Value-based Payment Arrangements in Children's Behavioral Health: A Provider Profile Report

Background/Introduction

Passage of the 2010 Affordable Care Act (ACA) brought about drastic changes within the healthcare payment paradigm, including a shift to paying for value instead of volume. By 2018, 90 percent of all Medicare fee-for-service payments will be tied to quality metrics.[i] Increasingly, state Medicaid programs and other healthcare purchasers are moving to restructure health and social services payments to meet the goals of the Institute for Healthcare Improvement's Triple Aim: improve the patient experience of care, improve overall population health, and reduce the per capita cost of healthcare.[ii] Aligning with this shift, state Medicaid programs and other healthcare purchasers have implemented a range of alternative payment methodologies, frequently referred to as value-based purchasing (VBP). Common VBP arrangements are defined as follows:

- *Pay for performance*: Providers are financially rewarded for meeting or improving their performance on pre-established quality measures.[iii]
- *Bundled payments*: Payments based on expected costs for a clinically defined episode or bundle of related health care services.[iv]
- *Episodes of care*: Provider is held accountable for the costs and quality of a defined and discrete set of services for a defined period of time.[v]
- *Case rate*: Fixed per member per month rate for every actual user.[vi]
- *Shared savings*: VBP payment model that pays organizations using a fee-for-service (FFS) model, but rewards organizations if spending is below the target at the end-of-year.[vii]
- *Shared risk*: VBP payment model in tandem with shared savings that penalizes organizations spending more than the target.[viii]
- *Capitation*: Fixed per member, per month rate for every eligible user.[ix]

In VBP arrangements, funders often provide incentives in the form of monetary compensation to healthcare providers that achieve goals above previously established targets. VBP arrangements incentivize providers to deliver effective, efficient care (including prevention, screening, and early intervention), and integrate information on the quality of healthcare, including patient outcomes and health status, with data on the dollars spent. VBP arrangements also offer incentives to providers that focus on managing health system utilization to improve care by using data and population health strategies. Finally, these arrangements typically identify and reward the best performing providers.

Attempts have been made to implement value-based payment arrangements across a variety of healthcare providers and environments, with varying levels of success and satisfaction. For community behavioral health organizations (CBHOs), as well as the broader healthcare sector, there is a need to address specific policy and practice improvement opportunities to better prepare for VBP arrangements for children, youth, and young adults. These include, but are not limited to: insufficient information on use of VBPs; lack of customized approaches specific to the child, youth, and young adult populations in health system reform efforts; lack of available information on issues relevant to child and youth populations; and lack of information about the technical assistance needs of states and providers preparing for VBPs specific to children, youth, and young adults.

In July 2016 the National Council for Behavioral Health conducted an environmental scan of its member organizations serving the child, youth, and young adult population to better understand the challenges faced in readying for the evolving practice environment, including VBP. Findings from this environmental scan provided a valuable foundation to begin to identify the resources and partnerships needed to prepare CBHOs and other types of organizations that provide services to children, youth, and young adults for VBP. The scan revealed that 26 percent of participating member organizations were involved in VBP arrangements. Thirty-seven percent of participating member organizations indicated they had approached payers or been approached by payers to implement VBP arrangements, but were not yet involved in an arrangement, and about one-third of those responding had engaged in no VBP arrangements at all. The scan did not probe reasons why purchasers or provider organizations were, apparently, not involved in VBPs; however, the financial and operational issues identified in the scan shed some light on potential barriers.

To further build upon these findings, the National Council conducted five phone interviews with providers across the country between June and August 2017 to gather in-depth information from organizations currently engaged in at least one VBP arrangement. Interview participants were drawn from survey respondents and National Council members and covered five regions of the United States. Participants were typically CEO or executive-level staff at their agencies.

Each interviewee engaged in a preliminary planning call where they received the interview questions in advance. This allowed participants to gather the necessary information prior to the actual interview and address all questions as fully and accurately as possible. Interviews lasted between 60 and 90 minutes and covered organizational demographic and overview information, details of each VBP arrangement, lessons learned, and advice they would offer to payers and providers. After their interview, the participant was sent a copy of their case study and given the opportunity to make amendments or clarifications to ensure accuracy of the information. Finalized notes and findings are presented in this report.

About the National Council for Behavioral Health

The National Council for Behavioral Health (National Council) is the unifying voice of America's community mental health and addictions treatment organizations. Together with our more than 2,900 member organizations, we serve our nation's most vulnerable citizens — the more than 10 million adults and children living with mental illnesses and addiction disorders. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life. The National Council pioneered Mental Health First Aid in the U.S. and has trained more than 1 million individuals to connect youth and adults in need to mental health and addictions care in their communities. A not-for-profit 501(c) (3) association, the National Council's mission is to advance members' ability to deliver integrated healthcare. We also offer state-of-the-science education and practice improvement consulting and resources to ensure mental health and addiction services are efficient and effective. Our work in the area of children and adolescents ranges from development of change packages for implementing trauma-informed care and Screening, Brief Intervention, and Referral to Treatment (SBIRT) to supporting practice implementation through use of

nationwide learning communities. The National Council also engages in an array of policy and advocacy activities to support our members and the broader behavioral health field with the ever-changing policy and regulatory environment.

Provider Profiles

CASA DE LOS NIÑOS

1101 N. 4th Avenue, Tucson, AZ 85705-7467

COMPANY OVERVIEW

Practice Type: Community-based children and family service agency
Number of Total Clients: 9,000 (*3,500 under 18 receiving behavioral health (BH) services*)
Total Operating Budget: $12,000,000 for BH program *(90 percent Medicaid, 10 percent private insurance)*
Services Provided: Prevention services for new parents using evidence-based home visiting models, e.g., Parents as Teachers and Nurse-Family Partnerships; child welfare family support services to assist families in learning to parent safely, including parent education, supervised visitation and crisis emergency shelter services, and a full continuum of behavioral health services for children and families, which including: individual, family, and group therapy for children and their families; parenting and life skills; crisis intervention; advocacy; psychiatric services; and specialized assessment and therapy.
Value-based Payment (VBP) Arrangements: Currently has one per-member/per-month (PMPM) arrangement.

