Reward for Quality Pilot Program

TWO-YEAR OUTCOMES REPORT

Magellan Behavioral Health of Pennsylvania
Lehigh Valley Care Management Center
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Executive Summary

The state of Pennsylvania, like most states in the country, is struggling to reduce health care costs while continuing to provide essential services to those in need. The growth in the ranks of those on Medical Assistance alone in the past few years has required the development of innovative approaches to bring more flexibility and efficiency to the system in order to maintain needed services.

As the nation’s leading manager of behavioral health services, Magellan Health Services understands the pressures governments face. In Pennsylvania, where Magellan manages the state’s HealthChoices behavioral health program in several counties, we are committed to collaborating with our partners to find ways to positively transform the delivery system.

The goal of the HealthChoices behavioral health program is to improve the accessibility, continuity, and quality of services for Pennsylvania’s Medical Assistance populations, while controlling the program’s rate of cost increases.

During the past two years, Magellan’s Lehigh Valley Care Management Center in Pennsylvania, our Lehigh and Northampton County partners and our network providers have embraced this goal through the development of preferred provider networks and a reward-for-quality approach that utilizes a financial pay-for-performance, value-based contracting strategy. It is an approach we have implemented in multiple pilots that emphasizes and promotes improvement in the quality of care.

The execution of a successful Reward for Quality program is dependent on the ability to measure provider achievement of the desired outcomes in providing quality care. Data and quantifiable metrics are essential. So, each level of care involved in our Reward for Quality program has certain indicators that are assessed, as well as multiple tiers of benchmarks to measure the attainment of goals. All indicators are reviewed quarterly to determine the potential “reward” for quality performance. Claims-based data is used to assess such indicators as:

- Admissions to higher levels of care
- Readmission to same or higher level of care
- Average length of stay
- Ambulatory follow-up rates
- Various clinical best practice measures based upon available data

The care provided to HealthChoices members based on these indicators is then made available to stakeholders through Magellan’s Provider Outcomes Dashboard, a unique web-based tool that further raises the bar for accountability and transparency.

In an environment where patient outcomes have increasingly become the model for judging behavioral health care, this technology provides consumers and their families with data about providers to help them make decisions about their treatment options. Making performance data publicly accessible means individuals are better equipped to select the best provider to fit their needs, which reduces inefficiencies and helps control costs. Providers, too, can access these consumer-based outcomes, which can be used to develop best practices and improve the quality of care they provide.

As you will see on the pages that follow, our Reward for Quality program is an innovative, quality-driven, cost-effective contracting mechanism that promotes—and will continue to promote—the transformation of our delivery system.
Overview of Reward for Quality Pilot Program

Prospective providers were identified based upon a review of specific quality metrics, audit history, and provider performance. Based on this review and analysis, a group of providers were identified for individual discussions.

Meetings were coordinated with each prospective participating provider in October 2009. During these individual sessions, the following elements of the Reward for Quality program were discussed:

- Measurement periods
- Reward payout dates
- Provider selection process
- Provider continued participation standards
- Benchmark data
- Payment criteria and mechanisms
- Individual provider baseline data
- Ongoing meetings

Providers were given the opportunity to review and discuss the information and to ask clarifying questions. Their start date in the pilot program depended upon their completion of the signed partnership consent.

Once the program was underway, data regarding indicators was collected quarterly from participating providers via Magellan’s database and/or via provider submission of information. Providers were also sent a reminder email when their data was due to Magellan for review.

In addition, quarterly meetings were held with participating providers (either in person or telephonically) to discuss program enhancements and/or barriers. This was also an opportunity for the providers to ask any questions, to give feedback to other providers on the implementation of the pilot and to share best practices.

Magellan reviewed provider data on a quarterly basis to determine which, if any, of the indicators were met. The amount of the reward payout was determined by the number of indicators met, which was communicated to providers. Providers who did not qualify for a reward payout were also notified of their outcomes for the quarter.

LEVELS OF CARE

Providers representing five levels of care participated in the pilot:

1. Residential Treatment Facility (accredited by the Joint Commission) [JC-RTF]: This level of care is for members who cannot be safely maintained in an outpatient or community-based setting. JC RTF’s are typically campus-based and provide residential units or cottages of up to 15 youth and are self-contained, meaning they have all of the resources to provide for the member’s educational, social, and mental health, drug and alcohol treatment needs. In RTF, children receive individual, group and family therapy. Medication management is provided by a psychiatrist at the program.

