Medicaid Pathway: Mental Health, Substance Abuse Treatment, Developmental Services

Medicaid Pathway to an Integrated Health Care System

State Staff Discussion

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Meeting Topics

Stakeholder Feedback and Group Discussion

- What is essential for success regardless of design model?
- What design model best supports reform goals?
- What State oversight changes are needed to support the reform?

Discussion Question #1

What elements are essential to support successful implementation of an ***organized delivery system***, regardless of final design?

Stakeholder Feedback – Supporting Success

Local/Regional Design

- Do not expect every region to look identical statewide; Communities have different demographics, challenges, economic realities and opportunities
- Design should consider how to create incentives for providers to engage and build on social capital in their local communities
- Person-centered care is enhanced when there is local control over clinical and service decisions
- Clearly and consistently define a "region"
- Consider provider specific payment models that support desired model of care and integration rather than one fiscal agent

Governance

- Governance should be separate from 'how the money flows'
- Fiscal agent component is not a necessary element to support a strong local governance model
- Fiscal agent model adds liability and administrative burden without adding value; often gets in the way of good collaboration and service delivery
- Local governance and decision-making is vital

Stakeholder Feedback – Supporting Success

Alignment of Expectations: State Contracts and Reform Initiatives

- Clearly define what the State is 'buying' and for whom
- Link payment to a clear set of expectations (target group, best practice, outcomes)
- State Plan and GC services should serve as base for defining what the State is 'buying' without the State getting prescriptive about how, when and how much service to provide
- Reduce the number of AHS Medicaid fund sources with multiple and conflicting program requirements
- Develop clear descriptions of how the Medicaid ACO and Medicaid Pathway Home and Community Based Service System changes will align and support each other
- Create contract requirements or other incentives that ensure reductions in 'high end' services (e.g., hospital, nursing facility, emergency, residential) result in investments in less costly and effective community systems

Stakeholder Feedback – Supporting Success

Data, Community Profiles and Assessments

- Currently local needs assessments are required by Hospital Service Areas (for non-profit hospitals); DA/SSA for Mental Health and Developmental Services and Area Agencies on Aging for elder services
- Standardization is needed about what is being 'assessed' and there should be a distinction between community needs versus provider agency needs
- Local governance groups need basic reliable data on trends, service utilization and themes in their region e.g., indicators of social well-being
- Model should promote asset based approach to community assessments

Quality and Outcomes

- Systemic outcomes should be balanced with unique individual zed person-centered goals/competencies e.g., payments linked to "transformed lives"
- Quality and outcomes should replace widget counting and prior authorizations

Funding

- New service delivery paradigm needs to account for "underfunded system" ; the current funding base may not be sufficient
- Shift as much away from administrative burden to create a more meaningful balance between indirect and direct services

Discussion Question #2

What delivery system model best supports early intervention, prevention, accountability and sustainability?

Stakeholder Feedback – Delivery Model Design

- **State structure should work for full integration, while community structure should start with partial and phase in full integration over time.**
- **Partial Integration Model (with move toward full integration as communities are ready)**
  - Define a core set of services and common set of community standards (e.g., standards around Model of Care)
  - Develop clear community expectations and shared outcomes across providers
  - Prioritize the State's goals and measure them consistently across programs
  - Don't be prescriptive about services and FTE's be prescriptive about outcomes
  - Data and quality measures with continuous quality improvement at the community level
  - Be clear about each entities role in outcomes, otherwise "no one is responsible for failure"
  - Shift "risk" from payer to provider
- **Model must be designed to re-invest savings.** Reductions in other areas (e.g., hospital, nursing facility, etc.) into home and community services and population health

Discussion Question #3

What State oversight activities would need to change to better support an organized and integrated delivery system?

Stakeholder Feedback – State Oversight Changes

- ***Revise Budgeting:*** State budget and legislative process need to move toward one unified or blended approach and not retain inflexible silos across Medicaid programs.
- ***Revise Auditing Practices:*** Program Integrity for bundled or global payments needs to support quality and best practice, not be based on old 'Fee-for-Service' models.
- ***Unify and Streamline***
  - ***Reporting:*** Provider Reporting requirements need to support person centered care and outcomes not count "widgets" differently across programs. All efforts should support maximizing direct service and minimizing indirect time.
  - ***Accountability:*** Can't layer new requirements on top of old models; need to make a wholesale change in measurement and oversight practices. If you are asking for providers to take risk, they need to have local control and flexibility in meeting the needs of community within agreed upon standards
  - ***Clinical Rules/Program Guidelines***: Currently clinicians must follow multiple sets of rules for the same type of client, depending on who is funding the program (e.g., DVHA, DMH, DCF, Commercial Plans, Medicare, etc.). There needs to be one cohesive set of rules regardless of AHS payer.
- ***Fund a Community (not isolated program decisions)***
  - Create agreement on what core services each community needs to have and what services may be regional, statewide or discretionary
  - Work toward one integrated System of Care plan, not several specialized plans
  - Need to support, not stifle, flexibility in service delivery

Medicaid Pathway Planning

REFERENCE SLIDES

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?

