Behavioral Health Payment Reform

How to Succeed in a World of Phase II Accountable Care Collaboratives

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A Shifting Landscape

- The 5 BHOs and 7 RCCOs are going away
- Replaced by 7 Regional Accountable Entities (RAE)
- What else do we know?
  - RFP coming out in October or November 2016
  - 7 RAEs will be selected through competitive bid with a 7/1/2017 go live date
  - Capitation to the RAEs for an identified set of covered BH diagnoses
  - Increased push for integrated care
- What DON'T we know?
  - Who will have RAE contracts
  - How RAEs will pay BH providers
  - What kind of bonus and shared savings programs will be used

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The purpose of this session…

- To help participants prepare for the payment reform aspects of this brave new world!

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Today's Agenda

1. Introductions
2. Group Brainstorm – How might the new RAE system change BH service delivery and financing in Colorado
3. What is Modern Value-Based Purchasing (VPB)?
4. Designing VBP Models at the RAE Level
5. Organizing at the Provider Level to Succeed in a VBP World
6. What do we start doing tomorrow?

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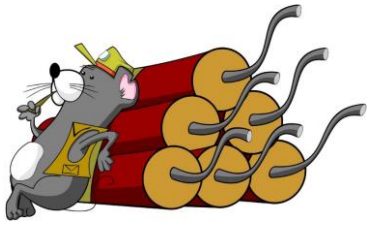
Introductions

- Your Name and Position
- Your Organization's Name and Location
- The BHO and RCCO you Serve
- What's something you're exciting about the shift from BHOs/RCCOs to RAEs?



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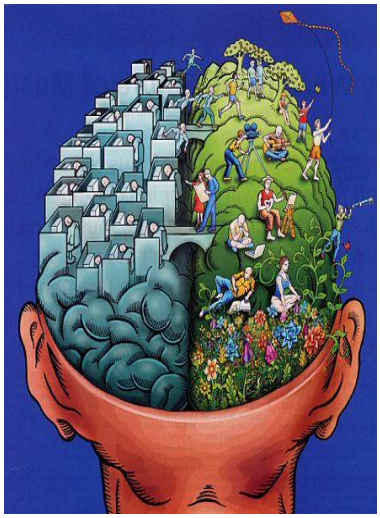
Group Brainstorm

- Simple 2-Part Question:
- How QUESTIONS do you have about how the new RAE system might change:
  - Behavioral Health Service Delivery, and
  - Behavioral Health Financing in Colorado?
- What PREDICTIONS do you have about the above?



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What is Modern VBP?

1. Exploring the Major Shift in Funding
2. Diving into Accountable Payment Models (Layer 1)
3. Examining Bonus and Shared Savings Models (Layer 2)

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Three Topics

1. Exploring the Major Shift in Funding
2. Diving into Accountable Payment Models (Layer 1)
3. Examining Bonus and Shared Savings Models (Layer 2)

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1. Funding Shifts Needed

- Payors and Policy Makers now Get It.
- The Health Care Funding Portfolio is Out of Balance

