C·B·H
Community Behavioral Health

Pay-for-Performance at Community Behavioral Health

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Medicaid and Behavioral Health Services

- Covers 70 million individuals nationally
- Single largest payer for behavioral health services
- Accounted for 26 percent of expenditures in 2009
- About one-fifth of enrollees had a behavioral health diagnosis
- Services (all, not just behavioral health) used by these enrollees accounted for almost half of all spending

Medicaid in Pennsylvania: HealthChoices

- Federal Government governs Medicaid program and grants waivers to states to implement a Medicaid managed care program
- Pennsylvania's waiver is a 1915(b) waiver first granted in 1997, renewable every two years
- Implemented Physical Health, Behavioral Health and Enrollment Broker

HealthChoices Program: Key Features

- County Right of First Opportunity:
  - Sole source contract
  - County options for acceptance of risk
- Provider choice for in-plan services:
  - All MA Providers in initial year.
  - Choice of two providers for each level of care within access standards; reviewed annually.
- All State and Federal Eligibility Categories of Medicaid included in HealthChoices.
- Broad behavioral health mandate; includes mental health, drug and alcohol, autism, behavioral health rehabilitation services for individuals with intellectual disabilities.
- Special populations included

HealthChoices Program: Key Features

- Pharmacy Benefits (with the exception of Methadone) paid for by Physical Health or FFS.
- State Plan Services, cost effective alternatives and supplemental services available.
- Consumer/Family Satisfaction Teams (C/FSTs) in every contract.
- Reinvestment of savings at the local level; must be committed to behavioral health and targeted to Medicaid population.
- Performance Measurement System.

Medicaid in Philadelphia: Community Behavioral Health

Philadelphia created Community Behavioral health (CBH) in 1997 to provide administrative services for the HealthChoices Behavioral Health Program.

- Philadelphia is the only county in PA that opted to create its own MCO.

CBH is a 501 (C)(3) Non-Profit with a Board of Directors comprised of County Board members and external members/family members.

CBH sits within the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), which falls under the Deputy Managing Director for Health & Human Services

PHILADELPHIA BEHAVIORAL HEALTHCHOICES PROGRAM

City of Philadelphia

Department of Behavioral Health Intellectual disAbility Services

Community Behavioral Health Board of Directors

- David T. Jones/Acting President
- Roland C. Lamb/Vice President
- Vacant/Secretary-Treasurer
- Keir Bradford –Grey/Member
- Ray Fabius, MD/Member
- Thomas Farley, MD, MPH/Member
- Cynthia F. Figueroa/Member
- Eva Gladstein/Member
- Liz Hersh/Member
- William R. Hite, Jr., Ed.D/Member
- Sandy Vasko/Member
- Deborah Irby/Youth Member
- Vacant/Consumer & Family Advisory Board Representative - Member

HealthChoices Administrative Services Organization (ASO) Medicaid Managed Care

Office of Intellectual disAbility Services (IDS)

Office of Addiction Services (BHS) (OAS)

Office of Mental Health (BHS) (OMH)

Community Behavioral Health (CBH)

Philadelphia Behavioral Health System

Medicaid in Philadelphia: Community Behavioral Health

The City of Philadelphia assumes full risk for the HealthChoices behavioral health, maintaining reserves and risk protections consistent with commercial insurers.

As of 12/31/2016, CBH covered 696,617 lives in 2016, holding contracts with over 178 providers, and providing services to over 115,010 members.

As an Accountable Service Organization (ASO), CBH manages the full spectrum of behavioral services.

Administrative dollars are shared with the DBHIDS (approximately $9 M)

- CBH Administrative dollars - $58 M in 2016

Consistently, CBH has low administrative expenses and retains no assets or any dollars/benefit from savings, thereby allowing all savings to be available for reinvestment.

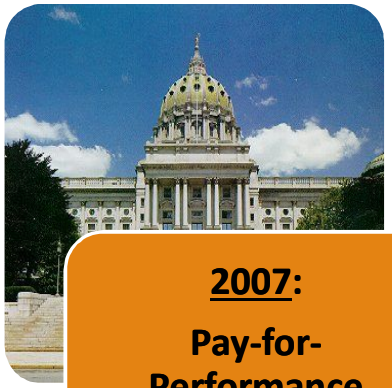
Behavioral Health P4P in Philadelphia

Beginning in 2010, use a Pay-for-Performance (P4P) model as a financial incentive to motivate providers to improve service quality

Must achieve a certain level of performance to receive a bonus payment

Payout at the end of the subsequent fiscal cycle based on performance during current fiscal cycle.