2. Residential Treatment Facility (Not accredited by the Joint Commission) [NJ-RTF]: This level of care is for members who cannot be safely maintained in an outpatient setting. NJ RTFs are located in the community and are smaller (no more than eight residents) self-contained programs, meaning they have all of the resources to provide for the member’s social and mental health, drug and alcohol treatment needs. In RTF, children receive individual, group and family therapy. Medication management is provided by a psychiatrist at the program.

3. Non-Hospital Drug/Alcohol Rehabilitation [Rehab]: This is medically monitored, 24-hour professionally directed evaluation, care and treatment for members who are addicted and in acute distress.

4. Intensive Case Management (ICM) / Blended Case Management (BCM) / Resource Coordination (RC): This level of care involves case management services delivered to the member’s home, residence and/or community setting. The goal is the rehabilitation of behavioral, social, and emotional issues. Case managers help clients become independent with their transportation and appointment needs. This is a time-limited level of care and members should be discharged once they are independent in the community.

5. Partial Hospitalization Program (PHP): This is a therapeutic program within a school setting that can include individual, group and family therapy and medication management.

6. Acute Inpatient Psychiatric (AIP): This is the most intensive level of care within the mental health system. Members are unable to be maintained safely in the community and are a danger to themselves or others. Stays are short-term, and the purpose is to provide emergency treatment with a comprehensive discharge plan to the community.
The goal for this program was to establish and create incentives for achievement of metrics that Magellan, our counties, the state and our providers could track and review on a regular basis. Throughout the initial rollout of this program, it was evident that we also wanted to include non-traditional measurable items as a supplement to the concrete metrics. These measures became the “Clinical Best Practice” of each agreement.

**PROVIDER BENCHMARKS AND RATE STRUCTURE**

The goal of the Reward for Quality pilot program was to establish and create incentives for achievement of metrics that Magellan, our counties, the state and our providers could track and review on a regular basis.

**YEAR ONE: 2009 – 2010**

In year one, five providers returned their signed consents to Magellan to participate in the pilot program. They included:

- One Partial Hospitalization Program (PHP)—This provider had various site locations for this level of care. We chose three site locations for the pilot.
- One Intensive Case Management Program (ICM)
- One Non-Joint Commission Residential Treatment Facility (NJ-RTF)
- One Joint Commission Residential Treatment Facility RTF (JC-RTF)
- One Non-Hospital Drug/Alcohol Rehabilitation Program (Rehab)

The first quarter began in November 2009.

**Year One: Provider Benchmarks**

<table>
<thead>
<tr>
<th>Provider</th>
<th>90-day Readmission Rates</th>
<th>Average Length of Stay</th>
<th>Clinical Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTF</td>
<td>Gold=10%; Silver=13%</td>
<td>Gold=Five months or 150 days; Silver=Seven months or 210 days</td>
<td>Gold=In-home family therapy for a minimum of three times per month; Silver=In-home family therapy for a minimum of two times per month</td>
</tr>
<tr>
<td>Rehab</td>
<td>Gold=5%; Silver=7%</td>
<td>Gold=20 days; Silver=23 days</td>
<td>Gold=Linkages to community programs/services initiated within first 30 days for the member and their support system, as appropriate, with defined disposition as part of treatment plan; Silver=family/support involvement in treatment within 30 days (&gt;75% of admissions)</td>
</tr>
<tr>
<td>ICM</td>
<td>Gold=1%; Silver=2%</td>
<td>Gold=10 months; Silver=12 months</td>
<td>Gold=Incorporate Consumer Health Inventory (CHI) into treatment plan; Silver=Evidence of CHI at intake, six months and discharge</td>
</tr>
<tr>
<td>PHP</td>
<td>Gold=15%; Silver=20%</td>
<td>Gold=120 school days; Silver=140 school days</td>
<td>Gold=Incorporate CHI into treatment plan; Silver=Evidence of use of the CHI at intake, six months and discharge</td>
</tr>
</tbody>
</table>

