The Oklahoma Enhanced Tier Payment System

Leveraging Medicaid to Improve Mental Health Provider Performance and Outcomes

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This paper has been prepared for the National Association of State Mental Health Program Directors (NASMHPD) Financing and Medicaid Division by Suzanne Fields, MSW and LICSW and Kelly English Ph D, LICSW of the Technical Assistance Collaborative.

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Introduction

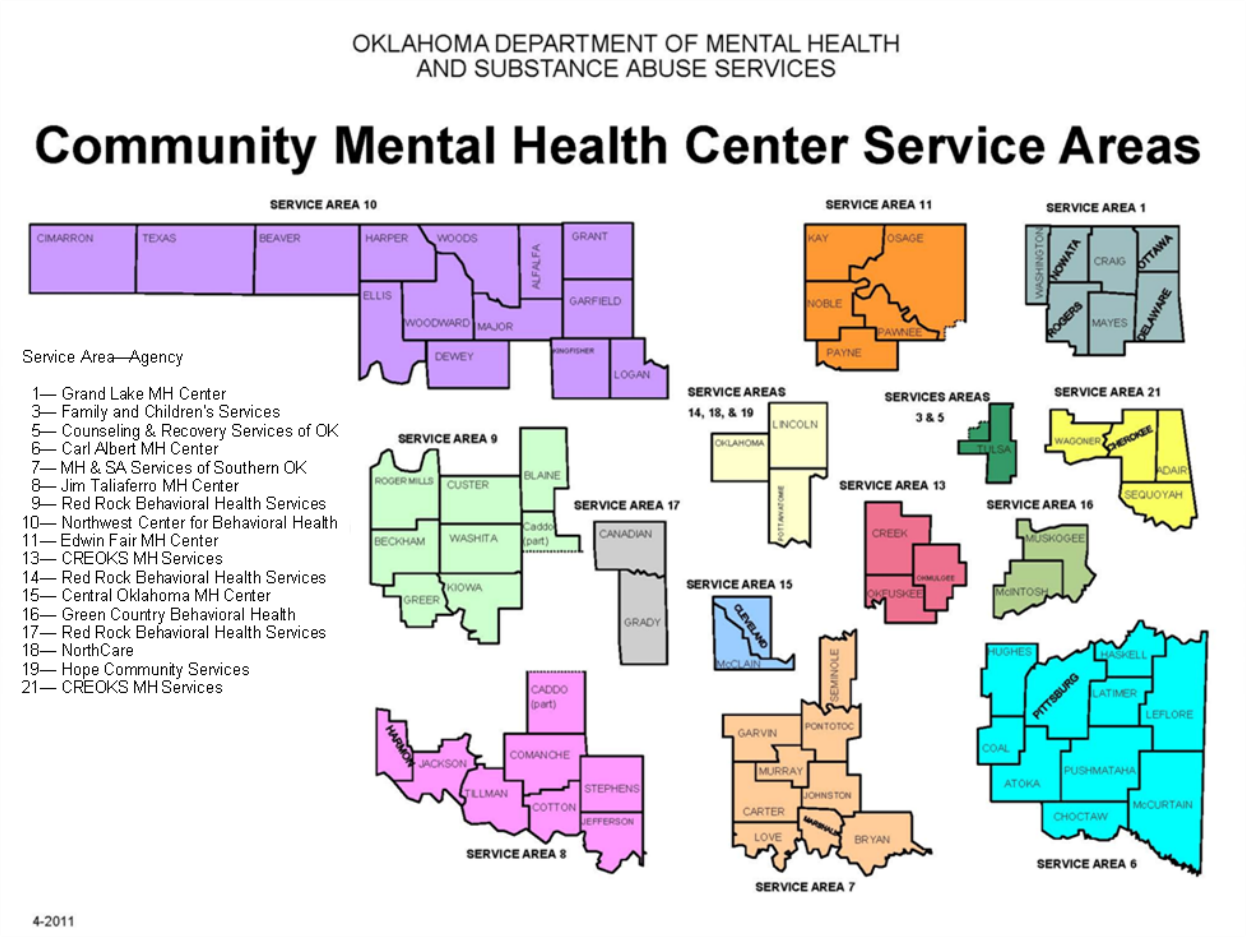
Like many state mental health authorities (SMHAs), the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was seeking creative solutions to improve provider performance in the face of state budget cuts. Through a collaborative process with the Community Mental Health Center (CMHC) provider community, the Oklahoma Health Care Authority (OHCA), and the state's Medicaid agency, ODMHSAS was able to accomplish something that many cash-strapped state agencies are seeking to do; that is, improve quality of care, increase provider payments, and serve more people in need. This case study of Oklahoma's Enhanced Tier Payment System (ETPS) will describe the overall system design, the stakeholder engagement process, and the process for obtaining approval from the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). It will also describe how the incentive payment process works, detail some of the changes providers made to their operations and business practices, as well as summarize lessons learned that can help other state mental health and Medicaid agencies maximize federal funding in order to drive quality and improve outcomes for people with mental health needs.

