Arizona Behavioral Health Payment Reform Toolkit Module 1: Transformation Strategies and Return on Investment (ROI) Small Group Exercise Worksheet

Instructions

Small Group Background:

- You will gather at your table based on your small group number.
- This is the group you will be working with for the next day and a half.
- Simulation Scenario:
  - You are a multi-disciplinary design team within a fictional region in a fictional state named Arizona.
  - Your design team is made up of MCO staff, providers, and consumers and advocates.
  - You have important problems to solve.

Small Group Organizing:

- Introduce yourselves
- Choose a pilot (who will operate the computer for later modules)
- Choose a recorder (who will take careful notes about the changes)
- Choose a timekeeper (who will make sure to keep you on task)

Small Group Exercise:

- Individual Assignment: Read the list of Practices with ROI evidence and put a checkmark next to the ones that appear to have relevance to your Region's Target Population.
- Small Group Work Step 1: Discuss any practice you'd like to add to the list.
- Small Group Work Step 2: As a group, code each practice as follows:
  - This is widely in use in the Arizona Medicaid system
  - This is somewhat used in Arizona and should be expanded
  - This is not really used in Arizona and should be expanded
  - None of the above
- Small Group Work Step 3: Your region is going to receive a $2 million Transformation Grant to implement <u>two</u> Initiatives that have a high probability of achieving the Triple Aim for Medicaid enrollees in your region with behavioral health disorders.
  - Identify your two priority initiatives.
  - Describe the sub-population that will be served by each initiative.
  - Write a brief description about why each initiative will be a good investment.

Module 1 Small Group Worksheet

Strategy 1 Name:
Subpopulation to Serve:
Why is this a good investment?
Other Comments:

Strategy 2 Name:
Subpopulation to Serve:
Why is this a good investment?
Other Comments:

Triple Aim Strategy Candidates for Your Region's Medicaid Enrollees with Behavioral Health Disorders

Menu of Strategies

Strategy 1: MHIP Program or Lookalike
Strategy 2: Medication Assisted Treatment in Primary Care
Strategy 3: BHC-Based Care Management Program
Strategy 4: BHC-Based Primary Care Clinic
Strategy 5: Community-Based Care Coordination Team ("Hot Spotting")
Strategy 6: Community Health Worker (CHW) Program for Adult
Strategy 7: Supportive Housing-Based Care Management
Strategy 8: Hospital/ER-Based SBIRT

Strategy 1: MHIP Program or Lookalike

Category: Behavioral Health in Primary Care

The Mental Health Integration Program (MHIP) has been developed by the University of Washington AIMS Centers. It is a best practice program that integrates behavioral health into primary care with linkages to specialty behavioral health. The program uses a well-defined set of clinical workflows supported by a care team that includes the primary care provider, a behavioral health care manager, a consulting psychiatrist, and other team members who screen, engage, treat and help patients manage their behavioral health conditions in primary care. If a patient's condition is too complex, a stepped care model is used to engage the patient in specialty care for a time limited period.

Financial and Utilization Results: Program Savings are estimated at $5,200 over four years; $1,300 per year average. This is approximately a 4:1 return on investment. A significant portion of this savings comes from reductions in inpatient admissions.

Strategy 2: Medication Assisted Treatment in Primary Care

Category: Behavioral Health in Primary Care

Buprenorhpine/Buprenorphine-Naloxone is an opiate substitution treatment used to treat opioid dependence. It is generally provided in addition to counseling therapies. Buprenorhpine/Buprenorphine-Naloxone is a partial agonist that suppresses withdrawal symptoms and blocks the effects of opioids. Two versions of buprenorphine are used in the treatment of opioid dependence. Subutex consists of buprenorphine only while Suboxone is version of buprenorphine that combines buprenorphine and naloxone. The addition of naloxone reduces the probability of overdose and reduces misuse by producing severe withdrawal effects if taken any way except sublingually. Suboxone is generally given during the maintenance phase and many clinics will only provide take-home doses of Suboxone. Buprenorphine and Buprenorphine/Naloxone are alternatives to methadone treatments and, unlike methadone, can be prescribed in office-based settings by physicians that have completed a special training.