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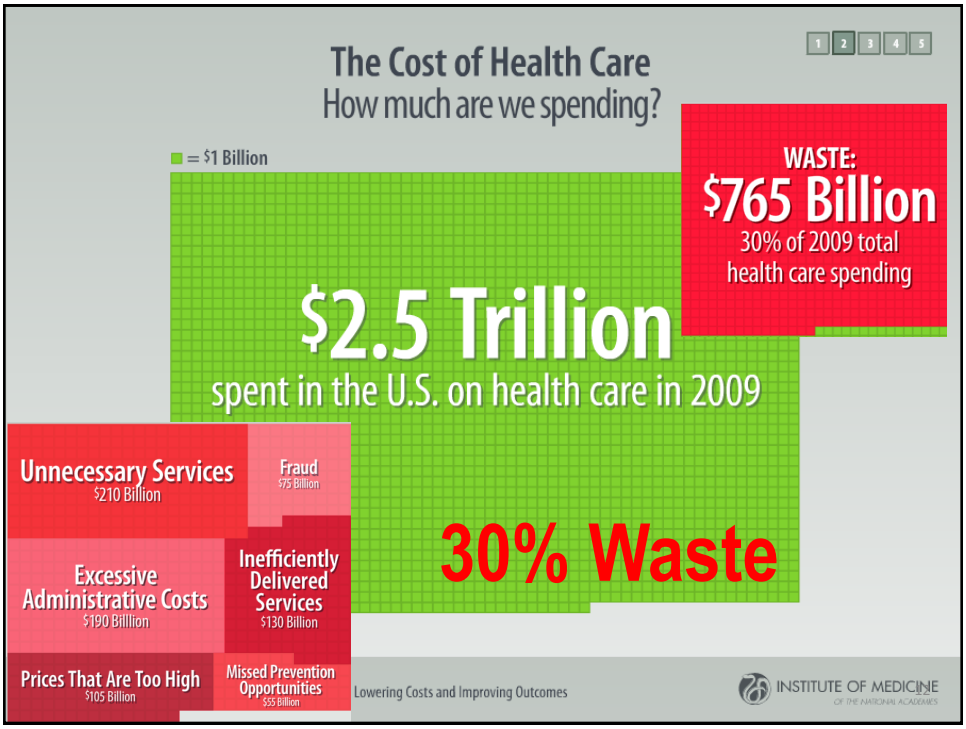
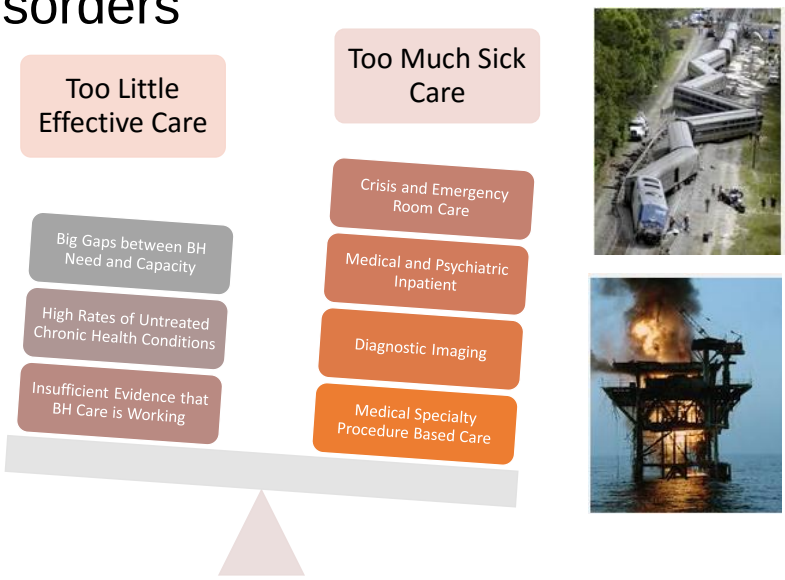


For Folks with Behavioral Health Disorders



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Where Many Systems are Headed

- Reduced Inpatient Admissions, Days, and Cost per Day + Reduced Emergency Department Visits + Reduced Diagnostic Imaging + Reduced Specialty Procedures =

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Brief Theory of Change: Cycle 1

Great Interventions

Example: Care Management to help patients manage their BH disorders & chronic health conditions

Hot Spotting

Identify and engage the 5%/ 50% population

Reduce Complex, High Cost Care

Example: Reduction in Emergency Room and Medical Inpatient

"Free Up" Money

Reduce use of care for preventable conditions

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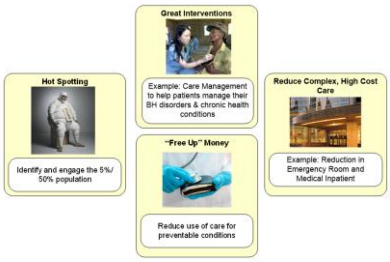
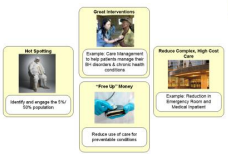
Brief Theory of Change: Cycles 2, 3

- The Freed Up Money is used to fund great interventions for the next layer of high need folks.
- Freeing up Money for to fund great interventions for a broader group, etc.





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A Key Colorado Question

- Assuming that you are in a region that will have a RAE that subscribes to this theory of change…
- What payment models will your new RAE use?

- Reduced Inpatient Admissions, Days, and Cost per Day + Reduced Emergency Department Visits + Reduced Diagnostic Imaging + Reduced Specialty Procedures =

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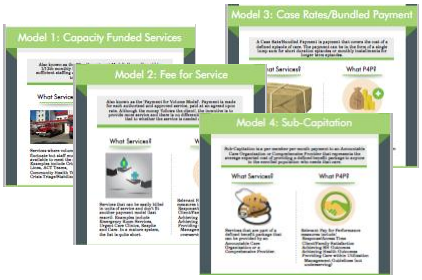
2. Accountable Payment Models

- APM Component 1
  - The Base Payment Layer
  - One Size Does Not Fit All
  - There are 4 Base Payment Models



- APM Component 2
  - The Bonus/Shared Savings Layer
  - Married at the Hip with Key Performance Measures
  - Needs to be a Substantial % of the Total Payment

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Model 1: Capacity Funded Services

Also known as the 'Fire Department Model'. Generally paid in 1/12th monthly increments based on a budget that supports sufficient staffing and other resources to field necessary capacity to meet POTENTIAL demand.

