State of Vermont

# Agency of Human Services and Agency of Administration

# Medicaid Pathway Overview
September 16, 2016

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# I. Why a Medicaid Pathway?

This document is intended to provide high-level information about the Medicaid Pathway.

The Medicaid Pathway is a process that supports Medicaid payment and delivery system reforms. The Agency of Human Services and Agency of Administration have engaged in innovative Health Care Reform with the recognition that:

- Health care cost growth is not sustainable;
- Health care needs have evolved since the fee-for-service system was established more than fifty years ago;
- More people are living today with multiple chronic conditions;
- The Center for Disease Control reports that treating chronic conditions accounts for 86% of our health care costs;
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health; and
- Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

One overarching goal of moving away from traditional fee for service payment models is to allow for providers to have a greater focus on wellness and prevention, health promotion, early detection and intervention. The Medicaid Pathway focuses on Medicaid funded programs across the AHS such that the social determinants of health can be addressed on balance with the traditional health care system. Medicaid Pathway planning principles are defined below.

## Medicaid Pathway 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 Care 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 broad measures that include structure, process and experience of care measures
  - Positive Health Outcomes includes 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 resulting from decisions made in one area in isolation of other factors

- **Create a Structural Framework to Support Integration**
    - 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 should align with current Health Care Reform efforts

## State of Vermont Medicaid Pathway Goals

The State's high-level goal for all health reforms is to create an integrated health system able to achieve the Triple Aim goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost. This goal is supported by both the All Payer Model and Medicaid Pathway initiatives.

As delivery system and payment reforms mature under the All Payer and Accountable Care Organization Models, services that support home- and community-based service and address the social determinates of health must also be integrated into an organized and accountable system of care. Physical health care, LTSS, and Mental Health and Substance Use Disorder Treatment systems cannot work in isolation. Reform objectives include the development of an *organized delivery system* for serving individuals and promoting integration across services for:

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

Through the Medicaid Pathway, State seeks to provide efficient, effective care to all Medicaid beneficiaries through an organized delivery system, and to ensure that care is patient-centered/directed and meets the criteria described in the Vermont Model of Care.

AHS has identified goals for care delivery, payment model and quality framework, and administration, described on the following page, to support this.

## Care Delivery Goals

- Support primary and secondary prevention, including Support early intervention to reduce risk factors.
- Support flexibility to allow individuals and providers to decide on necessary services based on a person's unique treatment and/or support plan needs and social determinants of health, including use of home-and community-based services.
- Foster integrated service delivery for Medicaid beneficiaries across the care continuum.

## Payment Model and Quality Framework Goals

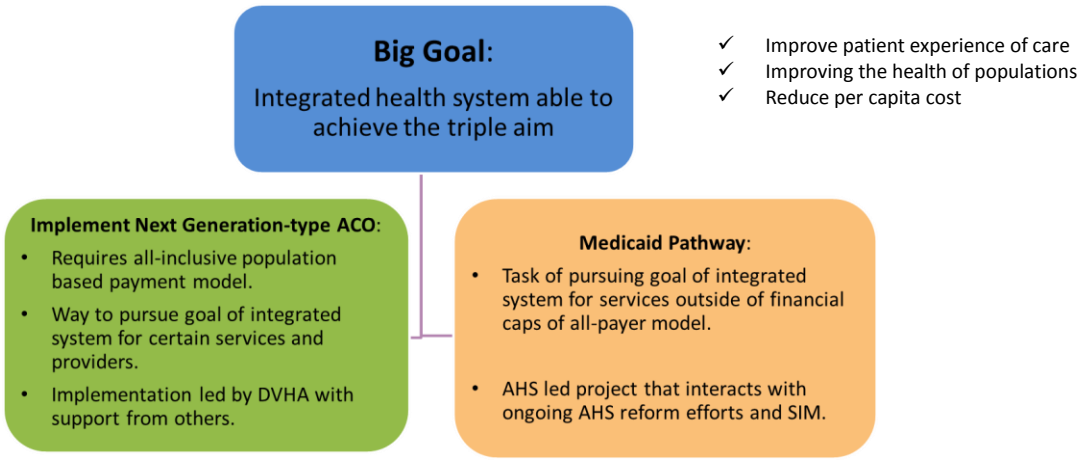
- Expressly move from fee-for-service payments to population-based payments, increasing accountability and risk to impacted providers.
- Incentivize high quality, efficient services and reduce incentive for high service volume.
- Increase flexibility in payment to support more efficient delivery of services.
- Reduce payment silos and fragmentation across provider and service types.
- Connect payments with quality in service delivery and health of Medicaid beneficiaries.
- Align measurement and reporting with values, principles and goals.
- Provide data and feedback to providers delivering care to support accountability for quality and cost.

