VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Tuesday, May 31, 2016; 11:00 PM to 12:30 PM

Pavilion Building 4th Floor Conf Room, Montpelier

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	11:00 – 11:05	**Welcome** Deborah Lisi-Baker	• Attachment 1: Meeting Agenda	
2	11:05 – 12:15	**Follow-up Discussions:** **1. All Payer Model & Medicaid Pathway** Michael Costa and Selina Hickman **2. DLTSS Payment Reform Initiative** Scott Wittman, Suzanne Santarcangelo, PHPG	• Attachment 2a: All Payer Model and Medicaid Pathway • Attachment 2b: Vermont Integrated Care Model & Payment Reform Planning	
3	12:15 – 12:30	**Public Comment** Deborah Lisi-Baker	Next Meeting: Thursday, July 7, 2016 • 10:00 am – 12:30 pm, Waterbury State Office Complex, Ash Conference Room, Waterbury	

Attachment 2a: All Payer Model and Medicaid Pathway

MEDICAID PATHWAY

INTEGRATED HEALTH SYSTEM UPDATE 5/25/16

KEY QUESTIONS FOR TODAY

1. What is the Medicaid Pathway?
2. Delivery system transformation:
    1. Goals
    2. Scope
    3. Organization
3. Next Steps

WHY IS THERE A MEDICAID PATHWAY?

- The All Payer Model is focused on an ACO delivery model for services that look like Medicare part A & B.
- The majority of Medicaid paid services (about 65%) are not equivalent to Medicare part A & B and/or will not be included in the initial ACO delivery model.
- To get to a truly integrated health system, AHS has to commit to delivery and payment reform for the 65% of cost that is not addressed yet through the all-payer model.

THE PROJECT IN PERSPECTIVE

Big Goal:

Integrated health system able to achieve the triple aim

- ✓ Improve patient experience of care
- ✓ Improving the health of populations
- ✓ Reduce per capita cost

Implement Next Generation-type ACO:

- Way to pursue goal of integrated system for certain services and providers.
- Enables Medicare, Medicaid and Commercial Payers to align value based payments for health care.
- Subject to additional regulation and caps on total spending.

Medicaid Pathway:

- Way to pursue goal of integrated system for services and providers outside of the financial caps of all-payer model.
- Enables Medicaid to align value based payment models with All Payer and ACO design.
- Subject to legislative caps on spending.

CRITICAL TAKE-AWAY:

The regulated revenue and financial cap deal with the feds and DVHA's implementation are part of the all-payer model and reforms, not the whole ballgame for payment and delivery system reform.

WHAT IS THE MEDICAID PATHWAY?

- The Medicaid Pathway is a Process.
- The process is facilitated by the State of Vermont and includes Medicaid service providers who provide services that are not wholly included in the initial APM implementation, such as LTSS, mental health, substance abuse services and others.
- The Medicaid Pathway advances payment and delivery system reform for services not subject to the additional caps and regulation required by the APM. The goal is alignment and integration of payment and delivery principles that support a more integrated system of care.

STEPS IN THE MEDICAID PATHWAY PROCESS

1. **Delivery System Transformation (Model of Care)**
   - What will providers be doing differently?
   - What is the scope of the transformation?
   - How will transformation support integration?
2. **Payment Model Reform (Reimbursement Method, Rate Setting)**
   - What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
   - Rate setting to support the model of care, control State cost and support beneficiary access to care
   - Incentives to support the practice transformation
3. **Quality Framework (including Data Collection, Storage and Reporting)**
   - What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?
4. **Outcomes**
   - Is anyone better off?

SOV provides support with readiness assessment, resources and technical assistance

DELIVERY SYSTEM TRANSFORMATION

COMPARISON OF NATIONAL EVIDENCED-BASED MODELS				
Core Elements Vermont Model *	Commission on Long-Term Care, September 2013 Report to Congress	CCBHC Model	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	(peer)		✓
Actively Involved Primary Care Physician		(coordinated)	✓	
Provider Network with Specialized Program Expertise	✓	✓	✓	✓
Integration between Medical & Specialized Program Care	✓	✓	✓	✓
Single Point of Contact for person with Specialized Needs across All Services	✓		✓	
Standardized Assessment Tool	✓			✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services			✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓
*** Elements Fully Align with CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care**				

