

The CSH Services Budgeting Tool 3.2

USER GUIDE

A tool to support agencies, communities, project planners, and systems leaders in estimating the total cost of care for providing quality supportive housing services that are evidence-based and can achieve positive outcomes for individuals, families, and communities.

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The CSH Services Budgeting Tool 3.2 User Guide

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Introduction

The purpose of the CSH Supportive Housing Services Budgeting Tool is to support agencies, communities, project planners, and system leaders to estimate comprehensive costs for supportive housing services. The tool uses a template that includes built in assumptions around best practice for four staffing models: Assertive Community Treatment (ACT), Intensive Case Management (ICM), Tenancy Support Services (TSS), and Critical Time Intervention (CTI). Each of these models is well researched and considered evidence-based practice, and the tool reflects the research around staffing and caseload sizes. Program budget considerations for each service model reflect the nuances specific to scattered site and single site (project-based) supportive housing models. The tool allows the user to input their average staffing costs, budget assumptions, and productivity expectations to determine Medicaid rates needed by agencies for a fiscally sustainable program. While other supportive housing service models exist, the ones included in this tool have the largest evidence base and strongest fidelity standards.

For agencies transitioning from a grants-based revenue model to incorporating Medicaid billing, the shift to projecting revenue and maintaining productivity goals to ensure fiscal sustainability will be an ongoing and likely challenging process. The tool helps your team project costs for each stage in this process, including the startup phase and sustaining your program.

For supportive housing agencies that are negotiating with Managed Care Organizations (MCOs), the tool gives you the rates necessary to sustain your program over time and the data you need to justify your rate request to MCOs.

There are no capacity limitations for leveraging or maximizing use of the tool; it is useful for all types and sizes of supportive housing programs, whether you're working with one project of 30 tenants or across a community serving thousands of tenants. This guide was developed to support agencies to effectively use the tool and to help providers and funders evaluate capacity from a person-centered perspective. It is intended to shift the paradigm of services funding from one of scarcity to a proactive approach that prioritizes quality.

Things To Keep in Mind

Start with a Service Plan and Tenant Needs

When thinking about creating a service budget, it can be tempting to start with the funding you think is available and work backwards, rather than starting with the actual costs of providing high quality services. **The best starting place for creating a budget is to begin with prospective tenants and their needs, and the services you intend to provide.** At this stage it can be helpful to sketch out a service plan with a list of services you intend to deliver versus what can be delivered in the community through other existing providers. Remember, an important role for supportive housing providers is to ensure your tenants receive quality services in their homes and communities, so be sure to include that capacity in your projections.

No “Official” Formula for Staffing and Budgeting Needs

There is no “official” formula for staffing and budgeting for supportive housing services, only suggested best practices. Quality supportive housing uses a variety of service models, depending on participant needs and the housing model (i.e., scattered site versus project based). Salary, fringe, operational, and service costs vary widely among communities across the country. Population-specific services also change the staffing calculation, with higher acuity tenants likely requiring specialized services and staff to meet their unique needs. Supportive Housing is an evidence-based practice, and there is a strong evidence base for multiple staffing models for many of the populations you serve. CSH encourages users to explore the reference guides linked throughout the tool to determine the staffing model best suited to meet your target populations, service plan, and community context.

Review Each Section of the Guide as You Use the Tool

This guide is intended to accompany the Services Budget Tool and will walk you through all the steps to get the most out of the tool. For additional questions, feel free to reach out to CSH at consulting@csh.org.

Getting Started with the Tool

Budget Components

Services Personnel

The largest percentage of most service budgets are the costs to employ or contract with services staff. This includes salaries, benefits, and fringe costs and should include not only direct service staff but supervisory staff and necessary administrative staff to get the work done. The tool will allow you to enter in less than a full-time salary so that you can share an administrative staff person or director across multiple programs if needed. More detail will follow later in the guide. For now, know that much of your budget will be salaries and benefits, and the staffing model you select will affect your program costs.

Other Services-Related Expenses

Often referred to as “OTPS” (Other Than Personnel Services), additional expenses that are common to most service budgets include consultant services, transportation for staff and clients, staff professional development and training, office supplies, technology support, and materials needed for service provision. The tool incorporates additional costs specific to starting a new program, as well as costs associated with becoming a Medicaid provider.

How the Tool Works

The tool contains separate tabs for each of the staffing models (Assertive Community Treatment (ACT), Intensive Case Management (ICM), Tenancy Supports (TSS), and Critical Time Intervention (CTI)) so that the user can compare cost and revenue projections within and across models. Each staffing model tab allows the user to specify the target population(s) and number of households to be served, whether tenants are new to supportive housing, and the housing model in which the program operates (scattered site, project based, or both).

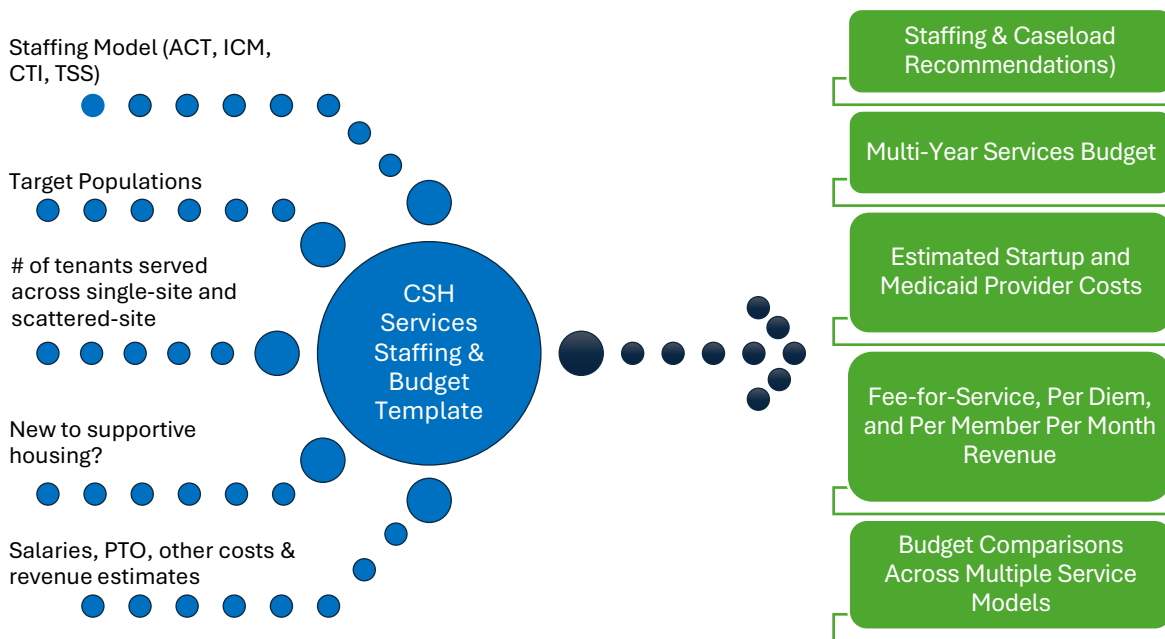
After entering these variables, the tool will calculate the number of staff recommended for your selected staffing model and offer suggestions for the number of supervisors and administrators needed to support the program. After you enter each staff member’s respective salaries into the budget tool, it will automatically generate the costs and units of service (UOS) associated with 15-minute increments, per diem, and per member per month reimbursement models. Knowing these projections is essential for providers looking to negotiate with MCOs on service rates. The tool will show you expected losses or gains depending upon the rates, so your agency can choose strategically what rates are needed for your program to be fiscally sustainable.

If you already know your reimbursement rates, you have the option of adding this to the tool to automatically generate your potential Medicaid revenue (CSH has also provided suggested rates based on total program costs). Additional inputs the user can enter include operating services (other

services-related expenses) and other sources of funding and revenue. The tool will then calculate your overall “net” gain: your revenue minus your costs.