## Administrative Goals

- Create a foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning that assesses accountability for delivering contracted services; appropriateness of care based on best practice and State standards; and outcomes.
- Reduce administrative burden to providers and the AHS.
- Standardize payment structure and quality measurement for similar services across AHS.
- Allow for seamless oversight and monitoring across AHS.
- Improve data collection to support future policymaking.
- Transition payments in a manner that is operationally feasible for both the State and providers.

## II. What is the Medicaid Pathway?

The Medicaid Pathway is a planning process led by the AHS-Central Office in partnership with the Agency of Administration. These planning efforts are designed to systematically review payment models and delivery system expectations across the AHS Medicaid program to refine State and local operations to better support the integration of Physical Health, Long Term Services and Support, Mental Health, Substance Use Disorder Treatment and Children's Service providers.




Current discussions and planning efforts relative to All Payer Models (Medicare, Commercial and Medicaid) and Accountable Care Organization development offer the opportunity to more fully realize Vermont's Model of Care throughout the entire health care system including long term services and supports and behavioral and mental health treatment services.

The Medicaid Pathway advances payment and delivery system reform for those services not subject to the additional caps and regulation that is expected under the State's All Payer Model. The ultimate goal of Medicaid's multi-year planning efforts is the alignment of payment and delivery system principles that support a more integrated system of care for all Medicaid supported services and enrollees. Table 1 below offers an overview of how an Organized Delivery Model, such as an Accountable Care or similar organizational approach, could support Vermont's Model of Care.

***Table 1: Delivery Reform Efforts and Opportunities to Support Vermont's Model of Care***

| Core Elements of Vermont's Model of Care | Delivery and 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** | 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** | 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** | Organized model could facilitate funding to support integration; performance-based payments could help to support care planning and single point of contact 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 |

| Core Elements of Vermont's Model of Care | Delivery and Payment Reform Opportunities |
|---|---|
| **Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services** | 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** | Organization and flexibility could create opportunities for integrated teaming such as Blueprint for Health and other models |
| **Coordinated Support during Care Transitions** | Organized model could enhance communications and training |
| **Use of Technology for Sharing Information** | Organized model could facilitate integrated clinical record |

Implementing alternatives to fee-for-service payment can also provide an opportunity for the State and providers to more fully support wellness and early intervention. Establishing alternative payment approaches may provide greater flexibility to support:

- Health Promotion
- Early Intervention and a Reduction of Client Risk Factors
- Provider Flexibility to Decide on Necessary Services
- Reduced Incentives for Volume
- Non-traditional (Home and Community Based) Services based on a Person's Unique Treatment and/or Support Plan Needs and Social Determinants of Health

## Transformation Elements & Work Plan Steps

To address comprehensive planning, the Medicaid Pathway process has defined five planning domains. These domains include: organized delivery system expectations, including supporting changes in State contracting and oversight practices; defined value based purchasing methodologies to support desired changes in delivery; payment model alignment and consistent approaches to rate development across programs; unified quality oversight and outcome monitoring across AHS Medicaid Programs. Lastly, the State will need to examine the resources needed for technical assistance and any staff, budget and business process changes to support and sustain necessary modifications in operation. Key areas of planning and sample design questions are summarized below.

