Financial Modeling Workbook Instructions

Broadly Defining Value for Your Model of Integrated Care

We encourage you to think first about creating or improving your strong, high quality, measurement-based integrated health care delivery model and then determine how to sustain your effort. Long term, quality is the best assurance of sustainability. A narrow view of sustainability might only consider finances, but we strongly encourage practices to consider all the ways that practicing measurement-based treatment to target contributes to the health of your patients and adds value to your organization.

- **Behavioral Health Care Access:** Improved access and wait times, ability to leverage access to Psychiatric Consultant time
- **Patient Experience:** Improved satisfaction due to improved access, decreased stigma, improved communication between multiple providers, improved symptoms, improved quality of life
- **Provider Experience:** Reduced isolation, increased support/improved access to specialty consultation, improved satisfaction, case-based learning, opportunity to work on a team, reduced burnout and turnover of staff
- **Quality of Care:** Patients consistently receive appropriate effective treatment; both brief evidenced-based behavioral interventions and supported medication management; population level impact, improved population level screening
- **New Funding Opportunities:** Behavioral health screening and outcomes are targets for accountable care organization (ACO) shared savings, and value-based payments
- **Health Care Savings:** treating depression has been shown to result in a $6:1 return on investment; patients with comorbid behavioral health and physical health conditions cost two to three times more than patients with physical health conditions

Cost of Behavioral Health Integration

There are two types of costs associated with implementing BH Integration. This modeling workbook focuses only on the ongoing costs of care. Organizations typically also have to invest resources in the practice change necessary to implement and optimize behavioral health integration work flows.

Collaborative Care Staffing

A full-time Behavioral Health Care Manager (1.0FTE) can generally support an active caseload of 60-100 patients. Clinics serving patients with complex socio-economic needs typically work best with a smaller caseload, while those serving patients with less complexity and adequate income can work at the upper limit.

We recommend three (3) hours of Psychiatric Consultant time for each full-time Behavioral Health Care Manager (BHCM). These three hours represents: one hour for weekly Systematic Caseload Review (SCR), one hour for preparation and documentation and one to cover availability throughout the week for urgent consultation as needed. Any direct patient care time should be added onto the base 3 hours. For more guidance, see Caseload Guidelines for Behavioral Health Care Managers and Psychiatric Consultants.

Financial Modeling Workbook Instructions

The following instructions provide clarification about how to complete the BLUE input fields in the Financial Modeling Workbook. They also explain some of the GRAY, PURPLE, and GOLD Fields.

Input	= User-entered value
Calculation	= Calculated field (not editable)
Benchmark	= Suggested benchmark (editable)
Linked Information	= Information copied from another cell

There are 4 TABS in the Worksheet.

Key tips:

- Gather a knowledgeable team to complete the workbook. The more accurate the information you put into this model, the more accurate and valuable the results will be.
- If you don't have real data, make your best estimate. You will want to update any calculations as you have the opportunity to collect actual data from your practice.
- This modeling workbook allows you to play with practice parameters to understand their impact. For example you can vary the length of appointment times or the percentage of staff time spent on the different tasks, to better understand the impact of different workflows.
- For the payer mix on the Net Financial Impact tab use any payer populations for which you plan to offer Collaborative Care.
- Remember to consider the licensure of your behavioral health staff when assessing reimbursement potential or method of billing.

TAB 1: Disclaimer

Users will not be able to populate the workbook until they sign the Disclaimer tab.

TAB 2: Staffing and Service Delivery

I. Staffing

Hours Per Week Per FTE	The number of hours that is equal to one Full Time Equivalent (FTE) in your organization (usually 40 hours, but may be less in some practices).
BHCM FTE	The total Behavioral Health Care Manager(s) FTE
Psychiatric Consultant FTE	Time allocated to your behavioral health integration program only. Benchmark recommends this should be at a MINIMUM ratio of 1.0 FTE BHCM (40 hours) to 0.075 Psychiatric Consultant FTE (3 hours).

II. Weekly Time Allocation and Service Unit Generation– Behavioral Health Care Manager

For Practices with experience, we suggest you use the most accurate data you can of how Behavioral Health Care Management staff actually spends their time and efforts (not just what they are scheduled for). Remember there is no category for No Show or Unfilled appointments, so the assumption is that any unused appointment time will be filled with charting, phone calls, or other activities listed.

