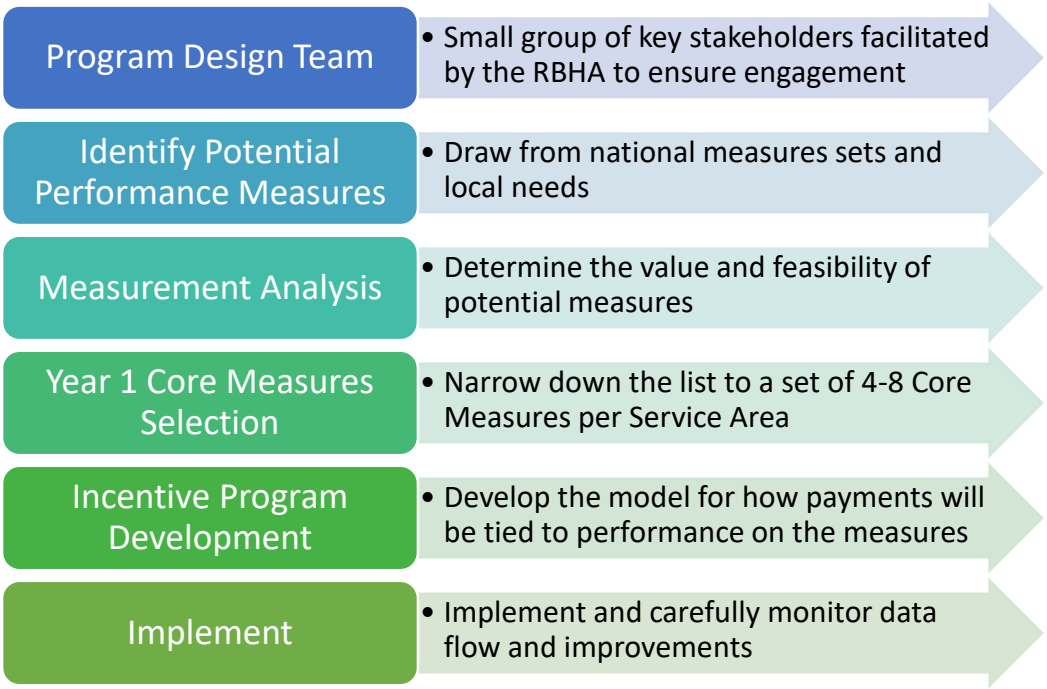
Regional Behavioral Health Authority
Value-Based Purchasing Initiative
Sample Performance Incentive Program

Overview

This document illustrates a Performance Incentive Program that Arizona RBHAs and their provider networks can use to inform the development of their Primary Care Incentive Programs and Performance-Based Contracts. The material is a composite of Performance Incentive Programs that have been developed in Oregon and California and reflects a number of value-based purchasing best practices.

Value-Based Purchasing Program Workplan Summary



Value-Based Purchasing Program Workplan Detail

Step 1 – Value-Based Purchasing Program Design Team

Pull together a group facilitated by the RBHA that consists of key stakeholders with the expertise needed to design the program. Experience is showing importance of provider engagement in order to achieve long term success.

Step 2 – Identify Potential Performance Measures

Drawing from national performance measure sets relevant to individuals with behavioral health disorders, combined with local needs, identify a set of performance measures that are candidates for the program. Attachment A contains 35 measures in seven domains that we recommend for consideration.

Performance Measure	Source
Area 1: Utilization & Cost	
Medical Inpatient Admission Rates	URS
Medical Inpatient Readmission Rates	CCBHC, HEDIS
Psychiatric Admission Rates	CCBHC, HEDIS
Psychiatric Inpatient Readmission Rates	URS
Emergency Department Visits	Various
Behavioral Health Crisis Episodes	Various

Step 3 – Measurement Analysis

The Value-Based Purchasing Program Design Team will evaluate each of the measures identified in Step 2, using the following questions.

1. Who has endorsed this measure, if anyone?
2. For what populations and sub-populations is this measure relevant?
3. What provider-types/service areas can positively impact movement on this measure?
4. Are data for this measure currently being collected?
5. If no to question 4, what infrastructure will be required to begin collecting data? What financial and staff investments will be required to implement this measure? How long will it take to begin collecting the data?
6. Are resources available to build the necessary infrastructure? Do the benefits of collecting this measure outweigh the costs?