**1. Delivery System Transformation (Integrated Model of Care and Population Health Activities)**

- What will providers do 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 costs 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 a preferred reimbursement model (e.g. support accountability and program integrity) while allowing the State to assess provider transformation (e.g. structure and process) and assure beneficiaries' needs are met?

**4. Outcomes**

- Is anyone better off?

**5. Readiness, Resources and Technical Assistance**

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

## Vermont's Model of Care

Vermont's Model of Care emerged over the course of several years and many discussions with a broad set of stakeholders. Discussions began as part of the "Dual Eligible Project" work groups from 2011-2014 and continued to be refined by the Vermont Health Care Innovation Project (VHCIP) Disability and Long Term Supports and Services Work Group from 2013-2016.

The Integrated Model of Care has been agreed upon by stakeholders as foundational to reform efforts. It was adopted by the VHCIP Practice Transformation Work Group and utilized to inform learning collaborative activities and training curriculums. It is now foundational to ACO and Medicaid Pathway planning discussions. The Vermont Integrated Model of Care is based on the recognition that:

- Older people and those with disabilities or multiple chronic 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.

Many of the AHS Specialized Programs support model of care elements within specialty areas. However, discussion is ongoing regarding how the State's Health Care Reform efforts can preserve and enhance the ability to incorporate <u>all</u> elements across the full continuum of health care services. Highlights of this model include:

1. **Person /Family Centered and/or Directed Services and Supports: Definition:** Care that is life-affirming, comprehensive, continuous and respectful in its focus on health needs (medical,

behavioral, long term care) as well as social needs (housing, employment), while promoting empowerment and shared decision-making through enduring relationships.

"One size does not fit all" organizational/systemic capacity is needed to effectively respond to a range of preferences regarding services and coordination.

2. **Access to Independent Options Counseling & Peer Support**: Independent, easy-to-access information and assistance to assist individuals and families/caregivers to: understand insurance options, eligibility rules and benefits; choose services and providers; obtain information and make informed decisions about services, including Peer and Recovery Support.

3. **Involved Primary Care Physician (PCP)**: All people with specialized needs will have an identified PCP that is actively involved in their care and who has knowledge about specialized service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options.

4. Access to Specialized Services: To ensure that specialized service providers are available and address comprehensive care planning and care coordination for persons with special needs, including referrals to PCP whenever needed to address co-occurring and/or complex medical conditions for the individuals served.

5. **Single Point of Contact (Case Manager)**: To ensure person centered care; coordination across all of the individual's physical , mental health, substance abuse, developmental, and long-term care service needs; relevant assessments are completed; develop and maintain comprehensive care plan; ensure support during transitions in care and settings.

6. **Medical Assessments and Disability and Long Term Services and Support Screening by PCPs, Medical Specialists:** PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits. If a person has mental health, substance abuse, functional or cognitive impairment, the PCP should be informed about specialized services, use a brief screening tool (if necessary) and refer the person to specialized providers for more in depth assessments as necessary.

7. **Disability and Long Term Services and Support Specific Assessments:** The Individual's Case Manager is responsible for assuring that all screening and assessment results (medical and specialized program related) are included in, and inform, the individual's Comprehensive Care Plan and are shared with the Individual's Care Team members.

8. **Comprehensive Care Plan**: For individuals with specialized service needs that go beyond PCP care, the case manager is responsible for developing and maintaining a single Comprehensive Care Plan that includes all identified needs, goals, preferences, services and supports (paid and unpaid).

9. **Individual Care Team (ICT):** For individuals with specialized needs that go beyond PCP care, the case manager is responsible for ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP.