What Services?

Services where volume may fluctuate but staff must be available to meet the need. Examples include Crisis Lines, ACT Teams, Community Health Teams, Crisis Triage/Stabilization.

What P4P?

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Referring Party Satisfaction
- Resolution of Problem
- Care Transition Success

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Model 2: Fee for Service

Also known as the 'Payment for Volume Model'. Payment is made for each authorized and approved service, paid at an agreed upon rate. Although the money 'follows the client', the incentive is to provide more service and there is no differentiation in payment tied to whether the service is needed or useful.

What Services?

Services that can be easily billed in units of service and don't fit another payment model (last resort). Examples include Emergency Room Services, Urgent Care Clinics, Respite and Care. In a mature system, the list is quite short.

What P4P?

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Achieving BH Outcomes
- Achieving Health Outcomes
- Providing Care within Utilization Management Guidelines (not overserving)

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Model 3: Case Rates/Bundled Payment

A Case Rate/Bundled Payment is payment that covers the cost of a defined episode of care. The payment can be in the form of a single lump sum for short duration episodes or monthly installments for longer term episodes.

What Services?

Services that are associated with a discrete episode of care. Examples include Inpatient Care, Detox Services, Health Home Services, Specialty BH Care, and Specialty Medical Care.

What P4P?

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Achieving BH Outcomes
- Achieving Health Outcomes
- Providing Care within Utilization Management Guidelines (not underserving)

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Model 4: Sub-Capitation

Sub-Capitation is a per member per month payment to an Accountable Care Organization or Comprehensive Provider that represents the average expected cost of providing a defined benefit package to anyone in the enrolled population who needs that care.

What Services?

Services that are part of a defined benefit package that can be provided by an Accountable Care Organization or a Comprehensive Provider.

What P4P?

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Achieving BH Outcomes
- Achieving Health Outcomes
- Providing Care within Utilization Management Guidelines (not underserving)

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Base Payment: Once Size Doesn't Fit All

Sample Service Array	Phase 1	Phase 2	Phase 3
Front Door Services			
1 1-800 Crisis Line	Capacity Funded	→	→
2 1-800 Access Line	Capacity Funded	→	→
3 Warm Line	Capacity Funded	→	→
4 Community Health Teams	Capacity Funded	→	→
Crisis and Acute Care Services			
5 Mobile Crisis Team	Capacity Funded	→	→
6 Crisis Triage/Stabilization	Capacity Funded	→	→
7 Emergency Department	Fee for Service	→	→
8 Urgent Care Clinics	Fee for Service	→	Bundled Payment
9 Inpatient	Fee for Service	→	Bundled Payment
10 Detox	Fee for Service	→	Bundled Payment
11 Respite Care	Fee for Service	→	Bundled Payment
Community-Based Services			
12 Person Centered Medical Home	FFS + Bundle	Bundled Payment	→
13 Behavioral Health Home	FFS + Bundle	Bundled Payment	→
14 ACT Teams	Capacity Funded	Bundled Payment	→
15 Specialty Behavioral Health Clinic	Capacity Funded	Sub-Capitation	→
16 Specialty Medical Clinic	Fee for Service	→	Bundled Payment
17 Residential Treatment Facility	Fee for Service	→	Bundled Payment
18 Consumer-Run Services	Capacity Funded	→	→
19 Prevention Services	Capacity Funded	→	→
20 Ancillary Services	Various	→	→

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Bonus/Shared Savings Layer

- Two Groups of Outcomes
  - Systemwide Outcomes:
    - Follow-up after hospitalization.
    - Reduction in inpatient admissions per 1,000.
    - Reduction in the increase in total health spending per person
  - Individual Outcomes:
    - Is Dale's depression score under 10 as measured by the PHQ-9 Tool?
    - Is Dale's diabetes under control?

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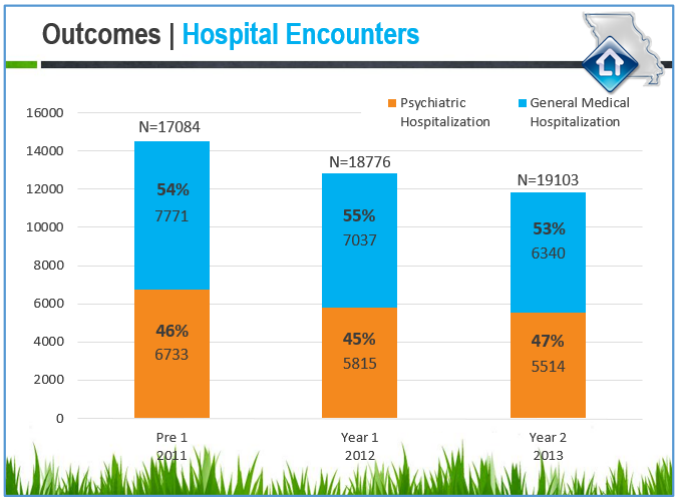
System Outcomes Example



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Individual Outcomes Examples

A1c: Approximate conversion to blood sugar levels

	A1c Value	Glucose mmol/L (mean)	Glucose mg/dL (mean)
	12.0 %	19.5	345
	11.0 %	17.5	310
Action Suggested	10.0 %	15.5	275
	9.0 %	13.5	240
Caution	8.0 %	11.5	205
Excellent	7.0 %	9.5	170
	6.0 %	7.5	135

Adapted from :American Diabetes Association Standards of Medical Care in Diabetes Diabetes Care 28:S4-S36, 2005

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

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Pay for Performance/Outcomes Process

1. Identify the most important Outcomes to measure.
2. Develop the Benchmark Metric for each Outcome (the goal).
3. Identify the Baseline Metrics for each Measure for each Provider (where are you now).
4. Measure Frequently.
5. You earn your Bonus if you:
   - Show Improvement, or
   - Hit the Benchmark (you're already there).

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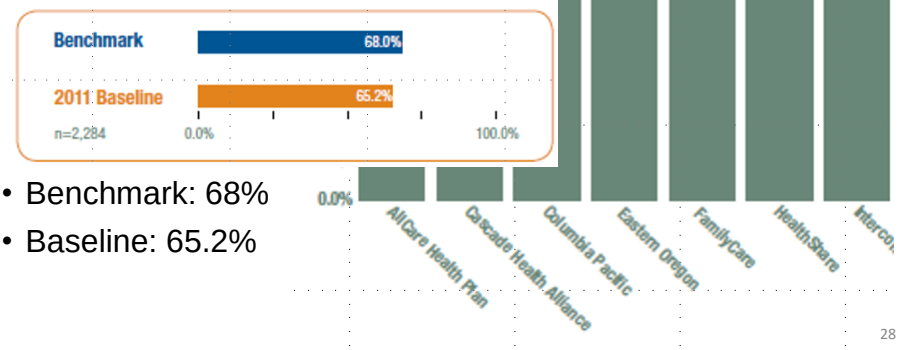
Oregon Example: Follow Up within 7 Days after Hospitalization

You earn your Bonus if you show improvement, or hit the benchmark



- Benchmark: 68%
- Baseline: 65.2%

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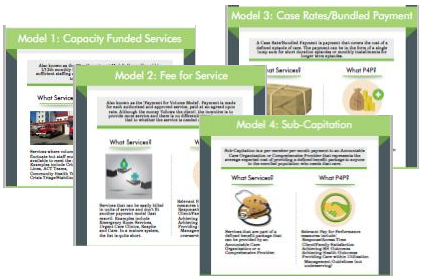
Questions and Comments…

- APM Component 1
  - The Base Payment Layer
  - One Size Does Not Fit All
  - There are 4 Base Payment Models



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Case Rate Flight Simulator

- The airline has two big lessons for healthcare:
  - Use a preflight checklist before surgery (Atul Gawande, The Checklist Manifesto)
  - Practice flying in a Flight Simulator before you try it in a real plane.

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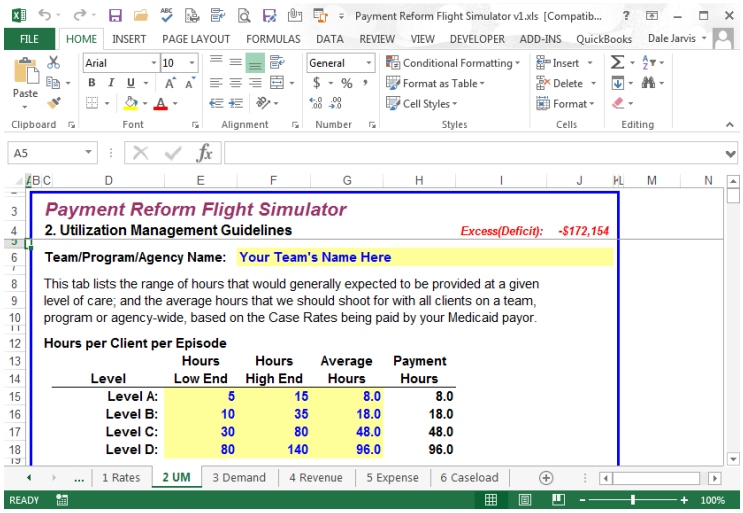
Case Rate Flight Simulator