History of P4P at CBH



2007:

Pay-for-Performance announced as a State initiative by DPW Deputy Secretary

CBH as the BH-MCO for Philadelphia had the opportunity to give input

Series of meetings with providers

Discussed: indicators and measurement process

Development of Measures

- Align with *DBHIDS Practice Guidelines*
- Some measures based on nationally recognized indicators of service quality (HEDIS):
  - 7-day and 30-day follow-up
  - Readmission
  - Early Engagement
- Non-HEDIS measures were developed with input from CBH and DBHIDS clinical teams, and with the providers themselves, to be more representative of best practices for and service needs of a Medicaid population
- Most measures use claims data

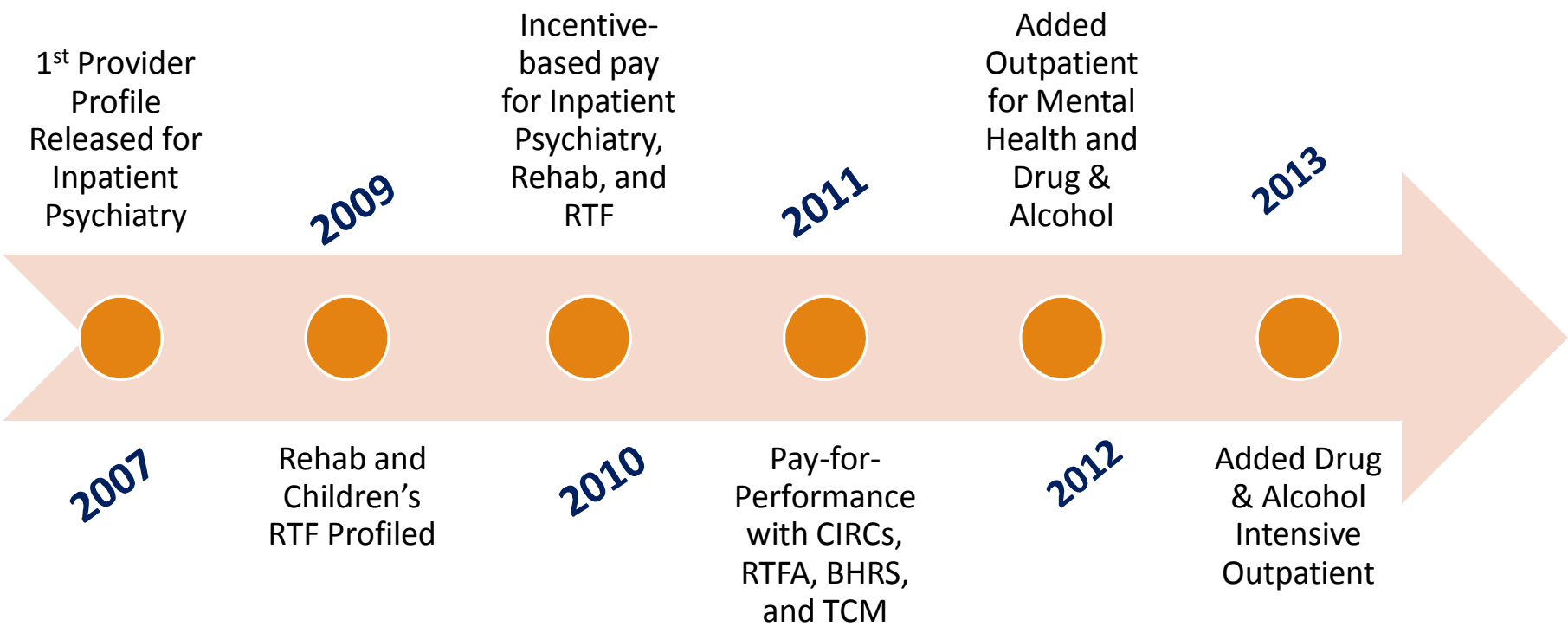
Development of Measures

- **BHRS (Wraparound)/School-based Services:**
  - Percent Having MT Claims Within 30 Days of Authorization Open Date
  - STS Family Engagement Survey
- **Psychiatric Inpatient:**
  - 7- and 30-day Follow-up Rate
  - 30-day Readmission Outcomes