10. **Support During Care Transitions:** For individuals with specialized needs that go beyond PCP care, the case manager is responsible for: initiating and maintaining contact at the beginning, during, and at the end of the care transition (including such things as identifying barriers to care and working with the individual, family and providers to overcome such barriers).

11. **Use of Technology for Information-Sharing:** Ultimate goal: A technological infrastructure that would:
    a. House a common case management database/system.
    b. Enable integration between the case management database and electronic medical records and between all providers of an Individual's ICT to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information.
    c. Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options.
    d. Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent.

Appendix 1 provides a summary overview of the model of care elements in comparison to other national frameworks.

## Alternatives to Fee-for-Service Payment Models & Value Based Purchasing

While there are many variations of provider payment models and reimbursement mechanisms, they all stem from three predominate payment methodologies: fee-for service, bundled payments and population-based payments. When developing payment models and reimbursement mechanisms, payers have a choice of creating the base payment model (i.e., the overall approach to paying for services) without value based enhancements, incentives or other goal oriented performance tools, or a payment structure in concert with Value Based Purchasing elements. For mature payment models already in operation, Value Based Purchasing elements can be added to it, or the program can be restructured to promote and reward service system change and quality.[1]

In Vermont's planning efforts, the following definition of Value Based Purchasing has been adopted:

> *Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.*

[1] Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf

This definition was derived from two primary sources: the Centers for Medicare and Medicaid Services Roadmap for Implementing Value Driven healthcare[2] and comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP.[3]

One step in developing a Value Based Purchasing program is to understand the base payment model, its potential unintended consequences and effects on provider service delivery, and its relationship to the goals of the desired change. [4,5] Each payment model has its own type of financial risks that are assumed by the payer and /or provider. FFS payment can create financial incentives for volume. Bundled payments put slightly more risk on the provider since it is unknown at the beginning of the "episode" exactly what services may be needed. Population-based payments create incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner, but can also put providers at risk if they treat populations that are sicker than average.

Examples of alternative payment models under review and their relationship to Medicaid Pathway and reform objectives can be found in Appendix 2.

# III. Medicaid Pathway Efforts to Date

## Current Planning Groups

The Medicaid Pathway includes the creation of work groups that are comprised of public and private sector stakeholders with expertise in the services under discussion. The work groups focus on all aspects of the proposed reforms including payment model, quality measures, delivery system reforms, and other necessary components.

Currently two work groups have been established. One group is focused on mental health, Substance Use Disorder Treatment and developmental disabilities services and encompasses Designated and Specialized Service Agencies and Alcohol and Drug Abuse Preferred Providers and Children's Service providers involved in the Integrating Family Services Initiative. The Mental Health, Substance Use Disorder Treatment and Developmental Services group began meeting in December of 2015. The second work group is focused on the long term supports and services offered through the DAIL Adult Service

[2] Ibid
[3] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html
[4] Ibid
[5] Miller HD. (2007). *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund. Can be found at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2007/sep/creating-payment-systems-to-accelerate-value-driven-health-care--issues-and-options-for-policy-refor/miller_creatingpaymentsystemsvalue-drivenhltcare_1062-pdf.pdf

Division including Choices for Care and other Medicaid funded supports. This work group began meeting in June of 2016. Descriptions of each group and their membership can be found in Appendix 3.

## Delivery System Design - Emerging Definitions

In defining options for a seamless and organized delivery system across specialized programs, the work group has discussed conceptual models and explored emerging national models. Definitions of key delivery system design components are outlined below.

**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 – Targeted Services**: 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

Using these definitions as a foundation, the work group has begun to discuss a continuum of provider integration that may best reflect the variation in regions that exists today. Delivery system models that support each level of integration are described on Table 2 on the following page.