Clinical Care Services – counted towards billing psychotherapy codes or BHI/CoCM

Warm Connection Visits of 16+ minutes	The total hours spent by the Behavioral Health Care Manager doing warm connection visits
Initial Assessment Visits	The Behavioral Health Care Manager's total hours spent doing initial diagnostic assessments
Follow-up Visits	The Behavioral Health Care Manager's total hours spent doing follow up visits
Group Treatment Visits	The Behavioral Health Care Manager's total hours spent doing group therapy services

Clinical Care Services – counted only if billing BHI/CoCM

Telephone Visits/Portal/Text Clinical Exchange	The BHCM's total hours spent on clinical communication.
Warm Connections Visit Under 16 minutes	The BHCM's total hours spent doing warm connections
Contact Attempts	The BHCM's total hours spent in phone calls, letters, other outreach activities, whether patient is reached or not
Systematic Caseload Review with Psych Consultant	The BHCM's total hours spent in direct consultation with the Psychiatric Consultant
Team Communication	The BHCM's total hours spent in ongoing collaboration with the treating medical provider and other qualified professionals
Clinical Documentation and Registry Management	The BHCM's total hours spent with clinical documentation and managing the registry

Administrative Tasks – not billable

Non-Clinical Activities (Scheduling Appointments, etc.)	The Behavioral Health Care Manager's total hours spent doing administrative task; not billable
Other (Staff Meetings, Trainings, etc.)	The Behavioral Health Care Manager's total hours spent in other required clinical and staff responsibilities, not billable

NOTE: *Time allocations must total 100% of the total hours per week. Sheet will show an error if assigned time is not 100%*

III. Weekly Time and Effort Allocation and Service Unit Generation– Psychiatric Consultant

Practices will differ widely in how they allocate Psychiatric Consultant time, depending on whether it is a consultation only function, or if the Psychiatric Consultant will also be seeing patients for direct traditionally billable Assessments and Follow-up. Both options are available on the worksheet.

Indirect Care and Administrative Tasks – Not billable

Registry Review	Time the Psychiatric Consultant spends reviewing the registry prior to Systematic Caseload Review
Direct PCP Communication	Psychiatric Consultant's time spent in direct consultation with treating medical providers
Systematic Caseload Review with the BHCM	Psychiatric Consultant's time spent in direct consultation with the BHCM
Charting	Psychiatric Consultant's time spent in charting consultation notes
Other (Research, Staff Meetings, Trainings, etc.)	Psychiatric Consultant's time spent in other required clinical and staff activities

Direct Care – Billable via Psychiatry CPT Codes

Assessment Visits	Psychiatric Consultant's time spent doing initial assessment visits
Follow-up visits	Psychiatric Consultant's time spent doing follow-ups

IV. Annualized Reimbursable Direct Care Services –

Working Weeks Per Year	The number of weeks in a year that a staff member is expected to be working seeing patients. This should be a full year minus paid time off (usually 46 to 48 weeks).

V. Case Load and Monthly Case Volume Capacity

Average (or Mean) Weeks Between First and Last Patient Contacts	The number of weeks in an average episode of care in your site
Average (or Mean) Number of Patient Care Services Provided	The average number of patient contacts per episode of care (either in person or on the phone)

***NOTE**: This section will calculate the following case load and patients served projections of capacity.*

- **Single Point in Time Case Load Capacity:** This cell estimates how many patients are possible to be on your Behavioral Health Care Manager(s) active caseload at any given time. This calculation factors in average duration of treatment (E68) and annual service units (F62) compared to average count of service units delivered per episode (E70) to calculate a potential capacity. *While there is no specific consensus on caseload size, it's common to have between 50 – 100 patients for a full time Behavioral Health Care Manager's*

at full capacity. See AIMS Center Caseload Guidelines for Behavioral Health Care Managers and Psychiatric Consultants

- **Projected Annual Caseload Capacity:** This cell estimates the number of unique individuals possible to serve over one year by all Behavioral Health Care Manager(s), on the basis of how many weeks on average individuals are active.
- **Projected Average Monthly Case Load Turnover:** – This cell estimates how many cases on average are opened and closed each month based on the estimates in the prior cells.
- **Projected # of Patients Served Per Calendar Month:** This cell estimates the number of unique individuals served per month who may be eligible for monthly payment reimbursement based on projected turnover and single point in time case load.
- **Projected Annualized Monthly Payment Potential** – This cell estimates the number of times a monthly payment could potentially be billed in a year (before accounting for payer mix), based on a calculation of how many months each unique patient would likely be eligible for billing.

TAB 3: Net Financial Impact

I. Payer Mix

Payer	The name of individual payers in your organizational payer mix. See NOTE below. Rows may be added if necessary. Formulas will need to be copied if rows are added.
% of Patients per Payer	The percentage of all patients who have a specific payer coverage (i.e. the percentage of Medicare patients out of all patients).This may be your overall patient population, or more specific to the population(s) you serve in the BH program. The latter is preferable if you have the data.
% of Patients per Payer Eligible for Billing BHI/CoCM codes	The percentage of total patients with that payer that you plan to bill via BHI/CoCM codes If you plan to bill all patients with that payer enter 100%. If only certain product types or qualifying criteria would be eligible enter less than 100%. This percentage is then multiplied by the percent of patients per Payer column to calculate the Adjusted % of Total Patients Eligible for Billing CoCM codes.