FUNDING AND REGULATORY ENVIRONMENT

The Arizona Health Care Cost Containment System (AHCCCS) operates under a Section 1115 waiver (https://www.azahcccs.gov/Resources/Federal/waiver.html). AHCCCS assigns individuals to a Tribal/Regional Behavioral Health Authority (T/RBHA) based on the zip code where individuals reside (https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/behavioralhealthservicesmap.html). Although American Indian members are also automatically assigned based on zip code, they have the option to receive behavioral health services from a RBHA, T/RBHA, Indian Health Service (IHS), or a 638 Tribal Facility. The T/RBHAs provide prevention, treatment, rehabilitation, and support services; crisis intervention; acute inpatient and residential care; and day treatment (https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf). AHCCCS has proposed an amendment to its 1115 Waiver to waiver the Institution for Mental Diseases (IMD) exclusion for Medicaid beneficiaries ages 21-64 (https://www.azahcccs.gov/Resources/Federal/PendingWaivers/imdwaiveramendment.html), which is pending with the Centers for Medicare and Medicaid Services (CMS).

VALUE-BASED PAYMENT ARRANGEMENTS

Arrangement Type	PMPM
Population(s) Covered	Children with behavioral health diagnoses
Number served	9,000 clients
Services included	The services described in the Company Overview section on page 3
Number of staff included	125 (all behavioral health staff)
Approximate start date	July 1, 2017
Preparation taken	• Worked with funder to create a phased implementation process moving from no-risk to fully at-risk by January 2018. • Data analysis and risk stratification of the current population of clients using DLA-20 (functional assessment) and services received. • Developed workflow to manage and streamline the referral process. • Evaluated internal capacity regarding services provided and ability to track outcomes.
Funder	Medicaid Managed Care
State agencies/ purchasers involved	Medicaid Managed Care Company has direct contract with state Medicaid program. Contracting in the future with three or four different health plans serving high needs populations.
Youth involvement	Youth are not involved, except as service recipients and there is no plan to include them in the future.
Family involvement	Family is not involved, except as service recipients and there is no plan to include them in the future.
System partner involvement	System partners are not involved, except as referral sources. There may be collaboration between system partners at the state level; however, the provider is unaware of any other system partner involvement.
Quality measures and performance metrics	1. Inpatient utilizations (50 per 1,000 members per month). 2. Multiple use of anti-psychotics (less than 2.5 percent). 3. Out of home readmission within 30-days (less than 13 percent). 4. E-prescribing (at least 70 percent). 5. Comprehensive Medical and Dental Program (CMDP) – One service per month after the child has been removed from the home for six months (75 percent of children). 6. CMDP access to foster care services within 72 hours of child being removed from home.
Rates received	PMPM for Medicaid-eligible children – $347.44. PMPM for children removed from their parents' homes – $417.63. *Note:* • *85 percent of services must still be put through the encounter/billing system*. • *The insurer set a separate PMPM with knowledge that youth removed from their parents' homes require additional services and supports.*
Incentives	No incentives for members. The agency provides a bonus for staff who meet productivity standards, but this was used prior to the VBP arrangement.
Do quality measures inform child	The quality measures inform measures for both the state Medicaid and child welfare offices.

system goals?	
Monitoring and evaluation	The payer monitors metrics monthly through claims data.
Outcomes achieved	Program started July 1. Unfortunately, there are projections of financial distress for providers and the systems six months from now.

LESSONS LEARNED

- Ensure the PMPM covers costs. The VBP arrangement represents a reduction in revenue for the same service population. There is not currently data that demonstrates the exact amount of loss; however, there is a prediction that it will be significant for providers and the overall behavioral health system, as providers will likely have to close. There is currently discussion between payers and providers to discuss renegotiation.
- The provider is financially responsible for services provided by other providers, as well. It is important to work with all included providers to ensure that they are following the established billing policy and reducing the amount of charge backs from Medicaid.

ADVICE AND TECHNICAL ASSISTANCE

Advice to Purchasers

- Payers need to be transparent about the data and other variables used to make decisions.
- Payers and payees should have conversations and work together to develop goals and decision-making processes.
- Payers and payees need to come to agreement on the risks, savings, and quality measures before, during, and after implementation.
- Payers need to ensure open communication with payees.

Advice to Providers

- Providers need to know their actual costs.
- Providers need to employ staff that know and understand data, business analytics, and cost information.

Technical Assistance Needed

- Technical assistance regarding costing services would be useful, as would standardized tools such as cost calculators.

CENTRA HEALTH

1920 Atherholt Road, Lynchburg, VA 24501

COMPANY OVERVIEW

Practice Type: Nonprofit Hospital System
Number of Total Clients: 3,800
Total Operating Budget: $33,200,000
Services Provided (Payer Mix):
20 bed inpatient unit for ages 5-17 (68 percent Medicaid, 32 percent commercial)
60 bed residential facility for ages 5-17 (100 percent Medicaid)
Multi-disciplinary Autism Clinic (36 percent Medicaid, 64 percent commercial)
11 Special Education Schools (100 percent Department of Education-funded)
Six In-Home Programs for Autism (68 percent Medicaid, 32 percent commercial)
Value-based Payment (VBP) Arrangements: Currently has one case rate with commercial insurer.

FUNDING AND REGULATORY ENVIRONMENT

Medallion 3.0, the state Medicaid program, operates under a 1915(b) waiver; physical health services are provided by six managed care organizations (MCOs). The state contracts with Magellan to serve as the state's Behavioral Health Services Administrator (BHSA). Under Medallion 3.0, assessment and evaluation, and outpatient psychiatric and substance abuse therapy services (individual, family, and group) are handled through the individual's MCO. Intensive in-home services for children and adolescents, therapeutic day treatment for children and adolescents, mental health care management for children with serious emotional disturbance and adults with serious mental illness, day treatment/partial hospitalization, psychosocial rehabilitation, and crisis intervention services are carved out of managed care and administered by Magellan.