These models are expected to be more fully defined, while the work group explores how to create policies and incentives that assist providers to achieve more integrated approaches to care and support the adoption of the Vermont Model of Care.

| Continuum of Integrated Delivery System Models: DRAFT for Discussion | | | | | |
|---|---|---|---|---|---|
| **Level of Delivery System Integration** | **Characteristics** | **Support for Objectives** | **Local Partnership Governance Model** | **Shared Functions** | **Flow of Funds** |
| **1. Coordinated Model** | ○ Provider & contract specific work and populations | ○ Provider Specific (incentives could be created for adoption of some aspects) | ○ None | ○ None | ○ Provider Specific |
| **2. Specialized Delivery System Integration: (Minimum Service Array - CCBHC-like model)**<br><br>**(Partial Integration)** | ○ Provider Led<br>○ State standards and oversight<br>○ Integrated care for target population | ○ Allows for adoption of model of care within targeted programs limited early intervention<br>○ 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<br>○ At discretion of local partnerships some funds could flow to defined local entity for shared administrative and quality incentive payments |
| **3. Integrated Community Delivery System: (Minimum Service Array plus additional health care partners based on local decision)**<br><br>**(Partial or Full Integration)** | ○ All of Above +<br>○ Integrated care for whole or subset of population<br>○ Streamlining of Medicaid fund sources to each provider<br>○ 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<br>○ Shared investments could be part of local agreements |

| | | | | | |
|---|---|---|---|---|---|
| **4. ACO Affiliated or Similar Model (statewide or regional)**<br><br>**(Full Integration)** | ○ All of Above +<br>○ Streamlining of all Medicaid fund sources | ○ Supports all objectives | ○ Required for resource decisions, priority setting and shared quality and outcome tracking | ○ All of the above +<br>○ budget monitoring, priority setting and resource planning | ○ Single Entity with shared investments |

***Table 2: Continuum of Integrated Models***

## Payment Models

Payment models that are being explored to support delivery system integration include:

- *Community, Population Based or Global Budget*: Development of a total budget by community and requiring providers to collaborate in order to manage to a total community budget. Another approach may involve developing a global budget by provider, while measuring integration and outcomes across the local system and individual provider performance.

- *Capitated or Sub-Capitated*: A capitation amount based on number of eligible members in region, regardless of need could be developed for a region, provider or group of providers. Provider specific sub-capitation amounts could also be developed based on services that are responsibility of each provider.

- *Case Rates:* There are several methodologies to developing a case rate or bundled payment approach. Monthly rates per enrollee (e.g. per member per month or PMPM) could vary based on program expectations or population type.

- *Care Coordination Case Rates/Enhanced Care Coordination Payments*: Develop payment model for care coordination that is fully compliant with Model of Care.

## Emerging Work – Long Term Services and Supports/Choices for Care

The Long Term Services and Supports planning kicked off in June of 2016 and the work group is currently reviewing services and scope. Discussions to date have focused on the Choices for Care program services. Upcoming work group topics include exploring delivery model designs, payment models and quality measures.

## Next Steps

To assure that products that emerge from both groups are coordinated and complimentary, representatives from each group have been identified to participate across groups. In addition a small team of representatives from both groups will meet with the State to better define which products and designs should be universal and which may vary based on differences in provider services and networks.

The State will be developing formal feedback tools to solicit written input from local regions statewide. The State will be developing an information gathering process with key questions to help determine:

- 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?
- What changes are necessary for year one?

In addition the State will be seeking formal mechanisms to solicit feedback from consumers and stakeholders who are not part of the on-going work groups.

# Appendix 1: Vermont's Model of Care and National Frameworks

| COMPARISON OF NATIONAL EVIDENCED-BASED MODELS | | | | |
|---|---|---|---|---|
| **Core Elements of Vermont's Model of Care*** | 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** | | | | |
| **CCBHC – Certified Community Behavioral Health Center Sec. 233 Demonstration** | | | | |