Development of Measures

- **Outpatient (MH and D&A):**
  - Behavioral Health Screening Events
  - Percent Discharged from Higher LOCs Having Follow-Up within 30 Days
- **Targeted Case Management:**
  - Percent of Authorizations Having At Least One 31-Day Gap Between Services

Implementation

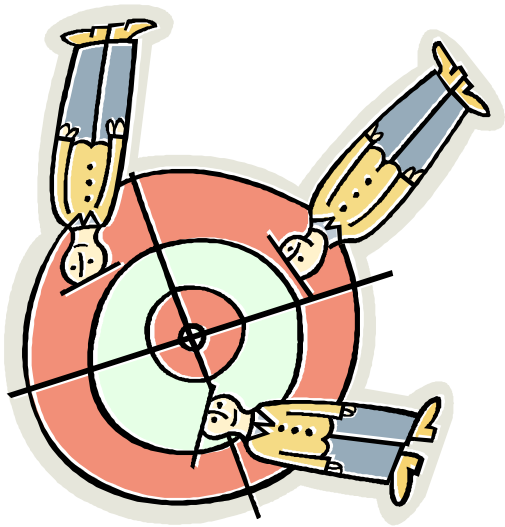


Current Process: Collaboration with Providers

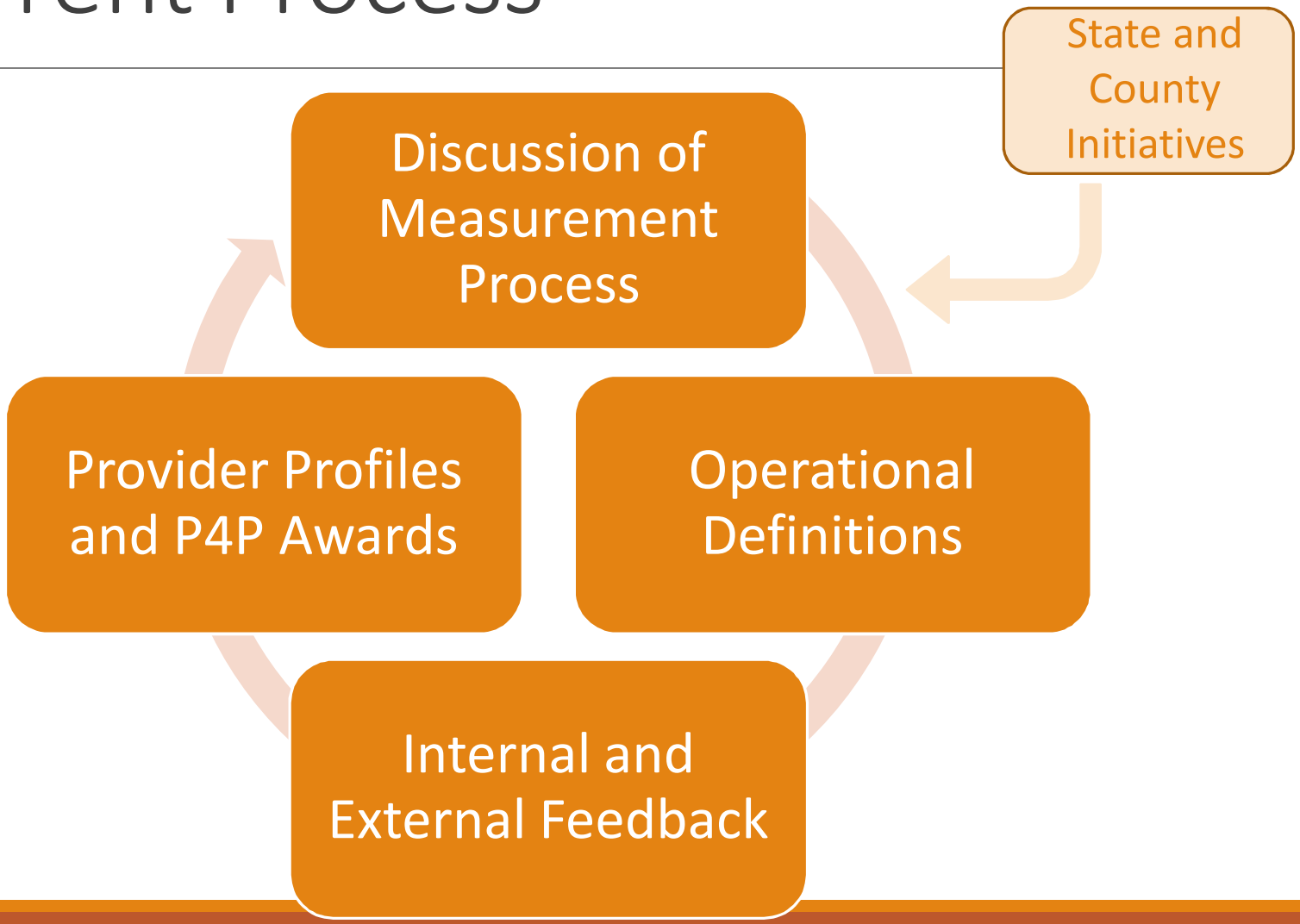
- Ongoing meetings with providers throughout the year:
  - P4P Advisory Committee
  - Webinars
  - Individually by request
- Discuss:
  - Issues of fairness and accuracy in measurements.
  - Need for case mix adjustment (e.g. Residential D&A for Women with Children, Children with ASD/ID)

