Payment and Delivery System Reform:

Mental Health, Substance Abuse Treatment, Developmental Disabilities Services

Medicaid Pathway to an Integrated Health Care System
Stakeholder Discussion July 14, 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

- Overview
  - Medicaid Pathway Context
  - Organized Delivery System Objectives
  - Medicaid Pathway Process
- Continuum of Integration Models
  - Delivery and Payment Reform
  - Quality Oversight and Outcomes
  - Resources
- Discussion
- Next Steps

Medicaid Pathway Context

- Older people and those with disabilities or multiple chronic conditions (substance use disorder, mental health challenges and other medical conditions) are the most complex and expensive populations that Medicaid supports.
  - In VT approximately 25% of Medicaid beneficiaries are enrolled in Specialized Programs; however, they account for 72% of Medicaid Expenditures (55% in specialized programs and 17% in physical health care).
- Evidence suggests that the integration of care (primary care, acute care, chronic care, mental health, substance abuse services and disability and long term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care and lower costs.
- Community based supports help prevent the need for care in more expensive, acute care settings, thus improving well-being, quality and controlling costs.
- Research has shown that environmental and socio-economic factors are crucial to overall health.
- Integration is a fundamental component of comprehensive, person-centered care.

Objective for Reform Planning

Develop an *organized delivery system* for serving individuals and promote integration across services for:

- Mental Health
- Substance Abuse Treatment
- Long-Term Services and Supports for individuals with developmental service needs
- Physical Health
- Long-Term Services and Supports for individuals with physical disabilities and older Vermonters

Medicaid Pathway Process

Delivery System Transformation (VT Integrated 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

- What resources are necessary to support the desired change and/or fund the delivery system?

Long Term Goal – Discussion Draft

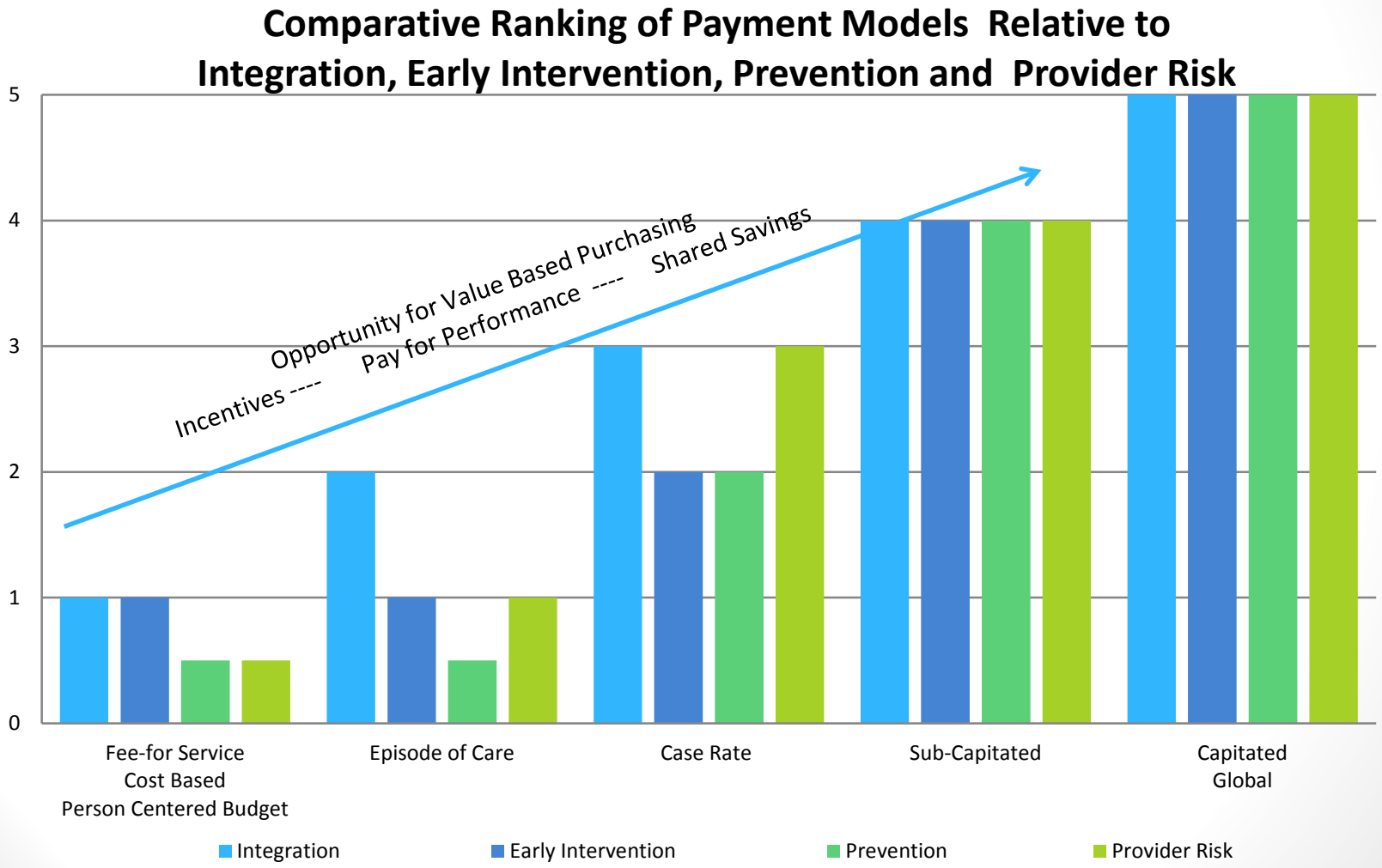
To support the creation of an organized, provider-led delivery system, such as an Accountable Care Organization or other structure, that can support the full continuum of AHS Medicaid funded services from pre-natal through end of life care, seamlessly integrated with physical health care.