The state is transitioning to Medallion 4.0, which will move community mental health services into managed care. The state released a Request for Proposals in July 2017 (http://www.dmas.virginia.gov/Content_pgs/medallion_4-home.aspx) with awards expected Fall 2017 and implementation, by region, in late 2018.

Virginia also operates a Commonwealth Coordination Care Plus (CCC Plus) program, which provides managed long-term supports and services to adults and children with disabilities. CCC Plus will have integrated behavioral health services beginning in 2018. In addition, the state operates a 1915(c) waiver to allow children and adolescents who have been in a psychiatric residential treatment facility (PRTF) for 90 or more days and who continue to meet PRTF level-of-care criteria, to receive home and community-based services (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/VA-Waiver-Factsheet.html#VA01R02).

VALUE-BASED PAYMENT ARRANGEMENTS

Arrangement Type	Case Rate
Population(s) covered	Youth up to age 18-years-old who meet criteria for the behavioral health inpatient unit and have the selected commercial insurance.
Number served	137
Services included	Inpatient Unit Only
Number of staff included	All Inpatient Unit Staff (approximately 40 staff)
Approximate start date	2010
Preparation taken	As there were going to be no changes clinically as a result of this arrangement, no clinical preparations were taken. For administrative preparation, a contracting expert and the mental health service line leader had an initial meeting and reviewed the cost of care using a per diem model to ensure that all costs were covered. They met with the insurance company and began negotiations.
Funder	Commercial Insurance Company
State agencies/ purchasers involved	There are no other state agencies and purchasers involved in this arrangement.
Youth involvement	Youth are not involved in any level of this arrangement, except as service recipients, and there is no plan to include them in the future.
Family involvement	Family is not involved in any level of this arrangement, except as participants in treatment, and there is no plan to include them in the future.
System partner involvement	There is no system partner involvement, nor is there a plan to include them in the future.
Quality measures and performance metrics	1. Length of stay – The insurance company creates a target for each individual child and the provider. 2. Readmissions – If patient is readmitted within 48 hours of discharge, no additional payment is received.
Rates received	$4,000 per episode of care regardless of number of days.
Incentives	Incentives are not used in this arrangement.
Do quality measures inform child system goals?	As this is a commercial insurer, there is no connection with larger children's system goals.
Monitoring and evaluation	There is no external monitoring or evaluation. The length of stay and readmission rate is tracked internally.
Outcomes achieved	Length-of-stay is considerably lower than the state average: 4.75-day average versus seven-day state average.

LESSONS LEARNED

- Be sure to have mechanisms in place to track the quality measures for which you are responsible.

ADVICE AND TECHNICAL ASSISTANCE

Advice to Purchasers

- Develop more quality measures to ensure providers are doing the "right things" for children, youth, and young adults, e.g., monitoring of antipsychotic use, use of evidence-based treatment, low readmission rates, no or low seclusion and restraints rates.

Advice to Providers

- Make sure the rate negotiation in the beginning covers all costs associated with the work.
- Do not be afraid to renegotiate rates as needed.

Technical Assistance Needed

- Any assistance for providers to identify their costs
- Any assistance that would help providers with readiness and implementation, including case studies, site visits, toolkits, Facebook groups, listservs, etc.
- Peer-to-peer opportunities where providers could to share successes, challenges/barriers, and lessons learned during readiness and implementation.

CHOICES COORDINATED CARE SOLUTIONS, INC.

102 East Main Street, Suite 403, Urbana, IL 61820

COMPANY OVERVIEW

Practice Type: Care Coordination Agency
Number of Total Clients: 469
Total Operating Budget: $6,000,000 ($2,700,000 Child welfare, $3,300,000 Medicaid)
Direct Services Provided: Care coordination, mobile crisis response services
In-Direct Services Responsible For: Through an extensive provider network: intensive in-home services, parent and youth peer support, respite, mentoring, traditional therapy (individual, group, and family), parent/family skills training, assessments, and evaluations are provided for the youth/families served.
Value-based Payment (VBP) Arrangements: Currently has one PFP VBP arrangement with the Medicaid agency.

FUNDING AND REGULATORY ENVIRONMENT

The current Medicaid program operates under 1932(a) authority with behavioral health benefits carved into managed care. In August 2017, the Illinois Department of Healthcare and Family Services (HFS) announced it was awarding contracts to five statewide Medicaid managed care organization (MCO), one organization to serve Cook County, and one specialized managed care contract for children in Department of Children and Family Services custody (https://www.illinois.gov/hfs/SiteCollectionDocuments/Notice_of_Award_MCO_RFP.pdf). The newly-procured Medicaid MCOs consolidate the current Family Health and Affordable Care Act Adults program, the Integrated Care Program, and the Managed Long Term Services and Supports program into a single contract (https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Pages/default.aspx) and will begin enrolling beneficiaries in 2018. In October 2016, HFS submitted a Section 1115 waiver, Behavioral Health Transformation, to CMS (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-pa.pdf). The waiver would add new benefits for adults with serious mental illness, and children and youth with serious emotional disturbance, including intensive in-home, supported employment, and respite care services (https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Documents/2018-24-001_RFP_Appendix_IV.pdf). At publication, the waiver remained pending.