Financial and Utilization Results: Program Savings are estimated at just under $10,000 and program costs are $4,500. This is approximately a 2.2 to 1.0 return on investment.

Strategy 3: BHC-Based Care Management Program

Category: Medical Care Management in Behavioral Health

Missouri's system of Community Mental Health Centers began the first statewide program of behavioral health clinic-based whole health care management based on a well-defined clinical and staffing model. The program uses a team led be a nurse care manager and staffed with case managers who have been trained to provide medical care management, supervised by a medical doctor.

Financial and Utilization Results: The initial group of highest needs clients had a net savings (after program expenses) of $500 per user per month. After significant expansion of the program the net cost savings are averaging $300 per user per month. There is no net additional cost for the first two years, i.e., investments in integrated behavioral health were offset by reductions in medical costs. For subsequent years, medical cost offsets exceed investments.

Strategy 4: BHC-Based Primary Care Clinic

Category: Primary Care in Behavioral Health

Cherokee Health Systems is one of the first FQHC systems in the country to do a large scale implementation of integrated care based on a community mental health center system being merged with a primary care clinic system. The Washtenaw Health Initiative is a second model, following a related design. Since then, the federal government has developed a grant program to fund over 100 clinics to advance the concept of a primary care clinic in a behavioral health setting.

Financial and Utilization Results: Cherokee has demonstrated 28% reduction in medical utilization for Medicaid patients and 20% decrease in utilization for patients with private insurance. A slight increase in primary care visits were offset by larger reductions in ER use, specialty care and hospitalizations.

Strategy 5: Community-Based Care Coordination Team ("Hot Spotting")

Category: Community-Based Care

In 2007, the Camden Coalition of Healthcare Providers began implementation of a citywide care management program to intervene and direct appropriate outreach to the most frequent utilizers of the emergency rooms and hospitals. The outreach teams consist of a social worker, health outreach worker/medical assistant, and a nurse practitioner. They assist with coordinating primary and specialty care, applying for benefits, securing temporary shelter, etc.

Financial and Utilization Results: The Camden effort made extraordinary progress with a seriously ill, yet engaged population. There was reduction of ER and hospital visits by 40% - 50%, with overall cost reductions of 25% - 50%. Preliminary studies had revealed that one percent of the city's population from a narrow geographic area accounted for a third of its medical costs.

Strategy 6: Community Health Worker (CHW) Program for Adults

Category: Community-Based Care

There are an increasing number of community health worker programs that are demonstrating improved health outcomes and cost savings for a wide range of populations. This initiative draws on the Denver Health program that used CHWs to provide community outreach to adults as a means of increasing access and continuity to health care services.

Financial and Utilization Results: Average savings per month were $22,943 (5%) for 590 patients; patients received more primary care & BH services and fewer inpatient and urgent care costs. Pre-study PMPM costs were $787. ROI: 2.28 to 1.00.

Strategy 7: Supportive Housing-Based Care Management

Category: Community-Based Care

Several studies of supportive housing programs have shown demonstrated cost savings: A 67% decrease in Medicaid costs pre- and one-year post housing in Massachusetts; a 41% reduction in Medicaid costs after one year for the 1811 Eastlake Project in Seattle; 24% reduction in emergency room and 29% reduction in hospital admissions from Chicago; a 27% reduction in hospital admissions and inpatient days from the California Frequent User Initiative. All programs have care management services that focus on the whole health needs of the residents. These programs have a very successful enrollment rate; that is, with effective outreach to the most severe cases, there is little to no rejection of enrollment by the contacted individuals.

Financial and Utilization Results: Reduced Medicaid costs per above. For this initiative, we have estimated a 30% reduction in high cost services for Disabled Adults, which is consistent with the Center for Health Care Strategies 2012 Policy Brief.