Reform 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 for individuals with developmental service needs
  - Long-Term Services and Supports for individuals with physical disabilities
- **The organized delivery system will support**:
  - Adoption of Vermont's Integrated Model of Care, including advancement of primary care and prevention
  - Service Delivery Reform, including population-based health and prevention and development of best practices
  - Quality Framework
  - Payment Reform, including value based purchasing
  - Efficient Operations and Oversight
  - Medicaid's Pathway for Alignment with the All-Payer Model

VT Integrated Model of Care: Core Elements

- Person-Centered and -Directed Process for Planning and Service Delivery
- Access to Independent Options Counseling & Peer Support
- Actively Involved Primary Care Physician
- 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 Tools
- Comprehensive Individualized Care Plan Inclusive of All Needs, Supports and Services
- Care Coordination and Care Management
- Interdisciplinary Care Team
- Coordinated Support during Care Transitions
- Use of Technology for Sharing Information

Draft Scope of Services

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

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

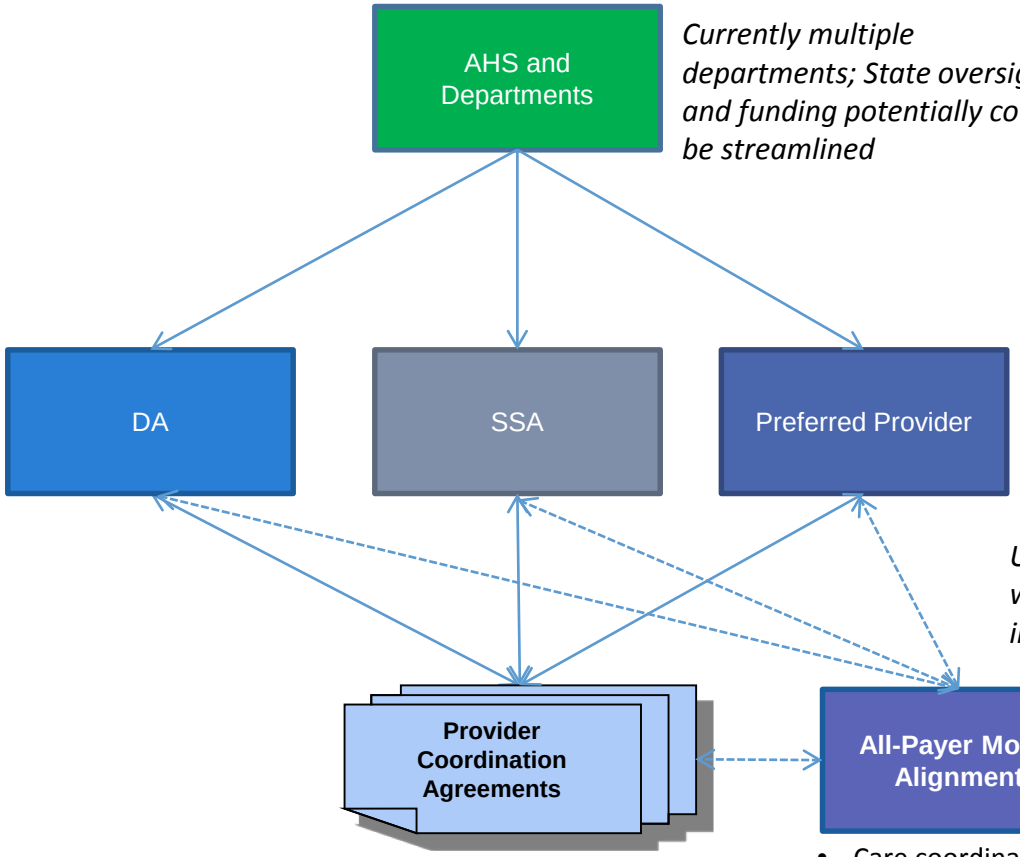
Under Discussion "TBD"

