERVICE	
TIME STUDY RESULTS; COMMUNITY SUPPORT WORKER (CSW)	
Time Study Results	
Visit Duration	1 Hour
Visit Billable Units	4.0
Average Case Load	12.7
Annual Visit Benchmark	**1530**
CSW Compensation	$39/ Hour

IMPROVE UNDERSTANDING OF BILLABLE AND NONBILLABLE ACTIVITIES

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

The example used in the development of the cost of care proforma is a Community Support Worker:

Billable community support worker activities *(above Umbrella study)*

- Implementation of a consumer's Plan of Care
- Mental Health interventions
  - Improve living skills, social skills, and support networks
  - Address social determinants of health
- Provide restorative information
- Provide individual mental health interventions
- Assist consumer in symptom self-monitoring and self-management
- Develop strategies and supportive mental health interventions
- Provide non-clinical coordination
- Documentation to support activities

Non-billable community support

- Referrals to community-based resources
- Administrative duties

Importance of documentation of activities both billable and non-billable to not only generate visit-based reimbursement but also to support the achievement of measures and metrics within the Value Based Arrangements.

EXPANDING TOOL BY ADDING OTHER PROVIDERS AND INDIRECT COST ALLOCATION OPTIONS (1/2)

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

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

INTEGRATED CARE DC
PROVIDER COST DETERMINATION TOOL
FINANCIAL EVALUATION
UPDATED EFFECTIVE 3/1/2024

						SOURCES AND COMMENTS
			Total			
Volume:	Non-Clinical	Clinical	Per Unit	Benchmark	Benchmark	
Visits; Clinical	1200	1200		1132	1410	MGMA Median and 75th Percentile for 2022 or internal time studies
Work RVUs	0	3103		2815	3363	MGMA Median and 75th Percentile for 2022
Productive Hours	1500	1470		1800	1800	Full time equivalent productive hours
Payer Mix	Non-Clinical	Clinical				
Medicaid	85.0%	55.0%				
Medicare	0.0%	15.0%				
Commercial	0.0%	25.0%				
Self Pay/Charity	15.0%	5.0%				
Total	100.0%	100.0%				
Full Time Equivalents		2.00				
Net Patient Revenue; Provider		$164,431	$137.03	$188,868	$234,296	MGMA Median and 75th Percentile for 2022
Net Patient Revenue; Non-Provider		$68,033	$56.69			
Other Operating Revenue		$0				Examples: Grants and Value Based Payments

EXPANDING TOOL BY ADDING OTHER PROVIDERS AND INDIRECT COST ALLOCATION OPTIONS (2/2)

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

Direct Costs									
Provider Salary				$108,000					
Provider Fringe				$27,000					
Non Provider Salary				$50,000					
Non Provider Fringe				$15,000					
Other Salary Related Cost				$0					
Total Provider Salary Cost				$200,000					
Supplies				$2,400					
Medical Malpractice Insurance				$2,653					
Other Non-Salary Related Costs				$1,000					
Total Non-Salary Related Direct Costs				$6,053					
Total Direct Costs				$206,053	$85.86				
Contribution Margin <Loss>				$26,412	$11.00				
Contribution Margin <Loss> %				11.4%					
Indirect Costs									
Full Overhead Allocation		$73,590	0.36				0.31	Computed Ratio of PE RVUs to Work RVUs	
Selective Overhead Allocation;		$11,623	0.06	$11,623	$4.84			Collection costs based upon a percentage	
Total Direct and Indirect Cost				$217,676	$90.70				
Net Margin <Loss>				$14,788	$6.16				
Net Margin <Loss> %				6.4%					
Net Margin from Above				$14,788	$14,788	$0			
				Revised CM	Change				
Key Financial Drivers	Change	Represented							
Volume	10.0%	Increase in Volume		$36,367	$21,579				
Payer Mix	10.0%	Commercial to Medic		$9,406	-$5,382				
Payer Rate	10.0%	All Payer Increase		$49,327	$34,539				
Salary	10.0%	Increase in Salary		-$1,012	-$15,800				

INTERACTIVE MODEL AND PROFORMA PRESENTATION

KEY TAKEAWAYS

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

- Understanding and measuring cost in delivery of services and programs is critical to the financial health of an organization.
- By utilizing time studies and benchmarking, organizations can analyze and optimize the time spent on various activities. This leads to improved resource allocation and workflow.
- Understanding the indirect costs associated with program or service lines allows for more accurate cost allocation, better financial management and decision-making.
- Comprehensive documentation of activities ensures proper billing and reimbursement, leading to the retention of current visit-based revenues.

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

Upcoming Webinars:

- **Decoding Healthcare Finances – *Costs of Care Office Hour***
  March 19, 2024, 12:00PM – 1:00PM ET

Connecting the dots to value-based care and quality

- **Understanding Cost of Care to Drive Value-Based Payment Arrangements, *Cost of Care Part 3***
  April 5, 2024, 12:00PM – 1:00PM ET
- **Quality Improvement to Optimize Financial Outcomes, Cost of Care Part 4**
  May 7, 2024, 12:30PM – 1:30PM ET

MEASUREMENT-BASED CARE

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

Use of Daily Living Activities 20 (DLA-20)

Assesses twenty (20) areas of functioning for adults impacted by mental illness or disability

Use of CAFAS instead of DLA-20 for adults eighteen (18) through (20)

DLA-20 assessment required

At intake

For adults in active treatment a minimum of every ninety (90) calendar days from date of intake

Use of scoring to measure improvement

Provider staff conducting the assessments must complete training

Training must be tracked through DBH's Learning Management System

DOCUMENTING CLINICAL SERVICES AND VALUE-BASED PURCHASING (VBP)

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

Payment Reimbursement:

- Accurate and comprehensive documentation of clinical services is essential for demonstrating the value and quality of care provided.

Accountability and Transparency:

- Clinical documentation enhances accountability by providing a clear record of the care provided.

Performance Improvement:

- Clinical documentation serves as a feedback mechanism to inform performance improvement initiatives.

Data-driven Decision Making:

- Clinical documentation provides the necessary data inputs for these analyses.

Q&A

REFERENCE LIST

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

- A Guide for Indirect Cost Rate Determination. (November 2023). U.S. Department of Labor Cost & Price Determination Division Office of Strategy & Administration/OSPE/OASAM. https://www.dol.gov/sites/dolgov/files/OASAM/legacy/files/DCD-2-CFR-Guide.pdf

- 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

- Value-Based Payment Roadmap for Coordinated Care Organizations. (September 2019). Oregon Health Authority. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf

- What are Relative Value Units (RVUs)? (June 2022). American Academy of Professional Coders. https://www.aapc.com/resources/what-are-relative-value-units-rvus

- What is Value-Based Healthcare? (January 2017). NEJM Catalyst-Innovations in Health Care Delivery. https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558

WRAP UP AND NEXT STEPS

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

- 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:**
  - *Decoding Healthcare Finances – Costs of Care Office Hour,* March 19, 2024, 12:00PM – 1:00PM ET
- For more information about Integrated Care DC, please visit: www.integratedcaredc.com