Strategy 8: Hospital/ER-Based SBIRT

Category: Hospital-Based BH EBP

Patients in medical hospitals and emergency rooms are screened for "hazardous" alcohol use. Those screening positive receive a brief intervention, delivered by health care staff or other professional. The intervention includes feedback on the patients' consumption compared to their peers and motivational interview to encourage reduction in consumption. Patients typically receive a single intervention lasting 15 minutes to one hour. Patients meeting diagnostic criteria would be referred to chemical dependency treatment.

Financial and Utilization Results: Gross savings per person range from $4,500 (hospital) to $6,000 (ER). Costs ranged from $156 (hospital) to $420 (ER). The return on investment ranged from 14 to 1 (ER) to 28 to 1 (hospital).

Arizona Behavioral Health Payment Reform Toolkit
Module 3: Designing an Alternative Payment Model at the Payor Level to Achieve the Triple Aim
Small Group Exercise Worksheet

Instructions

Small Group Exercise:

- Decide the Name of your Small Group; enter it in cell C6 of tab 1 Rates.
- Walk through steps 1 – 8 of the rate setting tab, identifying any questions you have about the scenario. If you can't answer any of the questions within the group, grab Dale, Karen or Jennifer.
- **Balancing Activity 1**
  - Test making changes to each variable, one at a time.
  - Describe the change you made.
  - Record the new Excess (Deficit).
  - Undo your change.
  - Repeat until you're ready to move on.

Change Description	Excess (Deficit)

- **Balancing Activity 2**
  - Discuss the pros and cons of changing each variable and develop an approach to balancing the budget.
    - Example 1: I'm just going to change the Rate because providers can live with less.
    - Example 2: I'm going tweak all four variable rather than make one big change.
- **Balancing Activity 3**
  - Balance the budget and enter your changes below.
  - Write down your justification on the Module 3 Worksheet.
  - Be prepared to defend your scenario.

Change Description	Excess (Deficit)

Arizona Behavioral Health Payment Reform Toolkit
Module 4: Organizing at the Provider Level to Succeed under Alternative Payment Models Small Group Exercise Worksheet

Instructions

Small Group Exercise:

Balancing Activity 1: Balance Demand and Capacity in Tab 3 Demand

- Is there an Excess or Deficit of FTEs? If YES, your options are…
  - Adjust the Clinician FTEs up or down in Step 3.
  - Revise the Direct Service Hours per FTE per Week by Clinician up or down in Step 1 or 3.
  - Revise the number of Active Clients in Step 2 above.
  - Do a combo of the above.
  - Record your changes below.

Change Description	FTE Excess (Deficit)

Balancing Activity 2: Balance Revenue and Expense in Tab 5 Expense

Is there an Excess or Deficit of Revenue over Expense? If YES, work on one or more of the following variables, but keep make sure to keep Capacity and Demand in Balance.

1) Revise the Average Hours per Client per Level of Care (Tab 2 UM).
2) Revise the Clinician FTEs (Tab 3 Demand).
3) Revise the Direct Service Hours per FTE (Tab 3 Demand).
4) Revise Salaries or Benefits (this tab).
5) Revise Other Expense (this tab).

Note: Assume for this exercise that you cannot change any of the Revenue Variables in tab 4.

Note: Having a large Excess is normally a sign of a problem somewhere in the system.

Record your changes below.

Change Description	FTE Excess (Deficit)

Arizona Behavioral Health Payment Reform Toolkit
Module 5: Small Group Exercise Worksheet

Instructions

- **The Task for Your Small Group:**
  - Develop a Behavioral Health Pay for Performance Program for your Region.
  - Feel free to steal shamelessly from the Portland project.
  - Keep in mind the Four Phases of Add-On Payments (slide 90)
- **Rules for the Exercise:**
  - The Program has to be organized around a Treat to Target approach to Outcomes at the Individual Client Level.
  - Phase 1 of the Program has to be ready to go live within 90 days.
  - You must design the first 2 Phases of the Program.

Worksheet

P4P Program Name:	
P4P Program Aim/Goal	
Phase 1	Phase 2
Phase 1 Description:	Phase 2 Description:
Payment Type (from slide 90)	Payment Type (from slide 90)
What it takes to Earn the Bonus:	What it takes to Earn the Bonus: