Digging Into the Arizona Behavioral Health Payment Reform Self-Help Toolkit

Dale Jarvis, CPA
www.djconsult.net
We cannot fix the healthcare quality and cost problems in the U.S. without better addressing the health and behavioral health needs of Americans with behavioral health disorders. This will require simultaneous efforts to improve the service delivery system and reform the payment models.

http://azpaymentreform.weebly.com/
Toolkit Audience

Here’s how this toolkit can benefit Arizona’s behavioral health stakeholders.

**Helping the State**
This toolkit contains a collection of payment reform-related best practices to assist DBHS and AHCCCS in refining their value-based purchasing policies.

**Helping the RBHAs**
RBHAs can *stress test* their payment reform and system transformation strategies and policies to support high performing provider networks that can be a model for the entire country.

**Helping Providers**
The toolkit is filled with information on practical information on how to prepare to succeed in a value-based purchasing environment.

**Helping Consumers**
There is a great deal of information in the toolkit to support consumer education, which can lead to empowerment, recovery, and whole health.
Two Discussion Topics

• The Arizona AHCCCS Value-Based Purchasing Design
• Organizing for Payment Reform within Your Organization
The Cost of Health Care
How much are we spending?

WASTE:
$765 Billion
30% of 2009 total health care spending

$2.5 Trillion
Total health care in 2009

30% Waste

Unnecessary Services
$210 Billion

Excessive Administrative Costs
$190 Billion

Prices That Are Too High
$105 Billion

Fraud
$75 Billion

Inefficiently Delivered Services
$130 Billion

Missed Prevention Opportunities
$55 Billion

Improving Outcomes

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
“Shocking News”

• Medicare Payment Reform is Working
  – 54 Medicare ACOs: $254 Million Savings in FIRST YEAR
  – 23 Pioneer ACOs: $147 Million Savings in FIRST YEAR
  – Physician Group Practice Demonstration: $108 Million Savings over the 5 Year Program
“More Shocking News”

• January 2015 Announcement
  – Moving 50% of all Fee for Service Medicare Payments into Alternative Payment Models (not Fee for Service) by 2018
  – Moving 90% of all Fee for Service Medicare Payments into APMs or Fee for Services Plus Pay for Performance by 2018
Arizona is on the Heels of CMS

• Arizona AHCCCS: Medicaid Contractors must implement **Value Based Purchasing** for the year beginning 10/1/2015
  – 15% of Long Term Care System Elderly and Physical Disability Program Payments
  – 20% of Children’s Rehabilitative Services
  – 20% of Acute Care Services
  – 5%(20%)(%) of RBHA-Behavioral Health Services

• With a plan to increase the percentages each year.
The Arizona AHCCCS Value-Based Purchasing Design
Value-Based Purchasing Defined

• Payors hold Providers Accountable for both the Cost and Quality of Care

• Using Strategies to Reward Providers for:
  – Reducing Inappropriate Care and
  – Providing High Value Care that is
    • Patient Centered,
    • Clinically Effective, and
    • Cost Effective
  – That can result in Bending the Cost Curve

• And sometimes using Strategies to put Providers at Risk if the above isn’t accomplished
High Value Care Defined

Accessible care provided by staff that communicate well.

- Achieves individual and systemwide outcomes
- Costs less than alternatives with comparable outcomes
What to Measure?

- Survey of 7 Federal Quality Programs
- 250 Quality Measures relevant to individuals with BH Disorders

<table>
<thead>
<tr>
<th>#</th>
<th>Measure</th>
<th>CCBHC</th>
<th>HEDIS</th>
<th>UDS</th>
<th>URS</th>
<th>PQRS</th>
<th>MU</th>
<th>NBHQF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number/Percent of clients requesting services who were determined to need routine care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mean number of days before the comprehensive person-centered and family centered diagnostic and treatment planning evaluation is performed for new clients</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Documentation of Current Medications in the Medical Records</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>Patient experience of care survey</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Family experience of care survey</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>Controlling High Blood Pressure (see Medicaid Adult Core Set)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Preventive Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### AHCCCS Acute Care P4P Measures