# Appendix 2: Payment Model Overview

| Summary Overview of Payment Models and VT Reform Opportunities | |
|---|---|
| **Payment Option** | **VT Reform Opportunities** |
| **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.<br>• Could promote early intervention/prevention.<br>• Payments could be tied to performance.<br>• Creates more predictable funding level. |
| **Capitated or Sub-Capitated:** Capitation amount based on number of eligible members in region, regardless of need. Sub-capitation amount based on services that are responsibility of each provider. | • Maximizes flexibility to develop service options that meet individual needs.<br>• Could promote early intervention/prevention.<br>• Payments could be tied to performance.<br>• Creates more predictable funding level that varies as eligible population changes |
| **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.<br>• Payments could be linked to performance rather than volume. |
| **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.<br>• Requires new funding or reinvested savings |

| Comparison of Payment Models Relative to Early Intervention, Prevention and Provider Risk | | | | | | |
|---|---|---|---|---|---|---|
| **Payment Type** | **Payment Model Overview** | | **Support for Key Objectives of Vermont Reform** | | | **Provider Risk** |
| | **Reimbursement Method** | **Enrollee Participation** | **Integration** | **Early Intervention** | **Prevention** | |
| **Cost Based** | Pre-determined definitions of allowable costs and service | N/A | Varies based on specifications in contract agreement | Varies based on specifications in contract agreement | Varies based on specifications in contract agreement | None, unless limits |
| **Fee for Service** | Defined Unit (e.g., minutes, hours, session, encounter, day) and procedure based | Client must actively seek services | Referral and/or Coordination Agreements | Potentially if diagnosed in early stages of condition | Only for pre-defined preventive services (e.g. well child, annual physical, screening test, etc.) | None, unless limits |
| **Person-Centered Budget** | Based on allowable services and individual plan | Client must actively seek services | Referral and/or Coordination Agreements | Typically for complex conditions | To prevent or slow further deterioration | None, unless limits |
| **Episodes of Care** | Episode or condition; time window (e.g. 30, 60, 90 days) | Client must actively seek services | Referral and/or Coordination Agreements | If diagnosed in early stages of condition | Typically 'condition' based payments | Moderate |
| **Case Rate** | Individual or multiple services; time window | Client must actively seek services | Information sharing; co-location | Depends on what is included in case rate and contract | | Moderate |
| **Sub-Capitated** | Target group and/or target services | Attribution to target group regardless of client utilization | Information sharing; integration; co-location; merge | Provider has flexibility to deliver preventive, curative and/or palliative services based on person centered approach to care | | High |
| **Capitated/Global Payment (Population based)** | All services and/or enrollees | All persons in a given region regardless of client utilization | Information sharing; integration; co-location; merge | Provider has flexibility to deliver preventive, curative and/or palliative services based on person centered approach to care | | High |

Appendix 3: Work Group Descriptions & Membership

## Mental Health, Substance Use Disorder Treatment, Developmental Services

The AHS has engaged representatives of the Designated and Specialized Service Agency System, the Substance Use Disorder Treatment Preferred Provider Network, consumers and other stakeholders to guide discussions on payment and delivery system reforms in partnership with the VHCIP demonstration and in preparation for participation in the All-Payer Model. Invited stakeholders include:

- Bill Claessens (Counseling Service of Addison County)
- Bob Bick (Howard Center)
- Catie Iacuzzi (Maple Leaf)
- Elizabeth Sightler (Champlain Community Services)
- Jason Goguen (BARRT)
- Mary Moulton (Washington County Mental health)
- Simone Rueschemeyer (Vermont Care Partners)
- Sandy McGuire (Howard Center)
- Ed Giroux (Howard Center)
- Ted Mable (Northwest Counseling and Support Services)
- Julie Tessler (Vermont Care Partners)
- Cathy Dubois (BARRT)
- Peter Mallory (People Education Advocacy and Recovery)
- Heidi Hall (Washington County Mental Health)
- DW Bouchard (Northeast Kingdom Human Services)
- Nancy Breiden (Disability Law Project, VT Legal Aid)
- Kathy Holsopple (Vermont Federation of Families for Children's Mental Health)
- Sarah Launderville (Vermont Center for Independent Living)
- Ed Paquin (Disability Rights Vermont)
- Deborah Lisi-Baker (VHCIP, Disability and Long Term Services and Supports Work Group Chair)
- Steve Rauh – Upper Valley Services and Family Representative
- Josh Smith – Green Mountain Services and Supports