NOTE: *We recommend developing your payer list with as much detail as needed. If different plans within a payer allow or disallow BHI/CoCM billing, or reimburse very different amounts, you should consider adding them as separate payers. We recommend using the payer mix of the population(s) served by our BH Integration program, if available, rather than your global payer mix.*

II. Reimbursement - Annualized Monthly CoCM Billing

NOTE: **ONLY list the payers you will be billing via BHI/CoCM codes in this section.** *Once the Payer Mix is populated in the first section, drop-down menus will appear with the same Payers when you click in the BLUE Payer boxes in both Reimbursement sections.*

Payer *Remember to Use Drop Down Menu!*	The name of an individual payer that you plan to bill via BHI/CoCM codes.
Estimated Average Monthly Reimbursement Rate	***This will auto-populate once you complete the Monthly Billing Rate tab, which we advise you to do at this step!***

III. Reimbursement –Annualized Billable Individual Services

Payer *Remember to Use Drop Down Menu!*	The name of an individual payer that reimburses you for direct care services (i.e. assessment, therapy).
BHCM Direct Treatment – Assessment Avg Payment	The average reimbursement amount from that payer, in dollars, for psychiatric assessment level of service codes (i.e. 90791).
BHCM Direct Treatment – Ongoing Avg Payment	The average reimbursement amount, in dollars, for ongoing therapy or medication level of service codes (i.e. 90832, 90834, 90837, 99212-99215).
BHCM Group Treatment Avg Payment	The average reimbursement amount, in dollars, for group therapy level of service codes (i.e. 90853).
Psychiatric Consultant Assessment Avg Payment	The average reimbursement amount, in dollars, for psychiatric assessment level of service codes (i.e. 90792).
Psychiatric Consultant Ongoing Avg Payment	The average reimbursement amount, in dollars, for psychiatric visit service codes (i.e. E&M codes)

IV. TOTAL Reimbursement – this will auto-populate from the sections above and the Monthly Billing Rate tab once it has been filled out. (see Tab 4: Monthly Billing Rate below)

V. Cost of Services

Annual Salary per FTE	The full time salary for a BHCM or Psychiatric Consultant at the agency.
Fringe Benefits % of Salary	The percentage of fringe benefits at your organization, based on FTE.
Organizational Overhead	The indirect or overhead rate at your organization. Includes support staff, clinical oversight staff and facility costs.

NOTE: *You may add rows for additional payers by following instructions in the grey box: 1) Unprotect the worksheet (no password is needed), 2) insert however many rows you need above the last row with data, 3) copy the formulas in any orange or grey cells to the new rows you added, and 4) re-protect the worksheet (no need to add a password when prompted).*

Financial Modeling Workbook Instructions

TAB 4: Monthly Billing Rate

This tab is used for calculating your practice's average monthly reimbursement for the BHI/CoCM codes, so it should be completed if you are billing any payers with this method. Since this payment varies based on treatment month and minutes spent with patients, you need to be able to estimate an average monthly payment so that it can populate the Net Financial Impact Tab.

NOTE: There additional codes utilized for integration in general that are not covered by all insurances (i.e. 99484). Gcodes in particular are for Medicare patients. FQHC and RHC practices are only allowed to bill on both a minimum and maximum of 20 minutes for General BHI, 70 minutes for initial month, and 60 minutes for subsequent months. Options for FQHC/RHC practices are highlighted below.

Not Seen or Threshold Not Met	**% of Patients who are not seen at all, or are under the time threshold during the month.**
20+ Minutes (G0511)	**% of Patients billed using General BHI Services Code**
30 min in ANY month (G2214)	% of Patients billed who meet the threshold for billing G2214
70 Initial Minutes (99492 or G0512)	**% of Patients who meet only the minutes threshold for billing 99492 or G0512**
100 Initial Minutes (99492 + 99494)	% of Patients who meet the threshold for 99492 + 99494
130 Initial Minutes(99492 + 99494 x 2)	% of Patients who meet the threshold for 99492 +99494 x 2
60 Subsequent Minutes (99493 or G0512)	**% of Patients who meet only the minutes threshold for 99493 or G0512**
90 Subsequent Minutes (99493 + 99494)	% of Patients who meet the threshold for 99493 + 99494

Average Reimbursement Amounts are added manually, based on your experience. The Medicare Benchmark Payments for the current year are provided, but are also editable to account for annual changes in the Medicare index.

The Average Monthly Reimbursement per Eligible Patient is calculated and used to populate the Estimated Monthly Reimbursement Rate in the REIMBURSEMENT: Annualized Monthly CoCM Billing Section of the Net Financial Impact Tab.

Return to the Net Financial Impact Tab to see the final results once the Monthly Billing Rate table has been completed. Feel free to revisit any of the Input fields to make changes in your activity allocation, target caseload size, payer mix, etc. to arrive at another projection. It's helpful to revisit the spreadsheet after 6-12 months of experience to test your assumptions.