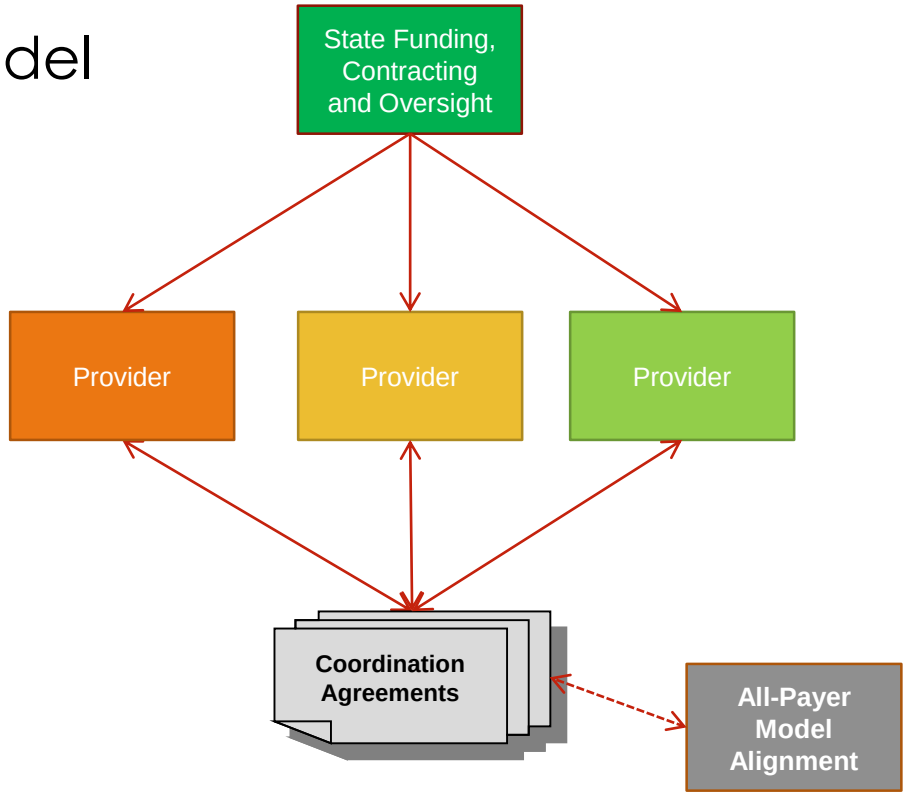
SCOPE OF THE MODEL- GROUP 1

Scope may change over time based on model discussions and findings. Current scope for work group planning includes:

- DMH Funded:
  - Adult and Children's MH services (Excluding Success Beyond Six, PNMI)
  - Emergency MH services
  - CRT
- ADAP & DMH Funded Substance Abuse Treatment & Recovery Services
- DAIL Funded Developmental Disability Services
- IFS Involved Services (CIS tbd)