Current Process: Setting Thresholds

- Use National and State benchmarks, when available
- Use distribution of provider scores
- Aim to make thresholds higher year by year to encourage improvement in performance
- Let providers know the thresholds ahead of time
- Send providers the data that we use to measure them



Current Process



Current Process: Determining Performance score

- Providers receive a total score for each level of care.
- We include other measures of quality from across CBH (Quality Improvement Plans, Compliance Error Rates, Credentialing) in the total score.
- Measures' weights (points) are determined by several considerations, such as CBH areas of focus.
- Providers receive extra points for improvement, or have points deducted for deterioration, as compared with previous measurement year.

Current Process: Incentive Pay

Pay-for-performance awards are formula based using the following components:

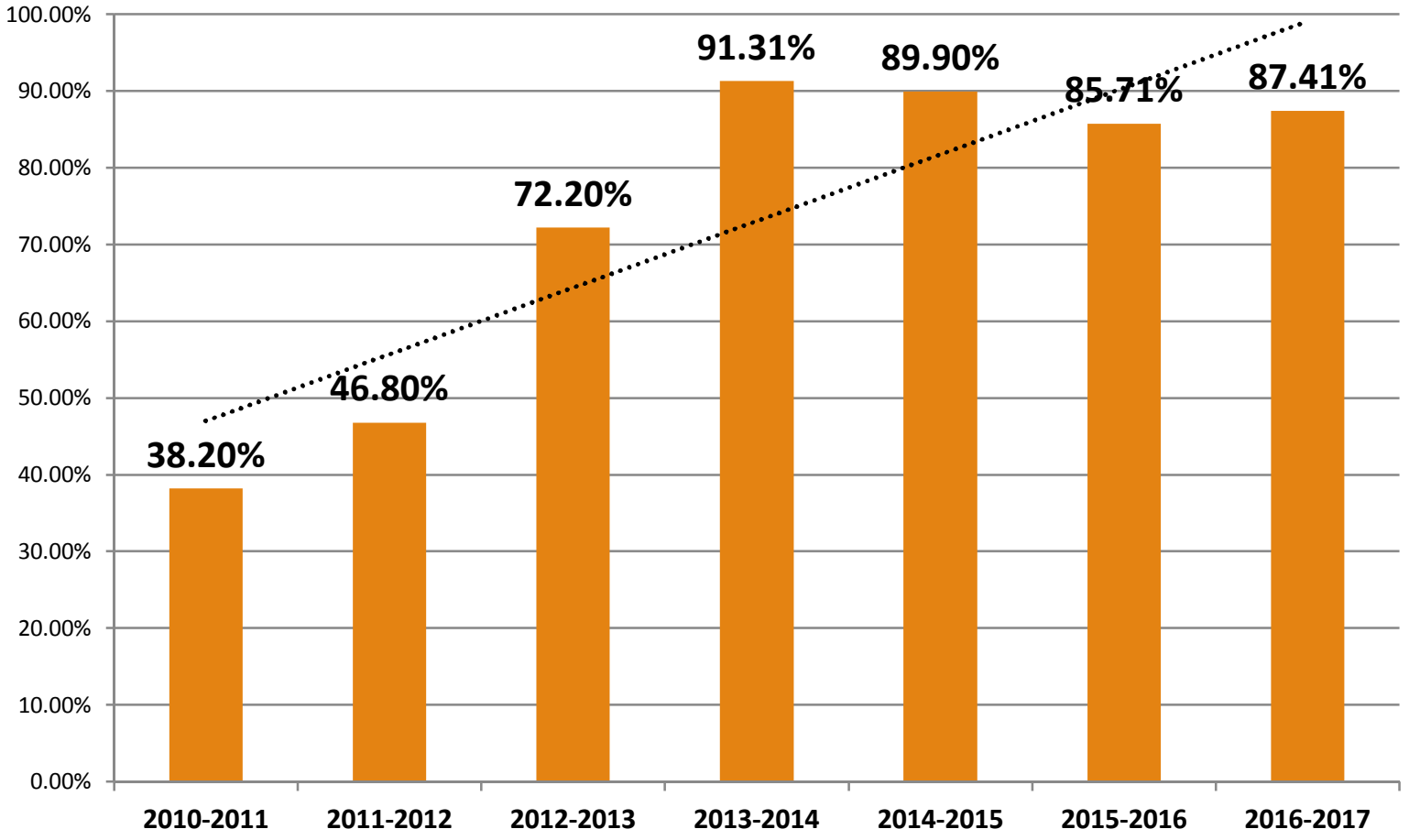
- Provider's total medical expenses for a level of care
- Provider's performance score for that level of care
- Payout percentage for that level of care (determined by CBH and DBHIDS leadership)
  - May be different for different levels of care