**Year One: Rate Structure**

<table>
<thead>
<tr>
<th>Tier #</th>
<th>Definition</th>
<th>Rate Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold #1</td>
<td>All three standards met at the Gold level</td>
<td>3.5%</td>
</tr>
<tr>
<td>Gold #2</td>
<td>Two standards met at the Gold level and one standard met at the Silver level</td>
<td>3.0%</td>
</tr>
<tr>
<td>Silver #1</td>
<td>All three standards met at the Silver level or two Silver and one Gold</td>
<td>2.0%</td>
</tr>
<tr>
<td>Silver #2</td>
<td>Two out of three standards met at the Gold or Silver level</td>
<td>1.5%</td>
</tr>
</tbody>
</table>
YEAR TWO: 2010 – 2011

Four of the five providers from year one remained in the program for year two. The goals moving into year two were to leverage our success with specific levels of care and expand our provider group. The expansion ultimately resulted in the addition of three new providers, and an added level of care for an existing provider from year one. The providers in year two included:

- One Partial Hospitalization Program (PHP)—This provider had various site locations for this level of care. We chose three site locations for the pilot.
- Three Intensive Case Management Programs (ICM)
- Two Non-Joint Commission Residential Treatment Facilities (NJ-RTF)
- One Non-Hospital Drug/Alcohol Rehabilitation Program (Rehab)
- One Acute Inpatient Psychiatric Facility (AIP)

As part of our overall analysis of the first year of the program, our conclusions resulted in broadening the provider benchmarks, streamlining the reimbursement structure, and increasing the percentage payouts.

**Year Two: Provider Benchmarks**

When discussing enhancements to the program for year two, Magellan decided to raise the bar and added a fourth indicator for each level of care. Since Magellan had completed the implementation of the Consumer Health Inventory (CHI) and the Consumer Health Inventory-Child (CHI-C) with all in-network case management providers, the CHI/CHI-C indicator for the ICM level of care was replaced with a new one.

Another requirement in year two was the addition of Clinical Practice Guidelines (CPGs) into the program. Providers that were part of this initiative were expected to integrate Magellan’s CPGs into their workflows to assist them in screening, assessing, and treating common disorders. These CPGs are intended to augment, not replace, sound clinical judgment. Magellan’s Quality Improvement department audits providers for adherence to these CPGs.

As a result of analysis in the program’s first year, Magellan: broadened the provider benchmarks; streamlined the reimbursement structure; and increased the percentage payouts.

**RTF**

- AIP Admission Rates: Gold=0%; Silver=10%
- 90-day Readmission rate: Gold=10%; Silver=13%
- Average Length of Stay of Discharged Members: Gold=Five months or 150 days; Silver=Seven months or 210 days
- Clinical Best Practice: Gold=In-home family therapy for a minimum of three times per month; Silver=In-home family therapy for a minimum of two times per month

**Rehab**

- 90-day Readmission Rates: Gold=5%; Silver=7%
- Average Length of Stay: Gold=20 days; Silver=23 days
- Clinical Best Practice: Gold=Assessment of mental health and linkage to mental health treatment 100% of the time; Silver=Assessment of mental health and linkage to mental health treatment 90% of the time
- Clinical Best Practice: Gold=Linkages to community programs/services initiated within first 30 days for the member and their support system, as appropriate, with defined disposition as part of treatment plan; Silver=family/support involvement in treatment within 30 days (>75% of admissions)

**ICM**

- AIP Admission Rates: Gold=1%; Silver=2%
- Readmission rate to AIP: Gold=0% ; Silver=0.5%
- Average Length of Stay of Discharged Members: Gold=12 months; Silver=18 months
- Clinical Best Practice: Gold=ICM will have a face-to-face encounter with member within two days of discharge from AIP or Crisis Residential; Silver=Evidence of coordination with AIP/Crisis Residential staff regarding member treatment/discharge from AIP or Crisis Residential

**PHP**

- AIP Admission Rates: Gold=15%; Silver=20% (Baseline data is 34%)
- Clinical Best Practice: Gold=95% collaboration with community-based/AIP providers for members who receive community-based services/Acute Inpatient services; Silver=90% collaboration with community-based providers for members who receive community-based services
Clinical Best Practice: Gold=Evidence of family therapy two times or more per month; Silver=Evidence of family therapy one time per month

Clinical Best Practice: Gold=95% of discharges are to a lower level of care; Silver=90% of discharges are to a lower level of care