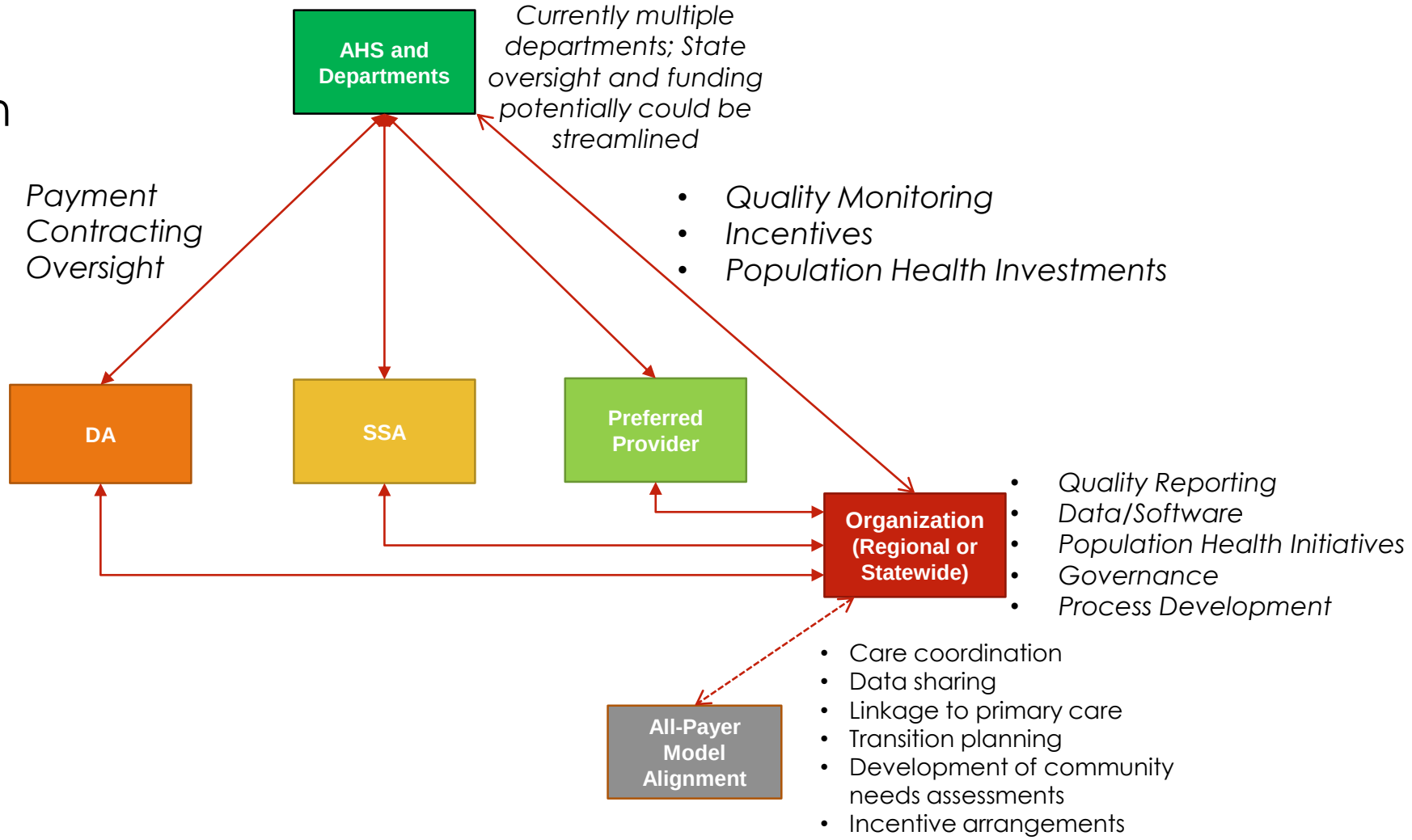
ORGANIZED DELIVERY SYSTEM OPTIONS

- Service Coordination Model



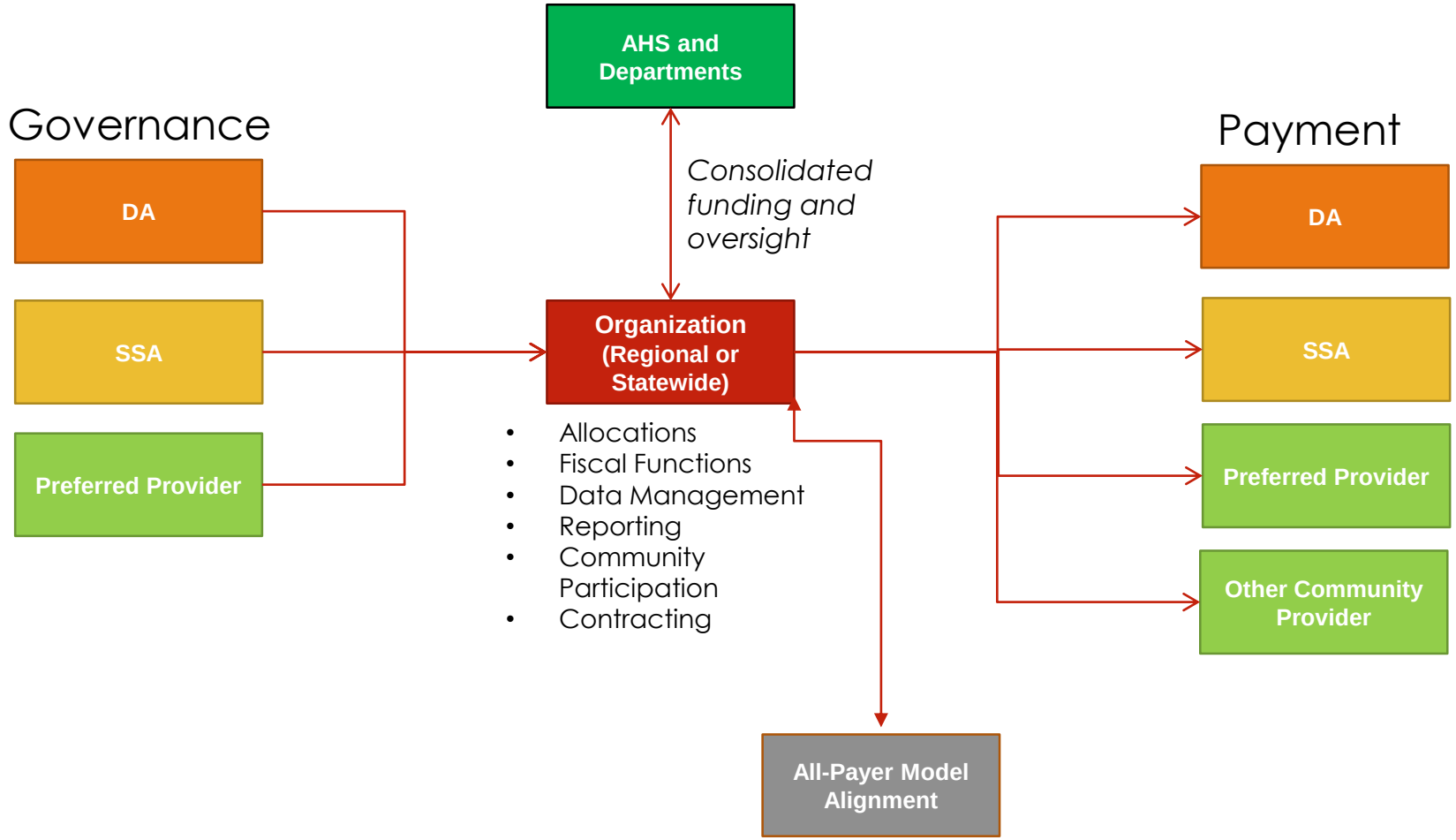
ORGANIZED DELIVERY SYSTEM OPTIONS

- Partial Integration



ORGANIZED DELIVERY SYSTEM OPTIONS

- Integration Model



Similar to the VCRHYP, IFS and CIS Delivery Models

NEXT STEPS

- Finalize Payment Reform Elements – June ‘16
- Develop Quality Framework – June/July‘16
- Evaluate infrastructure and funding requirements- June/July‘16
- Stakeholder feedback loop- ongoing
- Finalize Delivery System Design- July‘16
- Implementation planning- July-December‘16

- Implementation- July 2017

Attachment 2b: Vermont Integrated Care Model & Payment Reform Planning

Stakeholder Update & Discussion: VT Integrated Care Model & Payment Reform Planning

PHPG Presentation for DLTSS Work Group Discussion
April 7, 2016.

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

Discussion Topics & Goals

- Medicaid Pathway Planning
- Delivery System Transformation
  - Goals and Principles
  - Elements of Transformation
  - Vermont Integrated Model of Care
  - Objectives
- Alternatives to Fee-for-Service Payment Models
- Opportunities for Payment Reform to Support Delivery Reform
  - Design Considerations
- Status and Next Steps

Medicaid Pathway Planning

Medicaid Accountable Care Organization (ACO)

- Aligned with Medicare Part A and B Services (Physicians, Hospitals, Outpatient Services)

Mental Health, Substance Abuse Treatment and Developmental Services

- Designated/Specialized Agency & Alcohol and Drug Treatment Preferred Provider Delivery System Transformation

LTSS - Choices for Care

- Under Construction

Goals & Principles

- **Ensure Access to Care for Consumers with Special Health Needs**
  - Access to Care includes availability of high quality services as well as the sustainability of specialized providers
  - Ensure the State's most vulnerable populations have access to comprehensive care
- **Promote Person and/or Family Centered Care**
  - Person and/or Family Centered includes supporting a full continuum of traditional and non-traditional Medicaid services based on individual and/or family treatment needs and choices
  - Service delivery should be coordinated across all systems of care (physical, behavioral and mental health, and long term services and supports)
- **Ensure Quality and Promote Positive Health Outcomes**
  - Quality Indicators should utilize a broad measures that include structure, process, and experience of care measures
  - Positive Health Outcomes include measures of independence (e.g. employment and living situation) as well as traditional health scores (e.g. assessment of functioning and condition specific indicators)
- **Ensure the Appropriate Allocation of Resources and Manage Costs**
  - Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences of decisions in one area made in isolation of other factors
- **Create a Structural Framework to Support the Integration of Services**
  - Any proposed change should be goal directed and promote meaningful improvement
  - Departmental structures must support accountability and efficiency of operations at both the State and provider level
  - Short and long term goals aligned with current Health Care Reform efforts