- ADAP Medication Assisted Treatment Hub and Spoke
- DCF Contracted Treatment Services

Currently Out of Scope (for current work group)

- DVHA Funded MH and SAT Services (pending ACO development)
- LTSS/CFC (pending separate Pathway work group)
- Blueprint (pending ACO development)
- Inpatient MH (pending ACO development)
- PNMI
- State operated programs (Woodside, DCF-TCM, VPHC)

Delivery System Design: Service Coordination Model



Currently multiple departments; State oversight and funding potentially could be streamlined

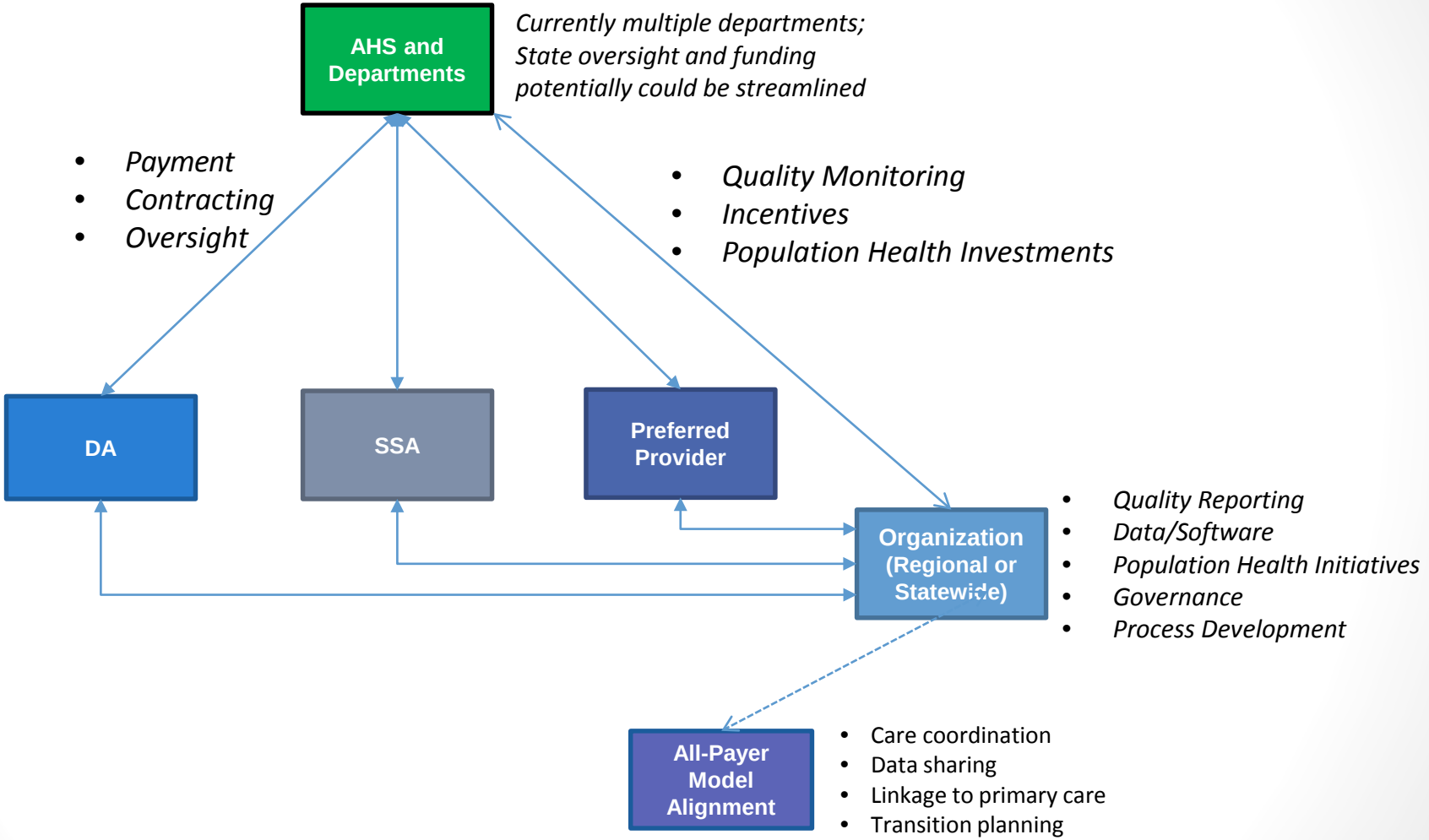
Unclear whether providers would coordinate with APM individually or collectively