AIP

- 30-day Readmission Rates: Gold =10%; Silver=15%
- Seven-Day Ambulatory Follow-Up (AFU): Gold =90%; Silver=75%
- Child Clinical Best Practice: Gold=Coordination of care to community-based providers within two days of admission to AIP; Silver=Coordination of care to community-based providers within three days of admission to AIP
- Child Clinical Best Practice: Gold=Successful discharge to community-based services 85% of the time; Silver=Successful discharge to community-based services 75% of the time

Clinical Best Practice

- Gold=Evidence of family therapy two times or more per month
- Silver=Evidence of family therapy one time per month
- Gold=95% of discharges are to a lower level of care
- Silver=90% of discharges are to a lower level of care
- Gold=Coordination of care to community-based providers within two days of admission to AIP
- Silver=Coordination of care to community-based providers within three days of admission to AIP
- Gold=Successful discharge to community-based services 85% of the time
- Silver=Successful discharge to community-based services 75% of the time

Year Two: Rate Structure

<table>
<thead>
<tr>
<th>Tier #</th>
<th>Definition</th>
<th>Rate Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>All four standards met at Gold</td>
<td>5.0%</td>
</tr>
<tr>
<td>4</td>
<td>Three standards met at Gold and one standard met at Silver</td>
<td>4.0%</td>
</tr>
<tr>
<td>3</td>
<td>All four standards met at Silver or three Silver standards and one Gold standard are met</td>
<td>3.5%</td>
</tr>
<tr>
<td>2</td>
<td>Three of the four standards are met at any level</td>
<td>3.0%</td>
</tr>
<tr>
<td>1</td>
<td>Two of the four standards are met at any level</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

JC-RTF

The outcomes presented for the JC-RTF are related to year one, as one of the RTF providers did not qualify for this period while the other RTF provider closed its program. Data is presented for the two review periods for which this one provider was eligible.

As the data suggests, the provider enrolled in the Reward for Quality program yielded better results for the 90-day readmission rate, but had a much higher average length of stay when compared to non-Reward for Quality providers. While members may be staying longer in the program, the readmission rates are lower.

### Year Two: Rate Structure

<table>
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<tr>
<th>Tier #</th>
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<tr>
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<td>4</td>
<td>Three standards met at Gold and one standard met at Silver</td>
<td>4.0%</td>
</tr>
<tr>
<td>3</td>
<td>All four standards met at Silver or three Silver standards and one Gold standard are met</td>
<td>3.5%</td>
</tr>
<tr>
<td>2</td>
<td>Three of the four standards are met at any level</td>
<td>3.0%</td>
</tr>
<tr>
<td>1</td>
<td>Two of the four standards are met at any level</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

**Clinical Best Practice**

The indicator for this level of care in this category was not able to be assessed, as supporting documentation was not available. During the quarterly meetings potential barriers to addressing this indicator were discussed.
NJ-RTF

90-Day Readmission Rate
Utilizing the same time period as for the JC-RTF, the 90-day readmission rate for the NJ-RTF provider enrolled in the program was 0%, while non-Reward for Quality providers had a rate of 16.67%.

<table>
<thead>
<tr>
<th></th>
<th>NJ-RTF Provider</th>
<th>Non-R4Q Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ-RTF Average Length of Stay (ALOS)</td>
<td>124</td>
<td>214.88</td>
</tr>
</tbody>
</table>

ALOS
Again, utilizing the same time period as for the JC-RTF, the ALOS for the NJ-RTF provider enrolled in the program was 124.00 days, while non-Reward for Quality providers had a rate of 214.88 days.

<table>
<thead>
<tr>
<th></th>
<th>NJ-RTF Provider</th>
<th>Non-R4Q Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ-RTF 90-Day Readmission Rates</td>
<td>0%</td>
<td>16.67%</td>
</tr>
</tbody>
</table>

Clinical Best Practice
The indicator for this level of care in this category was not able to be assessed, as supporting documentation was not available. During the quarterly meetings potential barriers to addressing this indicator were discussed.

Rehab

90-Day Readmission Rate
For the time period 4/1/11 to 6/30/11, the 90-day readmission rate for the rehab provider enrolled in the program was 0.0%, while non-Reward for Quality providers had a rate of 14.29%.

