



Adjusting Business Strategies to Adapt to Changing Market Forces

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Adjusting Business Strategies to Adapt to Changing Market Forces

Costing Out Your Services



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In Times of Change, What Do Most Businesses Do?

1. Nothing. What we've done in the past will continue to be successful.
2. Hire a consultant. We need a new strategic plan.
3. Start a new line of business. We should become an FQHC.



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What is the Usual Result?

- Provide services below cost to attract business. True cost not precisely known.
- Continue same line of business. Services provided are funded by a single purchaser.
- Subsidize one program with 'profit' from another.
- Look to private and public sources for continued funding.



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Providing Services at Rates Below Provider Cost

1. Other funding helps to subsidize services.
 - Often obscured by a collection of incremental solutions.
2. Can't turn clients away. The grant ends but demand does not.
3. Preservation of administrative infrastructure.



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Program Continuation is the Primary Measure of Success

- Your agency is not its mission. Ultimately, your agency is what you can market.
- Are your services really essential components of the community safety net?
- Cost reimbursement funds your mission.
- Fee for service funds your work.
- Case rates fund your successes.



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What Really Happens

- **Big organizations get bigger**
 - More vigorous competitors
 - Mergers and acquisitions
- **Small or non-adapting organizations languish and eventually disappear**
- **Some change business models.**



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Change Management Strategy Development

Four main areas of focus –

- Financial Management
- Treatment Services
- Marketing Strategies
- Partnerships/Networks



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Financial Management

- **In a Fee for Service contracting environment, clients = revenue**
- **Purchasers will want to buy services or outcomes, not to support the agency's mission or philosophy.**
- **Do you know EXACTLY what a unit of service costs?**



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Financial Management

- How well prepared are you to negotiate a case rate or other Pay for Performance contract?
- To diversify your revenue base
- Is your current ratio at 2 or 3?
- Revenue cycle management
 - Dealing with denied claims
 - A/R management



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What is the Current Ratio?

- The ratio of assets to liabilities is a measure known as the Current Ratio.
 - $\text{Assets} \div \text{Liabilities}$
- A current ratio of 2 means that a business's current assets are twice the amount needed to cover current liabilities.
- Generally a CR of 2 or more is considered healthy.
- We're talking about short term assets and liabilities and the ability to deal with normal vicissitudes of business.



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Treatment Services



- Minimize client no-shows and drop-outs.
- Are you using program and staff performance measures now?
 - You do have data, don't you?
 - If clients do not succeed in treatment, that is to be expected. What are you doing to adjust and improve program processes?
- NIATx +



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Treatment Services

- **Maximize client outcomes**
- **In a Pay for Performance environment, outcomes=revenue.**
 - How do your staff and the services they provide connect to client outcomes?
- **Can you assign cost to outcomes?**
 - Purchasers won't be looking to buy service units.
 - We're not there yet but you need to be prepared.





Marketing

- **What are clients seeking when they come to you?**
 - Hint: It might not correspond to your vision of recovery.
- **What do purchasers want when they contract with you?**
 - It might not be the lowest cost.
- **Why is your product the best relative to other choices the client or purchaser has available?**
 - What specific advantages do you offer?
 - How are you going to fill in any gaps?





Marketing

- **The Acme Foundation has given you a grant to pay for a billboard next to Hwy 99. What does it say?**
- **Under the DMC-ODS, clients will have more choices for treatment. Why should they choose your program?**
 - Cultural and linguistic competence
 - Evening & weekend hours
 - Child care
 - Transportation



Partnerships & Networks

- A different perspective on collaboration.
- Alliances, not Mergers
 - Achieve strength in numbers.
 - Benefit from economies of scale.
 - Provide a continuum of care



Partnerships & Networks



Centralize administrative and back office functions

- Purchasing.
- Insurance – Health, Liability, Workers Comp.
- Communications.
- IT / EHR.
- Assistance to clients with M-C and SSI applications.
- HR – recruitment, etc.



Partnerships & Networks

- Clinical Advantages
 - Share MD cost for DMC.
 - Share costs for clinical supervision.
 - Joint training, case conferences, UR.
 - Opportunities to share staff among programs.
 - More, better outreach.