<table>
<thead>
<tr>
<th>Quality Management Performance Measure</th>
<th>Minimum Performance Standard (MPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADULT MEASURES</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Utilization</td>
<td>TBD</td>
</tr>
<tr>
<td>Emergency Department (ED) Utilization</td>
<td>TBD</td>
</tr>
<tr>
<td>Readmissions within 30 days of discharge</td>
<td>TBD</td>
</tr>
<tr>
<td>Adult Asthma Admission Rate (Asthma in Younger Adults)</td>
<td>TBD</td>
</tr>
<tr>
<td>Use of Appropriate Medications for People with Asthma</td>
<td>86%</td>
</tr>
<tr>
<td>Follow-up After Hospitalization (all cause) within 7 Days</td>
<td>50%</td>
</tr>
<tr>
<td>Follow-up After Hospitalization (all cause) within 30 Days</td>
<td>70%</td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health Services</td>
<td>75%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>50%</td>
</tr>
</tbody>
</table>
### AHCCCS Acute Care P4P Measures

**ACOM Policy 315 CYE 16, Attachment B**

**Acute Care Contractor Quality Management Performance Measure Standards**

**DRAFT**

<table>
<thead>
<tr>
<th>Quality Management Performance Measure</th>
<th>Minimum Performance Standard (MPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADULT MEASURES</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency Department (ED) Utilization</td>
<td>TBD</td>
</tr>
<tr>
<td>Readmissions within 30 days of discharge</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>CHILDREN'S MEASURES</strong></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits: 15 mo.</td>
<td>65%</td>
</tr>
<tr>
<td>Well-Child Visits: 3 - 6 yrs.</td>
<td>66%</td>
</tr>
<tr>
<td>Adolescent Well-Child Visits: 12–21 yrs.</td>
<td>41%</td>
</tr>
<tr>
<td>Children's Dental Visits (ages 2-21)</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Quality Management Performance Measures selected for use in the Payment Reform Initiative are shaded*
AZ VBP At-A-Glance

AHCCCS Value-Based Purchasing Strategies

Capitation + Perf-Based Contracts

Shared Risk

Shared Savings

Bundled/Episode Payments

Centers of Excellence

Accountable Care Programs

Primary Care Incentives

Performance-Based Programs

Fee-For Service

Level of Financial Risk

Degree of Provider Integration and Accountability
Deconstructing the AZ VBP Menu

- Capitation + Perf-Based Contracts
- Shared Risk
- Shared Savings
- Accountable Care Programs
- Performance-Based Contracts
- Primary Care Incentives
- Fee-For Service
- Performance-Based Programs
- Bundled/Episode Payments
- Centers of Excellence
Deconstructing AZ VBP – Blue Boxes

• Most of the Payment will not be value-based
  – (typically some version of Fee for Service)
• Plus a Pay for Performance (P4P)(Bonus) Layer if the provider meets certain quality and/or cost targets
  – Primary Care Incentives for Primary Care Providers
  – Performance-Based Contracts for Other Providers
Deconstructing AZ VBP – Green Boxes

• Dump Fee for Service and Block Payment
• Replace with a Case Rate
  – Payment of a flat fee per patient for a predefined episode at a specific level of care
  – Regardless of how many services and how much money was spent
  – May involve service providers from multiple organizations
• Should also include a P4P Layer
Deconstructing AZ VBP – Red Boxes

• Capitation Definition:
  – An agreed upon payment from the Health Plan to a Provider Organization, including Accountable Care Organizations
  – Paid in the form of a Per Member Per Month (PMPM) for each enrollee who is assigned to the Provider Organization/ACO
  – In return for the PMPM, the Provider/ACO will assure timely access to a predefined set of health benefits and quality agreements,
  – And the payment flows regardless of whether an individual uses services or not
Deconstructing AZ VBP – Red Boxes

