HB 422: Children's Mental Health Outcomes
Overview of Performance-Based Contracting

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for the Children, Families, Health, and Human Services Interim Committee
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Background

As part of the House Bill 422 study of children's mental health outcomes, the Children, Families, Health, and Human Services Interim Committee is required to review the use of performance-based reimbursement models for providers. Often called “pay for performance” or “performance-based contracting,” these models require providers to undertake specific activities or meet certain benchmarks for services. Often, the provider's payment is linked to whether the standards are met.

This briefing paper provides general information about the use of such models and the various approaches they can take. It also summarizes key provisions of the models that will be discussed at the committee’s Jan. 11 meeting.

Contracting for Performance and Outcomes

The idea of setting performance targets for health care and human services has been around for decades and taken different forms over time. Medical payment models developed by health insurers surfaced as long ago as 1985.[1] Starting in the 1990s, some states began adopting performance-based contracts for child welfare services. More recently, Medicare and some insurance plans are restructuring payment for certain health care services in an effort to improve patient outcomes and reduce costs.

Passage of the federal Adoption and Safe Families Act of 1997 set national standards for the safety, permanency, and well-being of children in foster care. In the late 1990s and early to mid-2000s, many states began to work those standards into contracts for child welfare services.

A 2009 study funded by the Children's Bureau of the U.S. Department of Health and Human Services found that 25 states used performance-based contracting for child welfare services. However, only 14 of the states tied payment to performance. The remaining 11 states used performance data for other purposes, including contract renewal decisions.[2]

Examples of performance-based contracting in other arenas are harder to find. A 2010 survey of more than 9,000 nonprofit groups providing human services found that just 17 percent operated under any type of performance-based contract and an even smaller percentage had contracts tying reimbursement to performance.[3] And a 2008 effort to identify pay-for-performance contracts related to behavioral health found only 24 examples nationwide. Most of the contracts involved private health insurers, rather than government agencies.[4]

“Overall, there is less consensus on and implementation of a common set of quality improvement strategies and measures in behavioral health care than there is in general health

care," the researchers in the 2008 study concluded. Reasons they cited for the lack of consensus included:

- many behavioral health patients measure success of services based on their own personal experiences rather than standards set by someone else;
- the wide range of people licensed to diagnose and treat mental health issues makes it hard to obtain consensus on standards and to require accountability; and
- the means for measuring, analyzing, and improving quality of mental health services are less well developed than they are for physical health care services.

The report summarized the approaches used in the 24 plans that were reviewed. They included a wide range of measures and generally made incentive or bonus payments for meeting the targets. Plans most commonly set targets for:

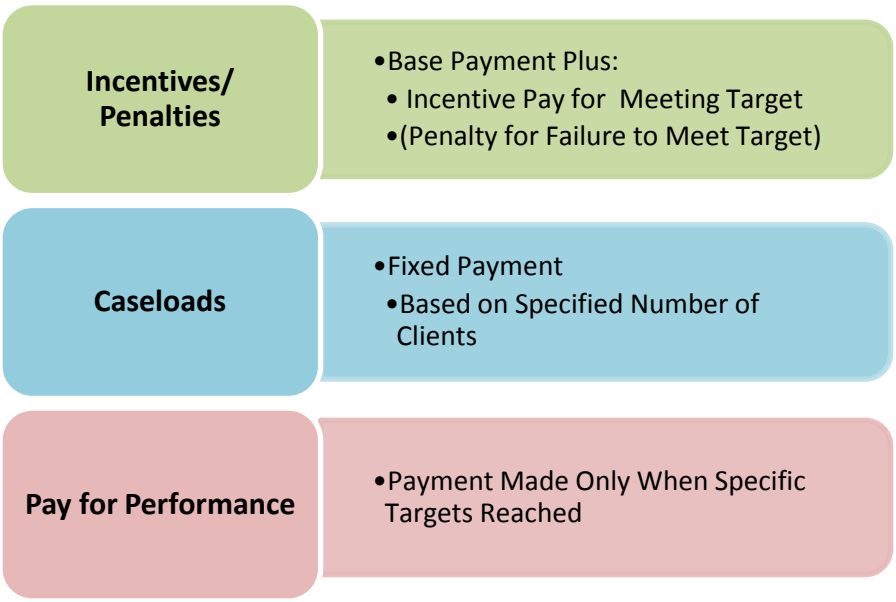
- measuring outcomes through some type of measurement tool;
- assessing a client's condition through use of an assessment tool;
- using an evidence-based practice; or
- keeping a client engaged in treatment.