Partnerships & Networks

- **Clinical Advantages**
 - Provide the opportunity to improve access and retention.
 - More program options under one roof.
 - Better care coordination..
 - Easier level of care transitions



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Partnerships & Networks

- **No one level of care can do it all. Neither can you as a stand-alone service. How do you forge clinical as well as business partnerships?**
- **In a network of care model, who is accountable for outcomes?**
 - How does this connect to payment under PPF or bundled reimbursement schemes?



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Partnerships & Networks

- **Consider your competition. Do you prefer them as collaborators or adversaries?**
 - Pick your partners carefully. They will be looking at you in the same way.
 - Real value for purchasers and clients must be created in order for network to survive.
 - Relationships among members must be complementary and supportive.



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Taking Stock: Do You Know . . .

- The implications of changes in public purchasing practices (i.e. the DMC-ODS) for your cashflow and bottom line.
- The costs and sources of revenue for each program or service. This includes administration and other overhead.
- The impact of different contracts, payer mixes, and your overall program portfolio on your organization's financial health.



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Taking Stock: Do You Know . . .

- The community benefit of subsidized services and contracts when purchasers are already obligated to provide access to specific Medi-Cal reimbursed services.
- The full costs at the global and service unit levels of maintaining current services and the community benefits of maintaining these services.
- The impact that particular services have on the fiscal health of other services, including reduced quality, compensation, and stability.



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Taking Stock: Do You Know . . .

- Do you know what your planned vs. actual unit costs are?
 - In near real time?
- Planned cost is what you put in the contract.
- Actual cost reflects what really happens.
 - Is it a result of true cost increases, low productivity, staff time spent in low performing programs, client no-shows, or what?



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Subsidizing Unprofitable Services with Profitable Ones.

- Keep your cash cows healthy. Don't weaken them to support unprofitable programs.
- Cross-subsidizing can delay the day of reckoning for weak programs until it's too late.
- What about the administrative overhead contributed by weak programs?



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Underestimating the Costs / Losses From Some Services

- Exacerbated by cross-subsidization.
- On what basis are administrative costs allocated? Actual utilization may exceed estimates.



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Providing Services Funded by a Single Purchaser


- Possibly volatile utilization.
- Most publicly funded SUD programs have only one purchaser.
- Who carries risk?
 - Purchaser - Cost Reimbursement
 - Provider - Fee for Service
- Who controls access to services?



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Looking to Public and Private Funding Sources


- An earlier generation of non-profits was based on a revenue model relying on fundraising, donations & foundation support.
- Non-profits created in the 60's and 70's tend to rely more on public funding.
- In either case public purchasers do not see their responsibility as guaranteeing the fiscal health of CBO's.



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Costing Out Services


- 1) Identify costs.
- 2) Assemble anticipated costs into a service delivery unit specific budget.
- 3) Define service units if these are not already defined by the purchaser.
- 4) Link service units to increments of cost.
- 5) Set the cost-service unit apparatus in motion.



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Why is this important?

- **Helps reduce audit risk**
 - Due to improper/inaccurate apportionment of costs.
- **Helps you to negotiate better contracts.**
 - Minimizes potential underpayment, i.e. your claimed cost per service unit is less than your actual cost.



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Where Do We Start?

- **We're not starting with a blank slate.**
 - There is a lot of budgeting expertise here.
 - There are existing and prior budgets to work from. (But don't repeat past errors.)
- **Many costs are already known.**



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Budget Building Blocks

- **Staff**
 - Direct Service
 - Administration & Support
 - Start with FTEs and salaries
 - Add the cost of payroll taxes and benefits.
- **Services & Supplies**
- **Indirect Costs**
- **Do this for each service delivery unit**
 - Facility/Level of care



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Apportionment of Costs

- **Inappropriate of administrative and other costs are a major source of audit disallowances.**
 - Indirect Charges
 - Facility, program or payer specific administrative costs.
- **You must use a methodology based on GAAP and/or 2 CFR 200.**



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Developing Unit Costs

- Unit costs form the basis for reimbursement.
- They are also global measures encapsulating total service delivery unit costs and services.
- What happens when there are unanticipated changes in cost or service utilization?



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Unit Costs Helps You Answer Two Basic Questions

- What do you plan to do with your substance abuse treatment resources?
 - How many units of service do you plan to provide with resources and at what planned cost?
- What did you actually do with your substance treatment resources?
 - How many actual units of service did you provide with those resources and at what actual cost?.



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What Are the Building Blocks of Unit Costs?

- What common *costs* are associated with substance abuse treatment?
 - Direct costs: (easily traceable to services)
 - Clinical salaries and fringe benefits
 - Travel
 - Copying
 - Indirect costs: (not easily traceable to services)
 - Facility rent or depreciation
 - Utilities: heat, light, power
 - Insurance for buildings



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What Are the Building Blocks of Unit Costs?

- Some costs are directly connected to a particular service delivery unit.
 - If a cost can be easily traced to an organizational unit and/or service, then it is a direct cost. Usually clinical salaries and fringe benefits, travel, and copying are direct costs because they can be traced with relative ease.



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What Are the Building Blocks of Unit Costs?

- Some costs are not directly connected to a particular service delivery unit (SDU) and are apportioned or allocate among several SDUs.
 - If a cost is not easily traced to organizational units or services, then it is an indirect cost. Examples:
 - Facility rent or depreciation
 - Utilities such as heat, light, and power
 - Insurance for buildings
 - Costs of general administration



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What are the Building Blocks of Unit Costs?



- Indirect Costs Continued:
- Indirect costs are usually allocated or apportioned on varying bases such as:
 - Square footage occupied by the organizational unit or service delivery unit
 - Pro-rata allocation based on relative cost
 - Number of staff FTEs assigned
 - Or GAAP-based methodology



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Computing Unit Costs

- **How are units of service costs computed?**
 - A multi step process to develop sound unit costs:
 - Assign costs to the various services (programs) offered
 - Assign administrative costs to the various services (programs) offered
 - Identify the type and amount of units of service provided by each service (program)
 - Calculate the cost per units of service (or unit service cost)





Computing Unit Costs

1. **Identify service delivery or organizational units and services for your organization.**
2. **Assign direct salary and wage costs to each organizational unit and to each service (or program).**





How Are Unit Costs Constructed?

3. **DETERMINE COST of FRINGE BENEFITS and ASSIGN TO EACH ORGANIZATIONAL UNIT and TO EACH SERVICE (or PROGRAM)**
4. **ASSIGN OTHER DIRECT and TRACEABLE EXPENSES TO EACH ORGANIZATIONAL UNIT and TO EACH SERVICE (or PROGRAM)**



How Are Unit Costs Constructed?



5. ASSIGN INDIRECT OPERATING EXPENSES TO EACH ORGANIZATIONAL UNIT and TO EACH SERVICE (or PROGRAM)



How Are Unit Costs Constructed?

6. ASSIGN THE COSTS OF ADMINISTRATIVE AND SUPPORT UNITS TO OTHER ORGANIZATIONAL UNITS and TO SERVICES (or PROGRAMS)



7. DETERMINE THE BASIS FOR UNITIZING THE SERVICE (or PROGRAM)



How Are Unit Costs Constructed?

8. IDENTIFY THE ACTUAL (or estimated, if prospective) ANNUAL (or other period) AMOUNT OF SERVICE FOR EACH SERVICE (or PROGRAM)

9. COMPUTE THE UNIT COST FOR EACH SERVICE (or PROGRAM) [Total Cost divided by STEP 9]



KPIs in SUD Treatment

- KPIs can answer or point to the answers to important questions about SUD treatment service operations. For example:
 - How much of the *service treatment capacity is planned* to be used for services?
 - How much of the *actual service treatment capacity was used* for services?
- The important thing is that your planned capacity and cost targets are accurate.



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KPI in Substance Abuse Treatment

- After the resources are planned and the level of activity is envisioned for the outpatient program, the planned *unit-of-service cost* can be computed or what could be called the *planned unit cost* for an outpatient hour of service.
- The *planned unit cost* now becomes a *KPI* operating as a target to be achieved in actual operations.



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KPI: Planned vs. Actual Use of Capacity

- Acme Recovery Services is planning to use 90% of its residential treatment capacity and 66% of its outpatient program capacity for DMC-ODS services.
- The actual utilization of capacity for each program is 80 percent and 50 percent, respectively.
- The programs missed the targets by 10% and 16%, respectively.
- Managers need to ask questions about what happened. What is behind the shortfall? (Or, if the variances were the other way around, what is behind the overutilization?)



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KPIs in Substance Abuse Treatment

- How much of the actual service treatment capacity was used?
- The use of the service treatment capacity can be assessed by dividing the *actual resources consumed* in a service by the *actual number of units of service produced* to calculate the cost per unit of service or, more briefly, a unit cost.