- **Capitation Definition + Performance-Based Contracts**: AHCCCS says you can’t pay Capitation without a P4P Layer
- **Shared Savings**: Use of a tracking system to determine whether your care reduced costs; if so, you get a share
- **Shared Risk**: You get to share in the Savings and any Losses.
# One Size Does Not Fit All

## Sample Service Array

<table>
<thead>
<tr>
<th>Front Door Services</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800 Crisis Line</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-800 Access Line</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warm Line</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Teams</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Crisis and Acute Care Services

| Mobile Crisis Team                   | Capacity Funded        |                        |                        |
| Crisis Triage/Stabilization          | Capacity Funded        |                        |                        |
| Emergency Department                 | Fee for Service        |                        |                        |
| Urgent Care Clinics                  | Fee for Service        |                        |                        |
| Inpatient                            | Fee for Service        |                        |                        |
| Detox                                | Fee for Service        |                        |                        |
| Respite Care                         | Fee for Service        |                        |                        |

## Community-Based Services

| Person Centered Medical Home         | FFS + Bundle           | Bundled Payment        |                        |
| Behavioral Health Home               | FFS + Bundle           | Bundled Payment        |                        |
| ACT Teams                            | Capacity Funded        | Bundled Payment        | Sub-Capitation         |
| Specialty Behavioral Health Clinic   | Capacity Funded        | Bundled Payment        |                        |
| Specialty Medical Clinic             | Fee for Service        |                        |                        |
| Residential Treatment Facility       | Fee for Service        |                        | Bundled Payment        |
| Consumer-Run Services                | Capacity Funded        |                        |                        |
| Prevention Services                  | Capacity Funded        |                        |                        |
| Ancillary Services                   | Various                |                        |                        |

---

Sample Service Array
Organizing for Payment Reform within Your Organization
Behavioral Health Payment Reform Roadmap
Behavioral Health Payment Reform Roadmap

Organize the Effort
Build your roadmap

Service Delivery Redesign
Identify triple aim initiatives

Balance the Portfolio
Create demand-capacity, revenue-expense budget

Performance Measures
Develop the performance measurement system

Accountable Payment Models
Determine payment models for each service area

Pay for Performance
Develop the bonus and shared savings models

Infrastructure Development
Identify needed payer and provider infrastructure

Stress Test
Test the design against potential problems and risks

Implementation Plan
Create phased implementation plan

Developed by Dale Jarvis & Associates

Phase 1
Go Live
**Organize the Effort**
Build your roadmap

**Service Delivery Redesign**
Identify triple aim initiatives

**Balance the Portfolio**
Create demand-capacity, revenue-expense budget
One Plan, Two Levels of Work

Education
How will Healthcare Reform change What we do and How we do it?

Readiness Assessment
What Gaps exist between What Is and Where We Need to Be?

Planning & Design
What are our Redesign Priorities/Strategic Initiatives (Who, What, When)?

External Work
Relationship building and Influencing Policy Makers and Funders

Internal Work
Using Rapid Cycle Improvement (RCI) Project Methods

Evaluation
Are we achieving our desired objectives?

Plan

Do

Study

What’s our Next Phase of Redesign Priorities/Strategic Initiatives?

Act

No or “Not Quite”

Yes? No?

Yes
Performance Measures
Develop the performance measurement system

Accountable Payment Models
Determine payment models for each service area

Pay for Performance
Develop the bonus and shared savings models
National BH Performance Measurement

• Individual Outcomes

• System Outcomes
Individual Outcomes

• University of Washington AIMS Center
Treatment to Target

1) Each client has a treatment plan with clearly established and measurable treatment goals. These goals will include:
   a. ‘Personal Goals’ (e.g., return to employment) and
   b. Measurable Clinical Outcome Goals related to the primary behavioral health problems that interfere with reaching personal goals and that are the target of treatment.

2) Clinical interventions in the treatment plan will be supported by research, using evidence-based practices (EBPs) when available.

3) Each client’s progress with regards to personal goals and clinical outcomes will be proactively tracked at least once per month.