Step 4 – Year 1 Core Measures Selection

Based on the Measurement Analysis, the Value-Based Purchasing Program Design Team will identify a small set of Core Measures for each Service Area that will be implemented in the first year of the program. Note that Attachment A takes a first cut at cross-walking the measures to six service areas. It will be critical to keep the list of Core Measures for each Service Area small – not more than 4 to 8 measures – in order to ensure proper focus. It is also important to select Year 1 Core Measures that can be collected and reported on in the first quarter of the measurement year. If it will take longer to implement the necessary infrastructure to collect and report on a measure, the measure should be deferred to Year 2 or Year 3.

Keep the list of Core Measures for each Service Area to no more than 4 to 8 measures.

The following example illustrates a set of Year 1 Core Measures for a California Medicaid health plan's Integrated Primary Care/Behavioral Health Clinics.

What are we tracking?	How are we measuring?
Patient Experience and Engagement	1. Tool TBD; considering Session Rating Scale (SRS), NHS Q, H-CAHPS
Stabilization and Improvement of Medical Conditions	2. Drawn from an identified list of Treat to Target Tools (See Note B in Attachment A)
Stabilization and Improvement of Behavioral Health Conditions	3. Drawn from an identified list of Treat to Target Tools (See Note B in Attachment A)
Utilization & Cost	4. Medical Inpatient Admissions from claims data
	5. Psychiatric Inpatient Admissions from claims data
	6. Emergency Department Visits from claims data
	7. Total Cost of Care from claims data

Step 5 – Incentive Program Development

The Value-Based Purchasing Program Design Team will design the Incentive Program. We recommend adapting the Oregon Health Authority's Coordinated Care Organization (CCO) Incentive Program design, which is in its third year of operation.

Under Oregon's model, the Medicaid authority holds back 3 percent of the monthly payments to CCOs, putting these dollars into a common 'quality pool.' To earn their full incentive payment, a CCO has to meet benchmarks or improvement targets on at least 12 of the 17 incentive measures and have at least 60 percent of their members enrolled in a patient-centered primary care home.

Here's how it works:

- **Step 5a - Compute Baselines:** Data was collected for each measure for each CCO for 2011. This became the Baseline Data Set. (Example: Follow up after hospitalization for mental illness – Columbia Pacific CCO 2011 Baseline: 57.1% of patients received a follow up visit within 7 days.)
- **Step 5b - Determine Benchmarks:** A Benchmark is set for each measure, drawing on national research and data sets. (Example: Follow up after hospitalization for mental illness – 2014 Benchmark: 68.8% of patients will receive a follow up visit within 7 days.) Most of Oregon's Benchmarks are based on national percentile data (e.g. National Medicaid 75th Percentile).
- **Step 5c - Determine the Improvement Targets:** An Improvement Target is set for each measure. If a CCO doesn't achieve the Benchmark but does achieve the Improvement Target, they earn credit for the measure. Most of Oregon's Improvement Targets use what's known as the Minnesota Method (see below).