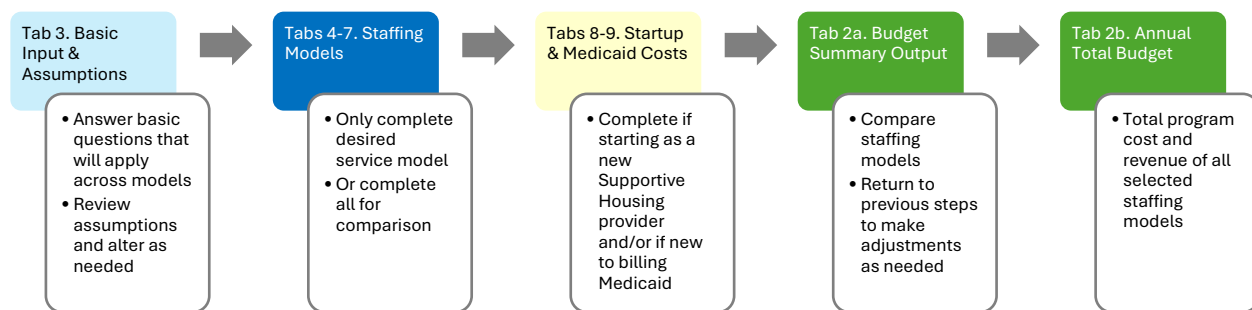
Figure 1: Inputs and Outputs in the Services Budget Tool

A user enters the fields on the left so that the tool can generate the summaries on the right:



Below is a step-by-step overview of how to use the tool. It outlines the order in which users should complete the various tabs in order to maximize use of the tool.

Figure 2: Order for Completing the Tool



- ✓ **Blue cells:** Inputs that impact formulas and outputs; **to be changed to desired values.**
- ✓ **Greens cells:** Outputs linked from other cells' inputs; **do not change these cells.**
- ✓ **Peach cells:** Outputs linked from other cells' inputs, **but that can be changed as desired.**

Using The Tool

Tab 2a: Budget Summary Output

Do not spend time reviewing this tab until you have completed *Tabs 3-9*. This tab compares the overall costs and revenues of each service model you select in *Tab 3. Basic Input & Assumptions*.

Figure 3: Summary Comparison of Service Models

Summary of Costs Based on Inputs (Staffing Model Tabs 4-7)	Assertive Community Treatment	Intensive Case Management	SH Tenancy Support Services	Critical Time Intervention
Number of FTE Employees	11	15	13	10
Annual Program Budget (Year 1 minus Start Up Cost)	\$1,732,648	\$1,672,471	\$1,363,245	\$1,192,950
Start Up Costs	\$575	\$0	\$0	\$0
Total Number of Tenants/Clients	100	100	65	100
Total Units of Service	43,392	54,240	48,816	37,968
Cost Per Unit	\$39.93	\$30.83	\$27.93	\$31.42
Per Tenant Per Month Cost	\$1,443.87	\$1,393.73	\$1,747.75	\$994.12
Per Tenant Per Year Cost	\$17,326.48	\$16,724.71	\$20,972.99	\$11,929.50

Summary of Revenue Based on Inputs (Tabs 4-7)	Assertive Community Treatment	Intensive Case Management	SH Tenancy Support Services	Critical Time Intervention
In-Kind / Community Partner Service	\$0	\$0	\$0	\$0
Program Service Fees	\$0	\$0	\$0	\$0
Grants	\$0	\$0	\$0	\$0
Private Insurance	\$0	\$0	\$0	\$0
Medicaid Reimbursement	\$954,624	\$908,412	\$688,804	\$567,863
Other Revenue	\$0	\$0	\$0	\$0
Total	\$954,624	\$908,412	\$688,804	\$567,863
Net	(\$778,024)	(\$764,059)	(\$674,441)	(\$625,087)

Tab 2b: Annual Total Budget Summary

Do not spend time reviewing this tab until you have completed *Tabs 3-9*. This tab shows your total program cost and revenue and is based on the inputs from *Tab 3* and *Tabs 4-9*. It sums the total cost of each model you selected “Yes” to in *Tab 3*, as well as any General Startup and Medicaid Admin Costs you included if you selected Yes to them in *Tab 3*. Anything you did NOT select (i.e., selected “No” on *Tab 3*) is not included in the total budget.

Figure 4: Annual Total Budget Summary

Models Included in Total: ACT, ICM, TSS, CTI								
Includes Start Up and New Medicaid Provider Costs								
ANNUAL TOTAL BUDGET SUMMARY								
A. PERSONNEL EXPENSES	Total	4. ACT	5. ICM	6. TSS	7. CTI	8. General Start Up	9. New Medicaid Provider	
Wages and Salaries	\$2,607,500	\$751,500	\$726,000	\$531,000	\$441,000		\$158,000	
Employee Benefits	\$782,250	\$225,450	\$217,800	\$159,300	\$132,300		\$47,400	
Contract Personnel	\$222,781	\$0	\$0	\$0	\$0		\$222,781	
Other Personnel Expenses	\$300	\$0	\$0	\$0	\$0	\$0	\$300	
Staff Development & Training	\$38,243	\$11,273	\$10,890	\$7,965	\$6,615	\$0	\$1,500	
Subtotal Personnel Expenses	\$3,651,073	\$988,223	\$954,690	\$698,265	\$579,915	\$0	\$429,981	
B. OPERATING EXPENSES								
Rent	\$127,000	\$36,500	\$36,500	\$36,500	\$17,500	\$0		
Utilities	\$38,000	\$9,500	\$9,500	\$9,500	\$9,500	\$0		
Building Insurance	\$50,000	\$12,500	\$12,500	\$12,500	\$12,500	\$0		
Housekeeping	\$40,000	\$10,000	\$10,000	\$10,000	\$10,000			
Communications (Phone, Data)	\$38,400	\$9,600	\$9,600	\$9,600	\$9,600	\$0		
Office Supplies	\$20,000	\$5,000	\$5,000	\$5,000	\$5,000	\$0		
Professional Liability Insurance	\$750	\$0	\$0	\$0	\$0		\$750	
Estimated Mileage	\$73,190	\$28,702	\$12,916	\$17,221	\$14,351			
Mileage Rate	\$2,540	\$0.635	\$0.635	\$0.635	\$0.635			
Est. Miles Per Day Per FTE	80	20	20	20	20			
Est. # FTE Traveling	26	10	5	6	5			
Vehicles	\$0	\$0	\$0	\$0	\$0	\$0		

Tab 3: Basic Inputs & Assumptions

At the top of *Tab 3. Basic Input & Assumptions* you will be prompted to answer questions that will guide the formatting for your budget:

Services Staffing Models

Select your Services Staffing Model(s) of choice by selecting “Yes” next to each model for which you plan to build and compare budgets. Select “No” next to the staffing models you will not be comparing. This will exclude these other staffing models and budgets from your budget summary tabs (Tabs 2a and 2b). To learn more about each staffing model, click on the “About Staffing Model” links next to the models.

Figure 5: Selecting Service Models for Budgeting & Comparison

1. Include the following Service Staffing Models in the Budget Summary Output Tab?		Follow link to Staffing Model Budget Tab	Want to explore the Staffing Models more?
Assertive Community Treatment (ACT)	Yes	Link to ACT Staffing Model Budget Tab	About the ACT Staffing Model
Intensive Case Management (ICM)	Yes	Link to ICM Staffing Model Budget Tab	About the ICM Staffing Model
Tenancy Support Service Coordination (TSS)	Yes	Link to TSS Staffing Model Budget Tab	About the TSS Staffing Model
Critical Time Intervention (CTI)	Yes	Link to CTI Staffing Model Budget Tab	About the CTI Staffing Model

Add-on Cost Assumptions

- **Include General Startup Costs?** If you are starting a new supportive housing program or have costs associated with this startup phase, select “Yes.” This will allow the costs you input in *Tab 8. General Startup Costs* to be included in your budgets in *Tabs 4-7* and the summary totals in *Tabs 2a and 2b*. Otherwise, select “No.”
- **Include Medicaid Administrative Costs?** If you plan to bill Medicaid for your supportive housing services, there are additional costs you may need to consider. Selecting “Yes” will

allow the costs you add to *Tab 9. Medicaid Admin Costs* to be included in your budgets in *Tabs 4-7* and the summary totals in *Tabs 2a and 2b*. Otherwise, select “No.”