4) PCHCHs or other organizations providing behavioral health care commit to achieving the following goals:
   a. Clinically significant improvements (or)
   b. If clinical improvements are not achieved, the client is reassessed, a new treatment plan is established, and treatment is changed, using evidence-based treatments for the target condition.
# Portland Oregon’s T2T Project

<table>
<thead>
<tr>
<th>Tool</th>
<th># Using the Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACORN</td>
<td>14</td>
</tr>
<tr>
<td>CAPI</td>
<td>1</td>
</tr>
<tr>
<td>Consumer Recovery Measure</td>
<td>1</td>
</tr>
<tr>
<td>Recovery Needs Level</td>
<td>1</td>
</tr>
<tr>
<td>BERS</td>
<td>2</td>
</tr>
<tr>
<td>DLA20</td>
<td>2</td>
</tr>
<tr>
<td>Happiness Scale</td>
<td>1</td>
</tr>
<tr>
<td>GAF</td>
<td>1</td>
</tr>
<tr>
<td>DECA</td>
<td>2</td>
</tr>
<tr>
<td>CBCL</td>
<td>4</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>1</td>
</tr>
<tr>
<td>Sheehan</td>
<td>1</td>
</tr>
<tr>
<td>Current Adaptive Functioning Index-Cross-Cultural (CAFI-XC)</td>
<td>1</td>
</tr>
<tr>
<td>Eyeberg Child Behavior Inventory (ECBI)</td>
<td>2</td>
</tr>
<tr>
<td>UCLA PTSD Index</td>
<td>1</td>
</tr>
<tr>
<td>Jesness Inventory</td>
<td>1</td>
</tr>
<tr>
<td>DASS-21</td>
<td>1</td>
</tr>
<tr>
<td>ESCII</td>
<td>1</td>
</tr>
<tr>
<td>LOCUS</td>
<td>1</td>
</tr>
<tr>
<td>CANS</td>
<td>1</td>
</tr>
<tr>
<td>Miller SRS</td>
<td>1</td>
</tr>
<tr>
<td>Miller ORS</td>
<td>1</td>
</tr>
<tr>
<td>Miller CORS (Child)</td>
<td>0</td>
</tr>
<tr>
<td>Miller CSRS (Child)</td>
<td>0</td>
</tr>
<tr>
<td>Miller YCORS (Young Child)</td>
<td>0</td>
</tr>
<tr>
<td>Miller YCSRS (Young Child)</td>
<td>0</td>
</tr>
<tr>
<td>Self-Created Tool</td>
<td>2</td>
</tr>
<tr>
<td>Thinking Skills Inventory (TSI)</td>
<td>0</td>
</tr>
<tr>
<td>Child Functional Assessment Rating Scale (CFARS)</td>
<td>0</td>
</tr>
<tr>
<td>Refugee Health Screener 15 (RH-15)</td>
<td>0</td>
</tr>
<tr>
<td>Brief Psychiatric Rating Scale (BPRS)</td>
<td>0</td>
</tr>
<tr>
<td>DSM Level 1 Cross-Cutting Symptom Measure - Adult</td>
<td>0</td>
</tr>
<tr>
<td>DSM Level 1 Cross-Cutting Symptom Measure - Child</td>
<td>0</td>
</tr>
<tr>
<td>World Health Organization Disability Assessment 2.0</td>
<td>0</td>
</tr>
<tr>
<td>General Anxiety Disorder 7-Item Scale (GAD-7)</td>
<td>0</td>
</tr>
</tbody>
</table>
Value-Based Purchasing Design
Two Value-Based Purchasing Elements

**Element One – Accountable Payment Models:** Moving to value-based purchasing also requires the use of Accountable Payment Models where the financial reward is embedded in the payment model. We believe that four payment models are appropriate for Behavioral Health: Capacity-Based, Fee for Service, Case Rate/Bundled Payment, and Sub-Capitation.