- Excel Workbook with 5 tabs



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Exercise 1

- Designing an Alternative Payment Model at the Payor Level

Payment Reform Flight Simulator

1. Case Rate Scenario Building

Team Name:	**Your Team's Name Here**			
1. What is the Population	30,000			
2. How many people will be served?				
Penetration Rate	10%			
Number of Clients	3,000			
3. How will they distribute across levels of care?	Level A	20%	600	
	Level B	37%	1,110	
	Level C	33%	990	
	Level D	10%	300	
		100%	3,000	
4. How much care will the average person need at each level?	Level A	10	Clinician Hours	
	Level B	20	Clinician Hours	
	Level C	50	Clinician Hours	
	Level D	110	Clinician Hours	
5. What's the Average Cost per Hour?	$158.62			

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Exercise 2

- Organizing at the Provider Level to Succeed under Alternative Payment Models

Payment Reform Flight Simulator

4. Revenue Tool *Excess(Deficit):* *-$172,154*

Team/Program/Agency Name: **Your Team's Name Here**

Step 1: Gross Charges

Clinician Type	Service Hours	Average Charge/Hour	Gross Charges	Direct Cost/Hr	Overhead Cost/Hr	Total Cost/Hr
Master's Level	13,248	$120.00	$1,589,760	$55.34	$64.33	$119.68
BA Case Manager	11,040	$90.00	$993,600	$41.21	$47.91	$89.12
Peer/Paraprofessional	4,416	$80.00	$353,280	$37.68	$43.80	$81.48
Psychiatrist	2,208	$500.00	$1,104,000	$235.51	$273.75	$509.26
Nurse Practitioner	1,104	$225.00	$248,400	$105.98	$123.19	$229.17
-	-		$0	$0.00	$0.00	$0.00
-	-		$0	$0.00	$0.00	$0.00
Total	**32,016**	**$133.97**	**$4,289,040**	**$62.21**	**$72.31**	**$134.51**

Step 2: Payor Mix, FFS Revenue and Contractual Allowances & Write-Offs

Payor	Payor Mix	Service Hours	Gross Charges	Case Rate Payor?	Allowance/ Write-Off %	Net Fees
Medicaid FFS	5%	1,601	$214,452	No	60%	$85,781

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Today's Scenario

- Everyone in this room wears 2 hats.
  - Management Team Member of a Behavioral Health Provider Organization.
  - Payment Reform Design Team Member of an Accountable Care Organization.

- Your 2-Part Job?
  - Develop an Outpatient Case Rate System that the ACO will use to pay the BH Provider Members.
  - Figure out how your organization can succeed under that Case Rate model.

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Today's Scenario

- Your ACO serves 30,000 Medicaid enrollees across a four-county region.
- You are responsible for providing a broad set of mental health services to all Medicaid enrollees that meet medical necessity criteria.
- Your ACO is beginning their payment reform effort by developing outpatient case rates individuals with a serious mental illness or serious emotional disturbance who are served by the specialty behavioral health system.
- Payment models for enrollees with mild and moderate mental health disorders, substance use disorders, and co-occurring disorders will be developed in the next phase.

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Exercise 1: Designing an Alternative Payment Model at the ACO Level to Achieve the Triple Aim

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Menu of Payment Models

1. Capacity Funded
2. Fee for Service/Per Diem
3. Stratified Case Rate/Bundled Payment
4. Global Budget/Sub-Capitation

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Menu of Payment Models

1. *Capacity Funded:* The Fire Department model; identify the staffing requirements and buy capacity.
2. *Fee for Service/Per Diem:* Payment for all authorized visits or days, paid at an agreed rate. This also includes bundled per visit (FQHC and CCBHC PPS) and bundled per diem.
3. *Stratified Case Rate/Bundled Payment:* Payment of a flat fee per patient for a predefined episode at a specific level of care, regardless of how much time and money was spent (e.g. Hospital DRGs and Mental Health Case Rates).
4. *Global Budget (Sometimes called Partial Capitation)*: A set monthly budget for every assigned patient for a portion of their care. The emerging model for Primary Care.