> *In Oklahoma we heard clearly from our providers,* ***"Pay us for what you want us to do"*** *and with them, we developed a win-win program. ETPS guides the direction of mental health services in Oklahoma.*
>
> *– Terri White, Commissioner*

Overview of Oklahoma's Public Mental Health System

The ODMHSAS serves as Oklahoma's state mental health and substance use authority with responsibility for providing leadership on policy issues related to mental health and substance use in the state. With an operating budget of $289,700,000, ODMHSAS is also responsible for delivering a range of publicly funded mental health and substance use services, serving approximately 72,000 people each year. Oklahoma's public mental health system is centralized (as opposed to a county-based system for example) and relies primarily on state general funds to support its operating budget. ODMHSAS has a formal agreement with the Oklahoma Health Care Authority (OHCA) to serve as the operating entity for a range of Medicaid covered mental health and substance use services. Medicaid dollars provide the largest portion of non-appropriated funding for mental health and substance use services.

A network of 15[1] CMHCs serving all 77 of Oklahoma's counties (see map), serve as the front door for accessing a range of treatment services including crisis services, outpatient therapy, case management, Program of Assertive Community Treatment, and other community-based services. These five state-operated and 10 contracted non-profit CMHCs serve as the safety-net provider of mental health services for uninsured adults and children in addition to serving Medicaid recipients in need of mental health services.



The Medicaid Process

As many SMHAs have recognized, ODMHSAS saw that its volume-based fee-for-service reimbursement system was not achieving the outcomes it wanted. ODMHSAS saw the potential to create a payment system similar to what physicians participating in Oklahoma's medical home initiative received for meeting certain established quality-of-care targets. ODMHSAS recognized an opportunity to use the "upper payment limit" to incentivize quality. The upper payment limit (UPL) is an estimate of the maximum amount that could be paid for Medicaid services under Medicare payment principles. Federal regulations place a ceiling on the State

[1] At the time the initiative began there were 15 CMHCs; there are now 14, serving 17 service areas.

Medicaid expenditures that are eligible for federal matching funds. These UPLs apply in the aggregate to all payments to particular types of providers; and are typically the amount that the Medicare program would pay for the same services. Because CMHCs were being reimbursed at 75 percent of the Medicare fee schedule (for 2007[2] non-facility practitioners), there was room between the current rate and 100 percent of the Medicare rate, otherwise referred to as UPL, to create an incentive corridor. With budget cuts limiting availability of state dollars, ODMHSAS saw the opportunity to improve quality of care by leveraging federal matching dollars to invest in this type of incentive system. Making this type of change to the provider payment methodology required Oklahoma to amend its Medicaid state plan.[3] This meant that ODMHSAS had to work closely with the state Medicaid agency, the Oklahoma Health Care Authority (OHCA), to prepare a state plan amendment (SPA), and negotiate with the Centers for Medicare and Medicaid Services (CMS).