<table>
<thead>
<tr>
<th></th>
<th>R4Q Provider</th>
<th>Non-R4Q Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab 90-day Readmission Rates</td>
<td>0%</td>
<td>14.29%</td>
</tr>
</tbody>
</table>

ALOS
For the time period 4/1/11 to 6/30/11, the ALOS for the rehab provider enrolled in the program was slightly higher at 33.67 days when compared to the other providers at 30.29 days. While the Reward for Quality provider had a slightly higher ALOS, it had no readmissions within 90 days.

Clinical Best Practice
The rehab provider involved in the program incorporated a thorough mental health assessment into the intake process, which allowed for a more comprehensive treatment approach and appropriate linkages to aftercare providers upon discharge. Technical assistance was provided to the provider in a collaborative way to efficiently capture this information. In the most recent two measurement periods, the provider’s outcomes in the second clinical best-practice measure of family involvement increased by five percentage points (from 57% to 62%). This is beneficial to members in that their families are more involved in their treatment.

ICM

Admission Rate to AIP
For the time period 4/1/11 to 6/30/11, the admission rate to AIP for the three ICM providers enrolled in the program was 3.63%, while non-Reward for Quality providers had a rate of 3.88%.

<table>
<thead>
<tr>
<th></th>
<th>R4Q Providers</th>
<th>Non-R4Q Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICM Admission Rates to AIP</td>
<td>3.63%</td>
<td>3.88%</td>
</tr>
</tbody>
</table>

30-Day Readmission Rate to AIP
For the time period 4/1/11 to 6/30/11, the 30-day readmission rate to AIP for the three ICM providers enrolled in the program was 0.67%, while non-Reward for Quality providers had a rate of 0.52%. While the Reward for Quality providers had a slightly lower admission rate to AIP, their 30-day readmission rate is a bit higher than the non-Reward for Quality providers.

<table>
<thead>
<tr>
<th></th>
<th>R4Q Providers</th>
<th>Non-R4Q Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICM 30-Day Readmission Rates</td>
<td>0.67%</td>
<td>0.52%</td>
</tr>
</tbody>
</table>
ALOS
In the most recent two measurement periods, one of the ICM providers decreased its own ALOS of discharged members from 14.2 months to 13.1 months. A second ICM provider decreased its ALOS of discharged members from 44.7 months to 19.2 months. The third ICM provider did not submit appropriate data for this measure to be calculated.

By having the providers focus on this indicator, they are more cognizant of the amount of time a member is receiving services in this level of care and assessing the appropriateness of this level of care. Magellan’s implementation of the Consumer Health Inventory (CHI) and Consumer Health Inventory-Child (CHI-C) may also have attributed to the decrease in the ALOS, as both focus on obtaining members’ perceptions of their own well-being and issues they would like to address.

Clinical Best Practice
All three ICM providers involved in the program had evidence of coordination of care with inpatient mental health and/or crisis residential providers when their members were admitted to these levels of care. Magellan provided technical assistance regarding the appropriate documentation of these encounters via the quarterly meetings.

PHP
AIP Admission Rate
This provider’s three sites with the highest rates of admission to AIP were all involved in the Reward for Quality program, so a comparison was made of the outcomes at these sites from year one to year two. Year one data shows a decrease and then a consistent trend in admissions to AIP, while year two showed a continued decrease in admissions to AIP.

AIP (Children and Adolescents only)
30-Day Readmission Rate
For the time period 4/1/11 to 6/30/11, the 30-day readmission rate for the child and adolescent AIP provider enrolled in the program was 4.40%, while non-Reward for Quality providers had a rate of 20.31%.

Seven-Day Ambulatory Follow-Up (AFU)
The child and adolescent AIP provider began participation in the program in review period three of year two. As the graph below indicates, the provider increased its seven-day ambulatory follow-up rate from review period three to review period four, and even exceeded the Office of Mental Health and Substance Abuse Services (OMHSAS) gold standard of 90% during review period four.

AIP 30-Day Readmission Rates

Non-R4Q Providers
R4Q Provider

AIP 7-Day Ambulatory Follow-Up

Gold Standard
Review Period 3
Review Period 4

90%
87.9%
98%

AIP 7-Day Ambulatory Follow-Up

Gold Standard
Review Period 3
Review Period 4

90%
87.9%
98%

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Clinical Best Practice
For the two measurement periods for which the provider participated in the program, evidence of both clinical best-practice indicators was provided. From the first to the second review period, the provider remained consistent in the coordination of care with community-based providers within three days of admission to AIP. The goal is to have the provider achieve the gold standard of two days or less. For the second indicator of discharge to community-based providers, the provider increased from 75% in review period one to 85% in review period two.

