Financial Incentives and Provider Reimbursement						
Policy #	**Policy Recommendations**	**Current State**	**Barriers**	**Required Change/ Recommended Action**	**Due Date**	**Status**
13.1	As MDHHS and its contracted Medicaid payers implement financial incentives, the incentives should be designed to accomplish the following objectives, while addressing concerns expressed by consumers to ensure that incentives will not result in reduced care, access or appropriate utilization.	Current CMHSP and PIHP contracts have a performance-based payment withhold that can be earned if process measures are met. Medicaid health plans are incentivized to improve performance on a standard set of quality metrics that are aligned with federal and national guidelines using a capitation withhold bonus. MHPs are required to incorporate quality metrics in provider payment methodologies, and incentivized to do so. The primary issue associated with the policy recommendation as written is the lack of connections to quality within provider payment models. MDHHS is providing guidance to MHPs for incorporating existing quality metrics into provider payment models, and align incentives around disproportionately low performing measures by regional service area.	Current PIHP savings is limited so an earned incentive may not be retained in some cases. Note: Additional barrier detail is provided on the planning worksheet.	1) MDHHS will review and evaluate the need for contract changes related to use of financial incentives and value -based payment models. 2) MDHHS will evaluate the need for, and consider adding, broad language to the MHP and PIHP contracts to support and clarify incentive payments to providers. This recommendation and planning should be aligned with action planning on shared metrics.	10.1.19	In Process
2.a.5.	MDHHS should pilot value-based payment models that incentivize harm reduction and long-term recovery outcomes and adopt successful models statewide. **Moved from Substance Abuse**	The group provided an overview of harm reduction activities in Michigan, which includes support for needle exchange programs and distribution of Narcan. The group noted the current limitations in terms of federal funding for these activities and explained that federal funding cannot directly be used to procure syringes but can be used to provide other support services. The group also indicated that SAMHSA has not issued any final guidelines on this issue. The group also explained that PA2 funding is fungible and can potentially be used to support harm reduction activities. The group explained that Michigan currently offers services through inpatient residential services but that there are still barriers to providing recovery housing. The group noted that some of these barriers are based upon licensure while others are based on financing of Medication Assisted Treatment programming. The group noted that MSHDA has provided funding to support housing units for recovery housing but that some of the other barriers have stymied progress on this issue. PIHPs currently have broad flexibility through a sub-capitation model to use value-based payment methodologies.		1) MDHHS will review and evaluate the need for contract changes related to use of value -based payment models. This recommendation and planning should be aligned with action planning on shared metrics.	4.2018 for FY19 contracts	In Process

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2.a.7.	MDHHS should incentivize the health care system to more effectively integrate, coordinate, co-locate and/or provide substance use disorder services. **Moved from Substance Use Disorders**	Current grant incentives to co-location of services MDHHS has integrated SUD funding with MH funding by transitioning to PIHPs. This is intended to increase integration of SUD and MH services. BHDDA, OROSC has incentivized integration through: • Providing SBIRT training to FQHCs and working to set up "health home" models in FQHC via partnership with OBOT and OTPs to integrate treatment for opioid addiction with PH services. • Proposal to use funding to develop Opioid Health Homes in Region 2 using the HUB-SPOKE Model for MAT developed in Vermont. • STR funding is being used to (via PIHPs) to incentivize hospitals to conduct SBIRT and "warm hand off referrals" from Emergency Departments. MSA has utilized PA 107 of 2013 withholds to incentivize reductions in ED utilizations. MHPs have reported on this (with bonus implications). Moving forward, new three year plans are being developed that must address this through specific causes, either Behavioral Health, SUD, or Dental. Several MHP plans are addressing SUD related ED utilization. This will continue to be addressed through contractual requirements to develop alternative payment methodologies and through additional quality measure. The Shared Metrics Work Group has developed several opioid related measures that will be applied to both MHPs and PIHPs. The intent is to use these to drive improvements. This is still in development.	Funding for expansion of current efforts	1) MDHHS will continue current efforts to more effectively integrate, coordinate, co-locate and/or provide services. 2) MDHHS will establish a means to track and report integrated care efforts and models, including any use of incentives.	Ongoing FY18	In Process