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One Size Does NOT Fit All

Sample Service Array	Payment Option	Payment Option	Payment Option
Front Door Services			
1 Member Services	Capacity Funded		
2 1-800 Crisis Line	Capacity Funded		
3 1-800 Access Line	Capacity Funded		
4 Warm Line	Capacity Funded		
5 Intake and Assessment	Capacity Funded	Fee for Service	Case Rate
Crisis and Acute Care Services			
6 Mobile Crisis Team	Capacity Funded		
7 Urgent Care Clinics	Fee for Service	Case Rate	Capacity Funded
8 Emergency Department	Fee for Service	Case Rate	Capacity Funded
9 Crisis Triage/Stabilization	Per Diem	Case Rate	Capacity Funded
10 Inpatient	Per Diem	Case Rate	Fee for Service
11 Detox	Per Diem	Case Rate	Fee for Service
12 Respite Care	Per Diem	Case Rate	Capacity Funded
Community-Based Services			
13 Person Centered Medical Home	Global Budget	Fee for Service	
14 Person Centered Health Home	Global Budget	Fee for Service	
15 Care Management	Global Budget	Fee for Service	
16 Specialty Behavioral Health Clinic	Case Rate	Fee for Service	
17 Specialty Medical Clinic	Case Rate	Fee for Service	
18 Residential Treatment Facility	Per Diem	Fee for Service	
19 Consumer-Run Services	Global Budget	Fee for Service	
20 Prevention Services	Global Budget	Fee for Service	
21 Ancillary Services	Various		

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The 10-Step Case Rate Model Design Process

Step 1: Identify Your Aims
Step 2: Define the Population
Step 3: Estimate the Penetration Rate
Step 4: Define the Categories and Levels of Care
Step 5: Estimate the Case Mix
Step 6: Estimate the Average Utilization at Each Level
Step 7: Estimate the Cost per Unit of Service
Step 8: Run Multiple Scenarios, Testing for Financial Feasibility
Step 9: Identify the Feasible Scenario that Best Matches Your Aims
Step 10: Design Your Implementation Plan

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The 10-Step Process

- Step 1: Define Your Aims
  - Remove barriers to providing the *right* care in the *right* setting at the *right* time by the *right* person.
  - Modestly reduce administrative barriers.
- Step 2: Define the Population
  - Those in your ACOs 30,000 enrollment base with a serious mental illness or serious emotional disturbance.

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The 10-Step Process

- Step 3: Estimating the Penetration Rate

	Low Rate	Medium Rate	High Rate
Penetration Rate	9.0%	10.0%	11.0%
Number of Cases	2,700	3,000	3,300

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The 10-Step Process

- Step 4: Define the Levels of Care

Level	Community-Based Services Level Descriptions
Level A:	Recovery Maintenance and Health Management (generally crosswalks to LOCUS Level 1)
Level B:	Low Intensity Community Based Services (generally crosswalks to LOCUS Level 2)
Level C:	High Intensity Community Based Services (generally crosswalks to LOCUS Level 3)
Level D:	Wraparound ACT-Level Care (generally crosswalks to LOCUS Level 4)

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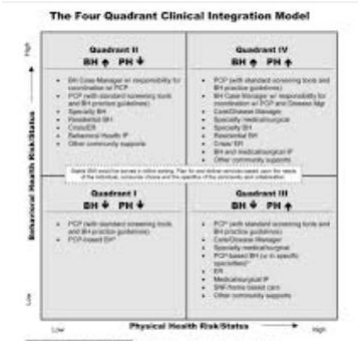
The 10-Step Process

- We have created multiple levels of care in order to ensure that organizations serving more higher-need cases receive more money and organizations serving more lower-need cases receive less money.
- Just think what would happen if provider organizations received the same Case Rate regardless of the level of need. There would be a huge incentive to "cherry pick" low need cases; a term called "adverse selection".
- We want to remove this incentive and, if anything, create a financial incentive to serve more complex cases.



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The 10-Step Process

- Step 5: Estimate Case Mix
  - In order to create Case Rates, we need to estimate how many people will be served at each level of care.
  - Fortunately, you have a long history of utilizing the LOCUS Level of Care tool for Adults and the CALOCUS for youth.

Level	Description	Mix
Level A:	Recovery Maintenance and Health Management	20%
Level B:	Low Intensity Community Based Services	37%
Level C:	High Intensity Community Based Services	33%
Level D:	Wraparound ACT-Level Care	10%
Totals:		100%

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The 10-Step Process

- Step 6: Estimate Average Utilization at Each Level of Care
  - We have studied historical utilization at each level and determined the following:

Level	Description	Minimum	Maximum	Average
Level A:	Recovery Maintenance and Health Management	5	15	10
Level B:	Low Intensity Community Based Services	10	35	20
Level C:	High Intensity Community Based Services	30	80	50
Level D:	Wraparound ACT-Level Care	80	140	110