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.

Long Term Delivery System Transformation

Delivery System Transformation	
What will providers be doing differently?	**How will Transformation Elements Support Integration with Physical and Mental Health, Substance Abuse Treatments and LTSSS**
Adopting the Vermont Integrated Model of Care	Through Consumer Experience of Integrated Care such as: • Person-centered planning • Bi-directionality of referrals between PCP and Community Service Providers • Standardized and comprehensive assessments • Active involvement of PCP in service planning • Single/Lead case manager • Interdisciplinary Teaming • Use of IT to support information sharing & outcomes
Shared governance to support, at a minimum: • Achieving the Model of Care • Assessing community needs and gaps • Using community profile and quality data to make decisions about community services, gaps, assets • Creating consensus regarding community investments to support population health and the integrated model of care	Through integration of delivery systems across physical and mental health, substance abuse treatment and long term services and supports shared: • Governance of community goals & progress • Assessments of community assets & gaps • Decision-making regarding resources and priorities • Accountability • Quality monitoring , improvement goals and outcomes
Promoting Population Health (Population-Based Health, Adoption of Best Practices; Address social determinates of health and early intervention)	Through coordination and accountability at the community level to promote innovation and monitor quality and outcome measures that “everyone can get behind” (i.e., all providers can impact)
Ensuring Efficient Operations and Oversight, including non-duplication of services and supports	Through consolidation of functions at provider and state level such as care coordination, data reporting and IT platforms across AHS programs

Continuum of Payment Models to Support Objectives



Quality & Outcome Framework

- Overall quality and outcome framework is related to, but broader than, quality metrics that may be used to determine incentive payments
- Quality and outcome framework becomes the foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning
  - *Accountability*: Confirm that contracted services were delivered. Did you get what you paid for? At minimum, requires submission of encounter data:
    - Service type, location, provider, duration, date
  - *Appropriateness*: Were the services delivered based on best practice and State standards (e.g., process and clinical, Model of Care, HCBS, Trauma, Recovery, Reliance, etc.)? Requires submission of data and medical records audits:
    - Core Data Elements – Build from HSE/SPP Task 5 Report
  - *Outcomes:* Did the services delivered produce the expected results?
    - Build from current AHS Dashboard and Comprehensive GC/Medicaid Quality Strategy work

Continuum of Integration Models

Based on Discussions to Date Several Integration Models are Emerging:

- Coordinated Model
- Specialized Delivery System Integration (Minimum Service Array)
- Integrated Community Delivery System (Minimum Service Array plus Additional Health Care Partners)
- ACO Affiliated or Similar Model (Fully Integrated Statewide or Regional)