Figure 6: Add-on Cost Assumptions

2. Add-on Cost Assumptions

Do you want to include general startup costs in your budget?	No	Link to General Startup Costs Tab
Do you want to include Medicaid administrative costs in your budget?	No	Link to Medicaid Administrative Costs Tab

Budget Assumptions

Rows 15-20 include assumptions made based on known costs or national averages. These can be altered if they differ for an organization or a region/community. If this information is unknown for an organization or community, then the information already loaded can be used as a practical guide.

Each of the values included in the Budget Assumptions section will be pulled into the Service Models tabs to which you selected “Yes.”

Travel considerations are divided into two categories:

1. **Travel to Scattered Sites:** If program staff offices are in separate buildings from their tenants, supportive housing programs will need to budget time and reimbursement for their staff to travel to meet their tenants. However, like commuting, **travel time to scattered sites is not considered a billable expense under Medicaid.**
2. **Client-Related Travel:** Supportive housing staff often accompany their clients to appointments, meetings, and other offsite engagements in which support may be requested. It is important that supportive housing programs budget time and reimbursement for their staff to travel for service coordination. **This travel time is potentially a billable expense under Medicaid.**

Figure 7: Budget Assumptions

3. Budget Assumptions		Input for Tailoring
Administrative/Indirect Rates	Administrative/indirect rates are generally between 10% and 15%.	15.0%
Travel to Scattered Sites	Transportation costs are a necessary budget component for scattered site. For agencies unsure of miles traveled per month, CSH recommends budgeting 20 miles per day per staff for scattered site. This is not billable time.	20.0
Client-Related Travel	Client-related travel varies greatly depending on the breadth of service coordination and transportation offered. CSH recommends up to 5 miles per day for client-related travel for service coordination (social security appointments, outreach, medical and social service appointments, support accessing other services). This is potentially billable time.	5.0
Mileage Rates	The 2024 Federal Mileage reimbursement rate is \$.67 per mile.	\$0.67
Annual Inflation	Annual inflation is currently set to assume a 5% increase in costs each year. This will need to be adjusted as inflation rates vary.	7.5%
Fringe	Employee fringe/benefits rate are usually between 30% and 40% of employees' salaries.	32.0%

Caseload Assumptions

The tool includes four service models (ACT, ICM, TSS, and CTI) and offers suggested caseloads for both scattered site and single site programs for providers that need guidance on how to set up their staffing models. Suggested caseloads for each service model are included in the **green boxes**. **Service providers with existing programs can add their current caseloads to the blue boxes.**

Figure 8: Caseload Assumptions Used in Service Models

4. Caseload Assumptions Used in Model

ACT Caseloads

Target population	Suggested Caseloads	
	Scattered Site Caseload	Single Site Caseload
ACT Target Populations include: people with serious mental illness, most often those with co-occurring substance use disorders and/or multiple other chronic health conditions. Program fidelity does not advise changing case load sizes for ACT.	10	10

If you are an **existing service provider**, add your caseload numbers to the **blue boxes**

ICM Caseloads

Target population	New Program Suggested Caseloads		Existing Program Caseloads	
	Scattered Site Case Load	Single Site Case Load	Scattered Site Caseload	Single Site Caseload
Individuals	10	15		
Families	10	15		
Individuals with dual dx SUD/SMI	10	10		
Individuals with ID/DD	10	10		
Older adults	10	15		
Transition Age Youth	10	15		

Tenancy Support Caseloads

Target population	New Program Suggested Caseloads		Existing Program Caseloads	
	Scattered Site Case Load	Single Site Case Load	Scattered Site Caseload	Single Site Caseload
Individuals	15	20		
Families	10	15		
Individuals with dual dx SUD/SMI	10	10		
Individuals with ID/DD	10	10		
Older adults	15	15		
Transition Age Youth	15	20		

CTI Caseloads

Target population	New Program Suggested Caseloads		Existing Program Caseloads	
	Scattered Site Case Load	Single Site Case Load	Scattered Site Caseload	Single Site Caseload
Individuals	20	20		
Families	12	12		
Transition Age Youth	15	15		

5. Supervisor to supervisee ratio

Recommended 1:8*	
Number of staff supervised by one supervisor	8

Note that the numbers are for **caseloads** (i.e. the ratio of tenants to staff members), not your overall case numbers (i.e. the total number of clients served). You will have the opportunity to add overall tenant numbers to your service models in *Tabs 4-7*.

Included in each service model tab (*Tabs 4-7*) is the option to select whether you are a **new provider** or an **existing provider**:

- If you select **new provider**, your caseloads will automatically populate with the **New Program Suggested Caseloads** (the **green boxes**);
- If you select that you are **not** a new provider, your caseloads will automatically populate with the **Existing Program Caseloads** (the **blue boxes**).

Finally, add your supervisor to supervisee ratio in cell F52; CSH recommends a ratio of 1:8 for all service models **except for ACT**.

Tabs 4-7: Service Models Tabs

Tab 4: ACT

About ACT

Assertive Community Treatment (ACT) is an intensive, team-based, multidisciplinary approach for community mental health services that can include housing-related supports. ACT teams serve individuals with serious and persistent forms of mental illness, including schizophrenia spectrum disorders, bipolar and major depressive disorders, personality disorders, and anxiety disorders like PTSD. **As a multidisciplinary approach, ACT teams share a caseload of 100 clients across a team of typically 10 staff members.**

Intended to be a “one-stop shop” for outpatient mental health services, ACT teams require high levels of coordination and provide a comprehensive array of services that focus on recovery, rehabilitation, and improved functioning in activities of daily living, including housing stability. ACT teams include specialists with backgrounds in mental health and psychiatry, nursing, employment, housing, substance use treatment, legal services, benefits access, and care coordination. ACT is an evidence-based practice with strong evidence of reducing hospitalizations and increasing housing stability when programs align with fidelity standards.

ACT Target Population, Tenant Size, and Caseloads

ACT has strict fidelity standards that providers are encouraged to meet regardless of the population being served. The number of tenants and recommended caseloads are prepopulated in the tool, but if you choose to set up your program differently, you can update the numbers and target population accordingly.

Figure 9: ACT Target Population and Caseloads

1. Please complete the blue boxes below:

Target Population	# of Tenants*	Recommended Caseload*
Individuals	100	10
Total clients	100	

*ACT fidelity recommends a team of 10 staff to support a caseload of 100 tenants (tenant to staff ratio is 100:10; caseload equivalent is 10:1)

ACT Staffing Model – Personnel & Salaries

The personnel section is divided into **billable** and **non-billable staff**:

- In states where ACT programs are covered by Medicaid, **billable staff** are those that are most likely to perform billable services. These include all client-facing, direct service roles like mental health specialists, housing and employment specialists, peer specialists, and psychiatric and behavioral health clinicians.
- **Non-billable staff** are members of the team that are not likely to perform services that are billable under Medicaid. These include program directors and administrative support.

Complete the personnel section by adding FTEs and salaries to each role under both staffing categories (the **blue cells**). The tool provides suggested FTE numbers for each staff member based on ACT's fidelity standards in the *italicized text* next to each role. CSH also offers general salary recommendations based on national averages, but because of variance across the country, it is necessary to update the salaries with rates that are competitive in your area.

Figure 10: ACT Personnel Information

2a. Please complete the blue boxes below with your staffing information.