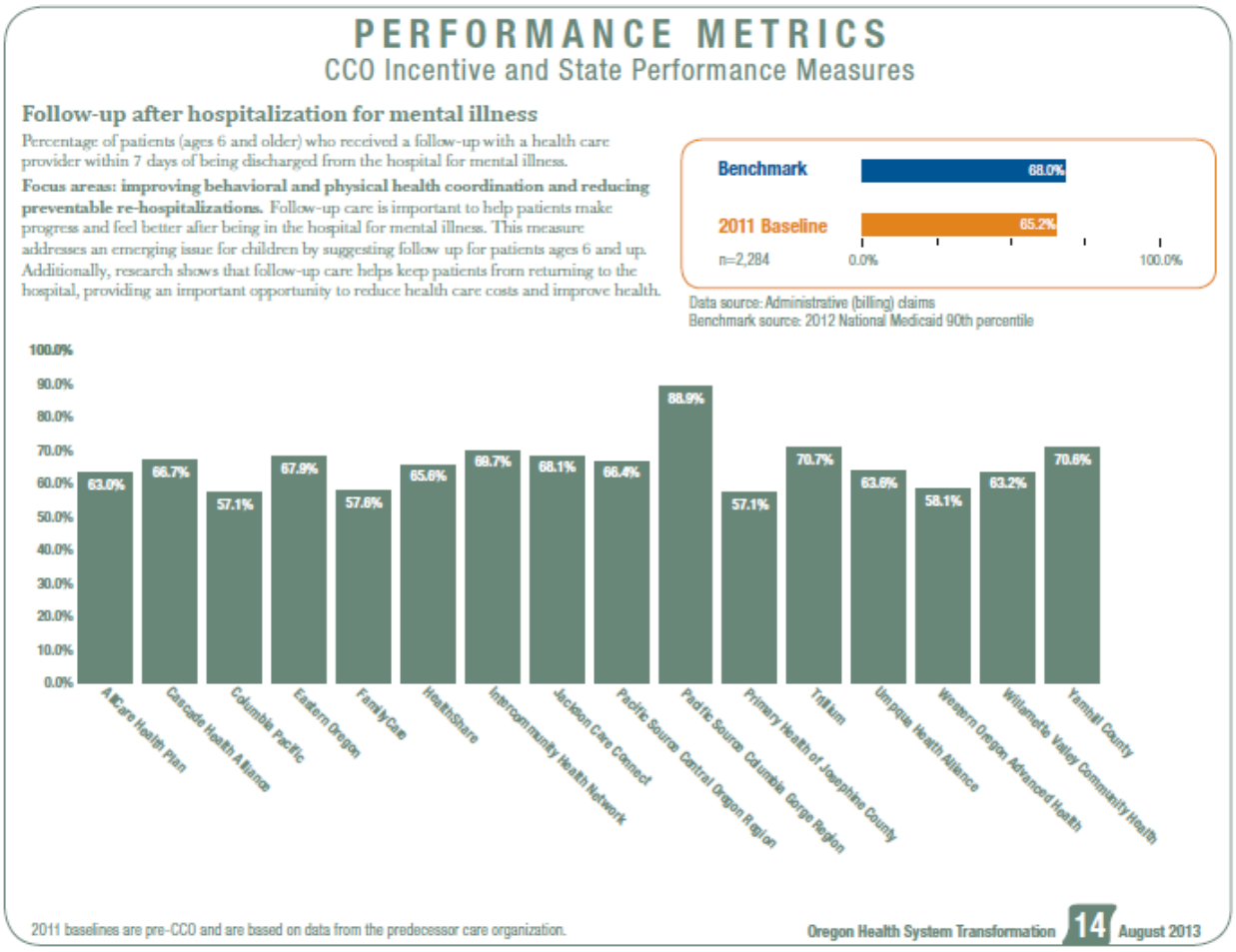
The Minnesota Method: The Minnesota Department of Health's Quality Incentive Payment System requires participants to have had at least a 10 percent reduction in the gap between its prior year's results and the performance target goal to quality for incentive payments.

For example, a health plan's current rate of mental health assessments is 45% and Oregon has set the performance goal at 90%. The difference between the plan's baseline and the performance target is 45%. The plan must reduce the gap by 10% to be eligible for payment; therefore the plan must improve their rate of mental health assessments by 4.5%, bringing their total rate to 49.5% before they are eligible for payment. In cases where the MN method results in required improvement rates of less than 3%, the health plan must achieve at least 3% improvement to be eligible for the incentive payment.

Additional details on the MN method are available online at: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf.

Note: The Oregon 2015 Benchmarks and Improvement Targets can be found in Appendix B.

- **Step 5d - Size the Incentive Pool:** Determine the amount to include in the Incentive Pool. Note that research is showing that incentive pools that are too small or have too long of delay in payouts are not having the desired effects. Oregon's 2014 Incentive Pool, which represented 3% of the total CCO budget, was $128 million. These funds are distributed, in full, every year based on the distribution formula described below.
- **Step 5e - Develop the Distribution Formula:** Oregon's distribution formula contains two phases.
  Phase 1: A CCO can earn 100% of their Incentive Pool (3% of their revenue) if they meet the Benchmark or Improvement Target on 12 of 17 measures. If a CCO meets fewer measures, they earn a prorated percentage of the 3%.
  Phase 2: After the Phase 1 funds are distributed, monies will be left in the Incentive Pool if one or more CCO doesn't earn their 100%. These funds are distributed to CCOs that meet the Benchmark or Improvement Target on four high value measures: SBIRT, Diabetes Control, Depression Screening and Follow-Up, and Health Home Enrollment. Thus, organizations that earn a passing score on these measures get double credit.
  Note: The 125 page 2014 Oregon CCO Final Report is being distributed as a companion to this document.
- **Develop the Payment Timeline and Tracking System:** The last component of the Incentive Program is a tracking system that compiles the data, presents that information in graphic format, and lays out the Incentive Payment Timeline (see the Oregon CCO January – March 2013 example below). Ideally, payments would be made quarterly. This is not always possible. Oregon's system pays once per year.



Step 6 - Implement

The final step is to implement the program, carefully monitor data flow and improvements, identify and address problems, and prepare for Year 2 and beyond.