Current Process: Incentive Pay

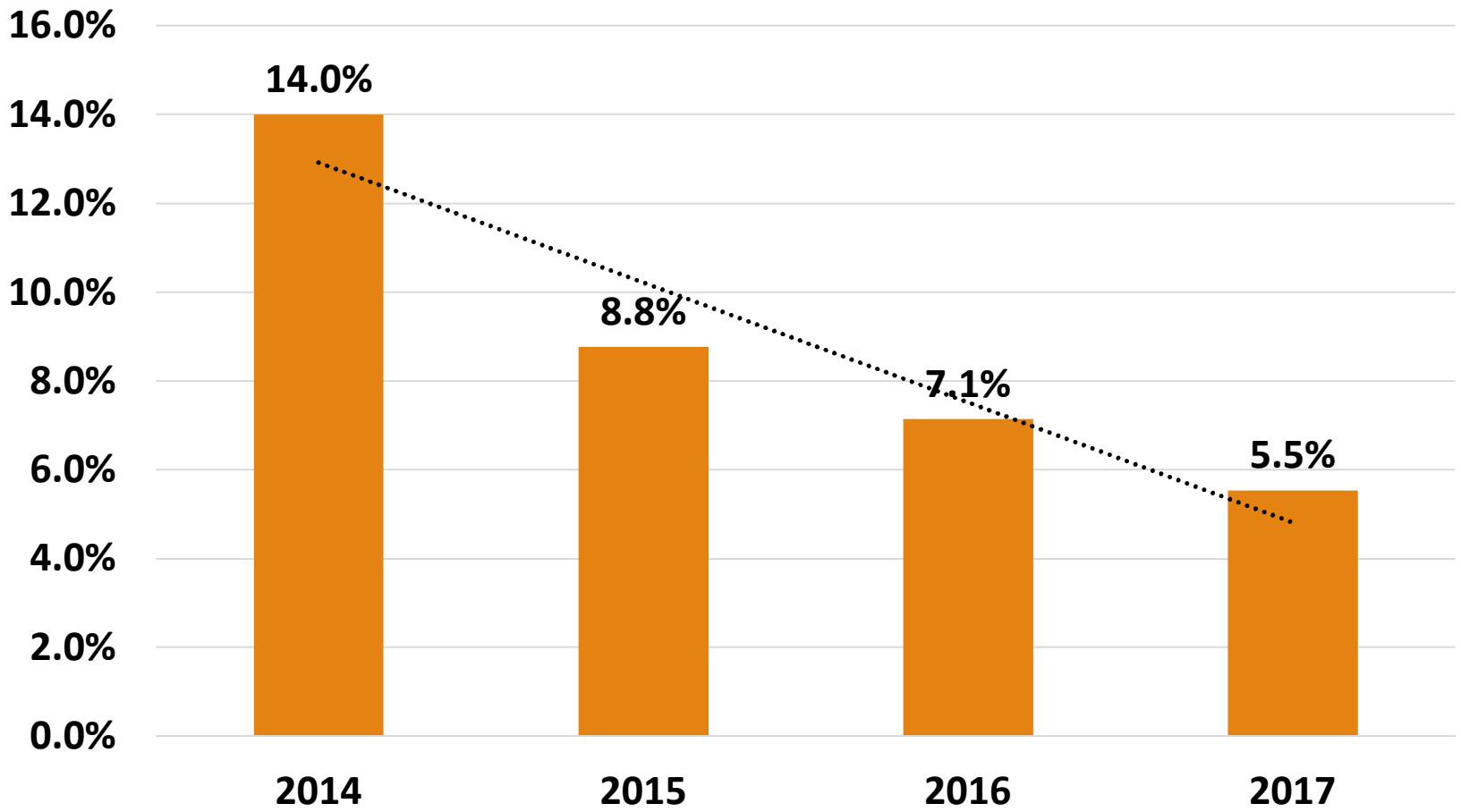
- In most recent P4P cycles (2013-2017):
  - Payout ranged from $6.5M to $9.5M annually
  - Average payout of $7.9M annually
  - On average, 25% of eligible providers received a performance award
  - Payout represents, on average, approximately 7% of total medical expenses for levels of care assessed for performance.