## Long Term Services and Supports/Choices for Care

The AHS has engaged representatives of the Home Health, Area Agencies on Aging, Nursing Facility, Residential Care, Traumatic Brain Injury and other service agencies, consumers and other stakeholders to guide discussions on payment and delivery system reforms in partnership with the VHCIP demonstration and in preparation for participation in the All-Payer Model. Invited stakeholders include:

- Patrick Flood (Citizen representative)
- Mike Hall (Area Agencies on Aging)
- Sarah Launderville (Vermont Center for Independent Living)
- Jackie Majoros (Long Term Care Ombudsmen)
- Joanne Bohen (Adult Day)
- Ed Paquin (Disability Rights Vermont)

- Deborah Lisi-Baker (VHCIP, Disability and Long Term Services and Supports Work Group Chair)
- Kim Lague (Central Vermont Home Health)
- Treny Burgess (Caledonia Home Health)
- Rita Laferriere (Vermont New Hampshire Home Health),
- Laura Pelosi (Vermont Health Care Association)
- Molly Dugan (Support and Services at Home)
- Lynn Lawson (Consumer)
- Trevor Squirrell (Brain Injury Association)
- Virginia Milkey (Community of Vermont Elders)
- Kirsten Murphy (Developmental Disabilities Council)
- John Pierce (Advocate/Consumer)
- Jeanne Hutchins (University of Vermont)
- Rosemary Mayhew (Bel-Aire Center)
- Joyce Touchette (Converse Home)
- Josh Smith (Green Mountain Support Services)
- Susan Shane (OneCare Vermont)
- Victoria Loner (OneCare Vermont)
- Julie Tessler (Vermont Care Partners)

## Work Group Discussion Topics

Discussion topics and questions for work groups include, but are not limited to:

- Overview of the current system (providers, expenditures, types of services)
- VT Integrated Model of Care
    - Care Delivery: are providers ready to implement an integrated approach to care?
    - What are the current program requirements?
- Scope for long term and short term planning related to both delivery reform and payment reform
- Opportunities for Performance Improvement in the Choices for Care Program
    - Identification of opportunities for improvement related to the VT Integrated Model of Care
    - Stakeholder rating of the "Top Ten" performance and outcome indicators for Choices for Care program
- Delivery Model Design Options
    - Organized Delivery System Models
    - Levels of Delivery Integration (formal and informal)
- Overview of Payment Models and how they support delivery model and reform goals
    - Level of accountability: (i.e., what VBP model do we employ?)
    - What level of risk can the providers take on?
- Consortium Governance
    - Should the governance structure be statewide or regional?
    - What are the necessary governance elements to achieve reform objectives?
- Quality and Outcomes
    - What quality measures should we use?

    - Are they aligned with the existing measures?
    - Is the health data infrastructure able to collect and report necessary quality and oversight data?
    - What data does the State stop collecting?
- Base Payment Model 'Straw Man' for Designated and Specialized Service Agencies
    - Examples of how a case-mix adjustment payment and global budget approach may apply in Vermont's specialized service system
- Vermont Care Partners Self-Assessment of Provider Readiness for Alternative Payment Models and Delivery Integration
- Formal Written Information Gathering Process
    - Development of a formal process for statewide information gathering and written stakeholder feedback on potential Medicaid Pathway delivery and payment models
    - Development of stakeholder questions for statewide feedback
- Implementation and operational considerations
    - Should the transformation process be mandatory or voluntary?
    - Are there enough lives/money/services for this to work?
    - Impact on non-Medicaid populations, services and funding
    - What is feasible in first year?