Billable Staff	FTE	Annual Salary (per FTE)	
Psychiatrist	1.0	\$240,000	Based on the # of clients, we recommend 1 Psychiatrists
ACT Team Leader (licensed clinical supervisor)	1.0	\$70,000	Based on the # of clients, we recommend 1 Team Leaders
Mental Health Professional	1.0	\$55,000	Based on the # of clients, we recommend 1 Mental Health Professionals
Psychiatric Nurse	2.0	\$80,000	Based on the # of clients, we recommend 2 Psychiatric Nurses
Employment Specialist	2.0	\$50,000	Based on the # of clients, we recommend 2 Employment Specialists
Peer Specialist	1.0	\$40,000	Based on the # of clients, we recommend 1 Peer Specialists
Substance Abuse Specialist	2.0	\$50,000	Based on the # of clients, we recommended 2 Substance Abuse Specialists
Housing Specialist	1.0	\$45,000	Based on the # of clients, we recommend 1 Housing Specialists
Total Billing Staff	11.0		
Non-Billable Staff			
Program Director	1.0	\$85,000	
Administrative Support	1.0	\$40,000	
Total Staff	13.0		

Add FTEs to billable & non-billable staff

Update salaries with local rates

Tab 5: ICM

About ICM

Intensive Case Management (ICM) is a case management model intended for higher acuity clients with multiple co-occurring chronic conditions that require a smaller caseload size than classic case management. Some states fund ICM as an individual caseload approach while others fund ICM as a team-based, shared caseload approach. ICM has a moderate evidence base that demonstrates potential for improved health outcomes, housing stability, and reductions in crisis care (emergency departments, hospital overnight stays). **Systematic reviews of ICM conclude that the closer the ICM staffing model is to Assertive Community Treatment, the more likely that positive program outcomes will be achieved.** ICM staff are intended to provide a multidisciplinary approach to case management, yet team structure and specialties can be determined based on the target population and wraparound service needs of that target population.

ICM Target Population, Tenant Size, and Caseloads

1. Start by selecting whether this is a new ICM program or an existing ICM program by selecting “No” (existing program) or “Yes” (new program) in cell 9E.
2. Next, select the populations with whom your program intends to serve, and add the **total number of tenants** your program serves in scattered site and in single site in the **blue cells**.

3. The caseload numbers will automatically populate in the **green cells**. If you select “No” in cell 9E, then the green cells will pull from the **Existing Program Caseloads** you included in *Tab 3*. If you select “Yes” in cell 9E, then the green cells will pull from the **New Program Suggested Caseloads** provided for you in *Tab 3*.

Figure 11: ICM Target Population and Caseloads

1. Please complete the blue boxes below:

Is this a new ICM Program (i.e. new staff and/or new tenants)?	Yes
--	-----

Choose whether this is a new ICM program or an existing ICM program

	Target Population	# of Tenants in Scattered Site	Recommended Caseload	# of Tenants in Single Site	Recommended Caseload
1	Individuals	20	10	50	15
2	Families	30	10	40	15
3	Select				
4	Select				
5	Select				
6	Select				
	Total clients	50		90	

Select your target populations and add overall tenant #s to scattered site and single site

ICM Staffing Model – Personnel & Salaries

The personnel section is divided into **billable** and **non-billable staff**:

- In states where ICM programs are covered by Medicaid, **billable staff** are those that are most likely to perform billable services, and generally correspond to members of the ICM case management team. These include case managers, social workers, employment specialists, and addictions counselors.
- Non-billable staff** are members of the team that are not likely to perform services that are billable under Medicaid. These include program directors, administrative support, supervisors, and housing specialists (landlord liaisons).

Complete the personnel section by adding FTEs and salaries to each role under both staffing categories (the **blue cells**). The tool provides the recommended number of ICM team members in cell 23D, but the user is responsible for determining how to structure the team and the number of each specific billable staff member you plan to serve in each role.

Figure 12: ICM Personnel Information

2a. Please complete the blue boxes below with your staffing information. Please note that the recommended number of ICM staff is calculated for you in the green box; you should aim for your total billable staff to add up to this number.

Recommended # of ICM Team Members	12.0	Based on the # of clients, we recommend 12 ICM Staff	
-----------------------------------	------	--	--

Billable Staff (ICM Team Members)	FTE	Annual Salary (per FTE)	
Specialist Case Manager (if applic)	2.0	\$45,000	
Peer Specialist	2.0	\$40,000	
Social Worker (LCSW)	2.0	\$52,000	
Social Worker (LMSW)	2.0	\$48,000	
Vocational or Employment Specialist	2.0	\$45,000	
Certified Addictions Counselor	2.0	\$45,000	
Total Billing Staff	12.0		

Non-Billable Staff	FTE	Annual Salary (per FTE)	
Program Director	1.0	\$70,000	Based on the recommended # of case managers, we recommend 1 FTE
Administrative Support	1.0	\$36,000	Based on the recommended # of case managers, we recommend 1 FTE
Housing Manager/Landlord Liaison	1.0	\$64,000	
Housing Specialist		\$50,000	
Supervisor	2.0	\$55,000	Based on the recommended # of case managers, we recommend 2 FTE
Total Staff	17.0		

**Add FTEs to
billable & non-
billable staff**

**Update
salaries with
local rates**

Tab 6: TSS

About TSS

The core services in supportive housing, Tenancy Support Services (TSS) help people access and remain in housing. Sometimes referred to as housing case management, **TSS are typically delivered at staff-to-client ratios of 1:10 for scattered site and 1:15 for clustered and single site supportive housing.** Caseload sizes can be adjusted based on acuity levels and housing stabilization needs. Because of the numerous, conflicting definitions of case management across service sectors, the term “tenancy support services” has begun to replace “housing case management,” particularly in states where housing-related services are being funded by State Medicaid Plans.

Tenancy Support Specialists – also known as Housing Case Managers and Community Support Specialists – provide pre-tenancy and tenancy-sustaining services to clients living in supportive housing and/or transitioning from homelessness or institutionalization. Pre-tenancy supports include outreach and in-reach services, assessment of housing preferences and barriers, and assistance with housing search and move-in arrangements. Tenancy sustaining services include ensuring rent is paid and recertifications are completed, safeguarding that lease obligations are met and tenancy rights are upheld, and helping tenants to make connections in their communities.

TSS Target Population, Tenant Size, and Caseloads

1. Start by selecting whether this is a new TSS program or an existing TSS program by selecting “No” (existing program) or “Yes” (new program) in cell 9E.
2. Next, select the populations with whom your program intends to serve, and add the **total number of tenants** your program serves in scattered site and in single site in the **blue cells**.

- The caseload numbers will automatically populate in the **green cells**. If you select “No” in cell 9E, then the green cells will pull from the **Existing Program Caseloads** you included in *Tab 3*. If you select “Yes” in cell 9E, then the green cells will pull from the **New Program Suggested Caseloads** provided for you in *Tab 3*.

Figure 13: TSS Target Population and Caseloads

1. Please complete the blue boxes below:

Is this a new supportive housing program (i.e. new staff and/or new tenants)?	Yes
---	-----

Choose whether this is a new TSS program or an existing TSS program

Target Population	# Tenants in Scattered Site	Recommended Caseload	# Tenants in Single Site	Recommended Caseload
1 Individuals	20	15	10	20
2 Families	10	10	10	15
3 Individuals with dual dx SUD/SMI	15	10	5	10
4 Older adults	5	15	5	15
5 Select				
6 Select				
Total clients	50		30	

Select your target populations and add overall tenant #s to scattered site and single site

TSS Staffing Model – Personnel & Salaries

The personnel section is divided into **billable** and **non-billable staff**:

- In states where Tenancy Support Services are covered by Medicaid, **billable staff** are those that are most likely to perform billable services. These most commonly include tenancy support specialists/service coordinators (aka housing case managers) and peer specialists.
- Non-billable staff** are members of the team that are not likely to perform services that are billable under Medicaid. These include program directors, administrative support, supervisors, and housing managers/landlord liaisons.

Complete the personnel section by adding FTEs and salaries to each role under both staffing categories (the **blue cells**). The tool provides suggested FTE numbers for each staff member based on best practice in the *italicized text* next to each role. CSH also offers general salary recommendations based on national averages, but because of variance across the country, it is necessary to update the salaries with rates that are competitive in your area.

Figure 14: TSS Personnel Information

2a. Please complete the blue boxes below with local staffing information.