**Element Two – Pay for Performance:** Moving to value-based purchasing requires the use of a payment approach where high performing providers are directly rewarded for the efforts to successfully provide patient centered, clinically effective, and cost effective care.
Model 1: Capacity Funded Services

Also known as the 'Fire Department Model'. Generally paid in 1/12th monthly increments based on a budget that supports sufficient staffing and other resources to field necessary capacity to meet POTENTIAL demand.

What Services?
Services where volume may fluctuate but staff must be available to meet the need. Examples include Crisis Lines, ACT Teams, Community Health Teams, Crisis Triage/Stabilization.

What P4P?
Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Referring Party Satisfaction
- Resolution of Problem
- Care Transition Success
Model 2: Fee for Service

Also known as the 'Payment for Volume Model'. Payment is made for each authorized and approved service, paid at an agreed upon rate. Although the money 'follows the client', the incentive is to provide more service and there is no differentiation in payment tied to whether the service is needed or useful.

What Services?

Services that can be easily billed in units of service and don't fit another payment model (last resort). Examples include Emergency Room Services, Urgent Care Clinics, Respite and Care. In a mature system, the list is quite short.

What P4P?

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Achieving BH Outcomes
- Achieving Health Outcomes
- Providing Care within Utilization Management Guidelines (not overserving)
A Case Rate/Bundled Payment is payment that covers the cost of a defined episode of care. The payment can be in the form of a single lump sum for short duration episodes or monthly installments for longer term episodes.

**What Services?**

Services that are associated with a discrete episode of care. Examples include Inpatient Care, Detox Services, Health Home Services, Specialty BH Care, and Specialty Medical Care.

**What P4P?**

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Achieving BH Outcomes
- Achieving Health Outcomes
- Providing Care within Utilization Management Guidelines (not underserving)
Model 4: Sub-Capitation

Sub-Capitation is a per member per month payment to an Accountable Care Organization or Comprehensive Provider that represents the average expected cost of providing a defined benefit package to anyone in the enrolled population who needs that care.

What Services?

Services that are part of a defined benefit package that can be provided by an Accountable Care Organization or a Comprehensive Provider.

What P4P?

Relevant Pay for Performance measures include:
- Response/Access Time
- Client/Family Satisfaction
- Achieving BH Outcomes
- Achieving Health Outcomes
- Providing Care within Utilization Management Guidelines (not underserving)
## One Size Does NOT Fit All

### Sample Service Array

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Front Door Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 1-800 Crisis Line</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 1-800 Access Line</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Warm Line</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Community Health Teams</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crisis and Acute Care Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Mobile Crisis Team</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Crisis Triage/Stabilization</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Emergency Department</td>
<td>Fee for Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Urgent Care Clinics</td>
<td>Fee for Service</td>
<td></td>
<td>Bundled Payment</td>
</tr>
<tr>
<td>9 Inpatient</td>
<td>Fee for Service</td>
<td></td>
<td>Bundled Payment</td>
</tr>
<tr>
<td>10 Detox</td>
<td>Fee for Service</td>
<td></td>
<td>Bundled Payment</td>
</tr>
<tr>
<td>11 Respite Care</td>
<td>Fee for Service</td>
<td></td>
<td>Bundled Payment</td>
</tr>
<tr>
<td><strong>Community-Based Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Person Centered Medical Home</td>
<td>FFS + Bundle</td>
<td>Bundled Payment</td>
<td></td>
</tr>
<tr>
<td>13 Behavioral Health Home</td>
<td>FFS + Bundle</td>
<td>Bundled Payment</td>
<td></td>
</tr>
<tr>
<td>14 ACT Teams</td>
<td>Capacity Funded</td>
<td>Bundled Payment</td>
<td></td>
</tr>
<tr>
<td>15 Specialty Behavioral Health Clinic</td>
<td>Capacity Funded</td>
<td>Sub-Capitation</td>
<td></td>
</tr>
<tr>
<td>16 Specialty Medical Clinic</td>
<td>Fee for Service</td>
<td></td>
<td>Bundled Payment</td>
</tr>
<tr>
<td>17 Residential Treatment Facility</td>
<td>Fee for Service</td>
<td></td>
<td>Bundled Payment</td>
</tr>
<tr>
<td>18 Consumer-Run Services</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Prevention Services</td>
<td>Capacity Funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Ancillary Services</td>
<td>Various</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pay for Performance

A step-by-step description to help states, health plans, regional systems of care, counties, provider associations, accountable care organizations, independent provider associations, health systems, and more implement a practical, best-practices approach to P4P.
Identify what's Important

Identify the performance measures that are important for the population you are serving. Pay careful attention to the national performance measurement work that is continuing to grow.