Delivery System Integration Continuum

Delivery System Models: DRAFT for Discussion					
Level of Delivery System Integration	**Characteristics**	**Support for Objectives**	**Governance Model Elements**	**Shared Functions**	**Flow of Funds**
Coordinated Model	Provider & contract specific work and populations	Provider Specific (incentives could be created for adoption of some aspects)	Provider Specific	None	Provider Specific
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Provider Led. State standards and oversight ; integrated care for target population	Allows for adoption of model of care within targeted programs, limited early intervention, limited to no impact on population health and prevention	Optional based on scope of services and local decisions regarding shared functions	Optional and could include: IT; data analysis and reporting; quality and outcome monitoring; assessment of community assets and gaps; claims processing ; etc.	Provider Specific . At discretion of local partnerships some funds could flow to defined local entity for shared administrative and quality incentive payments
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Same as above ; integrated care for whole or subset of population ; some streaming of Medicaid fund sources ; shared investments	Same as above with more flexibility for early intervention, population health and prevention based on partners	Required if shared investments are part of local agreements	Same as above	Same as above
ACO Affiliated or Similar Model (statewide or regional)	Same as above ; streamlining of Medicaid fund sources	Supports all objectives	Required for resource decisions, priority setting and shared quality and outcome tracking	All of the above plus budget monitoring, priority setting and resource planning	Single Entity with shared investments

Payment Models Based on Level of Integration - DRAFT for Discussion

Payment Model Reform (Reimbursement Method, Incentives and Rates) Based on Level of Integration				
Level of Delivery System Integration	**Target Population**	**Potential Reimbursement Approach**	**Potential Incentives**	**Potential Rate Base and Annual Adjustments**
Coordinated Model	Provider Specific	No change	Could have incentive payments for certain aspects of care	Rates Determined Annually
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Provider Specific	Provider Specific Case Rate Payment (Monthly per active member; e.g., persons needs to engage in services within the month for provider to receive payment); Child and Adult Rate	Quality Incentive Bonus for Achieving Pre-Defined Targets and/or Integration	Rates based on 3 year average, allocation and caseload, increased annually by defined percentage; consistent rate setting approach across all Medicaid fund sources
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Whole or Target Group in Region	Provider Specific Global Budget (1/12th annual allocation paid monthly; not based on client accessing services in a given month)	Shared Savings AND Quality Incentive Bonus for Achieving Pre-Defined Targets and/or Integration	Rates based on 3 year average allocation, increased annually based on % of savings achieved; consistent rate setting approach across all Medicaid fund sources
ACO Affiliated or Similar Model (statewide or regional)	Whole or Target Group in Region	Regional Capitation Payment PMPM; not based on client accessing services in a given month)	Shared Savings AND Quality Incentive Bonus for Achieving Pre-Defined Targets	Same as above

Quality & Outcomes Framework Draft

Quality			
Level of Delivery System Integration	**Accountability**	**Outcomes**	**Reporting**
Coordinated Model	Provider specific	Provider specific	Provider specific
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Provider specific; there could be shared community targets	Provider specific; there could be shared community targets	Could be shared reporting
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Provider specific , there could be shared community targets	Provider specific ; there could be shared community targets	Could be shared reporting
ACO Affiliated or Similar Model (statewide or regional)	Required Targets	Required Targets	Unified Reporting required

Resources (Identified to Date)

Resource Needs Identified to Date				
Level of Delivery System Integration	**IT & Data Infrastructure**	**Budget**	**Staff**	**TA and Workforce Development**
Coordinated Model	Provider Specific	Incentives to support adoption of model of care	No Unique Considerations	Workforce Training • Model of Care • DLTSS core competencies • Learning Collaborative for best practice
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	Data collection and reporting system that allows for consistent measurement of quality and outcome standards	• Funding to support workforce salaries and predictable COLA • Funding for quality incentives bonuses • Increased availability of options counseling • Independent evaluation of effectiveness of delivery system and outcomes • Funding for IT gaps at State and local level	Data Analytics State and Local TBD	
Integrated Community Delivery System - Minimum Service Array plus additional health care partners				
ACO Affiliated or Similar Model (statewide or regional)				

Discussion

- Do the incremental models advance the long term goals?
- Is there a preferred model or should communities have flexibility to adopt any level of integration?
- Is it feasible to implement multiple models across the State?

Next Steps

- Information Gathering and Feedback
  - Solicit input from local regions through a formal information gathering process
    - State staff and workgroup to develop a request for feedback with key questions and solicit formal input from each region
    - Expected Date of Release: TBD
  - Use formal feedback responses to inform planning
    - What model options are most viable over short term and long term?
    - What are the operational considerations of moving to a regional(or statewide) governance and decision making model?
    - Implementation Planning: What is necessary for year one?
- Implementation Timeline and Steps
- Coordinated Medicaid Pathway discussions between provider work groups
- Continue work on rate development methodology that can be used regardless of final payment model approach (e.g., capitated, case rate or global budget)
- Additional Consumer/Stakeholder Outreach – TBD