Results and Impact

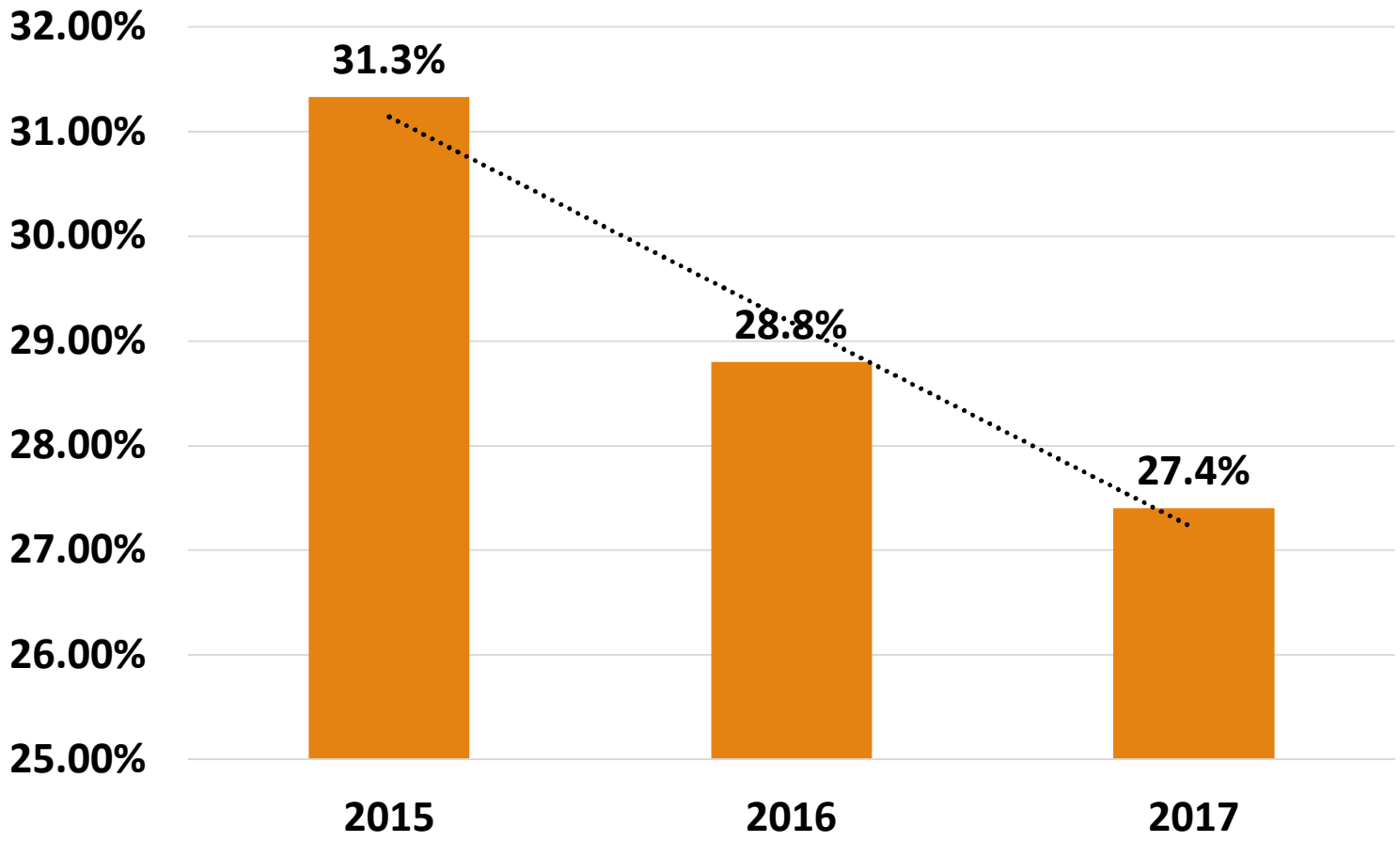
Targeted Case Management (TCM), Adult ICM: Percent Having TCM Contact Within 2 Days of Inpatient Admission