- Care planning
- Case manager assignment
- Data sharing
- Quality monitoring

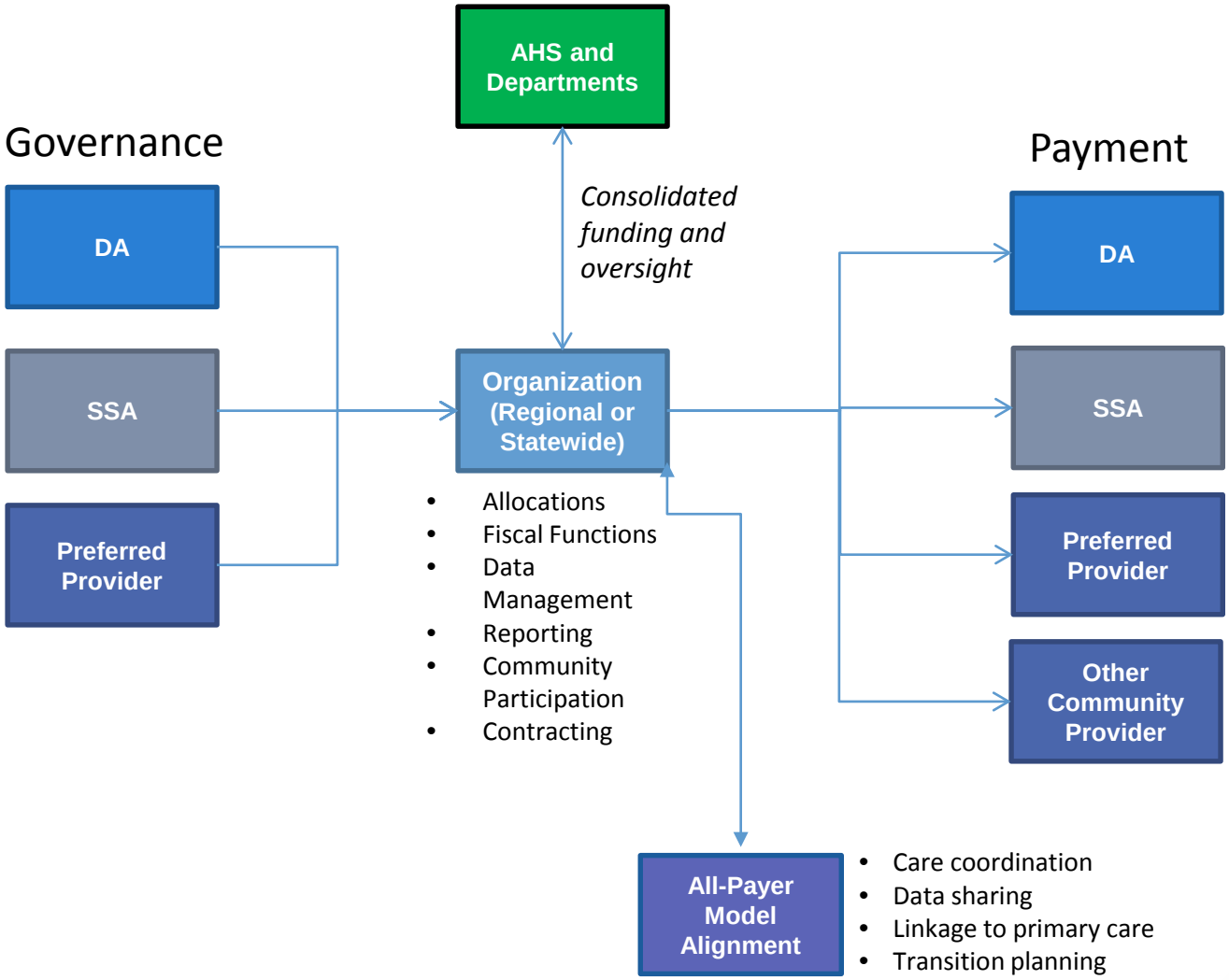
- Care coordination
- Data sharing
- Linkage to primary care
- Transition planning
- Development of community needs assessments
- Incentive arrangements

Similar to some current provider arrangements

Delivery System Design: Partial Integration



Delivery System Design: Integration Model



Similar to the VCRHYP, IFS and CIS Delivery Models