Emerging Definitions: Key Medicaid Pathway Delivery System Design Concepts
Draft for Discussion June 23, 2016

On the following pages we have begun to define key terms and delivery system design options that have been discussed during Medicaid Pathway meetings to date. During the June 16th and 30th meetings we will discuss and refine key concepts and delivery design options. **Please see discussion questions below.** In addition, various planning initiatives in Vermont and nationally (i.e., Integrating Family Services, Accountable Care Organizations, SAMHSA Integrated Health Care, Certified Community Behavioral Health Centers, Unified Community Collaborative) have been discussed. Detailed materials are available at the following links.

New Hampshire Integrated Delivery Network Request for Proposals
http://www.dhhs.nh.gov/business/rfp/documents/rfp-2016-ocom-05-build.pdf

AHS Integrating Family Services
http://humanservices.vermont.gov/Integrating-Family-Services

DVHA Medicaid ACO
http://dvha.vermont.gov/administration/1aco-rfp-final.pdf

Blueprint for Health Unified Community Collaborative
http://blueprintforhealth.vermont.gov/reports_and_analytics/community_network_analysis

A Standard Framework for Levels of Integrated HealthCare SAMHSA-HRSA Center for Integrated Health Solutions
http://www.integration.samhsa.gov/integrated-care-models

Enhancing the Continuum of Care, Integrating Behavioral Health and Primary Care through Affiliations with FQHC's
http://www.integration.samhsa.gov/images/res/CMHC%20FQHC%20Checklist%20v2.pdf

Certified Community Behavioral Health Centers
http://www.samhsa.gov/section-223

Medicaid Pathway Discussion Questions

1. In defining the delivery system *Integration, Partial Integration and Coordination*, what additions or clarifications would you make to the descriptions on page two?

2. In defining elements important for *Governance* what additions or clarifications would you make to the items on page three?

3. In reviewing the design options in Table One (page four), how does each option support the health care objectives (i.e., integration and adoption of the integrated model of care, early intervention, prevention, alignment with APM/ACO development)?

4. Are there other delivery system design options that could be considered? Which design options are the most feasible for 2017?

Emerging Definitions Vermont Delivery System Design

Full Integration: Separate entities develop a formal and/or unified governance structure that oversees a defined set of services and providers for a region or statewide. Structure is developed through contract agreements, corporate relationships (e.g., LLC, merger) or other legally recognized arrangements whereby providers share administrative services, data collection and/or tracking, responsibility for outcomes, responsibility for budget monitoring, budget decisions and investments in direct care. Providers have an in depth understanding of each other's roles and responsibilities. *Provider staff view work together as one of a single team and the principle of treating the whole person is applied to total population, not just identified target groups.*

- *Shared administrative functions* may involve: designation of one existing entity as "lead"; the creation of a new statewide or regional entity; a combination of methods.
- *Expectations and standards* for quality framework, integrated model of care and outcomes are defined by State and shared across providers
- *Target Group*: Whole or subset of population
- *Funding*: Flows to single entity or consortium and partners make decisions regarding resource allocation at the local level

Partial Integration/Affiliation: Separate entities create shared planning and decision making structure for certain aspects of service delivery, target populations or specific goals, while maintaining legally separate organizations. Written agreements between providers may include: direct referral arrangements (e.g., dedicated staff or slots for partner agencies); co-location of services or staff; purchase of service agreements for activities such as specialized care, staff supervision, training or administrative services (e.g., claims processing, human resources, IT support). Provider staff from multiple agencies view their work as part of interdisciplinary teams for specific target groups. *Providers have an in depth understanding of each other's roles and responsibilities as it relates to target group and scope of shared governance.*

- *Shared administrative functions* are determined through local planning and may involve: proactive assignment roles and responsibilities through an agreed upon decision making process; ad hoc assignment of functions as needs are identified to achieve shared goals.
- *Expectations and standards* for quality framework, integrated model of care and outcomes are defined by State and shared across providers
- *Target Group*: Whole or Subset of Population
- *Funding*: Could flow to locally entity for defined administrative functions and quality incentive payments. Payments for direct care remains provider specific

Coordination: Separate entities may share information regarding other organizations in the area with clients and/or make referral calls on the client's behalf; entities may have information sharing protocols and/or other agreements regarding how they coordinate services for shared clients. *Provider agencies may serve in consultant roles to each other regarding specific types of client profiles or conditions.*

- *Administrative functions are not shared*.
- *Expectations and standards* for quality framework, integrated model of care and outcomes are defined by State and shared across providers
- *Target Group*: Specific to provider type and/or individual contract agreement
- *Funding:* No shared funding

Standards for Governance (Partial or Fully Integrated Models)

Minimum functions essential for success in achieving reform outcomes:

- Strategic oversight and goal setting (shared community vision)
- Accountability for management of partnership agreements
- Consumer voice and involvement
- Community needs assessment and asset building
- Monitoring of quality data and community indicators of health (including consumer experience of care)
- Setting priorities for local quality improvement activity and monitoring
- Monitoring of service utilization and waiting list (across all involved providers)
- Decisions regarding use of shared savings or pooled provider funds for community reinvestment planning

Other Governance Functions that could be adopted:

- Decisions regarding technology infrastructure (e.g., EHR platforms, data collection and storage methods, use of health information exchange technology)
- Budget/total cost of care oversight
- Allocation of financial resources across providers

Table One: Organized Delivery Design Options

Organized Delivery Design Options					
Design Option	**Impact on Draft Scope of Services**	**How Does the Design Support Health Care Reform Objectives?**			
		Integration & Adoption of Model of Care	**Early Intervention**	**Wellness & Prevention**	**All Payer Model/ACO Alignment**
DA/SSA Network Focus: Create a DA/SSA provider payment methodology (e.g., child and adult payment model and quality framework); create incentives for regions that move to more fully integrated affiliation agreements and shared services with other members of the health care system. **Create Substance Abuse Treatment Continuum (LOC)**	Include only MH/DS/SAT dollars currently flowing to DA/SSA provider system (from all Medicaid Sources).	Continues potential for fragmentation of the SOC and how individuals are treated if does not include standards to integrate across LOC and SAT; Can't be diagnosed based – should move toward getting what you need when you need it – how does it help for persons who cross programs? Provider only focus if anything should be incremental and not the end goal – what can the State do for providers who already have all of these programs? How would they view a cohesive approach internally if State eliminated current program silos?	Creates some flexibility within the system	limited impact for whole population	
Regional Consortium of Providers- *Partial*	Define core scope and/or create	In many areas, partnerships may not			

Integration: Requires regions to identify healthcare partners (e.g., MH, DS, SAT, UCC, FQHC) ready to create a partial or fully integrated system.	incentives for greater integration.	come together due to relationships between programs - may make sense for provider but not for consumers. May be a good way to get more providers to be involved Who gets invited to the table? Step in the right direction.			
Regional Consortium of Providers- *Full Integration*: Requires all Medicaid providers (based on identified scope) to create regional governance and planning model to support unified and integrated service delivery.	No Change				
Statewide Medicaid Specialized Service Community Service Organization (CSO) for all services and providers not included in Medicare Part A and B scope.	No Change (could phase-in over time)				
Buildout of Current Medicaid ACO by adding more services	No Change (could phase-in over time)				

to Medicaid contract over time.					
Enhanced Care Coordination Payments: Develop case rate payment model that creates an incentive for care coordination compliant with Model of Care.	Target population based				
Other?					
Other?					