Financial Outcomes
The estimated additional revenue earned by NJ-RTF providers for year one was $15,671.74, while for the PHP provider the revenue was $4,260.06.

In year two, the rate structure payout amounts were increased. The estimated additional revenue payout for NJ-RTF was $11,957.62, which is less than year one given the provider who qualified for the payout only qualified for two of the four quarters in year two. The estimated additional payout for the PHP in year two was $9,859.92, which is more than double the year one amount.

The rehab provider’s estimated additional payout was $15,882.00 for year two; while the three ICM providers’ payout was $25,915.00. The AIP provider who joined the program in quarter three of year two had an estimated payout of $53,271.00.

As the data demonstrates, the end result to this collaborative effort was increased revenue for the participating providers.

R4Q YEAR ONE PAYOUTS

<table>
<thead>
<tr>
<th>LOC</th>
<th>Year</th>
<th>Quarter</th>
<th>Rate Increase</th>
<th>Standard</th>
<th>Projected Additional Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ RTF</td>
<td>1</td>
<td>1</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$3,955.07</td>
</tr>
<tr>
<td>PHP</td>
<td>1</td>
<td>1</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$1,674.96</td>
</tr>
<tr>
<td>NJ RTF</td>
<td>1</td>
<td>2</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$4,438.97</td>
</tr>
<tr>
<td>PHP</td>
<td>1</td>
<td>2</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$1,365.84</td>
</tr>
<tr>
<td>NJ RTF</td>
<td>1</td>
<td>3</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$7,277.70</td>
</tr>
<tr>
<td>PHP</td>
<td>1</td>
<td>3</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$1,219.26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>TOTAL:</strong> $19,931.80</td>
</tr>
</tbody>
</table>
### R4Q YEAR TWO PAYOUTS

<table>
<thead>
<tr>
<th>LOC</th>
<th>Year</th>
<th>Quarter</th>
<th>Rate Increase</th>
<th>Standard</th>
<th>Revenue by Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHP</td>
<td>2</td>
<td>1</td>
<td>3.50%</td>
<td>3 gold</td>
<td>$3,113.46</td>
</tr>
<tr>
<td>NJ RTF</td>
<td>2</td>
<td>1</td>
<td>1.50%</td>
<td>2 gold</td>
<td>$6,321.62</td>
</tr>
<tr>
<td>NJ RTF</td>
<td>2</td>
<td>2</td>
<td>2.50%</td>
<td>2 gold</td>
<td>$5,636.00</td>
</tr>
<tr>
<td>Rehab</td>
<td>2</td>
<td>2</td>
<td>2.50%</td>
<td>1 silver &amp; 1 gold</td>
<td>$5,636.00</td>
</tr>
<tr>
<td>ICM</td>
<td>2</td>
<td>2</td>
<td>2.50%</td>
<td>1 silver &amp; 1 gold</td>
<td>$4,831.00</td>
</tr>
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**TOTAL:** $116,885.54

### Testimonials

#### IU 20-PARTIAL HOSPITALIZATION PROGRAM

Overall, our experience in the Reward for Quality program has been positive and the rollout to our staff was quite simple. In the beginning, I went out and met individually with each of the teams that were to participate in this project.

I explained to them that this was an opportunity for them to take credit for the good work they do every day with the very challenging kids that come to these programs. I say ‘take credit’ because the data points that were to be measured (discharges to lower levels of care, minimizing admittance to inpatient or residential, number of family therapy sessions, coordination of care with outside agencies, use of evidence-based practices and measuring consumer/family satisfaction) were all beliefs/practices that the Partial at IU 20 already subscribed to. I’m sure this had a significant impact on our level of success.

We appreciated the opportunity to share our work.

*Jim McDonald, LSW Clinical Supervisor, Resolve Services*
PA MENTOR-INTENSIVE CASE MANAGEMENT

Pennsylvania Mentor was nominated as one of the providers of choice by Magellan Behavioral Health, so we were excited to participate in the Reward for Quality program. Our experience in the program has been very positive, and we have been able to recognize some areas of improvement.