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KPI: Comparison of Planned vs. Actual Unit Costs

- Planned and actual unit costs for residential treatment are \$150 and \$200, respectively, with a \$50 cost overrun.
- Planned and actual unit costs for outpatient services are \$50 and \$60, respectively, with a \$10 cost overrun.
- In both cases, the costs were higher than expected and the productivity of services was lower than expected.
- Managers will need to look into the reasons behind the cost overruns and/or lower than expected productivity. (If costs were lower than expected or service production still was higher than expected, managers would seek explanations.)



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Highlight Cost or Productivity Problems

- When dividing the (planned or actual) costs by the (planned or actual) units of service, there may be, for example, excessive costs (in the numerator) or poor productivity (in the denominator) that could produce unacceptable unit costs.
- High or low units costs deserve management attention—*why* are they high or low?



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Perform Cost-Outcome and Cost-Effectiveness Reviews

- The resources consumed for a particular target group may be estimated with the unit-of-service costs along with levels of service (unit-of-service cost x number of units received = resources consumed).



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Relationships Between Variables

- The notion of relationships extends to each service provided by substance abuse programs, especially in a multi-service organization where the programs are part of a continuum of care.
 - Costs
 - Quality
 - Volume
 - Rates
 - Staff



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Relationships Between Variables

- The costs incurred for a service delivery unit (SDU)
- The quality of care provided by an SDU
- The volume of service needed to deliver at the established reimbursement rate to break even or achieve a profit
- The rate (revenues) received from the purchaser for providing a service
- The role of staff and staff training



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Cost Examples

- Increased staff turnover which leads to more expensive replacement personnel which leads to increased personnel costs & increased Unit Costs
- Increased staff turnover which leads to less expensive replacement personnel which leads to lower personnel costs & lower Unit Costs
- Increased staff turnover which leads to less expensive (and less experienced) replacement personnel which leads to lower personnel costs which leads to lower productivity (fewer units of service) & increased Unit Costs



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Volume

- If client volume decreases, it leads to lowered number of units of service = increased Unit Costs
- If client volume decreases and reimbursement rate doesn't change, it leads to decreased cash flow which leads to increased borrowing which leads to = increased Unit Costs
- If costs remain constant and level of service increases = decrease in Unit Cost (but *not* in direct proportion to increase in services)



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Rates

- If reimbursement rate is lower than Unit Cost of Service, this leads to decreased cash flow, which leads to increased borrowing = increased Unit Costs
- If reimbursement rate is lower than Unit Cost of Service this can lead to a decrease in number of professional staff, salary, and fringe benefits costs, and increase in staff case load or leads to lower Units of Service = increase *or* decrease in Unit Cost



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Productivity

- **How many hours per year are staff assigned to direct service delivery?**
 - 1,400 is a good benchmark
- **Productivity has a direct impact on actual unit cost.**
 - High productivity lowers unit cost, providing value to purchaser.
 - Low productivity raises unit cost, creating liability for provider.



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Managing Managed Care Contracts

- Managing a substance abuse treatment organization: a complex process requiring periodic assessments of performance.
- Key Performance Indicators (KPIs) are an important tool to measure performance.
- KPIs are comprehensive measurements, generally expressed in ratios or percentages, with upper and lower boundary targets.



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Key Performance Indicators



- The dashboard of your car has several KPIs: gas gauge, oil pressure warning light, water temperature gauge, speedometer
- Using these four key indicators and assuming a competent driver, one can drive from point A to point B.
- Most KPIs are *diagnostic*—they tell you something needs attention. (oil pressure)
- However, some are also *prescriptive*—they tell you something needs attention *and* what needs to be done. (gas gauge)



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Building a KPI Dashboard

- **What are the key operational areas or domains to examine?**
- **What aspects of these domains are:**
 - Easily accessible
 - Easily calculated (assuming calculation is needed at all)
 - Easily understood by purchasers and non-technical readers.
 - And, have a direct bearing on vital program processes and conditions.



KPI Candidates for SUD Treatment

- **Admissions**
 - Planned vs. Actual
- **Client Engagement**
 - How many drop out?
- **Client Retention**
 - How many complete treatment?
- **Monthly and YTD Reimbursement**
 - Planned vs. Actual
 - Number of denials





A Few More KPIs

- **Planned vs Actual Unit Cost**

And . . .

- .



Questions?

Victor Kogler – vkogler@cibhs.org



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