VALUE-BASED PAYMENT ARRANGEMENTS

Arrangement Type	P4P
Population(s) covered	Medicaid population, including youth involved with juvenile justice and child welfare.
Number served	315
Services included	Care Coordination
Number of staff included	30
Approximate start date	2013 (currently in the fourth year)
Preparation taken	• Used the established Choices model of care coordination and provider network development. • Engaged in outreach to Community Mental Health Centers (CMHCs), hospitals and primary care physicians (PCPs) for inclusion in the network. • Held community forums to introduce the model and gather information from stakeholders. Completed a gap analysis in the organization's first year, which provided the basis for new service development.
Funder	Department of Healthcare and Family Services (State Medicaid Authority)
State agencies/ purchasers involved	Child Welfare and Medicaid are the primary drivers, but the Department of Mental Health (DMH) partners with both agencies in the delivery of children's behavioral health services. DMH participated in discussions about clinical criteria for Choices CCS's Medicaid model. DMH also provided support planning and hosting two family conferences. DMH, along with Medicaid and Child Welfare, participated in stakeholder discussions and planning related to new service development for the four-county catchment area.
Youth involvement	Youth are employed by the Family Support Organization to provide reimbursable peer support. There is no additional youth involvement.
Family involvement	Family members are members of the Quality Management Committee. They determine key quality indicators that Choices CCS are measured on for performance payment. As part of this work, family groups are facilitated to obtain input. A family member also serves as a co-chair on the committee. Family members are also employed by the Family Support Organization to provide reimbursable family peer support.
System partner involvement	Child welfare, juvenile justice, and Medicaid are members of the Quality Management Committee. They determine key quality indicators that Choices CCS is measured on for their performance payment.
Quality measures	1. Increase knowledge and education for families and providers (four trainings with families as primary audience and other stakeholders in attendance), 2. Child and Adolescent Needs and Strengths (CANS) indicators – Demonstrate positive maintenance or increased functioning around school, preschool, and daycare environments. 3. CANS indicators – Positive maintenance or increased functioning around natural supports. 4. Child and Family Team (CFT) survey indicator (optional but everyone on team can complete survey monthly) – Satisfaction with care coordination facilitation. 5. CFT survey indicator – How satisfied are you that your voice is heard and respected?

	6. Annual quality improvement (QI) project – System of care (SOC) principles and values (year 1); mapping and adapting practice – evidence-based practice (year 2); psychotropic medication initiative (year 3) – education campaign for staff and stakeholders.
Performance metrics for the quality measures	1. Education and knowledge for families = Four unique trainings over the fiscal year 2. CANS school functioning = 75 percent 3. CANS natural supports = 75 percent 4. CFT Care Coordination facilitation satisfaction = 90 percent 5. CFT family voice = 90 percent
Rates received	$419 per member, per month
Incentives	For achieving specific targets, Choices receives payments from a demonstration risk pool (DRP). The incentive is the ability to retain up to 15 percent of the dollars, 5 percent is guaranteed and 10 percent can be earned by achieving the other five indicators.
Do quality measures inform child system goals?	As a pilot site for system reform, Choices is working on implementation of new services identified in the gap analysis (respite, crisis support, parent peer support, and intensive in-home services), as well as enhancements to mobile crisis response services to reduce psychiatric hospitalizations.
Monitoring and evaluation	The Quality Management Committee meets quarterly and looks at the status of each of the indicators. Choices also submits monthly, quarterly, and annual reports to the state Medicaid office related to specific outcomes, as well as an annual report for the Quality Management Committee key indicators and quality improvement plan.
Outcomes achieved	For FY2017 – Achieved four out of five targets. Choices fell shy of achieving the school measure target (68 percent).

LESSONS LEARNED

- Established Medicaid and child welfare providers within the provider network were the initial focus for launching new services. Due to these providers being the target, implementation was stalled for new services. The lesson learned is that there is a need to include all willing providers in service development efforts to expedite implementation and service enhancement.
- Create a comprehensive plan for family outreach that includes different methods of communication (social media, mail, personal outreach, etc.) through different partnerships with community providers, community organizations, and the faith-based community. This is the only way to make sure your communication reaches as many families as possible and to educate the community about your services.
- Ensure all staff understand their role in outreach to families and the importance of family involvement.
- Offer training to identified family leaders early in the project to ensure they understand their role and are prepared to participate in governance. Examples of topics include advocacy, quality improvement and evaluation methods, leadership, governance, etc.
- When developing your implementation and quality improvement plans, include reporting to families and other stakeholders in the initial plan. Receiving input from the inception of the effort will help the organization to offer better quality and improved outcomes.
- Get feedback from funders in early stages of implementation to ensure reporting is meeting their needs and they have information they can disseminate to all necessary audiences.
- Allocate appropriate resources to update data systems to make collection of required data efficient for staff.

ADVICE AND TECHNICAL ASSISTANCE

Advice to Purchasers

- Focus on measures that build on the established foundation from providers in the service area, or other current/previous initiatives, e.g., System of Care grant.

Advice to Providers

- Include families when developing and monitoring the chosen measures.
- Have families represented in quality improvement efforts and ensure that what they think is important is included in quality improvement activities.
- Make sure you have mechanisms to collect data and make sure your data collection methods are realistic.

Technical Assistance Needed

- Structured data systems or guidance regarding data systems, i.e., what capabilities should your system have and how flexible should it be?

FAMILY SERVICE AND GUIDANCE CENTER

325 SW Frazier, Topeka, KS 66606

COMPANY OVERVIEW

Practice Type: Community Mental Health Center specializing in pediatric behavioral health services
Number of Total Clients: 5,615 (*5,564 under the age of 21*)
Total Operating Budget: $15,000,000 (*57.9 percent Medicaid, 40.2 percent private insurance, 2.9 percent uninsured*)
Services Provided: Individual, group, and family therapy; psychiatric treatment; medication management; psychological testing; crisis intervention services; case management; 24/7 crisis program; community psychiatric support treatment (*skills training*); attendant care and respite care; parent support; professional resource family care; psychosocial groups, wraparound facilitation; admission evaluation; community-based services team (CBST) meetings to review/approve psychiatric residential treatment facility (PRTF) placements.
Value-based Payment (VBP) Arrangements: Currently has three different arrangements with each of the three Medicaid Managed Care Companies: one is shared savings and two are pay-for-performance.

FUNDING AND REGULATORY ENVIRONMENT

KanCare, the state Medicaid program operates under a Section 1115 waiver. In January 2017, CMS declined to extend Kansas' waiver (https://issuu.com/tcj5/docs/kansas_011717). Kansas reapplied for a waiver extension in May 2017 (https://www.kdads.ks.gov/docs/default-source/CSP/bhs-documents/kancare-1115-waiver-extension-draft-for-public-comment-5-31-17.pdf?sfvrsn=0), which is pending before CMS. Behavioral health services for children and youth with serious emotional disturbance are provided via a 1915(c) waiver, operated by the Kansas Department for Aging and Disability Services (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/KS-Waiver-Factsheet.html#KS0320).

VALUE-BASED PAYMENT ARRANGEMENTS

Arrangement Type	Shared Savings	P4P 1	P4P 2
Population(s) covered	All covered clients Ages 0 – 18	All covered clients who had a billed behavioral health service within the last 18 months Ages 0 – 18 *High-Risk Cohort* – Those with co-occurring physical and mental health disorders	All covered clients Ages 6 - 18

Number served	986	689-721 *(varies month-to-month)*	1,943
Services included	Psychiatry targeted case management Therapy diabetes screening	All services included in the Company Overview are included in the VBP arrangement.	All services included in the Company Overview are included in the VBP arrangement.
Number of staff included	250 staff. All staff who have direct contact with clients help monitor and implement the VBP measures.		
Approximate start date	January 1, 2016	December 1, 2016	April 1, 2017
Preparation taken	• Built on the former Kansas Health Home model. Redeployed the same activities. • Incorporated director of care coordination into established meetings regarding high-risk clients. • Identify clients by insurance company through the electronic medical record (EMR). • Over a month period, each high-risk family that was not actively engaged in services was called by the community-based services (CBS) director. • CBS director created a letter that was also mailed to the last known address for all clients in the attributed members list, in addition to phone calls. • EMR was updated to enable tracking of measures. • Began tracking emergency room utilization for clients and those discharging from the hospital.		
Funder	Medicaid Managed Care	Medicaid Managed Care	Medicaid Managed Care
State agencies/ purchasers involved	State Department of Health and Environment (Medicaid) has to approve all arrangements.		
Youth involvement	Youth are not involved in any level of this arrangement, except as service recipients, and there is no plan to include them in the future.		
Family involvement	Family is not involved in any level of this arrangement, except as participants in treatment, and there is no plan to include them in the future.		
System partner involvement	There is no system partner involvement, nor is there a plan to include them in the future.		
Quality measures	1. Acute behavioral health inpatient – 30-day readmission 2. Emergency room utilization 3. PCP visits 4. Seven-day follow-up after BH inpatient discharge 5. Follow-up care for children prescribed ADHD medications after the initial appointment	1. Seven-day follow-up after BH inpatient discharge 2. High-risk cohort seen in office visit every 30-days 3. Annual medication review for those identified by MCO 4. Diabetes screening for those diagnosed with schizophrenia or bipolar disorder during the one-year agreement 5. High-risk cohort members will have no adverse	1. Metabolic monitoring for children and adolescents on antipsychotics (APM) 2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA) 3. Diabetes screening for people with schizophrenia or bipolar disorder who are using

		events related to the risk factors associated with their high-risk cohort designation (ER, inpatient, etc.)	antipsychotic medications (SSD) 4. 30-day readmission 5. Seven-day follow-up after hospitalization for mental health (FUH)
Performance metrics for the above measures	1. 30-day = 10.91 percent 2. ER Utilization = 626.35 3. PCP Visits = 95 percent 4. Seven-day follow-up = 85.43 percent 5. ADHD = 50.81 percent	1. Seven-day follow-up = 50 percent 2. High risk cohort office visit = 100 percent 3. Annual medication review = 100 percent 4. Diabetes screening = 33 percent 5. High risk cohort adverse events = 50 percent	1. APM = 41.19 percent 2. SAA = 56.63 percent 3. SSD = 79 percent 4. 30-day readmit = 16.46 percent 5. FUH = 79.06 percent
Rates received	Shared savings are earned based on measures met. Shared savings payments are calculated as follows: a. Total earned points divided by the total points available equals the earned shared savings percentage. b. The earned shared savings percentage is then multiplied by the CMHC maximum shared savings amount to determine the payment amount.	• $1 PMPM for seven-day follow-up measure • $20 PMPM for each high-risk member seen face-to-face • $80 per medication review • $0.75 PMPM for diabetes screening measure • $1.50 PMPM for no adverse events measure	FSGC receives a portion of the allotted amount of money based on their performance in relationship with other community mental health centers
Incentives	N/A		
Do quality measures inform child system goals?	The quality measures help the organization to identify those clients with high utilization. The identified clients and their families are then able to be educated on the appropriate use of services to reduce waste. FSGC is actively working to improve delivery of whole person care and integrate services into community. This information is used to inform services and the organization's progression into the provision of whole person care. FSGC is working with one of the MCOs on future plans to begin to develop quality measures that impact the system, however current quality measures do not have a direct impact on child system goals.		

Monitoring and Evaluation	MCO reviews claims data and sends reports to provider every six months.	MCO reviews claims data monthly. Monthly meetings during initial six months of implementation, thereafter quarterly meetings.	MCO reviews claims data. Frequency is yet to be established.
Outcomes Achieved	1. Seven-day follow-up (goal = 68.65 percent, 2016 actual = 81.67 percent) 2. Follow-up for ADHD medication (goal = 42 percent, 2016 actual = 48.39 percent)	Monthly Outcomes: (June 2017) • Seven-day follow-up (goal 50 percent, met 88.9 percent) • High-risk cohort seen in office visit (no specific goal, met 27.5 percent) • Medication reviews (no specific goal, have completed all current) Annual Outcomes: • On target to meet Diabetes screening (goal: 33percent, met 44 percent) • On target to meet adverse events (goal 50 percent, met 82.5 percent)	Outcomes are calculated annually. Initial outcomes are anticipated to be assessed in Jan./Feb. 2018.

LESSONS LEARNED

- Build on what the organization is already familiar with and provides. For example, FSGC had a health home program that was established and ended. Learnings from that program were used as preparation for the VBP arrangements (care coordination, administrative tracking, etc.).
- This is both a clinical and administrative process. Organizations should expect that it will take at least a half-time full-time equivalent (FTE) to track the required data.
- Relationship building with representatives from the Medicaid Managed Care Company is important for the patient population covered under Medicaid. It allows clear and open communication and more efficient processes when challenges arise.
- There is quite a bit of the work that is not covered financially, e.g., outreach and engagement of clients, coordination for clients who do not meet serious emotional disability (SED) criteria, but require a care coordinator to help manage complex medical and mental health conditions, etc. This work needs to be considered in the rate negotiation.

ADVICE AND TECHNICAL ASSISTANCE

Advice to Purchasers

- Have a responsive designated point person who interacts with the agency.
- Consider allowing reimbursement for outreach services for a short amount of time.
- Ensure clients that the provider is being measured on have recently received services from the provider, as it is hard to influence the behavior of clients who are no longer involved in treatment from the provider.

- Be able to explain quality measures and the monitoring process to providers (make things simple).
- Ensure you have the ability to transfer data from provider to purchaser systems with ease.
- Provide funding tor all services that are expected to be provided (i.e., case management).

Advice to Providers

- Make sure the target population, goals, and expectations are clearly defined prior to implementation.
- Hire administrative staff who can assist with tracking information.
- The ability to rely on your electronic health record and MCO portals reduces the resources required for reporting.
- Build relationships with the funder to ensure efficient communication and prompt responses to inquiries.
- Build relationships with other providers who engage in similar work to create a peer relationship/network that can share lessons learned and strategies.

Technical Assistance Needed

- VBP purchasers should provide training, coaching, and technical assistance about expectations and measures prior to the measurement period beginning.
- Providers need access to staff training to get them to think more holistically about the clients.

ROCKY MOUNTAIN YOUTH CLINICS

9197 Grant Street, Suite 200, Thornton, CO 80229

COMPANY OVERVIEW

Practice Type: Integrated Care – Pediatric Primary Care
Number of Total Clients: 24,000 *(up to age 21)*
Total Operating Budget: $10,000,000 *(75 percent Medicaid, 5 percent CHIP, 13 percent commercial, 7 percent uninsured)*
Services Provided: Primary medical care, behavioral health counseling, preventive dental services, healthy living programs, partner with health department for women, infants, and children (WIC) and lactation counselor, care coordination, asthma support program, family planning, food pantry and emergency food, nutrition support
Value-based Payment (VBP) Arrangements: Currently has four VBP arrangements, one Accountable Care Collaborative (ACC) (*https://www.colorado.gov/hcpf/accountable-care-collaborative*) and three pay-for-performance.

FUNDING AND REGULATORY ENVIRONMENT

Colorado's Department of Health Care Policy and Financing (DHCPF) is in the midst of reforming their Medicaid program. Behavioral health care is currently provided by regional behavioral health organizations that are assigned based on where the beneficiary resides and operated under a 1915(b) waiver. The state released a formal Request for Proposals (RFPs) to complete Phase II of the reform plan, which joins physical and behavioral health under one accountable entity. RFPs were due July 2017, with awards to be announced Fall 2017 and implementation to occur Summer 2018 (https://www.colorado.gov/pacific/hcpf/accphase2).

The state will procure seven Regional Care Collaborative Organizations (RCCOs), which will provide physical and behavioral health services and help Health First Colorado (Colorado's Medicaid program) to obtain needed community and social services (https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations). In February 2016, the DHCPF announced it will retain a capitation payment methodology for core behavioral health services. The capitation will be paid to the regional entity responsible for managing the health needs of Medicaid enrollees in their region. The capitation is designed to support the full continuum of behavioral health services from outpatient therapy to alternative community services to crisis response and hospitalization. This continuum will feature the current list of covered 1915(b)(3) alternative services for treatment of mental health, substance use disorders, and co-occurring conditions (https://www.colorado.gov/pacific/sites/default/files/Framework%20for%20Behavioral%20Health%20Reimbursement.pdf).

Rocky Mountain Youth Clinics (RMYC) operates its business in an environment that is regulated by several state departments. This includes: The Division of Insurance that regulates the health insurance industry, the Colorado Department of Healthcare Policy and Financing that runs the state Medicaid and Child Health Plan Plus (CHP+) programs, and the Colorado Department of Public Health and Environment (CDPHE) that administers state general funds to support the implementation and operation of school-based health clinics. Medicaid payments to support

primary care are primarily fee-for-service (i.e., there is limited Medicaid managed care in Colorado), but the state funding to support integration of primary medical and behavioral health services and broader care coordination has grown significantly under the ACC in recent years through per-member/per-month (PMPM) payments tied to patients attributed to primary care practices. The foundation community in Colorado plays a major role in expanding access to care for vulnerable populations and supporting delivery of comprehensive care in primary medical settings.

VALUE-BASED PAYMENT ARRANGEMENTS

Arrangement Type:	ACC	P4P 1	P4P 2	P4P 3
Population(s) covered	All Medicaid eligible patients, including youth involved with juvenile justice and child welfare	All patients, including youth involved with juvenile justice and child welfare	For patients covered by funder	For patients covered by funder
Number served	17,000	20,000	800	800
Services included	Care coordination	All services listed in Company Overview	All services listed in Company Overview	All services listed in Company Overview
Number of staff included	All staff (140)	125	All staff (140)	All staff (140)
Approximate start date	2012	2015	January 1, 2017	July 1, 2016
Preparation taken	• Designed, hired, and trained care navigator positions for each clinic. • Made changes to electronic health record (EHR) to collect required data. • Changed workflows and policies. • Trained all staff on new team model.	Made decisions regarding which quality measures RMYC was able to provide information on based on target population.	Utilized model created under previously implemented VBP arrangements (ACC and P4P1).	Utilized model created under previously implemented VBP arrangements (ACC and P4P1).
Funder	Medicaid through the Accountable Care Collaborative	State Innovation Model Grant through Centers for Medicare and Medicaid Services administered by the	Commercial insurer	Commercial insurer