Select the Vital Few

Crosswalk the performance measures to the service areas that should be accountable for each measure.

Select the “vital few” measures for each service area that are high value candidates for the P4P program.
Complete a Gap Analysis

Determine the data collection and infrastructure requirements to implement the P4P model at the provider and payor levels.
Assess existing capabilities, and estimate the time and cost required to fill the gaps at each level.

Revise & Phase your Design

Revise the list of measures based on what was learned in step 3.
Organize the P4P program into 2-4 Phases based on provider and payor readiness: 1) Pay for Participation; 2) Pay for Reporting; 3) Pay for Performance; 4) Pay for Success.
Identify Baseline & Benchmark Metrics

Gather performance data to identify the Baseline Metrics for each Measure for each Provider (where you are now).

Determine the Benchmark Metrics that you will set for each P4P Measure (your goal).

Develop your Payment Model

Determine the size of the P4P funding pool.

 Decide the payment frequency and algorithm you will use to recognize improvement.

 Recommendation: Providers earn their Bonus if they: 1) Show Improvement; or 2) Hit the Benchmark).
Implement

Begin Phase 1 of the P4P program.

Carefully monitor data flow and improvements, identify and address problems.

Move into the next Phases until the program is fully implemented.
Follow-up after hospitalization for mental illness
Percentage of patients (ages 6 and older) who received a follow-up with a health care provider within 7 days of being discharged from the hospital for mental illness.
Focus areas: improving behavioral and physical health coordination and reducing preventable re-hospitalizations. Follow-up care is important to help patients make progress and feel better after being in the hospital for mental illness. This measure addresses an emerging issue for children by suggesting follow up for patients ages 6 and up. Additionally, research shows that follow-up care helps keep patients from returning to the hospital, providing an important opportunity to reduce health care costs and improve health.
What’s Next

• Give us Feedback!

We welcome your feedback!

6/2/2015

Please use the "Comments" link below, and then provide any feedback in the "Leave a reply" section. (Be sure to click "Submit" when you are ready to post!)

Please be sure to reference which specific area or page you are referring to (a link would be great!).

Please keep in mind that all comments will be public.
What’s Next

• RBHA Value-Based Purchasing Plans coming soon.
• Additions to the Toolkit based on the VBP Plans.
• RBHA-Specific VBP Provider Success Checklists
• RBHA-Specific VBP Provider Success Content
• A set of webinars on the above material
What Else?

ARIZONA BEHAVIORAL HEALTH PAYMENT REFORM TOOLKIT

Identify Baseline & Benchmark Metrics

Gather performance data to identify the Baseline Metrics for each Measure for each Provider (where you are now).

Determine the Benchmark Metrics that you will set for each P4P Measure (your goal).

Develop your Payment Model

Determine the size of the P4P funding pool.

Decide the payment frequency and algorithm you will use to recognize improvement.

Recommendation: Providers earn their Bonus if they: 1) Show Improvement; or 2) Hit the Benchmark.

Phase 1
Go Live

Develop the bonus and shared savings models.

Infrastructure Development
Identify needed payor and provider infrastructure.

Implementation Plan
Create phased implementation plan.

Utilization-Financial Modeling
Create demand-capacity, revenue-expense budget.

Performance Measures
Develop the performance measurement system.

Accountable Payment Models
Determine payment models for each service area.

Pay for Performance
Develop the bonus and shared savings models.

Service Delivery Redesign
Identify triple aim initiatives.

Identify Funding Pools
What are the service areas?

Project Plan Development
Build your roadmap.