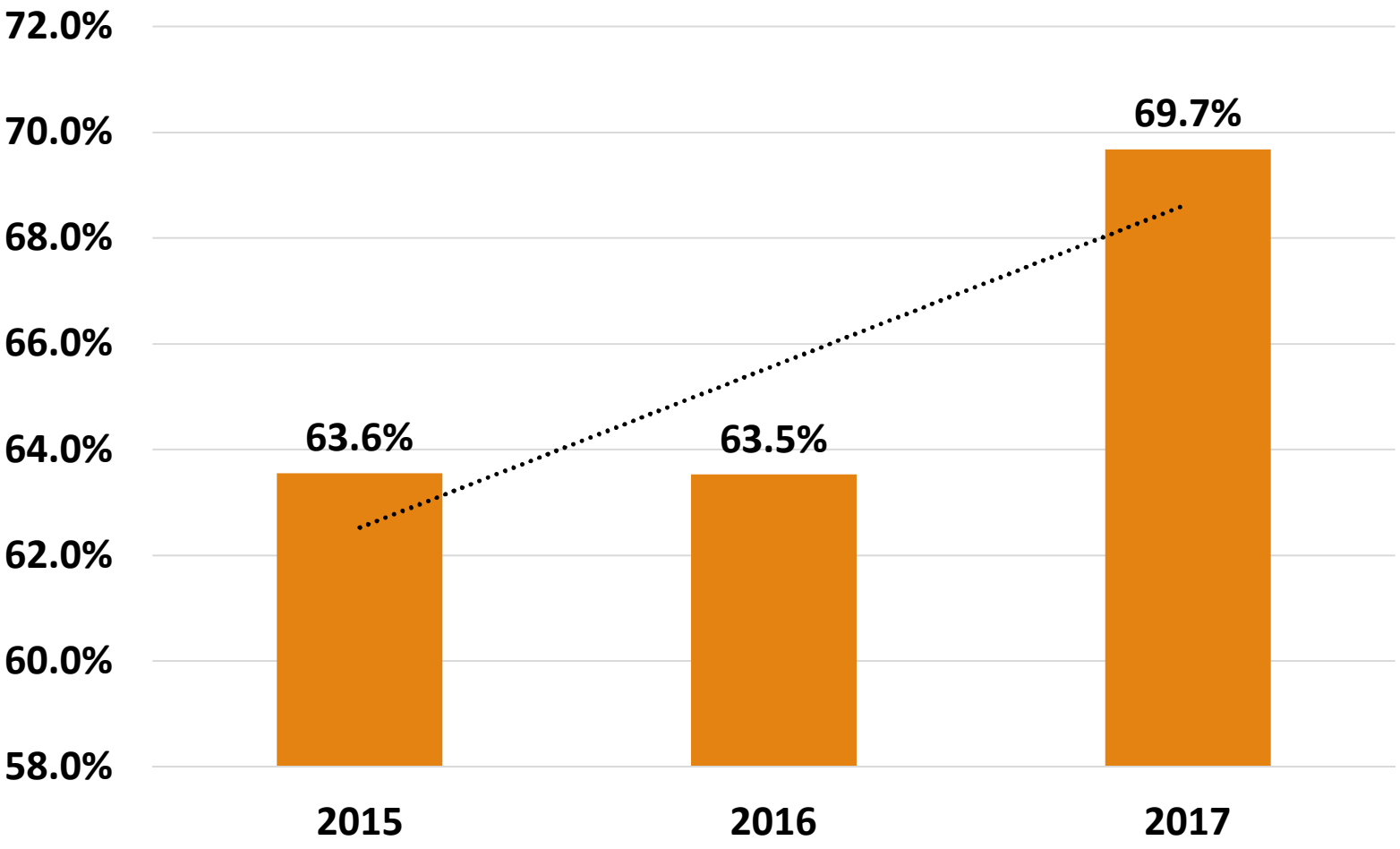
Targeted Case Management, ACT: Percent of Authorizations Having At Least One 31-Day Gap Between Services