As part of the SPA process, a required task was to perform an analysis of the gap between the current payment and the UPL so as to ensure that payments would not exceed the UPL. Throughout the SPA process, ODMHSAS and the OHCA worked closely with the CMS central and regional offices as they designed the methodology to ensure that it was consistent with efficiency, economy, and quality of care. One concern raised by CMS during the negotiation process was that the OHCA would be making payments to ODMHSAS rather than directly to providers. Assurances had to be made to CMS that ODMHSAS was simply a conduit for the money; that the CMHC providers would receive disbursements based on their performance, and that all of the money would end up with providers. Additionally, as is required in a state plan, ODMHSAS and OHCA had to detail specific rate methodologies that would be applied to specific provider types defined in the state plan.[4] Oklahoma submitted the SPA to CMS in February 2008 and received final approval in early May 2008 with an effective date of July 1, 2008.

Provider Engagement Process

As is required with any change to provider payment methodology as part of a SPA, states must inform affected parties. Apart from the regulatory requirement, ODMHSAS knew that obtaining buy-in from the provider community would be critical to achieving the types of changes they wanted to see in the system. Thus ODMHSAS held a series of meetings with providers to seek their input and obtain feedback about the payment design and the measures that would be used to monitor performance. While the collaborative nature of the relationship between

[2] Although the plan was effective July 2008, the measures went into effect and the initiative was launched in January 2009.
[3] It is important to note here that Oklahoma made this state plan change before the CMS SMD letter #10-020 in which CMS clarified its policies regarding state plan reviews.
[4] The Oklahoma State Plan Amendment is provided in Appendix A.

ODMHSAS and the CMHCs was a good foundation for this effort, six issues were critical to achieving provider's buy-in. First, the state prepared a proposal that it took to providers for comment. This was an important step as it focused the discussion on specifics versus generalities. Initially, providers were concerned about the state's proposal. In response, the state held numerous meetings with providers to discuss the proposal, to respond to concerns and refine the approach. Second, the payment was a supplemental payment for meeting certain benchmarks. This is in contrast to other approaches that withhold funding to incentivize quality. Because ODMHSAS used non-contracted dollars to pay provider bonuses for the first six months of the initiative, it allowed providers a "risk free" window of opportunity to make changes to their operations, staffing, and programs that could help them eventually achieve the benchmarks and receive the supplemental payment. The third major factor in gaining provider buy-in was that sources of existing data were used to the extent possible. Limiting the burden on providers to collect new data for this initiative was critical for providers who were already grappling with limited resources. Fourth, the state engaged in a "practice run" process with providers. The state ran reports with existing data against the proposed benchmarks and provided reports to each provider. This allowed providers to see their areas of strength and weakness; showing many that they were close to the benchmarks in some areas, and highlighting where they had to most focus their effort. This reassured most providers that the benchmarks were attainable with some service delivery modifications, but to improve even further it would necessitate greater system change. Fifth, the natural sense of competition that can exist in the provider community became a factor in motivating providers to participate. As providers began to see the interest of other providers to implement this payment approach, it motivated all of the providers to join and not miss out on an opportunity. Finally, providers were considering this proposal while simultaneously grappling with major budget gaps and fiscal challenges. As a group they realized that there were no other opportunities on the horizon to address existing budget constraints other than this approach. This allowed them to view the risk from a different perspective.

Measure Identification

Initially, ODMHSAS began the initiative with six measures and expanded six months later to the twelve measures currently in use. Providers already submitted claims and periodic demographic data that allowed for these measures to be tabulated. The only new measure that did not previously exist was the access to treatment measure. The access to treatment measure was not based on claims data but on a secret shopper approach conducted by state staff.

The highest priority for ODMHSAS was improving access to care. Therefore selection of indicators involved identifying those points in time when ensuring access was most critical. For

example, two indicators measured how quickly people were able to receive an appointment following a crisis event or hospitalization. Client engagement in treatment (modeled on The Washington Circle performance measure) was also identified as an important measure of provider performance. Self-reported reduction in drug use was selected as well as a medication visit within 14 days of admission. See Table 1 for the initial six measures.

First Group of Six Measures: Table 1

Measure	Description
Outpatient crisis service follow-up within 8 days	The percent of outpatient crisis service events, that were followed-up by an outpatient non-crisis service within eight days.
Inpatient/crisis unit follow-up within 7 days	The percent of inpatient/crisis service events that were followed-up within seven days of discharge.
Reduction in drug use	The percent of individuals who have self-reported a reduction in drug use over a seven-month period.
Four services within 45 days of admission	The percent of clients receiving at least four services within 45 days of the start date of an outpatient episode.
Medication visit within 14 days of admission	The percent of clients with a medication visit within 14 days of admission.
Access to treatment (adults)	The interval between initial contact and receipt of treatment services.

