Using Performance-Based Contracting to Support Improved Outcomes for Youth and Families

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I. Value-Based Purchasing and Performance Measures

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Value-Based Purchasing
Performance-Based Payment Structures

Value Based purchasing (VBP) refers to any purchasing practices aimed at improving the value of health care services, ***where value is a function of both quality and cost****…(Source: Agency for Healthcare Research and Quality)*

Alternative Payment Arrangements – Providers are rewarded (bonuses, share in savings) or penalized (reductions in payments, assumption of risk) based on meeting pre-established targets or benchmarks for measures of quality and/or efficiency and/or outcomes.

CT: enhanced FFS payments to BH clinics for weekend/off-hours

MI: payments to CMHCs over and above the capitation rates for Medicaid-enrolled children involved with child welfare who have serious mental health conditions

Choices, Inc and Wraparound Milwaukee – population case rates with shared savings and risk for reducing use of residential treatment and psych inpatient

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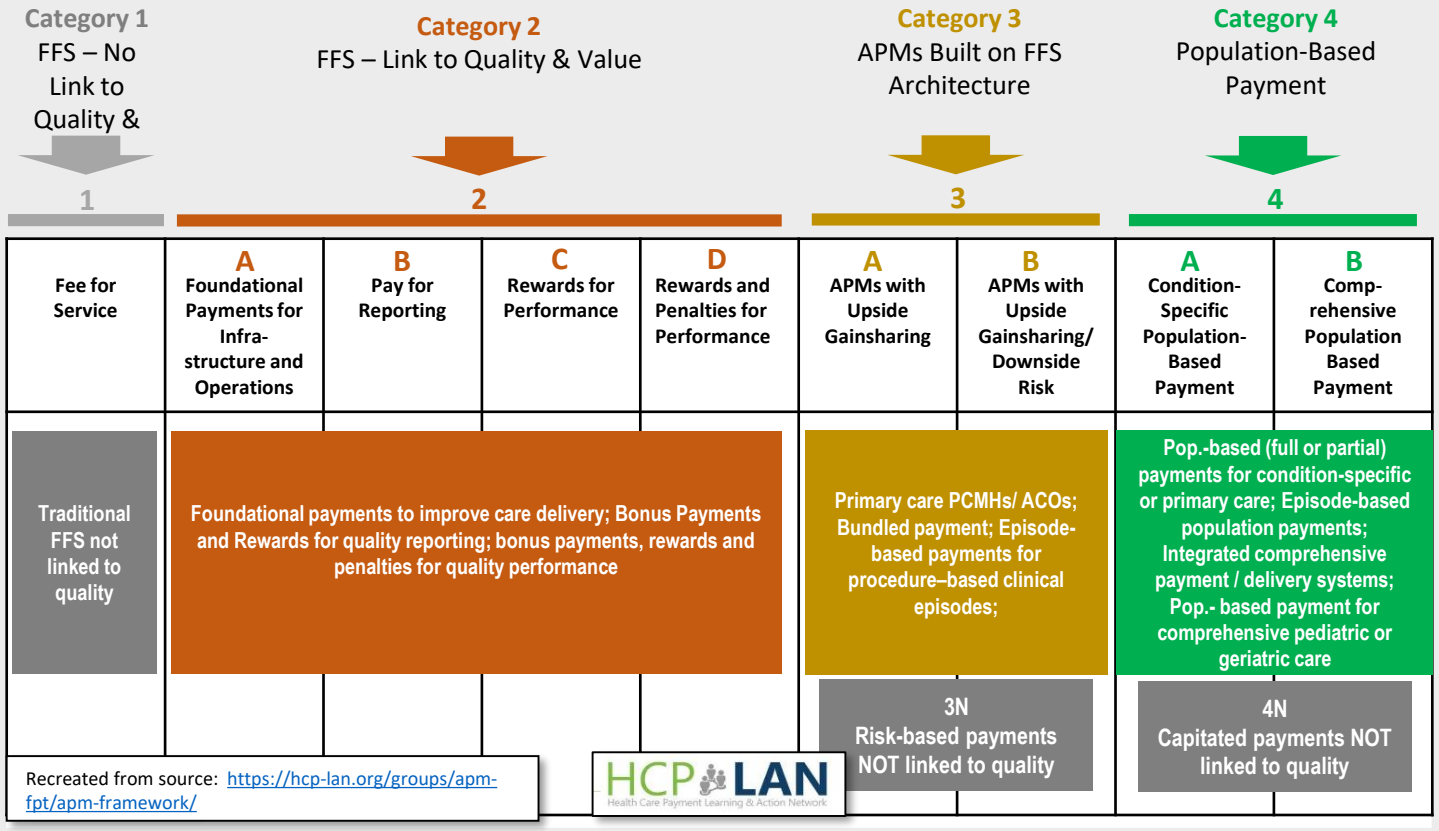
Health Care Payment Learning and Action Network (LAN) Framework for Alternative Payment Arrangements (APM)