Billable Staff	FTE	Annual Salary (per FTE)	
Tenancy Supports Service Coordinator	7.0	\$40,000	Based on the # of tenants, we recommend 7 FTE
Peer Specialist	4.0	\$40,000	Based on the # of tenants, we recommend 4 FTE
Total Billing Staff	11.0		
Non-Billable Staff	FTE	Annual Salary (per FTE)	
Program Director	1.0	\$65,000	Based on the # of tenants, we recommend 1 FTE
Administrative Support	1.0	\$36,000	Based on the # of tenants, we recommend 1 FTE
Housing Manager (liason with landlord)	1.0	\$50,000	
Supervisor	1.0	\$45,000	Based on the # of tenants, we recommend 1 FTE
Total Staff	15.0		

Add FTEs to billable & non-billable staff

Update salaries with local rates

Tab 7: CTI

About CTI

Critical Time Intervention (CTI) is a 9-month, time-limited approach that uses a brokerage case management model that emphasizes intentional connections and coordination with mainstream community providers to ensure ongoing support as CTI services taper down. CTI can be a successful intervention for tenants in Rapid Rehousing with low to moderate acuity. It can also be used in Permanent Supportive Housing when CTI services are used to transition tenants from outreach and crisis services to mainstream ACT and ICM services once housed and working toward housing stability. CTI is an evidence-based approach with multiple stages of engagement and program fidelity standards for individuals and families. More on CTI can be found at <https://www.criticaltime.org/>.

CTI Target Population, Tenant Size, and Caseloads

1. Start by selecting whether this is a new CTI program or an existing CTI program by selecting “No” (existing program) or “Yes” (new program) in cell 9E.
2. Next, select the populations with whom your program intends to serve, and add the **total number of tenants** your program serves in scattered site and in single site in the **blue cells**.
3. The caseload numbers will automatically populate in the **green cells**. If you select “No” in cell 9E, then the green cells will pull from the **Existing Program Caseloads** you included in *Tab 3*. If you select “Yes” in cell 9E, then the green cells will pull from the **New Program Suggested Caseloads** provided for you in *Tab 3*.

Figure 15: CTI Target Populations and Caseloads

1. Please complete the blue boxes below:

Is this a new CTI program (i.e. new staff and/or new tenants)?	Yes
--	-----

Choose whether this is a new CTI program or an existing CTI program

Target Population	# Tenants in Scattered Site	Recommended Caseload	# Tenants in Single Site	Recommended Caseload
1 Individuals	20	20	20	20
2 Transition Age Youth	0	15	15	15
3 Select				
Total clients	20		35	

Select your target populations and add overall tenant #s to scattered site and single site

CTI Staffing Model – Personnel & Salaries

The personnel section is divided into **billable** and **non-billable staff**:

- In states where CTI is covered by Medicaid, **billable staff** are those that are most likely to perform billable services. These are generically called CTI Workers and Specialists.
- **Non-billable staff** are members of the team that are not likely to perform services that are billable under Medicaid. These include program directors, administrative support, and supervisors.

Complete the personnel section by adding FTEs and salaries to each role under both staffing categories (the **blue cells**). The tool provides suggested FTE numbers for each staff member based on best practice in the *italicized text* next to each role. CSH also offers general salary recommendations based on national averages, but because of variance across the country, it is necessary to update the salaries with rates that are competitive in your area.

Figure 16: CTI Personnel Information

2a. Please complete the blue boxes below with your local staffing information.

Billable Staff	FTE	Annual Salary (per FTE)	
CTI Workers	3.0	\$45,000	Based on the # of tenants, we recommend 3 CTI Workers
Specialist Position (if applic.)	1.0	\$60,000	
Total Billing Staff	4.0		
Non-Billable Staff	FTE	Annual Salary (per FTE)	
Program Director	1.0	\$68,000	Based on the # of tenants, we recommend 1 Supervisors
Administrative Support	1.0	\$32,000	
Supervisor / Field Work Coordinator	1.0	\$60,000	
Total Staff	7.0		

Add FTEs to billable & non-billable staff

Update salaries with local rates

Tabs 4-7: Completing the Medicaid Revenue and Budget Templates

The Medicaid revenue and budget templates for all four service models are structured the same way and include the same elements:

Units of Service (UOS) and Medicaid Reimbursement Rates

The **dotted orange box labeled “2b. (OPTIONAL)”** should only be updated if you intend to bill Medicaid for services. The tool allows you to play around with Medicaid rate-setting and revenue potential for three reimbursement types: **(1) 15-minute increments**, in which your billable staff is reimbursed for every 15 minutes of eligible time worked; **(2) Per diem**, meaning the number of clients seen per day; and **(3) Per member per month**, meaning the number of clients seen per month. In the first group of

blue cells, you have the option to update inputs related to your staff’s billable potential, also known as “Units of Service” (UOS):¹

- Hours worked per week and days off per year: These inputs are used to calculate UOS for both 15-minute increments and per diem reimbursement types.
- Productivity rate:² This is used to calculate UOS for 15-minute increments and a suggested average number of clients seen per FTE per day.
- Average number of clients seen per day:³ This is used to calculate UOS for per diem.

Next, you should complete your Medicaid reimbursement inputs (the blue cells):

1. Select the reimbursement type on which you’d like to base your Medicaid revenue projections.
2. Determine the percentage of your budget that you would like Medicaid revenue to help cover.

Once you’ve added the reimbursement type and budget percentage, a reimbursement rate will be generated for you (displayed in the highlighted red text).⁴ You can either add this amount to your Reimbursement Rate, or you can add a different rate of your choosing.

Figure 17: Medicaid Reimbursement Structure

2b. (OPTIONAL) Only complete rows 37-49 if you are planning to be reimbursed by Medicaid. Otherwise, leave as is.

Unit of Service (UOS) Assumptions for Billable Staff

FTE Hrs/Week	40.0	
Holiday days	10.0	We recommend at least the 10.0 Federal holiday days
PTO days	20.0	We recommend 20.0 PTO days
Personal days	3.0	We recommend 3.0 personal days
Other days off	1.0	We recommend 1.0 other days off
Productivity	75%	Billable staff will never have 100% productivity - 75% productivity is a healthy goal for single site; scattered site will vary
Avg. # Clients Seen per Day	6.0	Based on your productivity, we recommend 6 clients seen per FTE per day
Annual UOS per Client	12	

Select your Medicaid Reimbursement Type & Rate

Reimbursement Type	Per member per month	
% of Budget covered by Medicaid	60.0%	Based on the overall cost in cell F92, a reimbursement rate of \$641 will cover this percent of your budget
Reimbursement Rate	\$650.00	

¹ Note that none of these inputs will impact the revenue potential for a per member per month (PMPM) schedule; PMPM is entirely dependent on the number of clients seen each month.

² Staff will not be able to bill 100% of the time they work, so productivity choice is an important one. Activities like staff meetings, case notes, supervision, and some forms of transportation are all considered non-billable activities. On average, we suggest setting a goal of 75% productivity for site-based staff; productivity for scattered-site staff will vary depending on how much time is spent traveling between client meetings. CSH has materials to support a time study for your agency if you need assistance in determining billable staff productivity.

³ The tool suggests the average number of clients seen per day in the *italicized font*, based on your productivity rate.

⁴ Your suggested reimbursement rate is calculated based on your annual program budget, using the inputs you provide in the subsequent section, section 3 “Program Budget.” You should complete this section prior to playing around with reimbursement rates so that you are given an accurate estimate based on total program costs.

Annual Budget Template

The Annual Budget Template includes four columns: **Annual Program Expenses**; **Annual Medicaid Administrative Expenses**; **Annual Budget WITHOUT Startup Expenses**; and **Startup Expenses**.

Annual Program Expenses	Annual Medicaid Administrative Expenses	Annual Budget WITHOUT Startup Expenses	Startup Expenses
<ul style="list-style-type: none"> Includes everything in your typical program budget: annual personnel expenses, annual operating expenses, annual indirect costs, and annual revenue 	<ul style="list-style-type: none"> Pulls in all annual or ongoing costs from Tab 9. Medicaid Admin Costs Only populates if you selected "Yes" to including Medicaid provider costs in Tab 3. Basic Input & Assumptions 	<ul style="list-style-type: none"> The sum of Annual Program Expenses and Annual Medicaid Administrative Expenses 	<ul style="list-style-type: none"> Pulls in all costs from Tab 8. General Startup Costs and one-time/startup costs from Tab 9. Medicaid Admin Costs Only populates if you selected "Yes" to including general startup costs and/or Medicaid provider costs in Tab 3. Basic Input & Assumptions

The template is divided into **categories A-G** and includes specific line items that are either automatically calculated for you or require your manual input. Not all line-items are relevant to all columns; gray cells should remain empty, green cells are automatically calculated for you, and blue cells should be filled in manually.

Figure 18: Annual Budget Template

3. Please complete the blue boxes in the budget template below:

TSS Annual Budget Template				
	Annual Program Expenses	Annual Medicaid Administrative Expenses	Annual Budget WITHOUT Startup Expenses	Startup Expenses (Medicaid & General)
A. PERSONNEL EXPENSES				
Wages and Salaries	\$636,000	\$0	\$636,000	
Employee Benefits	\$203,520	\$0	\$203,520	
Contract Personnel	\$0	\$0	\$0	
Other Personnel Expenses	\$0	\$0	\$0	\$0
Staff Development & Training	\$0	\$0	\$0	\$0
Subtotal Personnel Expenses	\$839,520	\$0	\$839,520	\$0
B. OPERATING EXPENSES				
Rent	\$0		\$0	\$0
Utilities	\$0		\$0	\$0
Building Insurance	\$0		\$0	\$0
Housekeeping	\$0		\$0	
Communications (Phone, Data)	\$0		\$0	\$0
Office Supplies	\$0		\$0	\$0
Professional Liability Insurance	\$0	\$0	\$0	
Estimated Mileage	\$0.00	Estimated mileage rates pulled from Basic Input & Assumptions Tab	\$0	
Mileage Rate	\$0.670		\$0.670	
Est. Miles Per Day Per FTE	25		25	
Est. # FTE Traveling	0		0	

Column D: Annual Program Expenses

Categories A-B of your Program Expenses column make up the bulk of your overall budget. These include your Personnel Expenses (including employee salaries, benefits, staff development, and training), as well as your Operating Expenses, which include all other costs of running your program (like rent, utilities, IT, transportation, etc.). Employee salaries and benefits, as well as costs associated with expected gas and mileage, are calculated for you in the **green cells** based on your staffing inputs from **Section 2a (Personnel)** and the assumptions you included in *Tab 3*. All other costs need to be manually entered into the **blue cells**.

Categories C-E display your Total Direct, Administration (Indirect), and Total Program Costs, and are automatically calculated for you in the **green cells**. Your Total Direct Cost sums up your personnel and operating expenses; your Indirect Costs are automatically calculated based on the rate you included in *Tab 3*; and your Total Program Costs are the sum of the two.

Category F displays your revenue. You should add your various sources of existing or anticipated revenue into the **blue cells**. Your Medicaid Revenue potential is calculated for you in the **green cell**, based on the reimbursement structure you included in the Medicaid Reimbursement section. The percentage of your program costs covered by your Medicaid Revenue is provided for you below your budget template in the **highlighted red text**.

Category G displays your overall net – your program revenue minus your program costs. This amount is calculated for you in the **green cell**. If your net is less than zero, the amount will show up in a **red parenthesis**.

Figure 19: Annual Revenue, Medicaid Reimbursement, and Net

F. REVENUE	
In Kind /Community Partner Service	\$0
Program Service Fees	\$0
Grants	\$0
Private Insurance	\$0
Medicaid Reimbursement*	\$576,000
Other Revenue	\$0
TOTAL REVENUE	\$576,000
G. NET	
	(\$389,448)

Medicaid is covering 60% of your annual budget*

****Your annual budget equals your program costs plus your annual Medicaid administrative costs (it does not include startup costs or one-time Medicaid costs)**

Medicaid revenue, calculated from the Medicaid Reimbursement Rate you inputted in Section 2b.

Without additional funding, your budget is netting a negative amount

Column E: Annual Medicaid Administrative Expenses

Column E: Annual Medicaid Administrative Expenses pulls in all annual or ongoing costs from *Tab 9. Medicaid Admin Costs*. These costs will only be included in the Annual Medicaid Administrative Expenses if you select “Yes” to “Medicaid Admin Costs” in *Tab 3* and select either “Apply to All” or

“Apply to Tab [XX]” in *Tab 9*. This will be discussed in more detail in the section on *Tab 9. Medicaid Admin Costs*.

Many line items in the Budget Template do not apply to Annual Medicaid Administrative Expenses; these items remain empty, and the cells are grayed out.

Note that while this column includes costs associated with becoming a Medicaid-billing provider, this column **does not** have anything to do with Medicaid revenue generation. The amount of revenue that you can expect to receive through Medicaid reimbursement will be included in the Annual Program Expenses column, not the Annual Medicaid Administrative Expenses column.

Figure 20: Annual Medicaid Administrative Expenses and Medicaid Reimbursement

TSS Annual Budget Template			
	Annual Program Expenses	Annual Medicaid Administrative Expenses	Annual Budget WITHOUT Start Up Expenses
Miscellaneous Expenses (Client Emergency Fund, Tenant supplies)	\$0	\$0	
Security Deposits	\$0		
PWLE Focus Groups	\$0		
Subtotal Operating Expenses	\$0	\$12,450	\$12,450
C. TOTAL DIRECT	\$515,310	\$218,401	\$733,711
D. ADMINISTRATION (INDIRECT)	\$77,297	\$32,760	\$110,057
E. TOTAL PROGRAM COSTS	\$592,607	\$251,161	\$843,768
F. REVENUE			
In Kind /Community Partner Service	\$0		\$0
Program Service Fees	\$0		
Grants	\$0		
Private Insurance	\$0		
Medicaid Reimbursement*	\$108,480		
Other Revenue	\$0		
TOTAL REVENUE	\$108,480		
G. NET	(\$484,127)		

Annual/ongoing Medicaid costs, pulled from **Tab 9**.

Medicaid revenue, calculated from the Medicaid Reimbursement Rate you inputted in **Section 2b**.

Column F: Annual Budget Without Startup Expenses

Column F: Annual Budget Without Startup Expenses sums the Annual Program Expenses and Annual Medicaid Administrative Expenses columns to produce a **total annual budget**. The Total Program Costs that display in this column are used to calculate the suggested Medicaid Rate in **Section 2b, Medicaid Reimbursement Rates**.

Figure 21: Annual Budget Without Startup Expenses

TSS Annual Budget Template			
	Annual Program Expenses	Annual Medicaid Administrative Expenses	Annual Budget WITHOUT Start Up Expenses
C. TOTAL DIRECT	\$515,310	\$218,401	\$733,711
D. ADMINISTRATION (INDIRECT)	\$77,297	\$32,760	\$110,057
E. TOTAL PROGRAM COSTS	\$592,607	\$251,161	\$843,768

Used to calculate Medicaid Reimbursement Rate in **Section 2b**.

Column G: Startup Expenses (Medicaid & General)

If you selected “Yes” to including General Startup Costs and/or Medicaid Administrative Costs in *Tab 3*, then these one-time costs will show up in Column G: Startup Expenses. These expenses are pulled in from *Tab 8. General Startup Costs* and *Tab 9. Medicaid Admin Costs*. Note that only **one-time** Medicaid Administrative Costs are included in this column; all annual/ongoing Administrative Costs are included in Column E: Annual Medicaid Administrative Expenses.

Multi-Year Budget

The Multi-Year Budget projects your costs and revenue over a three-year period. **Year 1** takes your Annual Budget WITHOUT Startup Expenses and combines that with your Startup Expenses to give you a total overall budget for your first year. These amounts are automatically calculated in the **green cells** in Column I.