Following six months of using six measures, an additional group of six measures were selected. This second group of measures included access and engagement measures similar to those in the first grouping, but also included clinical outcome measures. Three of the group two indicators measured client improvement on the Client Assessment Record (CAR), a standardized assessment tool already required in Oklahoma that measures client functioning in nine domains. Three domain areas were selected for inclusion in the second group of measures: interpersonal, medical/physical, and self-care.

Second Group of Six Measures -Table 2

Measure	Description
Improvement in CAR score: Interpersonal domain	The percent of individuals who have reported an improvement or reached a score of 20 on the interpersonal domain over a seven month period.
Improvement in CAR score: Medical/physical domain	The percent of individuals who have reported an improvement or reached a score of 20 on the medical/physical domain over a seven month period.
Improvement in CAR score: Self-care/basic needs domain	The percent of individuals who have reported an improvement or reached a score of 20 on the CAR domain of self-care/basic needs over a seven month period.
Inpatient/crisis unit community tenure of 180 days	The percent of individuals who have not been readmitted to inpatient/facility-based crisis stabilization

Measure	Description
	after an inpatient/facility-based crisis stabilization discharge six months prior.
Percent of clients who receive a peer support service	The percent of clients who received one or more peer support services.
Access to treatment (children)	The interval between initial contact and receipt of treatment services.

For the access to treatment measure for adults and children, the state implemented a "secret shopper" method to gather data. Each month, ODMHSAS personnel develop various scenarios representing person(s) seeking treatment and use these scenarios as the basis for anonymous telephone conversations with the agencies to assess if each provider meets the established access criteria. The calls are scored based on the length of time between initial contact and the time that a face-to-face clinical meeting is provided. Additionally, the staff conducting the call summarizes the conversation with the provider in detail including who they spoke with, length of call, time of day, when appointments were offered, if directions were provided and transportation needs were assessed, and if clear instructions on what to expect were provided. This summary is sent to the agency's executive director to provide detail on how the agency's "front door" is operating.

Financing and payment methodology

As noted previously, a Medicaid state plan requires a separate payment methodology for each provider type. In Oklahoma, the two provider types allowed to participate in this payment system are governmental providers and private providers. Each quarter, the state calculates the difference between the providers claimed activities and the allowable UPL. The state groups the governmental providers' data together and completes this calculation, creating a pool of funding that can be distributed based on performance. The state repeats this process with the private providers' data creating another pool that can be distributed to private providers. Then the state calculates each provider's performance on the twelve required measures. Providers must meet the benchmarks established in order to receive payment. The dollars are distributed to providers based on the volume of clients served; providers that serve 10% of the total number of clients receive 10% of the pool. Payments are also calculated on providers who exceed a benchmark by one standard deviation, referred to as a "bonus" payment. The bonus payment dollars come from any remaining money in the pool that is not distributed if a provider (or providers) does not meet benchmark requirements. In this way, providers are incentivized not only to meet benchmarks but to exceed them.

Additionally, the state has adopted a "safety valve" approach in this methodology which allows providers who are within one standard deviation below the benchmark to receive a 50% partial

payment. This ensures that providers receive some payment for partially meeting benchmarks. However, if a provider performs more than one standard deviation below the benchmark, that provider does not receive payment for that measure. Providers that receive only a 50% partial payment or 0% of their available funds for a measure leave money "on the table" to be distributed as a bonus to providers exceeding the benchmarks by at least one standard deviation.

In FY 2009, this initiative resulted in $6 million in payment to providers, [5] increasing to $19.7 million in FY 2010 and an estimated $28.6 million for FY 2011.

Findings

Results of the initiative have been very positive. As Table 3 shows, improvements since the start of the initiative have been made in the key areas of access to care, client engagement, and clinical outcomes.

Table 3

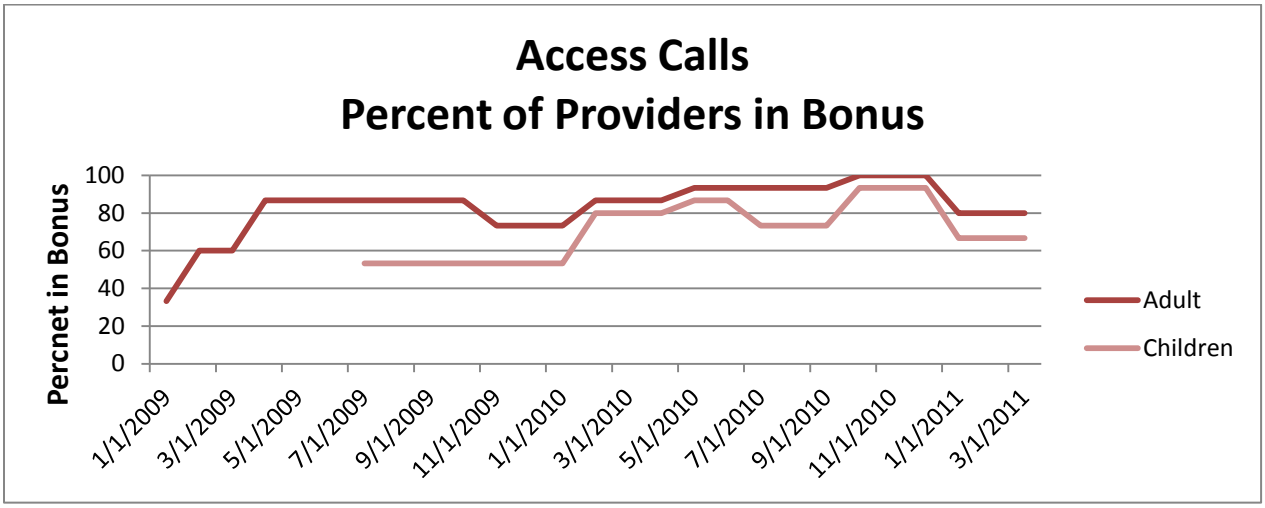
Measure	Result %	Number of CMHCs in the Bonus
Group one measures		
Outpatient crisis service follow-up within 8 days	Jul 2008 = 29.8 Jan 2009 = 30.6 Apr 2009 = 66.2 Jun 2010 = 80.5	Jan 2009 = 4 Apr 2009 = 11 Jun 2010 = 11
Inpatient/crisis unit follow-up within 7 days	Jul 2008 = 53.9 Jan 2009 = 58.2 Apr 2009 = 79.0 Jun 2010 = 78.2	Jan 2009 = 4 Apr 2009 = 10 Jun 2010 = 9
Reduction in drug use	Jul 2008 = 36.7 Jan 2009 = 43.0 Apr 2009 = 52.7 Jun 2010 = 46.7	Jan 2009 = 4 Apr 2009 = 9 Jun 2010 = 7
Four services within 45 days of admission	Jul 2008 = 45.2 Jan 2009 = 42.9 Apr 2009 = 62.9 Jun 2010 = 65.0	Jan 2009 = 2 Apr 2009 = 10 Jun 2010 = 10
Medication visit within 14 days of admission	Jul 2008 = 41.4 Jan 2009 = 37.5 Apr 2009 = 49.7 Jun 2010 = 57.2	Jan 2009 = 2 Apr 2009 = 6 Jun 2010 = 10
Access to treatment (adults)	Secret shopper method	Jan 2009 = 5 Apr 2009 = 13 Oct 2009 = 15 Jun 2010 = 14
Group two measures		

[5] Oklahoma's 2009 FMAP rate was 65.90 percent.

Measure	Result %	Number of CMHCs in the Bonus
Improvement in CAR score: Interpersonal domain	Jun 2009 = 25.6 Jul 2009 = 25.6 Jun 2010 = 36.4	Jul 2009 = 4 Jun 2010 = 7
Improvement in CAR score: Medical/physical domain	Jun 2009 = 47.1 Jul 2009 = 46.8 Jun 2010 = 55.4	Jul 2009 = 5 Jun 2010 = 7
Improvement in CAR score: Self-care/basic needs domain	Jun 2009 = 40.0 Jul 2009 = 40.0 Jun 2010 = 50.0	Jul 2009 = 6 Jun 2010 = 7
Inpatient/crisis unit community tenure 180 days	Jun 2009 = 73.2 Jul 2009 = 74.9 Jun 2010 = 75.3	Jul 2009 = 1 Jun 2010 = 4
Percent of clients who receive a peer support service	Jun 2009 = 1.1 Jul 2009 = 2.0 Jun 2010 = 10.3	Jul 2009 = 1 Jun 2010 = 8
Access to treatment (children)	Secret shopper method	Oct 2009 = 8 Jun 2010 = 14

As indicated in Graph 1 below, the percent of providers meeting access criteria has increased and remained steady over time.

Graph 1



In order to better understand the changes providers made to achieve these results, ODMHSAS sent out a survey eight months in to the process.[6] Providers described instituting practices such as: hiring new staff so as to increase appointment availability, developing urgent-care and

[6] Note that at the time the survey was conducted only the "group one" measures had been implemented.

walk-in clinics, as well as creating evening/weekend capacity. The engagement measures led to changes such as: assigning staff to make "welcome calls", post-appointment follow-up and appointment reminder calls, conducting trainings for "front-line" office staff to improve customer service, and enhancing tracking and supervisory systems and practices so as to better monitor engagement indicators. One provider described that including indicators of engagement as performance measures was, "….transformative in our service delivery system."

Providers did report concerns about measures that they perceived as having limited control over such as access to psychiatry and follow-up post-discharge from an inpatient or crisis unit. Responses to the provider survey indicated that the limited supply of psychiatrists, particularly in rural areas, made this the most difficult measure to implement. Despite this, some providers found creative solutions to the problem such as employing tele-health and developing a partnership with a local hospital in order to utilize the services of psychiatric residents. With regard to post-discharge follow-up, some providers worked hard to establish (or improve) relationships with inpatient units in order to impact this outcome.

As the data in Table 3 further indicates, the number of providers eligible for the bonus payment has also increased over time. Interviews with ODMHSAS and providers suggested that this result in part stemmed from the fact that providers were quite supportive of one another's efforts. At monthly meetings convened by ODMHSAS, CMHC directors shared changes they were making to their operations, staffing, and culture to improve their performance, creating a learning collaborative of sorts where providers educated each other. ODMHSAS' Integrated Client Information System (ICIS) was also cited as playing an important role in improving performance. Providers were able to view not only their organization's performance in "real time" but it also allowed individual clinicians to see how their clients were doing on certain key indicators as well. In this way the ICIS allowed them to make adjustments accordingly as part of a continuous quality improvement process. It also permitted providers to view one another's agency level aggregate data so they could see how their "competitors" were performing. It was suggested that the ability to view one another's data bred a sort of healthy competition amongst providers that created an important non-financial incentive.

One of the other relevant findings from the effort was that more people were served as a result. ODMHSAS reported a 22% increase in people served from January 2009 through June 2010. It is important to recognize that service volume determines how large the provider's share of the payment will be; so in some ways this finding is unsurprising given the financial incentive. However results from the provider surveys suggest changes providers made as part of the ETPS were not driven by volume considerations but were really about improving their business practices so as to improve the quality of the client experience. This is reflected in the comments of one provider who stated: ***"This process occurred at a good time for change at***

our agency. We have undergone and are currently still makings lots of changes, mostly attitudinal, but overall philosophical changes. This process actually helped [us], although burdensome at times to be cognizant of doing things right and good."

A second significant finding is the report from providers that the infusion of these dollars has stabilized their workforce by increasing their staff's tenure in their organizations. Agencies have used these dollars to increase training, and support their staff in understanding the "business" side of the work. Agencies use clinician level reports with staff as part of supervision, and have tied merit raises and bonuses to staff performance. A third finding is that the state has used this initiative to further promote community integration and recovery oriented approaches, including use of peer services and implementation of important community approaches not funded by Medicaid such as parenting classes.

The Future

The ODMHSAS and providers are currently planning additions to this approach. First, ODMHSAS is planning to implement this approach with certain categories of substance use providers by January 1, 2013. This will include not only substance use measures but co-occurring measures as well. Second, the state plans to augment child –specific measures to support improvements in the system for children and their families such as better substance use screening for youth and early intervention measures. Also under discussion is the addition of public health measures such as suicide prevention.