Our length of stay has decreased since the start of the program, and we have reassessed the needs of clients who have been in the program for more than two years. We have also been able to encourage and motivate our clients when working toward discharge and seeking out their natural supports in order to ensure a successful and smooth transition to a less intensive service.

We recognized a pattern of hospitalizations with certain clients and have put systems in place to be able to monitor the frequency of hospitalizations. The ICM/RC Supervisor is tracking incident reports on a monthly basis, and once we recognize a client with a pattern of hospitalizations, there is a team meeting scheduled between the ICM, supervisors and other supports or agencies involved in the case. Included in the team meeting is the development of a comprehensive crisis plan that will assist the client in utilizing all interventions prior to being admitted to the hospital.

These systems are now integrated into our existing departmental procedures, and our team has responded with positive feedback.

Stacey Dean, UR Non-Residential Services

PYRAMID-NON-HOSPITAL DRUG AND ALCOHOL REHABILITATION

Overall, our experience with the Reward for Quality program has been very positive. The implementation process was very easy because the quality measures that Magellan was looking for coincided with our internal Performance Improvement measures. This made data collection and submission fairly easy because we gather the information requested, along with other indicators, on a monthly basis through our PI efforts.

In addition to the ease of data collection, I believe that the program has also had a positive impact by raising the awareness of certain quality measures with all direct care staff. The Reward for Quality program further emphasizes our internal goals and provides an additional incentive for reaching these goals.

Pyramid Healthcare would like to thank Magellan for allowing us to be a part of this program, and we look forward to a continued partnership in the future. Our mutual goal is to provide the highest quality services for those in need to assist them with success on their road to recovery.

Jason Hendricks, Vice President of Operations
Conclusion

The development of a Reward for Quality program has proven to be a valuable tool in increasing overall transparency with outcomes data and increasing provider awareness of standard outcome metrics. Providers who participated in the pilot program performed better than a comparable provider group in key indicators such as readmission rates and ambulatory follow-up. Overall provider performance in our two-year pilot yielded the following:

- Reward for Quality providers (JC-RTF, NJ-RTF, Rehab, AIP) had lower readmission rates than providers not involved in the program.
- The NJ-RTF provider in the Reward for Quality program also had a lower ALOS than the non-Reward for Quality providers.
- The Reward for Quality JC-RTF and Rehab providers had longer average lengths of stay compared to the non-Reward for Quality providers; however, the Reward for Quality providers had considerably lower readmission rates.
- The three Reward for Quality ICM providers had lower AIP admission rates than the non-Reward for Quality providers.
- Reward for Quality ICM and PHP providers showed a downward trend in average length of stay.
- The children and adolescent AIP provider in Reward for Quality increased in the seven-day ambulatory follow-up indicator, even exceeding the OMHSAS gold standard during one measurement period.
- The total estimated payouts for all providers in both years were $136,817.34 (Year one: $19,931.80; Year two: $116,885.54).
- The PHP provider was the only provider that received a payout in all seven quarters, receiving an additional $14,119.98.

Next Steps

Magellan’s provider network is a key asset in delivering on our goals of managing high-quality care for our members. Ongoing investment and engagement with these key partners is critical to ensuring alignment of provider incentives on payment to achieve quality goals. For this reason, we plan to further expand upon the Reward for Quality program in a number of key ways:

- Develop payment methodologies that represent our goal to move toward a “preferred provider” model, and support programs with both financial incentives and reduced administrative burdens for superior performance and outcomes.
- Enhance provider profiling capabilities to assist in the identification of a high-performance network and begin to select network providers based on quality.
- Implement alternative provider payment arrangements and creative payment models that incent providers and reward for high quality.
- Explore the development and implementation of an incentive program that focuses on improved outcomes for individuals with serious mental illness or serious emotional disturbances that have a high risk of needing intensive levels of care.
- Focus provider agencies on employing evidence-based practices to further increase the opportunity for positive consumer outcomes and ensure clinical excellence. These may consist of, but are not limited to: Peer Services, Wellness Recovery Action Planning (WRAP), Comprehensive Continuous Integrated Systems of Care (CCISC), Wraparound Services, Medication Assisted Treatment, and Motivational Enhancement Therapy.