Elements Of Transformation

- **Delivery System Transformation (Model of Care)**
  - What will providers be doing differently?
  - What is the scope of the transformation?
  - How will transformation support integration?
- **Payment Model Reform (Reimbursement Method, Rate Setting)**
  - What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
  - Rate setting to support the model of care, control State cost, and support beneficiary access to care
  - Incentives to support the practice transformation
- **Quality Framework (including Data Collection, Storage and Reporting)**
  - What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?
- **Outcomes**
  - Is anyone better off?
- **Readiness, Resources, and Technical Assistance**

VT Integrated Model of Care

- Created by DLTSS Work Group and agreed upon by stakeholders as foundational to reform efforts
- Adopted by Practice Transformation Work Group and utilized to inform transformation activities
- Foundational to Mental Health, Substance Abuse Treatment, Developmental Services, Choices for Care, and Accountable Care Organization discussions
- Vermont Specialized Programs support many of the model of care elements.
  - How can this reform effort preserve and enhance our ability to incorporate all elements across the health care delivery system?

VT Integrated Model of Care

Core Elements	Current Vermont DLTSS Models	Payment Reform Opportunities
Person-Centered and -Directed Process for Planning and Service Delivery	✓	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services
Access to Independent Options Counseling & Peer Support	✓	Organized model could support multi-payer expansion of capacity of cost effective supports and services
Actively Involved Primary Care Physician	Variable	Payment flexibility for care coordination services could support interaction with PCP; Organized model could enable single clinical record, physician supports and training
Provider Network with Specialized Program Expertise	✓	Organized model could support multi-payer expansion of capacity and planning across the full continuum of services
Integration between Medical & Specialized Program Care	Variable	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services
Single Point of Contact for person with Specialized Needs across All Services	Variable	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services; opportunity to develop training protocols/best practices across care management entities
Standardized Assessment Tool	✓	Tool could be modified to include all medical and functional needs
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services	Variable	Payment flexibility could expand range of services available to meet individual needs
Care Coordination and Care Management	✓	Organization and flexibility could create opportunities for integrated care coordination
Interdisciplinary Care Team	Variable	Organization and flexibility could create opportunities for integrated teaming such as Blueprint and other models
Coordinated Support during Care Transitions	Variable	Organized model could enhance communications and training
Use of Technology for Sharing Information	Variable	Organized model could facilitate integrated clinical record
* Elements Fully Align with CMS & National Committee for Quality Assurance DLTSS Model of Care		
✓ Currently required or supported through State or Federal Rule and/or Specialized Program Policies		

Objectives

- Develop an organized delivery system for serving individuals with specialized health service needs and promote integration of:
  - Physical Health
  - Mental Health
  - Substance Abuse Treatment
  - Long-Term Services and Supports
- The organized delivery system will support:
  - Vermont's Model of Care
  - Payment Reform, including value based purchasing
  - Service Delivery Reform, including population-based health and prevention, quality improvement and development of best practices
  - Medicaid Pathway and All-Payer Model (APM)
  - Efficient Operations and Oversight

Alternatives to Fee-for-Service

Alternative payment models historically have been used in Vermont to support desired models of care/delivery system reform for disability-specific services:

- Developmental Disabilities Services (DAIL)
- Community Rehabilitation & Treatment Services (DMH)
- Success Beyond Six - Clinicians in Schools (DMH)
- Enhanced Family Treatment (DMH)
- IEP Related School Health Services (AOE)
- Jump On Board for Success (JOBS) - Adolescent Supported - Employment (DMH/VR)
- Runaway/Homeless Youth Crisis Stabilization Services (DCF)
- Children's Integrated Services (DCF)
- Integrating Family Services (AHS)
- Medication Assisted Treatment Services (DVHA/ADAP)