In addition, the state now has to grapple with raising the bar for higher quality standards. Most providers are exceeding the benchmarks established and are receiving bonus payments. Discussion is underway on where to go next. From the state's perspective, this is a good problem to have; they have improved their system and implemented a process that can be adapted for the future. The state was clear with providers from the beginning that this would not be a static process but one that would be continually adjusted to improve the state's system to meet the needs of consumers and families. Currently one measure is a rolling measure in which the benchmark continually increases. The state will continually review measures and adjust as appropriate. The state is also considering maintaining some measures "as is" even though providers are performing well, in order to ensure the system's ability to maintain the achieved gains.

As one provider noted this has given them the ability to think about things most providers and states can't seriously consider. ***"We have new problems-but they are good problems-such as how to improve our tele-health capacity or how to improve our infrastructure in information technology or our facilities."***

Summary

The Oklahoma Enhanced Tier Payment System provides very important lessons for mental health and substance use authorities, Medicaid agencies, providers, clients, and stakeholders. Even for those states for which an UPL incentive system is not an option, this approach still provides lessons applicable for all states.

It demonstrates that states and providers can engage in a mutually beneficial process to improve quality and that it is the partnership between the state and provider community that helps reach that goal.

It challenges the common assertion that provider rates already include payment for quality or that providers should have been performing in a certain way all along; therefore, additional payment is not needed. By shining a spotlight on what was most important to the state—enhancing outcomes—the state improved how its system performed. Additionally, Oklahoma was able to demonstrate that agencies provided something extra for that money—and those extras were the key to important changes in their system.

Finally, the Oklahoma Enhanced Tier Payment System provides a template for how mental health authorities, substance use authorities, and Medicaid agencies can address mutual goals. Promoting health improvement and aligning financial incentives to pay for outcomes, not simply volume of service provision is essential. The expertise of the mental health and substance use authorities to shape system performance in this area is essential to a state Medicaid program. Medicaid authorities are acutely aware that persons with untreated mental health and substance use issues lead to increased Medicaid costs; and therefore could benefit greatly in partnering with their sister agencies to implement mental health and substance use specific performance benchmarks that improve the system.

APPENDIX A

The Oklahoma State Plan Amendment

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES OTHER TYPES OF CARE

9. Clinic Services (continued)

(e) Supplemental Payments for Behavioral Health Community Networks (BHCN)

Eligibility Criteria

- In order to maintain access and sustain improvement in clinical and nonclinical care, supplemental payments will be made to CMHCs that meet the following criteria:

- Must be a freestanding governmental or private provider organization that is certified by and operates under the guidelines of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center (CMHC) and;

- Participates in behavioral quality improvement initiatives based on measures determined by and in a reporting format specified by the Medicaid agency.

The state affirms that the clinic benefit adheres to the requirements at 42 CFR 440.90 and the State Medical Manual at 4320 regarding physician supervision.

Payment Method

(a) Two supplemental payment pools by type of provider consisting of state governmental and private providers will be established. The payment pools will be calculated based on the difference between 100 percent of the Medicare non facility physician fee schedule and the base Medicaid fee schedule (which is 75 percent of the Medicare fee schedule) multiplied by volume associated with paid claims data from the State's MMIS.
(b) For State fiscal year 2009, State governmental providers will receive 100 percent of the difference between the base Medicaid rate and the payment ceiling, which is 100 percent of the applicable Medicare rate. For State fiscal year 2009, private providers will receive 50 percent of the difference between the base Medicaid rate and the payment ceiling.
(c) Supplemental payment to private providers will be further differentiated, depending on whether the provider is a state designated CMHC. Supplemental payments to CMHC private providers will equal 90 percent of the available payment pool amount as defined in part (b). Supplemental payment to private, non-CMHCs equals the remaining ten percent of the payment pool.

Total pool payments will be made quarterly to the ODMHSAS, for encounters with dates of service associated with paid claims from Oklahoma's MMIS in the prior quarter. The ODMHSAS will make payment to providers. A voluntary reassignment form will be on file.