		Accountable Care Collaborative		
State agencies/ purchasers involved	Colorado Medicaid	Colorado Medicaid	No state agency involvement	No state agency involvement
Youth involvement	Youth are not involved at the provider level. The ACC has an advisory group that includes youth, family, and providers.	Youth participate in advisory groups at the state level and at regional health connectors.	Youth are not involved in any level and there are no plans to include them in the future.	Youth are not involved in any level and there are no plans to include them in the future.
Family involvement	Families are not involved at the provider level. The ACC has an advisory group that includes youth, family, and providers.	Families participate in advisory groups at the state level and at regional health connectors.	Families are not involved in any level and there are no plans to include them in the future.	Families are not involved in any level and there are no plans to include them in the future.
System partner involvement	System partners are not currently involved; however, it is likely they will be involved in the next iteration of the ACC advisory group.	System partners participate in advisory groups at the state level and at regional health connectors.	System partners are not involved in any level and there are no plans to include them in the future.	System partners are not involved in any level and there are no plans to include them in the future.
Quality measures	Set targets for the regions: 1. Increased well-child check rates (3 – 9-year-olds) 2. Decreased ER visits	1. Weight assessment and counseling 2. Using appropriate medications for asthma 3. Influenza immunization 4. Depression screening 5. Maternal depression screening 6. Developmental Screening	Not yet specified.	1. Influenza immunization 2. Using appropriate medications for asthma 3. Diabetes control 4. Number of inpatient days in a one year period 5. Rate of ED visits in a one year period
Performance metrics for quality measures	Detailed quarterly reporting for care coordination that is scored by the ACC and includes: 1, What are social emotional medical	Required to identify site specific goals, currently include: 1.Screening for BH needs 2. Timely intervention	N/A	1. Influenza immunization = 70 percent; 2. Appropriate prescriptions asthma = 50 percent

	needs being addressed? 2, What are the resources they are connected to?	3. Care planning-having shared treatment plan documented in EHR. 4. Building healthcare IT (HIT) infrastructure.		3. Diabetes Control = 26 percent 4. Number of inpatient days per 1,000 in one-year period = 73.52 5. Rate of ED visits per 1000 in one year = 179.15
Rates received	$3 – 3.50 PMPM for care coordination depending on the region. All other services billed fee-for-service.	• Get an additional $1.40 PMPM for Medicaid members for operating within an integrated care model. • Receive $5,000 per site for reporting quality measures, completing practice transformation assessment, and participating in collaborative conferences with other participating practices.	$5 PMPM rate on top of fee-for-service to support all services	Two levels: • $2 PMPM as long as provider stays favorable with insurer and meets the quality reporting requirements. • Receive an additional $1 PMPM for meeting two of the five quality measures (quality threshold target)
Incentives	There are no incentives for these arrangements.			
Do quality measures inform child system goals?	The state Medicaid department tried to align the quality measures where possible with National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS).			
Monitoring and evaluation	Quarterly reports on social-emotional and medical needs being addressed and resources clients are connected to. The ACC uses claims data and a scoring mechanism to verify the quarterly reports. Data is also being used to identify patients falling behind on preventive care.	Quarterly reports on quality measures. Annual report on progress toward goals. Medical home monitors assessment.	RMYC reports all data to the state Medicaid agency through the State Innovation Model (SIM) grant reporting. The state Medicaid agency provides quality measure information to the payer.	RMYC reports all data to the state Medicaid agency through the SIM grant reporting. The state Medicaid agency provides quality measure information to the payer.
Outcomes achieved	Agency has connected more	Outcomes had not been fully analyzed, but progress has	Outcomes were not established at the	At the time of the interview, the first performance period

	patients to robust resources. The well-child rate is also improving.	been made. Created custom data fields in the EHR to capture discrete data (e.g., behavioral health screening scores) and added encounter and referral forms to support the behavioral health and care navigation services.	time of the interview.	had just ended. The provider was awaiting information regarding outcomes and did not receive them before publication of this document.

LESSONS LEARNED

- Changing the EHR to support care planning and documentation is a long, difficult process.
- There are significant upfront costs to becoming data-informed. It is a time and resource investment. For example, the encounter forms that were built specific to the behavioral health and care navigation programs required extensive design and development resources, both with the organization's experts and the IT vendors. This also applied to the custom reports that needed to be created to meet reporting requirements. RMYC spent over $50,000 changing the EHR and getting meaningful reports to support and evaluate the integrated model.

ADVICE AND TECHNICAL ASSISTANCE

Advice to Purchasers

- As a practice, purchasers should include providers in the process from the beginning, especially when defining quality. Providers should be able to talk about what is meaningful for them and have input into the performance and quality measures established.
- Provide financial compensation to cover the costs of changes to reporting requirements, as those changes can be incredible resource intensive.

Advice to Providers

- Make sure your EHR vendor is flexible.

Technical Assistance Needed

- Help practices break down how to identify patients at high risk, adapt workflows and how to engage patients for each metric. Workflow changes include: when to screen for risk during the patient visit, who on the team enters score, who reviews it, who talks about the risks (medical provider, consult with care navigator, or behavioral health specialist), when and how are they introduced to the patient for additional help, and what is the follow-up. All these require new ways of communicating within the team and with the patient. Other considerations for implementing providers include pulling reports on high-risk patients, finding times during clinical hours for the team to huddle and plan care together using data from the reports, then decide who and how patient outreach will be done – by phone, using the patient portal, etc.
- Funding and advice to support EHR redesign for an integrated model of care and managing various outcomes.
- Aligning metrics across all providers.