Alternatives to Fee-for-Service

Potential Benefits	Potential Risk	Mitigation Strategies
Providers have flexibility to decide on necessary services. Reduces the incentive to overuse or provide unnecessary services. Allows providers to address prevention and also supports use of non-traditional services based on a person's unique treatment and/or support plan needs.	**Payer/Beneficiary Risk** *Underutilization* • May create incentive to provide the lowest level of care possible or delay care until after the end date of the bundled payment. • Avoidance of high-risk (potentially more expensive) individuals. *Under/Over Diagnose* • Not diagnose complications of a treatment before the end date of the bundled payment. • Over diagnosed cases to draw down case rate payments for an increased number of recipients. *Over or Other Utilization* • Increasing the number of bundles provided (e.g., encouraging surgery for individuals who are ambivalent between medical management and surgical treatment options). • Moving services in time or location to qualify for separate reimbursement ("unbundling") **Provider Risk** • Case Rate set to low to support complex needs • Unanticipated need drives costs higher than expected (e.g., natural disaster, under reported need).	**Quality Oversight & Measurement Strategies** *Outcome Tracking* - Delayed or low level care could lead to poor outcomes, tracking positive outcomes mitigates risk. *Utilization monitoring* - Using encounter data (i.e., information on the date and type of service rendered) to look for trends. Encounter data may include service type and location, wait times, dates of service, and client characteristics such as health status, diagnosis, other related conditions, experience of care and progress. *Recipient Experience* of Care Measures (Survey) Grievance and appeal (Trend Analysis) Critical Incident Data (Provider Report) – Using data to look for trends within or across providers that signal potential problems or support reports of consumer satisfaction. *Best Practice Guidelines* – Measuring provider fidelity to best practice **Process and Structure Strategies** Use of independent ombudsmen Desk audits and chart reviews **Financial Strategies** Retrospective adjustment to payment for positive or negative performance on any of the above Incentive payments in addition to the bundled payment.

Payment Reform Options

Option	Opportunities	Operational Considerations	
		MH/SAT/DS Alignment	LTSS/Choices for Care
Community, Population Based or Global Budget Develop total budget by community and require providers to collaborate in order to manage to budget.	• Maximizes flexibility to develop service options that meet individual needs • Could promote early intervention/prevention • Payments could be tied to performance • Creates more predictable funding level	• Would require organized delivery system across full array of services included in scope of services • Could be perceived as a model that "caps" specialized services	• Communities have relatively large numbers of community providers; would require high level of organization at community level
Case Rates Develop daily/weekly/monthly rates per enrollee (e.g. per member per month or PMPM) Rate could vary based on program or need.	• Provides additional flexibility to develop individualized service packages • Payments could be linked to performance rather than volume	• Some programs currently have case rates • Payment tied to active program participation • Potential service may overlap with APM (depending on scope of services)	• Diversity of delivery network may require development of complex risk adjustment model
Individual Budgets Develop individual budgets based on need.	• Care planning process/providers would have flexibility to offer alternative services • Payments could be tied to performance, depending on level of organization at the community level	• Would require development of complex needs assessment process and risk adjustment model • Less effective approach for promotion of early intervention/prevention	• Would require development of complex needs assessment process and risk adjustment model • Payments underlying budget may continue to be paid on fee-for-service basis
Care Coordination Case Rates/Enhanced Care Coordination Payments Develop payment model for care coordination that is fully compliant with Model of Care.	• Provides additional flexibility at the community level to coordinate care and adhere to Model of Care requirements • Funding potentially could be derived from projected savings/ACO	• Care coordination services reimbursed as part of current case rate models • Other approaches offer additional flexibility to promote service delivery reform and value-based purchasing	• Other approaches offer additional flexibility to promote service delivery reform and value-based purchasing

Design Considerations

What operational elements best support reform objectives?