Year 2 takes your Annual Budget WITHOUT Startup Expenses and multiplies that by an assumed annual inflation rate. This assumed inflation amount is pulled in from *Tab 3*. All costs and revenue are calculated in the **peach cells** – rather than lock the formulas like in the green cells, you have the option to change these values if the defaults we’ve provided for you end up changing each year. However, the overall totals are calculated for you in the **green cells** in Column J.

Year 3 takes the amounts in Year 2 and multiplies them by the same assumed annual inflation rate pulled in from *Tab 3*. Like Year 2, all costs and revenue are calculated in the **peach cells** so that you have the option of making changes if your inputs vary from year to year. However, your overall totals are calculated for you in the **green cells** in Column K.

Grand Total sums the total of Years 1-3 to give you a total overall projected budget over three years in Column L.

Figure 22: Multi-Year Budget

	TSS Multi-Year Budget			
	Year 1	Year 2	Year 3	Grand Total
A. PERSONNEL EXPENSES				
Wages and Salaries	\$536,000	\$562,800	\$590,940	\$1,689,740
Employee Benefits	\$171,520	\$180,096	\$189,101	\$540,717
Contract Personnel	\$14,102	\$14,808	\$15,548	\$44,458
Other Personnel Expenses	\$180	\$189	\$198	\$567
Staff Development & Training	\$6,690	\$7,025	\$7,376	\$21,090
Subtotal Personnel Expenses	\$728,492	\$764,917	\$803,163	\$2,296,572
B. OPERATING EXPENSES				
Rent	\$0	\$0	\$0	\$0
Utilities	\$0	\$0	\$0	\$0
Building Insurance	\$0	\$0	\$0	\$0
Housekeeping	\$0	\$0	\$0	\$0
Communications (Phone, Data)	\$0	\$0	\$0	\$0
Office Supplies	\$0	\$0	\$0	\$0
Professional Liability Insurance	\$750	\$788	\$827	\$2,364
Estimated Mileage	\$0	\$0	\$0	\$0
Mileage Rate	\$0.655	\$0.688	\$0.722	\$2.065
Est. Miles Per Day Per FTE	25	25	25	75
Est. # FTE Traveling	0	0	0	0
Vehicles	\$0	\$0	\$0	\$0

Tab 8: General Startup Costs

Only complete Tab 8 if you selected “Yes” to include General Startup Costs in *Tab 3*. The expenses included on this tab are common expenses associated with starting a new service delivery program. This will vary depending on an organization’s existing structure. For example, if an organization already has an electronic health record (EHR), then costs may only include adding users or licenses. Thus, the user should take some time to review which costs are applicable and which costs need to be ignored or altered if the cost is different from what is known to the organization or user.

CSH has provided standard startup items in Column B but has also left space for you to add additional expenses not listed. In Column C (Basis), add the context, frequency, or amount of the purchase (ex., per employee, per month, one-time cost, etc.). Enter the per-unit cost of the item in Column D, and the number of units to purchase in Column E. The total cost will be calculated in Column F.

All costs listed in this section are aggregated and included in each service model’s Startup Expenses (Column G) if you selected “Yes” to include General Startup Costs in *Tab 3*.

Figure 23: General Startup Costs

	Basis	Cost	# of Units	Total	Notes
A. PERSONNEL EXPENSES					
Other Personnel Expenses					
Advertising/Posting				\$0	Costs of posting on hiring websites or search firms if necessary given local market conditions, per
Signing Bonuses				\$0	employee signing bonuses
Background Checks				\$0	Costs of background checks for each hired employee, if used
Bonuses or overtime pay for				\$0	
Other				\$0	
Other				\$0	
Staff Development and Training					
Training				\$0	Costs for training as new staff are being onboarded
Other				\$0	
Other				\$0	
Other				\$0	
Subtotal Startup Personnel				\$0	
B. OPERATING EXPENSES					
Rent				\$0	Rent for office space during the ramp up phase
Utilities				\$0	Utilities prior to services beginning
Building Insurance				\$0	Insurance for new building or space prior to services beginning
Communications, Cell Phones				\$0	Purchase of cell phones for newly hired employees, ongoing service costs will be included in each annual budget
Office Supplies, Misc.				\$0	Paper, staplers, pens, other items necessary to prepare workspaces for new staff
Vehicles (purchase)				\$0	Purchase of vehicles for use by staff when working with clients
Vehicle Insurance				\$0	Initial insurance payment for purchased vehicles
Building Renovations				\$0	Renovations to office space to ready it for start of services
Furnishing/Equipment					
Desks				\$0	Number of desks needed for newly hired employees
Chairs				\$0	Number of chairs needed for newly hired
				\$0	Copier purchase for service delivery team if needed. Scanner is relevant if converting any paper documents to digital for storage in electronic health record.
Scanner/Copier				\$0	
Shredder or shredding service				\$0	If providing health services or a Medicaid provider,
Filing cabinets, locked				\$0	Filing cabinets designed to hold client medical or
Filing cabinets, standard				\$0	
Licenses, Electronic Health Records				\$0	The initial cost of electronic health record licenses and setup. Ongoing costs will be included in each annual budget.

Tab 9: Medicaid Administrative Costs

If your organization is planning to transition to billing Medicaid for the services you provide your supportive housing tenants, complete this tab to understand the administrative costs associated with becoming a new Medicaid provider. The tool specifies which components are required by CMS, which are required by your State Medicaid Agency, and which are optional. This allows the user to prioritize costs, especially when working with a limited budget. Many of the costs are prepopulated based on national averages, or costs known to CSH. However, any **blue cell** can and should be adjusted to match local costs and/or costs known to your organization.

To start calculating the Medicaid Administrative Costs for your agency:

1. Make sure you select “Yes” to the question “Do you want to include Medicaid administrative costs in your budget summary?” in *Tab 3*.⁵
2. Select the staffing model tab you want these costs applied to in Cell F5. You can select one model or all models. The model(s) selected will display these costs in their tab, as well as in the two budget summary tabs (*Tab 2a. Budget Summary Output* and *Tab 2b. Annual Total Budget Summary*).
3. Familiarize yourself with the budget items and select “Yes” to any you will need to include in your estimates in Column H.
4. Items that are required by CMS or your State Medicaid Agency are labeled in **red** and items that are optional are labeled in **yellow** in Column C.
5. Update the **blue cells** with local costs and relevant quantities/units.
6. The **green cells** automatically populate with the known variables and the total annual costs.
7. Helpful context, notes, and reference points are included in Column J.

Figure 24: Medicaid Administrative Costs

1. To show and use these inputs, select “Yes” in cell D8 on tab 3, “Basic Input & Assumptions.”

2. Then SELECT the Staffing Model Tab you want these costs applied to HERE (E5):

Apply to All

3. Familiarize yourself with these budget considerations and select YES to any you will need to include in your estimates.