PBC Models and Their Risks to Providers

Performance-based contracts usually contain requirements for either using certain practices, reaching certain benchmarks, or achieving certain outcomes for clients. In general, the contracts fall into one of three models, with varying levels of risk to the provider, as follows.

- *Incentives and Penalties*: These contracts set a base payment for services and also provide incentive payments for meeting certain performance measures. In some variations, providers must pay a penalty for failure to meet the measures. In this model, providers face little risk because their base payment for services is not affected by their performance on the standards being measured.
- *Caseloads*: In this model, providers are expected to maintain a certain caseload level and are reimbursed for that caseload. If their caseloads exceed the target level, they are not compensated for the additional number of people they're serving. This model contains a moderate level of risk for the provider, who must manage caseloads in order to keep the costs of services from greatly exceeding the contract amount.
- *Pay for Performance*: These contracts pay providers only when they meet specific benchmarks or when clients attain a certain outcome. For example, reimbursement could be made when a child is placed in an adoptive home or when the provider delivers a specified service within a certain number of days. This model places all the risk on providers because they are paid only for meeting the contract targets.

The graphic below illustrates the models and their risk levels to providers.



As states have experimented with these approaches, some have included "hold harmless" clauses in their initial contracts so that providers aren't immediately penalized for failing to meet performance measures. They also have often modified their requirements over time as both government agencies and providers find that the model in use needs to be tweaked to better accommodate a state's particular circumstances.

Lessons Learned Along the Way

Studies of performance-based contracting note the challenges that states have faced in putting these models into place and recommend steps for states to take as they develop such programs. The following items are frequently cited:

- The contracts need clear performance measures.
- Reliable data is needed for evaluation, and all parties must have trust in the way data is collected, analyzed, and reported.
- Penalties and incentives must be clearly stated, and incentives must be large enough to be meaningful.
- Providers should have a role in designing the performance measures and incentives.
- Precautions must be taken to ensure that providers don't take only the easiest-to-serve clients.

Measurement and PBC Efforts in Other States

The table below provides a brief synopsis of key elements of the measurement and performance-based contracting efforts that speakers from other states will discuss at the committee's Jan. 11 meeting.

	Minnesota	Tennessee	Wyoming
Practice Used	Standardized measurement tools at admission, during treatment, and at discharge	Performance-based contracting using incentives and penalties	Tiered payments and ongoing clinical reviews
Services Involved	Children's mental health	Foster Care	Inpatient and outpatient mental health treatment for adjudicated children
What's Measured	Children's initial functioning and progress during treatment	Number of days in care, permanent placement, and readmissions to care	Length of stay in and readmission to residential psychiatric care
Date Started	Pilot: 2006-2008 Statewide: July 1, 2009	Phase 1: 2006 Statewide: July 1, 2009	July 2012
Impetus	Executive branch initiative; subsequent legislative action	Settlement of a lawsuit over child welfare services	Executive branch action
How Developed	Advisory council work group	State contracted with Chapin Hall of the University of Chicago to work with stakeholders on contract targets/design	Creation of a Clinical Services Unit in the Department of Family Services
Use of Data	No formal use yet	To calculate incentive payments and penalties	To track length of stay and readmission into residential treatment
New IT Requirements	Yes	No	No

Endnotes

1. Lucia Francesca Bruno, "Pay-For-Performance Incentives in Healthcare: Purpose, Politics, and Pitfalls," *Physicians News Digest*, May 3, 2012.
2. "Examples of Performance Based Contracts in Child Welfare Services," Planning and Learning Technologies, Inc., The University of Kentucky and The University of Louisville, *Children's Bureau, U.S. Department of Health and Human Services*, July 27, 2009.
3. "New Ideas, New Strategies: Supporting Sustainability with Incentive-Based Financing Strategies," *The Children's Outcomes Project*, 2014.
4. Robert W. Bremer, Sara Hudson Scholle, Donna Keyser, Jeanine V. Knox-Houtsinger, and Harold Alan Pincus, M.D., "Pay for Performance in Behavioral Health," *Psychiatric Services*, Vol. 59 No. 12, December 2008.