Summary of Findings

Summary/Themes Across Providers

The organizations included in this report all provided behavioral health services to children, youth, and young adults. The other most common services provided were care coordination, crisis intervention and response, and family and/or parent programs. Of these sites, the state Medicaid office, commercial payers, and state agencies (such as the Department of Education and the Department of Health) were the most common payers. The majority of the respondents indicated that their payer breakdown has not changed since implementing their VBP arrangement(s). Other themes found from the sites interviewed include:

- **Pay-for-performance is the most common VBP arrangement used or being considered.** Among nine total VBP arrangements noted, six of the arrangements were pay-for-performance (financial payments tied to measured performance), followed by two case rate arrangements (a single negotiated payment for all services) and one per-member/per-month arrangement (a set payment per patient for specified medical services).
- **Care coordination and therapy services are the most common services being reimbursed through VBP arrangements, five and six arrangements respectively.** Additionally, four of nine identified VBP arrangements reimburse for the entire broad scope of services provided by the agency, which includes crisis intervention and response and family and/or parent programs.
- **Incentives were less common in the VBP arrangements.** Only two of five respondents noted that they used incentives, such as money, gas cards, etc., in any capacity. One respondent only used financial incentives for internal staff and not members or clients.
- **Clinical outcomes from validated screening and assessment tools, readmission and follow-up visits are the most common quality measures attached to VBP arrangements**. Some examples of screening and assessment tools used are child and adolescent needs and strengths (CANs) indicators, adverse childhood experiences (ACEs) screenings, metabolic screenings, and depression screenings. One respondent also noted goals to train families and a primary stakeholder audience throughout the year in topics to be determined by their quality council and reduce emergency room visits – both of which are assessed as quality measures in their VBP arrangement.
- **Standards for performance metrics, quality, and monitoring vary among organizations.** Several respondents are required to submit reports to their funder on a periodic basis: quarterly, twice per year, or annually. One respondent is not required to officially report on performance metrics or quality measures to the funder, as both the funder and the respondent monitor the metrics internally. One respondent has a quality management committee that meets quarterly to assess the status of each of their quality indicators.

Lessons Learned

The most poignant lesson learned is that VBP arrangements require both administrative and clinical structures and supports. Respondents noted many other lessons learned, but there were several themes that emerged, many of which were consistent across providers.

1. ***Costs –*** There are many upfront costs to implementing value-based purchasing arrangements. These costs include, but are not limited to: outreach to the target population, changes to the electronic health record, training for staff and, in one case, hiring of a part-time staff. It is important for providers to understand that these costs are generally not covered by the funder, so organizations should consider whether financial incentives will cover these upfront costs.
2. ***Relationships –*** It is important to build and maintain relationships with the funder as well as community partners. Ensuring there are open lines of communication and a quality improvement feedback loop is necessary.
3. ***Implementation –*** A few of the respondents noted that they built their value-based payment models on previous programs or projects they had in place. It was important to streamline transition of the new arrangement into the existing structure to avoid disruption in service for clients and pushback from staff.

Advice to Purchasers and Providers

Respondents were also asked to articulate what advice they would give providers involved in or considering VBP arrangements. This advice centered around four main topic areas: communication and relationship building, reimbursable activities and costs, data collection, and quality measures.

Communication and Relationship Building: Respondents noted a need to have open communication between the parties in the VBP arrangement throughout the entire implementation process. It is imperative to have ongoing conversations between payer and payee to establish shared goals and quality measures, discuss savings and risks, and be clear about expectations, target population, and desired outcomes. Another respondent also stressed the importance of having a designated "point person" who is highly responsive between the payer and payee who can answer questions, provide guidance, and troubleshoot issues. One respondent noted that that it is important to build relationships with other providers implementing VBP arrangements to create a network of peers, troubleshoot issues quickly, and share best practices.

Reimbursable Activities and Costs: Providers need to analyze their organizational budget and actively negotiate their VBP arrangements in a manner that covers actual cost at the outset. They must have a good enough understanding of their overhead costs and be prepared to renegotiate rates based on shifts, as needed. Providers noted the need to have dedicated staff who have experience with data, business analytics, and cost information and that these enhancements must be covered by the rates. Respondents also suggested that providers should also be able to bill for or be reimbursed for activities that are attached to the arrangement, i.e., conducting outreach to the identified population for the value-based payment arrangement and making changes to the electronic health record to collect the quality measures. One respondent also emphasized that the goals of their arrangement should be

aligned with payment of services to the fullest extent possible. They also suggested that purchasers should allocate a pool of money to pay for services that typically do not qualify for reimbursement, but are still expected to be provided, such as case management for individuals who do not qualify for the provider's standard set of services.

Data Collection: Both providers and purchasers need to ensure that their data transfer systems are consistent, current, and functional. Both parties should be able to explain the data collection and transfer processes in detail; being transparent and allowing the other to fully understand the expectations and how the data will be used to make decisions. Purchasers need to be able to succinctly explain their data evaluation and monitoring processes and the quality measures to providers. Providers should try to utilize their EHRs and managed care organization portals to do this and work with flexible EHR vendors. In terms of the data collection, providers need to be realistic about the mechanisms they can implement and the costs, time, and other resources associated with using data for quality improvement and decision-making. It was also suggested that hiring competent administrative staff who can readily assist in tracking the information is essential.

Quality Measures: When defining measures, it was suggested that providers should include families and young people in the process to select the measures to be tracked. Ensuring that the needs and voices of families are integrated throughout and used to determine what is most important to track is critical.

Technical Assistance

The final component of the interview asked respondents to identify areas where technical assistance may be helpful. Technical assistance needs included:

1. **Staff Training:** Providing training for staff on new processes, working as a team, treating clients holistically, and understanding the quality measures.
2. **Costing:** Providing training, coaching, and consultation for providers on how to properly cost services and develop a rate to cover costs.
3. **Value-based Purchasing Readiness:** Providing training, coaching, and consultation on topics related to value-based purchasing readiness, including, but not limited to: risk stratification, effective and efficient workflows, aligning quality measures with data collection across programs and provider types, and data system requirements.

This technical assistance could be delivered through a variety of mechanisms, including, but not limited to: peer opportunities, case studies, site visits, podcasts, webinars, email listservs, or some other mechanism of information dissemination with a consortium of successful VBP experts and providers.

In summary, although a minimal amount of value-based payment arrangements currently exist among providers delivering children's behavioral health services, it is an emerging practice for which CBHOs should begin preparation. With the understanding that VBP arrangements are both clinical and administrative, the findings from this report provide the framework for both potential and current providers and purchasers to ready themselves for an environment in which incentives are given for exceeding goals for care. Though these targets vary between providers, the need is clear – establishing relationships and open communication, defining quality measures and costs, and maintaining excellent data systems are universal components to address when implementing VBP arrangements.

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