Mental Health Outpatient, Child Non-ASD: Percent of Episodes Having Two or Fewer Services



Residential Treatment Facilities for Children, General: 30-Day Follow Up



Changes achieved through P4P

- Drew providers' attention to performance measures
- Improved data quality
- Clarified care management processes
- Eased new contractual requirements
- Influenced rate negotiation

P4P Impact on Provider Performance

- Looking back over a 3 or 4 years from most recent P4P cycle:
  - 38.3% of the measures showed improvement
  - Varies by level of care – 0% to 100%
  - Over 50% of measures for selected child services had improvement :
    - Inpatient Psychiatric Hospitalization
    - Outpatient Drug and Alcohol
    - Wraparound Services for Children with Autistic Spectrum Disorders
  - Over 50% of measures had improvement for Assertive Community Treatment and look-alike (Blended Enhanced Targeted Case Management)
  - D&A Residential Rehabilitation Services for population using methadone medication treatment – improved in all measures

Global Challenges

- Performance measurements for behavioral health
- Performance standards for behavioral health
- Size of Provider Network
- Variability of Provider Network
- Data availability – dependence on administrative data
- Case mix – ability to control is limited by data source

Moving to Value-based Purchasing

THE SHIFT FROM P4P TO P4V

Moving to VBP: Lessons Learned from P4P

P4P process and provider collaboration has helped to inform and lay the groundwork for transition to VBP:

- Buy-in from and collaboration with internal and external stakeholders is essential for success:
  - *What is it that each stakeholder group values?*
  - *Each has a part to play in the success of the process.*
- Quality measures for VBP will be selected, in part, from existing P4P quality measures:
  - *Expand gradually*
  - *Start with "low hanging fruit," e.g. Psych Inpatient*
- Importance of including consumer voice

Moving to VBP: Lessons Learned from P4P

- Ask providers about needs for technical assistance, e.g. claims, data infrastructure, accepting financial risk
- Importance of controlling for case mix:
  - *Determination of VBPs needs to include risk analysis to avoid cherry-picking by providers*
  - *Especially important with Medicaid population that has complex needs, including housing vulnerability/homelessness, co-occurring substance use and/or physical health issues*
- Importance of *using the results* to inform cross-departmental decisions (Be data informed!)
- Importance of ongoing evaluation: *Is what we're doing working? If not, why not?*

Thank you!