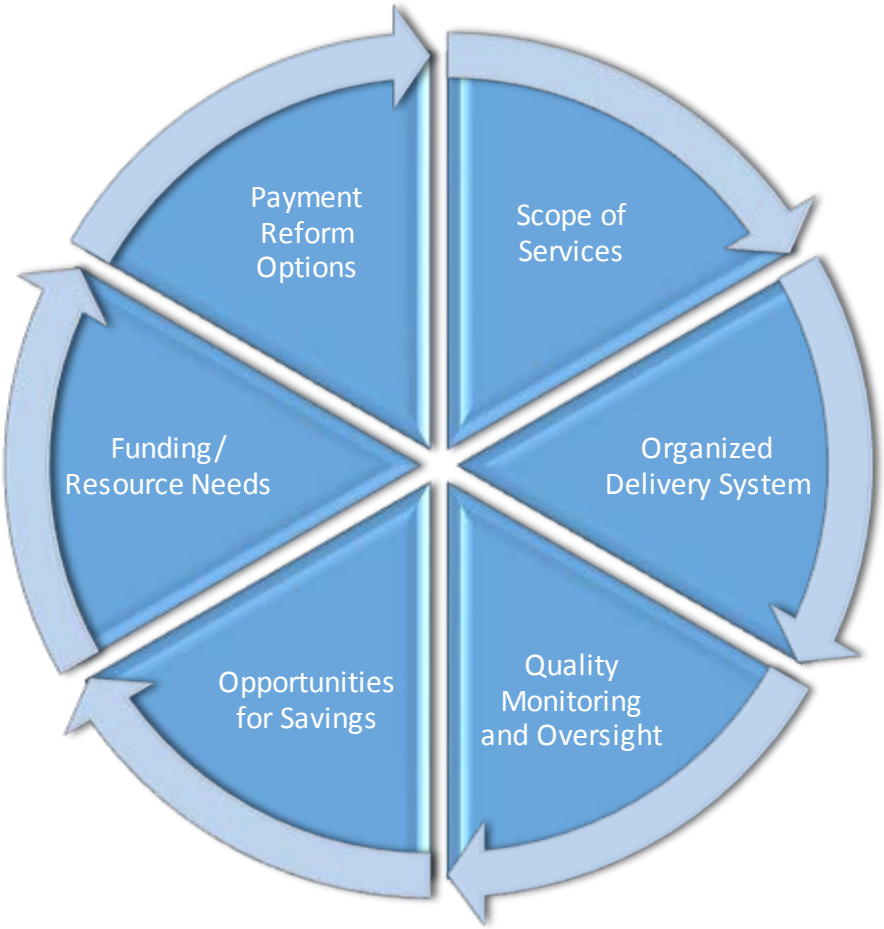
Design Element	Description	Design Objectives/Considerations

Scope of Services	Core set of services to be provided as part of the organized delivery model	• Meet all model of care principles, including integration across all services
		• Support full continuum or care, including prevention and intervention
		• Create Pathway to All-Payer Model
		• Current systems of care (e.g., provider characteristics, service coordination)
		• Uniformity/consistency with current and proposed initiatives
		• Accountability
		• Feasibility of model throughout the State
		• Implementation options
		  • Uniform v. community variances
		  • Voluntary versus mandatory provider participation
		  • Single entity or multiple entities in each region
		  • Phase-in of services, requirements, incentives, etc.
		• Funding and State administrative readiness

Organized Delivery System and Governance	Governance model and requirements for provider organization at the community level	
Payment Reform Options	Methodologies that promote the adoption of the model of care and other reform objectives	
Funding/ Resource Needs	Resources necessary to adequately fund activities and services, as well as State administrative functions	
Opportunities for Savings	Ability to contain costs (e.g., intervention/prevention, reductions in hospital/nursing facility utilization, service delivery efficiency, administrative efficiency)	
Quality Monitoring and Oversight	Activities to measure and promote program performance (including structure, process and outcomes)	

Relationship of Design Elements

- Program design elements are inter-related
- Preliminary design decisions will be established, then re-evaluated
- Models also will be re-evaluated as other program reform efforts emerge



Status and Next Steps

1. Mental Health, Substance Abuse Treatment, Developmental Services alignment group working on options for organized delivery system and payment models
   - Reviewing scope and model considerations

2. DLTSS Written Comments on Integrated Delivery System & Payment Reform by April 30th to Julie Wasserman Julie.Wasserman@vermont.gov
   - Feedback and/or recommendations on Opportunities, Challenges and Design Considerations (Slides 11 and 12).

3. Convene a working group to address LTSS Medicaid Pathway

4. Next DLTSS Quarterly Meeting - July 7th 2016

Presentation Acronyms

ACO:	Accountable Care Organization
ADAP:	Alcohol and Drug Abuse Program
AHS:	Agency of Human Services
AOE:	Agency of Education
APM:	All Payer Model
CFC:	Choices for Care
DAIL:	Department of Disabilities, Aging and Independent Living
DCF:	Department for Children and Families
DLTSS:	Disability and Long Term Services and Supports
DMH:	Department of Mental Health
DS:	Developmental Services
DVHA:	Department of Vermont Health Access
LTSS:	Long Term Services and Supports
MH:	Mental Health
SAT:	Substance Abuse Treatment
VR:	Vocational Rehabilitation