Attachment A: Recommended Performance Measures

Performance Measure	Source (see Key below)	Crisis Services	ACT	Integrated Health Homes	Primary Care	Specialty Behavioral Health	Permanent Supportive Housing
Area 1: Utilization & Cost							
Medical Inpatient Admission Rates	URS		**X**	**X**	**X**		**X**
Medical Inpatient Readmission Rates	CCBHC, HEDIS		**X**	**X**	**X**		**X**
Psychiatric Admission Rates	CCBHC, HEDIS		**X**	**X**		**X**	**X**
Psychiatric Inpatient Readmission Rates	URS		**X**	**X**		**X**	**X**
Emergency Department Visits	Various		**X**	**X**	**X**		**X**
Behavioral Health Crisis Episodes	Various		**X**	**X**		**X**	**X**
Area 2: Access to Care							
Number of new patients with initial evaluation provided within 10 business days	CCBHC			**X**	**X**	**X**	
Follow-up after hospitalization for mental illness within 7 days	CCBHC, HEDIS		**X**	**X**	**X**	**X**	**X**
Percentage of patients who had at least one visit with a PCP in the preceding year	OR PCPCH		**X**	**X**	**X**	**X**	**X**
Area 3: Experience and Engagement							
Patient Experience and Engagement	CCBHC, HEDIS, See Note A	**X**	**X**	**X**	**X**	**X**	**X**
Family Experience of Care	CCBHC, HEDIS	**X**	**X**	**X**	**X**	**X**	**X**
Area 4: Medical Care Quality							
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	CCHBC, HEDIS		**X**	**X**	**X**	**X**	**X**

Performance Measure	Source (see Key below)	Crisis Services	ACT	Integrated Health Homes	Primary Care	Specialty Behavioral Health	Permanent Supportive Housing
Percentage of patients with Diabetes with HbA1c controlled	CCBHC, HEDIS, UDS, PQRS, MU		**X**	**X**	**X**		**X**
Percentage of patients with Hypertension whose blood pressure was adequately controlled	CCBHC, HEDIS, UDS, PQRS, MU		**X**	**X**	**X**		**X**
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	CCBHC, HEDIS, UDS, PQRS		**X**	**X**	**X**	**X**	**X**
Metabolic Monitoring for Children and Adolescents on Antipsychotics	CCBHC, HEDIS			**X**	**X**	**X**	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	CCBHC, HEDIS, UDS, PQRS, MU			**X**	**X**	**X**	
Area 5: Behavioral Health Care Quality							
Screening for Clinical Depression and Follow-Up Plan	CCBHC, UDS, PQRS			**X**	**X**	**X**	
Depression Remission at Six and Twelve Months	HEDIS, CCBHC, PQRS		**X**	**X**	**X**	**X**	**X**
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	CCBHC, PQRS			**X**	**X**	**X**	
Stabilization and/or Improvement of Behavioral Health Conditions based on a validated measurement instrument	See Note B		**X**	**X**		**X**	**X**
Antidepressant Medication Management	CCBHC, HEDIS		**X**	**X**		**X**	**X**
Rate of Youth Out-of-Home Placements	WA State			**X**		**X**	

Performance Measure	Source (see Key below)	Crisis Services	ACT	Integrated Health Homes	Primary Care	Specialty Behavioral Health	Permanent Supportive Housing
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	CCBHC		**X**	**X**		**X**	**X**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	CCBHC, HEDIS		**X**	**X**		**X**	**X**
Initiation and engagement of alcohol and other drug dependence treatment	CCBHC, HEDIS, PQRS, MU		**X**	**X**		**X**	**X**
Retention in SUD Treatment: Percentage of patients who are still in care 90 days after the start date	See Note C		**X**	**X**		**X**	**X**
Area 6: Practice Setting Quality							
Availability of same day appointments	Oregon PCPCH			**X**	**X**	**X**	
Has implemented a certified electronic health record and meets meaningful use standards	Oregon PCPCH			**X**	**X**	**X**	
Organization has a documented clinic-wide improvement strategy with performance goals	Oregon PCPCH	**X**	**X**	**X**	**X**	**X**	**X**
Upon receipt of a patient from another setting of care or provider of care (transitions of care), performs medication reconciliation	Oregon PCPCH		**X**	**X**	**X**	**X**	**X**
Percentage of patients whose medication regimen is reconciled	Oregon PCPCH		**X**	**X**	**X**	**X**	**X**
Area 7: Psychosocial Measures							
Housing Status	CCBHC		**X**	**X**		**X**	**X**
Employment/Education Status			**X**	**X**		**X**	**X**

Performance Measure	Source (see Key below)	Crisis Services	ACT	Integrated Health Homes	Primary Care	Specialty Behavioral Health	Permanent Supportive Housing
Criminal Justice Involvement			**X**	**X**		**X**	**X**

Key: CCBHC: Certified Community Behavioral Health Clinic; **HEDIS**: National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set; **MU**: CMS Meaningful Use; **Oregon PCPCH:** Oregon Patient Centered Primary Care Home; **PQRS**: CMS Physician Quality Reporting System; **UDS**: FQHC Uniform Data Set; **URS**: SAMHSA Uniform Reporting System.