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Current VBP Landscape in Medicaid Behavioral Health and in Children's Services

- 40% of State Medicaid Directors polled in 2016 reported plans to expand VBP arrangements

- Most VBP arrangements in Medicaid to date relate to physical health care

- Most behavioral health VBP arrangements in Medicaid to date relate to adults

- Child welfare systems to date have had more involvement with VBP purchasing related to children with high BH needs/high costs

- Almost no VBP arrangements in Medicaid and few in child welfare relate solely to PRTFs

- Most VBP arrangements affecting behavioral health do not extend further than Category 2 of the Health Care Payment Learning and Action Network (LAN) Framework for Alternative Payment Arrangements (APM)

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Performance Measures Tied to Payment

Connecticut

- Enhanced Clinic Payment for behavioral health outpatient services with a focus on *access and primary care coordination*
  - Targets for routine, urgent and emergent care
  - Weekend and evening hours
  - Requires MOUs with primary care
  - Screening targets for co-occurring conditions

➢ LAN Category 2C –rewards for performance

Oregon Coordinated Care Organizations

- Seventeen measures used - the following are specific to BH or relevant to BH
  - Satisfaction with care
  - Screening for clinical depression and follow-up
  - Adolescent Well-Care visits
  - Follow-up care for children prescribed ADHD medication
  - Access to Care
  - Alcohol or other substance misuse screening
  - ED utilization
  - Developmental screening in first 36 months

LAN Category 2B - pay for reporting

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Optum-Multiple States

- Enhanced payment to Outpatient BH Providers for meeting specified quality and cost targets

- Ratings focus on quality and cost targets:
  - One star for defined quality metric targets
  - One star for cost targets
- Separation of targets allows providers to gain from meeting quality targets even if can't meet cost; and protects against exclusive focus on cost by requiring those who meet cost targets to also meet quality targets

➢ LAN Category 2C – rewards for performance

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Oklahoma Enhanced Tiered Payment System

- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) designed a performance outcomes payment plan with an overarching goal to proactively increase the recovery of Oklahomans from mental illness and substance abuse
- Performance payment is based on the number of members attributed to the provider and agency performance on each measure (meaning providers can earn a bonus for individual measures as opposed to “all or nothing”).
    - Facilities are divided into four tiers based upon their relative performance.
    - Those in the lowest tier earn zero incentive dollars; those in the next lowest tier earn 50% of their allotment; those in the next tier earn 100% of their allotment; and, those in the highest tier earn 150% of their allotment.

LAN Category 2C – rewards for performance

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Oklahoma Measures

Outpatient Crisis Service Follow-up within 8 Days	Inpatient/Crisis Unit Follow-up within 7 Days	Reduction in Drug Use	Engagement: Four Services within 45 Days of Admission	
Medication Visit within 14 Days of Admission	Access to Treatment - Adults	Improvement in CAR (Client Assessment Record) Score: Interpersonal Domain	Improvement in CAR Score: Medical/Physical Domain	
Improvement in CAR Score: Self Care/Basic Needs Domain	Inpatient/Crisis Unit Community Tenure of 180 Days	Peer Support: % of Clients Who Receive a Peer Support Service	**Access to Treatment – Children: The interval between initial contact and receipt of treatment services**	

Access to Treatment – Children: The interval between initial contact and receipt of treatment services

- → Bonus = See clinician for screening in 0-3 days
- → 2 pts. = Come in within 4-5 days and will see clinician
- → 1 pt. = Come in for paperwork 1-5 days, but won't see clinician
- → 0 pts. = Anything else

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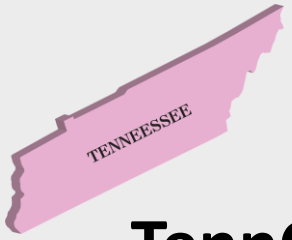

TennCare Incentives for Enhanced Care Coordination

- Payments to providers from MCOs to make specific clinical and organizational changes

- A set rate for each member for each month specific services are delivered

- Outcome payments based on core quality and efficiency metrics (e.g., hospital readmissions, ER visits, initiation and engagement of SUD treatment)

LAN Category 2C – rewards for performance

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Community Care Behavioral Health
Allegheny County, PA

Assertive Community Treatment (ACT) Pay for Performance

- ACT providers earn up to 110% of current fee schedule for ACT, with
  - ✓ 80% payment for all services rendered
  - ✓ 20% additional for reducing inpatient psychiatric use (withhold amount)
  - ✓ 10% additional bonus for meeting overall target of reducing average inpatient psychiatric use to $9,000 or less during the calendar year

- ACT providers had to remain within a total ACT service use cost cap per person per year

- ➢ Both ACT providers earned the full 20% withhold amount plus 10% bonus
- ➢ Providers achieved a 64% and 28% reduction in average inpatient cost per person
- ➢ CCBH moving to bonuses for improvement in competitive employment rates among ACT recipients

LAN Category 2D – rewards and penalties for performance

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Approaches to Measurement

Measures Related to Structure , e.g.

- Care coordinator caseload size
- % of informal supports in plans of care
- Family peer support on staff and caseload size
- Staff capacity (e.g., % of staffed trained in EBPs; racially/ethnically/linguistically diverse staff)

Measures Related to Process, e.g.

- Time to family engagement after referral
- Time to child and family team convening and plan of care development
- # of face-to-face contacts with family
- Time to mobile crisis response
- Fidelity to EBPs

Measures Related to Outcomes, e.g.

- Clinical and functional improvement
- Numbers of children on 2, 3, 4 plus psychotropic meds; on specific classes of meds
- Community tenure versus out-of-home placement
- School attendance
- Juvenile justice involvement/recidivism
- Placement disruption
- Family and youth satisfaction
- Cost

National Quality Measures and Children

Measure
1a. Follow-up care for children prescribed ADHD medication (CHIPRA-20; NQF-108)
1b. Management of ADHD in primary care for school-aged children and adolescents (NQF-107)
2. Follow-up after hospitalization for mental illness (CHIPRA-21; NQF-576)
3a. Developmental screening in the first 3 years of life (CHIPRA-8; NQF-1448)
3b. Developmental screening by 2 years of age (NQF-1399)
4. Pediatric Symptom Checklist (NQF-722)
5a. Depression screening by 13 years of age (NQF-1394)
5b. Depression screening by 18 years of age (NQF-1515)
6a. Risky behavior assessment by age 13 years (NQF-1406)
6b. Risky behavior assessment by age 18 years (NQF-1515)
7. Suicide risk assessment (NQF-1365)
8. Documentation of DSM-IV diagnostic evaluation for depression (NQF-1364)
9. Diagnosis of ADHD in primary care for school-aged children and adolescents (NQF-106)

II. Performance-Based Contracting with Residential Treatment Facilities: Examples from Child Welfare

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Wisconsin Department of Children and Families

➢ Legislative mandate to create a performance-based contracting system for group homes, residential treatment centers, and therapeutic foster care

Goals:

- Improve outcomes for children in out-of-home care
- Increase transparency and accountability
- Support implementation of continuous quality improvement

➢ Influences rate-setting, but payments not yet tied to bonuses or penalties

➢ Performance-based data dashboards by program on DCF website

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Wisconsin Performance-Based Measurement Framework

Optimal: Child has reached legal permanency through reunification, adoption, or legal guardianship
Very Favorable: Child has moved to a family relative placement
Favorable: Child has moved to a less restrictive setting from previous provider
Unfavorable: Child has moved to a placement that is the same type as the previous placement
Very unfavorable: Child has moved to a placement that is more restrictive than the previous placement
Poor: Child is missing from out-of-home care, has moved to a placement in a hospital, detention, corrections, or has discharged from care as missing or to corrections

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WI Use of Child and Adolescent Needs and Strengths (CANS)

- DCF also uses a CANS dashboard for each program – allows for analysis of program's population
  - ✓ Is program with poorer outcomes serving a higher acuity population?
  - ✓ For CQI purposes, what can be learned from programs with similar populations but different outcomes?

Concerns Expressed by WI Providers

- The extent to which providers control the outcomes*
- Data integrity and the ability to have access to the data

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*State contracted with Chapin Hall at University of Chicago to analyze provider effects on children's outcomes

Found:

- *Providers have substantial effects on the outcomes of children placed in their care*
- *While counties also influence child outcomes, providers have a somewhat greater impact than counties*

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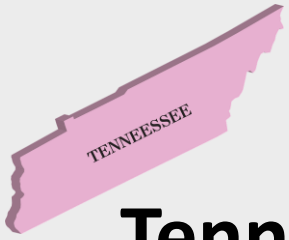


Tennessee Department of Children's Services

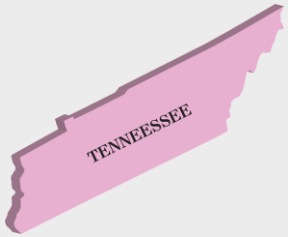
- 3 measures tied to re-investment or penalty calculations:

  Care Days: a 10% decrease in the baseline number of care days used during the period
  Permanency: a 10% increase in the baseline number of youth achieving a Permanent Exit
  Re-Entries: performing within a specified corridor for the number of Re-Entries

- Stratify and risk-adjust programs by type, case mix, geography

- Introduced network-wide assessment, using performance banding:

high performance, average, and low; high performers receive higher reinvestment dollars and lower penalties; low performers receive higher penalties; performance band placement change when network-wide re-assessment occurs



Reports for TN Providers

- Baselines, Targets and Actuals Workbook – Provided annually
  - Focuses on care day use, permanency, and re-entry outcomes
  - Provides fiscal calculation as to amount of reinvestment dollars earned or penalty dollars owed

- Monthly Activity Reports – with such data as child-specific care days

https://www.tn.gov/content/dam/tn/dcs/documents/for-providers/Perf_Based_Contracting_Contract_Incorporation.pdf

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Illinois Department of Children and Family Services

- Performance-based contracting with residential treatment centers, independent living and transitional living
- System of penalties and rewards, risk-adjusted for various factors
- Strong focus on aftercare – 90 days required; weekly face-to-face, travel costs included in contracts
- No reject and providers must provide data

Goals:

- Improve safety and stability
- Clinical and functional improvement
- Improve outcomes at discharge and post-discharge

Measures

- Days spent in active treatment (e.g., not in psychiatric hospital, detention, or runaway)
- Sustained Favorable Discharge:
  - Favorable: positive step-down to less restrictive
  - Sustained: remain in discharge placement for 180 days
  - Unfavorable: negative step-up to more restrictive setting,
  - Disrupted placement, or lateral move to another RTC

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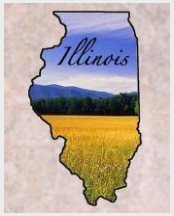
LAN 2D – rewards and penalties



Illinois Outcomes

- 15% decrease over two year period in youth who were negatively discharged (e.g., runaway, detention)

- 33% increase over two year period in youth favorably discharged

Improvements attributed to:

- Focus on quality improvement for struggling providers, and ending contracts with poorly performing providers

- Agencies that performed well had a well-defined treatment model and staff who understood the model

Other findings:

- Staff in poorly performing agencies blamed youth

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State of Michigan and West Michigan Partnership

- Private entity overseeing network of foster care providers, including RTCs
- Receives a case rate from the State Department of Health and Human Services
- Providers receive rewards and penalties

RTC-Related Measures:

- 50% of children in residential treatment will have ALOS of 9 months or less
- No re-entry to residential care within one year
- 85% of caregivers will have monthly face-to-face meetings with RTC

LAN 2D – rewards and penalties

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California Department of Social Services

➢ Pays Short Term Residential Therapeutic Centers a higher rate (than previous long-stay group home approach) to meet certain program expectations:

- ✓ Engagement of families and youth
- ✓ Provision of mental health services
- ✓ Provision of family services
- ✓ Provision of aftercare

LAN Category 2A and B – foundational payments and pay for reporting

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Rhode Island Department of Children, Youth and Families

- Working with BBI to strengthen RTC family engagement

RTC Measures:

- 100% of RTCs have action plan with family engagement strategies
- 80% of families receive staff communication weekly
- 50% of families receive in-home support twice weekly post discharge for three months

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II. Performance-Based Contracting with Residential Treatment Facilities: Examples from Behavioral Health Managed Care

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Magellan – Maricopa County, AZ

- Paid RTCs an incentive payment for reporting outcomes

LAN Category 2B – pay for reporting

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Community Behavioral Health (CBH) Philadelphia, PA

- BH MCO performance-based contracts with RTCs; not yet tied to rewards or penalties

Measures:

o Number of elopements in one month
o Number of restraints
o Number of planned discharges
o School performance measures

• Youth and family satisfaction surveys that track satisfaction with treatment and satisfaction with post-treatment outcomes

• Community tenure measures, e.g.

- Attendance at first appointment in community-based treatment service following return home
- Recidivism to hospital or PRTF in 30, 90, 180 days

LAN Category 2B - pay for reporting

Measures Applicable to PRTFs Based on Best Practices

Outcome Measures

- Reduction in use of seclusion and restraint – also cost benefit to PRTF
- Reduction in length of stay – shorter LOS, better outcome
- Reduction in use of multiple psychotropic medications, e.g. reduction in 3 or more antipsychotics
- Reduction in readmissions
- Reduction in admission to higher level of care (e.g. inpatient psych, detention)
- Improvement in clinical and functional outcomes
- Family satisfaction; youth satisfaction
- Cost

Structural Measures

- % of staff trained in evidence-based practice (e.g., trauma-focused, strength-based)
- # of family peer support providers available to families of enrolled youth; % of families receiving peer support
- Youth Advisory Council; # of youth peers

Process Measures

- 100% of youth on psychotropic meds receive metabolic monitoring
- Provision of aftercare services for specified period of time
- Fidelity to evidence-informed treatment model
- **Families engaged at onset, throughout stay, at discharge, and during aftercare**
- **Youth engaged at onset, throughout stay, at discharge, and during aftercare**

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Research on Family and Youth Engagement in Residential Treatment Centers

- 30% of 293 RTCs polled said parents/caregivers were the primary decisionmaker in their child's treatment plan

- 21% included youth or families in program oversight (e.g., on boards, in quality oversight, on advisory bodies)

- 88% reported that staff had not heard of family-driven or youth-guided principles or that staff required further training to implement them

Brown, J., Barrett, K., Ireys, H., Allen, K., Pires, S. & Blau, "Family Driven Youth Guided Practices In Residential Treatment: Findings from a National Survey of Residential Treatment Facilities." *Residential Treatment for Children and Youth,* 27: 149-159, 2010.

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Meaningful Youth and Family Engagement in Residential Treatment Settings

Inform	Consult	Involve	Collaborate	Empower
Websites	Focus Groups	Co-Lead Workshops	Advisory Groups	Strategy Groups
Information Repositories & Kiosks	Surveys	Present at Conferences	Networking & Peer Support	Steering Committees
Media Releases	Face-to-face Interviews	Serve as Expert Panelist	Support Groups	Decision-making
Feature Stories	Public Meetings & Forums	Facilitate Groups	Family Advisory Councils	Hired in Staff Roles or Peer Roles
Fairs & Events	Suggestion Boxes	Development, Review and Dissemination of Materials/Products	Youth Advisory Councils	Leaders in Youth Movement & Family Movement
Open Houses	Interviews		Liaison to Provider and Policy Groups	
Fact Sheets, Brochures, and Leaflets	Patient Experience Trackers			

Safety, Transparency & Trust, Empowerment, Choice, Collaboration, Mutuality, Culturally Responsive, Peer Support

Nikkel, P., Bergan, J., Simons, D. Operationalizing and Funding Youth and Parent Peer Support Roles in Residential Treatment Settings TA Network 2018

TA NETWORK

SAMHSA
Substance Abuse and Mental Health Services Administration

Authentic Youth and Family Engagement Happens When...

- The voice and actions of youth; and the voice and expertise of parents are valued.
- Youth are utilized as resources in their own development and in the development of their community.
- Families are viewed and utilized as resources in the support and success of their youth.
- Authentic youth and family voice is present, empowered, and interwoven throughout the system and the organization.
- Youth and caregivers are valued for their experiences and expertise, not viewed as the problem.
- Youth consumers, parents and family members are advocates and educators.
- Youth and parents are actively involved members on boards and committees.
- Youth and families are decision makers and part of policy development.
- There is equal partnership and shared respect.

Challenges Inherent in VBP Arrangements

PRTFs need capacity to implement effective program approaches, e.g.

- engagement of families and youth;
- peer support capacity;
- provision of culturally and linguistically appropriate care
- ability to provide aftercare;
- training of staff in strengths-based, trauma-informed approaches;
- capacity to monitor psych meds and to coordinate with primary care;
- how to move from a milieu approach to a partnership with families and youth

➢ MCOs and providers need the administrative capacity to manage VBP arrangements e.g.

- capacity to collect, report and share data;
- financial management and capital to assume risk;
- data-driven quality improvement processes

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Lessons from VBP Arrangements

- Process is important – work with PRTFs to define measures (IL, WI)
- Need data feedback loops with providers (e.g., data dashboards)
- View quality improvement as a partnership with providers
- Can phase in alternative payment arrangements, moving further along the LAN framework with experience

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Examples of Incentives to Providers

- Decent rates
- Flexibility and control
- Timely reimbursements
- Back up support for difficult administrative and clinical challenges
- Access to resources for training and staff development
- Capacity building support
- Less paperwork; more meaningful data

In return for providing some or all of these incentives to providers, purchasers should expect providers to achieve performance and outcomes that improve the quality and cost of care

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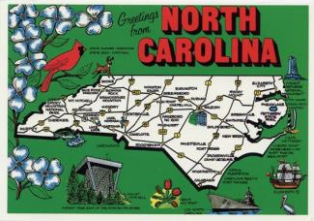

North Carolina Medicaid Context

- August 2018 RFP – Prepaid Health Plans for physical, basic behavioral, and pharmacy (commercial plans and provider-led entities)
  - Investments in social determinants of health, e.g., housing, safety

- BH I/DD Tailored Plans – serious mental health, I/DD – until Tailored Plans are implemented, these populations remain FFS and managed by LME-MCOs

- BH I/DD Tailored Plans likely to include:
  - Closed provider networks in Tailored Plans
  - Incentives for integrated PH/BH care (Note. PRTF measures could include metabolic monitoring measures, psych med monitoring, coordination with PCP)

- BH I/DD Tailored Plans must meet state-set quality measures and outcome goals – *State will seek community input, build on best practices, and build on LME-MCO requirements for performance measurement*

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Important Related Opportunities

- *Family First Prevention Services Act*
  - Use of Title IV-E for home and community based services (mental health, SUD, in-home)
  - Focus on reducing use of congregate care, and RTCs must meet quality parameters

- *Integrated Care for Kids (InCK) – Center for Medicare and Medicaid Innovation*
  - First CMMI pediatric model – focus is on children's behavioral health
  - Focus on reducing out of home placements
  - Requires partnership between State Medicaid agency and a local lead entity
  - Requires alternative payment arrangement approach

- *Results Act – Social Impact Bonds – State and Local Pay for Success Initiatives*
  - $100m fund at Treasury Dept – 50% must benefit child populations
  - 20 priority outcomes, 7 related to children (e.g., reduction in congregate care; improvement in behavioral health clinical and functional outcomes)
  - Feb 2019 RFP

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