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The 10-Step Process

- Step 7: Estimate the Cost per Unit of Service

Code	Description	Prescri-ber	RN	Masters Level	Below Masters Level	Billed per Hour
90801	Psychiatric Diagnostic Interview	35%	0%	65%	0%	$260.36
90804	Individual psychotherapy	0%	0%	100%	0%	$151.25
90806	Individual psychotherapy	1%	0%	99%	0%	$151.25
90847	Family psychotherapy	0%	0%	100%	0%	$137.42
90853	Group psychotherapy	0%	0%	100%	0%	$275.72
90862	Pharmacologic management	100%	0%	0%	0%	$234.04
H0004	Behavioral Health Counseling	0%	0%	100%	0%	$144.21
H0036	Community Supportive	25%	0%	18%	57%	$55.50
H2010	Medication Services	0%	79%	21%	0%	$331.30
H2014	Skills Training/Development	0%	0%	25%	75%	$90.77
Total						$158.62

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The 10-Step Case Rate Model Design Process

Step 1: Identify Your Aims
Step 2: Define the Population
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Step 6: Estimate the Average Utilization at Each Level
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Step 8: Run Multiple Scenarios, Testing for Financial Feasibility
Step 9: Identify the Feasible Scenario that Best Matches Your Aims
Step 10: Design Your Implementation Plan

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Let's Jump Over to Excel

Case Rate Flight Simulator

1. Case Rate Scenario Building — *BH-ACO Excess(Deficit):* *-$1,059,234*

Team Name: Your Team's Name Here

1. What is the Population		30,000		
2. How many people will be served?				
Penetration Rate		10%		
Number of Clients		3,000		
3. How will they distribute across levels of care?	Level A	20%	600	
	Level B	37%	1,110	
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	Level D	10%	300	
		100%	3,000	
4. How much care will the average person need at each level?	Level A	10	Clinician Hours	
	Level B	20	Clinician Hours	
	Level C	50	Clinician Hours	
	Level D	110	Clinician Hours	
5. What's the Average Cost per Hour?		$158.62		

6. What are the Total Costs if our Estimates are Accurate and we paid Fee for Service?		Clients	Hrs/Client	Total Hours
	Level A	600	10	6,000
	Level B	1,110	20	22,200
	Level C	990	50	49,500
	Level D	300	110	33,000
	Total Hours			110,700
	Average Hourly Rate			$158.62
	Total Costs			$17,559,234

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Exercise 1: Small Group Instructions

- Name Your Small Group; enter it in cell E6 of tab 1 Rates.
- Activity 1: Test making changes to each of 3 variables, one at a time in the following order.
    1. Average Cost per Hour
    2. Average Hours per Case
    3. Case Mix
  - Record the Excess (Deficit) for each variable change.
  - Undo your change.
  - Repeat until you've finished testing the effect of each variable.
- Activity 2: Now Balance Your Budget
  - With the combination of variable changes you think make the most sense.
  - Be prepared to defend your scenario in front of the full group.

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Exercise 2: Organizing at the Provider Level to Succeed under Alternative Payment Models

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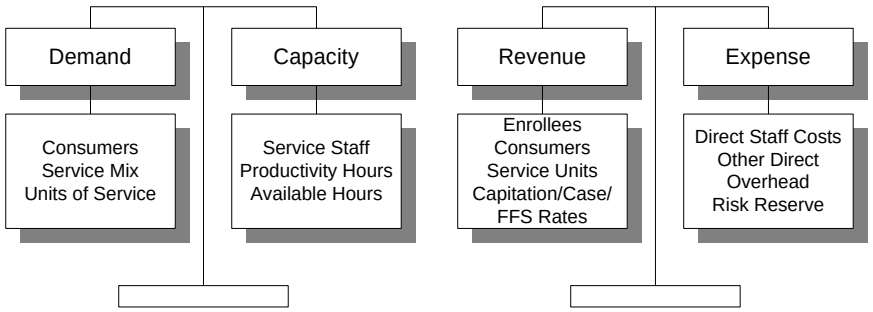
Exercise 2 Overview

- Now that you've set rates, using your ACO hat,
- It's time to shift gears and put your Provider Organization Management Team hat on.