Note A: There is a growing body of research that patient engagement is strongly correlated to positive outcomes. Many organizations are beginning to use tools that measure engagement at every session such as Scott Millers Session Rating Scale. Many consider this is significant step forward in measuring patient experience and engagement, especially for those with behavioral health disorders.

Note B: An emerging standard of care for primary and behavioral health is known as Treat to Target (T2). T2T uses standardized tools such as the PHQ-9, GAD-7, and DLA-20 to measure individual improvement. Using this approach, providers draw from a menu of tools the measurement instrument that is most relevant for each client and measures improvement at least monthly. The results for all patients in a program, organization, and sub-population are then compiled and reported using reporting tools that show the rate of improvement across all tools in use.

Note C: For individuals with Substance Use Disorders, initiation and engagement, which is a foundational measure set, should be complimented with an assessment of how many patients are still in care after the start date. This 90 day retention metric is emerging as an important measure of whether treatment will have long lasting benefits.

Attachment B: Oregon 2015 CCO Incentive Measure Benchmarks and Improvement Targets

Updated November 24, 2014

The Metrics & Scoring Committee has selected the measure set, adopted updated benchmark and improvement targets, and selected challenge pool measures for 2015, reflecting improved CCO performance. Challenge pool measures are indicated with an asterisk in the measure column below.

Measure	2015 Benchmarks	2015 Improvement Targets
Adolescent well care visits	62.0% *2014 national Medicaid 75th percentile (administrative data only)*	Minnesota method with 3 percentage point floor.
Alcohol and drug misuse (SBIRT)*	12% *Metrics TAG recommendation, weighted to accommodate inclusion of adolescents.*	Minnesota method with 3 percentage point floor.[1]
Ambulatory care: Emergency department utilization	39.4/1,000 member months *2014 national Medicaid 90th percentile*	Minnesota method
CAHPS composite: Access to care	87.2% *2014 national Medicaid 75th percentile; weighted average of adult and child rates*	Minnesota method with 2 percentage point floor
CAHPS composite: Satisfaction with care	89.6% *2014 national Medicaid 75th percentile; weighted average of adult and child rates*	Minnesota method with 2 percentage point floor
Colorectal cancer screening	47% *Metrics & Scoring Committee consensus*	Minnesota method with 3 percentage point floor
Controlling hypertension	64% *2014 national Medicaid 75th percentile*	N/A – 2015 is first year of pay for performance on this metric

[1] The 2015 improvement targets for SBIRT will be based on CY 2014 performance, recalculated to include adults and adolescents. Note the 2014 SBIRT measure does not include adolescents; CCO performance in 2014 will be determined only on adults.

Measure	2015 Benchmarks	2015 Improvement Targets
Dental sealants on permanent molars for children	20% *Metrics & Scoring Committee consensus; based on national EPSDT data and HP2020 goals.*	Minnesota method with 3 percentage point floor Use 2014 baseline to calculate improvement targets.
Depression screening and follow up*	25% *Metrics & Scoring Committee consensus*	N/A – 2015 is first year of pay for performance on this metric
Developmental screening*	50% *Metrics & Scoring Committee consensus*	Minnesota method
Diabetes: HbA1c poor control*	34% *2014 national Medicaid 75th percentile*	N/A – 2015 is first year of pay for performance on this metric
Effective contraceptive use	50% *Metrics & Scoring Committee consensus*	Minnesota method with 3 percentage point floor.
Electronic Health Record adoption	72% *Metrics & Scoring Committee consensus*	Minnesota method with 3 percentage point floor
Follow up after hospitalization for mental illness	70% *2014 national Medicaid 90th percentile*	Minnesota method with 3 percentage point floor
Mental, physical, and dental health assessments for children in DHS custody	90% *Committee consensus*	Minnesota method with 3 percentage point floor[2]
Patient Centered Primary Care Home enrollment	Goal: 100% of members enrolled in Tier 3 PCPCH	N/A – measure is on sliding scale
Timeliness of prenatal care	90% *2014 national Medicaid 75th percentile*	Minnesota method

[2] The 2015 improvement targets for DHS Custody will be based on CY 2014 performance, recalculated to dental assessments. Note the 2014 DHS Custody measure does not include dental assessments; CCO performance in 2014 will be determined only on mental health and physical health assessments.