4. Adjust any cost estimates in Column E to local estimates as needed. This is especially important for salaries.

Expense considerations for new Medicaid providers	Required?	Frequency of Expense	Basis	Cost	Units	Select Yes to include line item in Start Up or Annual Budget	Annual Total	Notes
A. PERSONNEL EXPENSES								
Wages and Salaries								
Quality Improvement (QI) Manager	Required-CMS	Ongoing - Annually	1 per agency	\$65,000	1	Yes	\$65,000	This may be a new position for many agencies. It is needed to ensure compliance with funder rules and regulations and to ensure billing is accurate and correct. This role can be combined with another role and/or be fulfilled by an existing position, as it may not require a full time LOE.
Additional QI administrative support	Not Required (optional)	Ongoing - Annually	1 per agency	\$45,000	1	Yes	\$45,000	Only as needed.
Compliance Officer	Required-State Medicaid	Ongoing - Annually	1 per agency	\$65,000	1	Yes	\$65,000	In smaller agencies this role is often combined with another role. There are requirements for this role to have the ability to report directly to the ED and also directly to the Board of Directors regarding agency compliance. For details see U.S. Dept. of Health and Human Services Office of the Inspector General and your state's Medicaid agency requirements for Medicaid Compliance Officers.
Contract Personnel								
Medicaid Consultant	Not Required (optional)	Start Up	1 per agency	\$20,000	1	Yes	\$20,000	Will help agencies be more effective and speed up the process in becoming a Medicaid biller; can help with administrative and Board policy changes, rules and requirements, quality improvement policies and practices, assisting with national accreditation, etc. Consultants can also help with compliance requirements to review policies, help with internal audit readiness, etc. Cost range: \$10,000-\$30,000 (or 130-200/hour).
Billing Support Subcontract	Not Required (optional)	Ongoing - Monthly	1 per agency	\$259,975	6.5%	Yes	\$202,781	Most billing agencies will cost 5-8% of claims submitted. In other words for each \$100 submitted in billing claims, the subcontracted billing agency would receive \$5.00-\$8.00 depending on the agreement. A consultant can help you to estimate your Medicaid revenue potential in order to decide if a billing support subcontract makes more fiscal sense than purchasing a billing software and doing all billing in house.
Other Personnel Expenses								
								If background checks are not yet included in your organizational budget, include them here or in

⁵ Note: If you do not select “Yes” on Tab 3, you may see \$0 or ERROR in Column I: Annual Total.

Transition to Medicaid Reimbursement Timeline

This chart is designed to show how an organization can project the transition from grant funding to Medicaid billing over time. The chart calculates reimbursement estimation and grant expenditures across a 15-month timeline based on an agency's estimate of Medicaid reimbursement that is feasible and reasonable to expect with the staffing model(s) selected, target population(s) served, and local Medicaid benefits. CSH does not recommend planning an organizational budget with more than 75% of services funded by Medicaid, as it is best practice to also braid in other funding such as CoC funding, private grants, and other donations to help support the services not covered by Medicaid, like staff travel and landlord engagement. This chart is just an example. For more information on how to calculate or project anticipated Medicaid revenue for your agency, please contact CSH Consulting at consulting@csh.org.

Figure 25: Medicaid Reimbursement Incremental Timeline

Example Ramp Up to Medicaid Reimbursement from Grant Funding				
Total Program Budget				
\$ 4,154,709.24	Percent of Budget covered by Grant Funding	Percent of Budget covered by Medicaid Reimbursement	Anticipated Grant Funding	Anticipated Medicaid Reimbursement
Month 1	100%	0%	\$ 4,154,709.24	\$ -
Month 2	99%	1%	\$ 4,113,162.14	\$ 41,547.09
Month 3	97%	3%	\$ 4,030,067.96	\$ 124,641.28
Month 4	95%	5%	\$ 3,946,973.77	\$ 207,735.46
Month 5	90%	10%	\$ 3,739,238.31	\$ 415,470.92
Month 6	85%	15%	\$ 3,531,502.85	\$ 623,206.39
Month 7	80%	20%	\$ 3,323,767.39	\$ 830,941.85
Month 8	70%	30%	\$ 2,908,296.47	\$ 1,246,412.77
Month 9	60%	40%	\$ 2,492,825.54	\$ 1,661,883.69
Month 10	50%	50%	\$ 2,077,354.62	\$ 2,077,354.62
Month 12	40%	60%	\$ 1,661,883.69	\$ 2,492,825.54
Month 14	30%	70%	\$ 1,246,412.77	\$ 2,908,296.47
Month 15	25%	75%	\$ 1,038,677.31	\$ 3,116,031.93

References

1. ACT Model Description and Staffing Recommendations
Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: Building Your Program. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.
<https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344>
SAMHSA published a guide to setup and implementation of the ACT model. In its guide, a ratio of 10-12 FTE ACT workers to 100 clients is recommended. In general, the program does not recommend exceeding a ratio of 10 clients per FTE. More specifically, for every 100 clients, the ACT model recommends at least 1 psychiatrist, 2 psychiatric nurses, 2 employment specialists, and 2 substance abuse specialists. In addition, the program recommends including peer specialists, mental health professionals, and program assistants on the ACT team as well.
2. ACT Youth Recommendations
Vijverberg, Richard, et al. "The Effect of Youth Assertive Community Treatment: a Systematic PRISMA Review." BMC Psychiatry, vol. 17, no. 1, 2017, doi:10.1186/s12888-017-1446-4.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5541424/>
In this systematic literature review, the authors found that 8 of 13 randomized, controlled trials of ACT in youth featured small caseloads of fewer than 10 clients per ACT worker. Four studies did not report their caseload size and only one study featured a larger caseload.
3. CTI Implementation Manual
Center for the Advancement of Critical Time Intervention. Silberman School of Social work at Hunter College.
<https://www.criticaltime.org/>
4. CTI Families
Samuels, Judith. Young Family Critical Time Intervention (CTI): Successful Transitions from Homelessness to Stability. Strengthening At Risk and Homeless Youth Mothers and Children, 2010.
<https://www.criticaltime.org/wp-content/uploads/2011/10/Samuels-Young-Families.pdf>
The Youth Family Critical Time Intervention model recommends a caseload of 12 families per case worker.
5. CTI Youth
Munson, Michelle R., et al. "Cornerstone Program for Transition-Age Youth with Serious Mental Illness: Study Protocol for a Randomized Controlled Trial." Trials, vol. 17, no. 1, 2016, doi:10.1186/s13063-016-1654-0.

<https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-016-1654-0>

The Cornerstone program adapted the CTI model for transition-age youth with serious mental illness. A randomized, controlled trial evaluating and validating this model was initiated in April, 2016 and the results of the trial are not yet available. That said, the trial uses a case worker caseload of 15 youth. The trial further specifies that all case workers are trained social workers.

6. Literature Review of ICM

Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. Intensive case management for severe mental illness. Cochrane Database of Systematic Reviews 2017, Issue 1. Art. No.: CD007906. DOI: 10.1002/14651858.CD007906.pub3.

<https://pubmed.ncbi.nlm.nih.gov/28067944/>

In a meta-analysis conducted by the Cochrane Review, ICM was defined as a model in which caseloads were less than 20. The meta-analysis found that, based on this cutoff, ICM appeared to reduce hospital stays and lead to higher client retention in services. That said, the Cochrane Review emphasized that the current randomized, controlled trial evidence for ICM is low to moderate quality at best.

7. Comparison of ACT and ICM in Rural Settings

Meyer, Piper S, Morrissey, Joseph P. A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas PSYCHIATRIC SERVICES Psychiatry Online, January 2007, Vol. 58, No. 1.

<https://ps.psychiatryonline.org/doi/pdfplus/10.1176/ps.2007.58.1.121>

8. Society for Human Resource Management Guidelines

Sammer, Joanne M. "Updating Salary Structure: When, Why and How?" Society for Human Resource Management, 21 May 2013.

<https://www.shrm.org/resourcesandtools/hr-topics/compensation/pages/updating-salary-structure.aspx>

This article from the Society for Human Resource Management provides recommendations for salary scale review in the local labor market. The article recommends conducting regular reviews on a specific schedule, at least every three to five years but as often as every 18 to 24 months is common as well. The article also recommends conducting a salary review when there are major events that impact the organization. The article also suggests garnering feedback from employees and managers about salary satisfaction and being intentional about linking the salary structure to the overall HR strategy and the market. Some questions to ask include: (i) Has the organization established appropriate pay grades and maintained updated job descriptions with require skills?; and (ii) Does the company have a clear idea of whether it is paying for the position or for the skills that people bring to it and the organization?

9. Comparison of Case Management Interventions

Ponka D, Agbata E, Kendall C, Stergiopoulos V, Mendonca O, Magwood O, et al. (2020) The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review, 26 July 2019

<https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0230896&type=printable>

This article provides a systematic review to examine the effectiveness and cost-effectiveness of case management interventions on health and social outcomes for homeless populations. Case management approaches were found to improve some if not all of the health and social outcomes that were examined in this study. The important factors were likely delivery intensity, the number and type of caseloads, hospital versus community programs and varying levels of participant needs.