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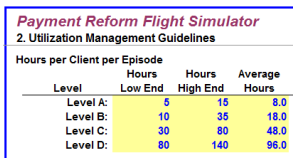
Exercise 2 Overview

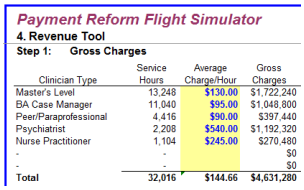
- Tab 2: Utilization Management Guidelines
- Tab 3: Demand/ Capacity Projections
- Tab 4: Revenue
- Tab 5:Expenses and Excess (Deficit)



Payment Reform Flight Simulator
2. Utilization Management Guidelines

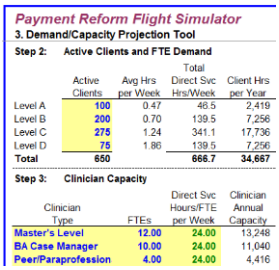
Hours per Client per Episode

Level	Hours Low End	Hours High End	Average Hours
Level A:	5	15	8.0
Level B:	10	35	18.0
Level C:	30	80	48.0
Level D:	80	140	96.0



Payment Reform Flight Simulator
4. Revenue Tool
Step 1: Gross Charges

Clinician Type	Service Hours	Average Charge/Hour	Gross Charges
Master's Level	13,248	$130.00	$1,722,240
BA Case Manager	11,040	$95.00	$1,048,800
Peer/Paraprofessional	4,416	$90.00	$397,440
Psychiatrist	2,208	$540.00	$1,192,320
Nurse Practitioner	1,104	$245.00	$270,480
-	-		$0
-	-		$0
Total	32,016	$144.66	$4,631,280

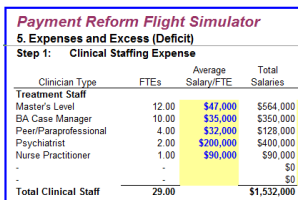


Payment Reform Flight Simulator
3. Demand/Capacity Projection Tool
Step 2: Active Clients and FTE Demand

	Active Clients	Avg Hrs per Week	Total Direct Svc Hrs/Week	Client Hrs per Year
Level A	100	0.47	46.5	2,419
Level B	200	0.70	139.5	7,256
Level C	275	1.24	341.1	17,736
Level D	75	1.86	139.5	7,256
Total	650		666.7	34,667

Step 3: Clinician Capacity

Clinician Type	FTEs	Direct Svc Hours/FTE per Week	Clinician Annual Capacity
Master's Level	12.00	24.00	13,248
BA Case Manager	10.00	24.00	11,040
Peer/Paraprofession	4.00	24.00	4,416



Payment Reform Flight Simulator
5. Expenses and Excess (Deficit)
Step 1: Clinical Staffing Expense

Clinician Type	FTEs	Average Salary/FTE	Total Salaries
Treatment Staff			
Master's Level	12.00	$47,000	$564,000
BA Case Manager	10.00	$35,000	$350,000
Peer/Paraprofessional	4.00	$32,000	$128,000
Psychiatrist	2.00	$200,000	$400,000
Nurse Practitioner	1.00	$90,000	$90,000
-	-		$0
-	-		$0
Total Clinical Staff	29.00		$1,532,000

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Exercise 2 Highlights

- Tab 2 - Utilization: You are either providing more or less hours per case than what you've built for your case rates wearing your ACO hat.
- Tab 3 – Clinician FTEs: You either have enough or not enough FTEs to meet demand.
- Tab 5 – Expenses and Excess (Deficit): You either have Red or Black ink on your bottom line.
- Let's look at what's in my version.

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2 Key Questions

- Question 1: Go to Tab 3-Demand, cell G35 and write down your FTE Excess or Deficit. Do you have an Excess or Deficit of FTEs?
- Question 2: Go to Tab 5-Expense, cell F51 and write down your Excess or Deficit of Revenue over Expense. Are you in the Black or Red?

Total Capacity	29.00	1,104	32,016
Client Demand			40,610
Excess (Deficit)			(8,594)
FTE Excess (Deficit)			(7.78)

Total Revenue	$5,964,112 (from Tab 4)
Excess (Deficit)	$295,262
Excess (Deficit) %	5%

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Exercise 2: Small Group Instructions

- Activity 1: If there's an Excess or Deficit of FTEs in Tab 3:
  - Adjust the Clinician FTEs up or down.
  - Revise the Direct Service Hours per FTE per Week up or down.
  - Revise the number of Annual Cases up or down.
  - Change the Average Hours per Case in Tab 2 up or down.
  - Do a Combo of the above.
- Activity 2: If there's an Excess or Deficit in Tab 5
  - Revise the Average Hours per Client per Level of Care in Tab 2.
  - Revise the Clinician FTEs in Tab 3.
  - Revise the Direct Service Hours per FTE per Week in Tab 3.
  - Revise Salaries or Benefits in Tab 5.
  - Revise Other Expenses in Tab 5.
  - Or a combo of the above.
    - **WITHOUT THROWING THE FTE DEMAND & CAPACITY OUT OF BALANCE!!!!**

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How Did You Do?

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Final Question: What's Your Current State of Mind?

1. Enlightened and Energized
2. Enlightened and Exhausted
3. In the Dark and Energized
4. In the Dark and Exhausted

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