VERMONT CARE PARTNERS

Payment and Delivery System Reform:

Mental Health, Substance Abuse Treatment, Developmental Disabilities Services

July 28, 2016

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Medicaid Pathway Context

- Older people and those with disabilities or multiple chronic conditions (substance use disorder, **developmental disabilities,** 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/family directed** care.

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Medicaid Pathway Context Continued

- **Without adequate resources and more flexibility of resources it will be impossible to fully achieve the goals of the Pathway.**

- **Re-allocation of medical dollars to achieve adequate investment in community based services and supports will reduce costs not only in the health care delivery system, but in the rest of Vermont's health and human services system (corrections, education, DCF, children's psychiatric hospitalization, labor and more).**

- **The social model of care, inclusive of peer supports, is a fundamental component of comprehensive, person/family directed care.**

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Objective for Reform Planning

Develop an organized delivery system that promotes **not only financial strength, sustainability and accountability for all providers, but that also supports the enhancement of the social model of care,** integrated care delivery, **and prevention, wellness and long term services and supports for individuals, families and communities.** This is inclusive of services for:

- Mental health conditions
- Developmental disabilities
- Substance use disorders
- Physical disabilities
- Physical health needs

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Medicaid Pathway Process

Readiness, Resources and Technical Assistance / Solid Foundation

- **Adequate financial resources are necessary to support the current state of our delivery system. What is the process for achieving adequate financial resources and** what resources are necessary for the desired change? **How will sustainable funding be ensured over time?**

Payment Model Reform (Reimbursement Method)

- What are the best reimbursement methods to support the **Social Model of Care now** and into the future? e.g. fee for service, case rate, episode of care, capitated, global payment)?
- **What funding levels are necessary for a stable and high quality workforce?**
- How can we create financial incentives to support the practice transformation**, inclusive of enhanced care coordination**?
- **How can we develop an objective budget review and reimbursement setting process that takes into account projected needs and projected costs to ensure stable qualified staffing and high quality care?**

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Medicaid Pathway Process

Quality and Outcomes 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?
- **How do we reduce and streamline data collection and reporting?**
- **What are the preferred metrics based on the social and health care value of the needs of the people we are serving?**
- **How do we ensure the collection and reporting of required data yet avoid financial fee for service type reconciliation of data?**
- **Utilization of RBA format.**

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Medicaid Pathway Process

Delivery System Enhancement and Transformation (Social Model of Care / VT Integrated Model of Care)

- What will providers be doing differently?
- What is the scope of the **enhancement**/transformation?
- How will transformation **enhance the social model of care and** integration?

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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 • Interdisciplinary team inclusive of PCP • 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 • **Enhancing the social 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

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Vision

- **To enhance a person/family directed service delivery system to better meet the social and health care needs of Vermonters with no wrong door for services and service coordination and integration available as needed.**

- **To develop a streamlined consistent payment model to maximize resources and best meet the needs of Vermonters social and health care needs with incentives for health promotion, prevention and population health initiatives.**

- **To develop adequate, predictable, and sustainable funding for a high quality service delivery system.**

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Long Term Goals

- **The Medicaid Pathway aligns with the All Payer Model in a financially sustainable and realistic manner.**

- **A delivery system that incentivizes and prioritizes the Social Model of Care and an integrated delivery system that has a "No Wrong Door" approach to caring for all Vermonters.**

- A provider-led statewide organization **that allows for integration with the APM, has an efficient and streamlined infrastructure and that has a quality/performance pool.**

- **Providers will assume risk once a solid and sustainable financial foundation is in place.**

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Short Term Goals

- **Statewide resource strengthening and payment reform process.**
- **Regional and statewide care delivery goals.**
- **Resource leveling to provide parity to the social model of care enabling the retention of a quality workforce to support coordination and integration rather than competition with health care.**
- **A streamlined payment model that maximizes the use of resources to best meet the social and health care needs of Vermonters**
- **Payment for services based on cost. Additional incentive payments based on achieving a set of negotiated and established outcomes. Outcomes developed both regionally and statewide.**

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Short Term Goals Continued

- **A payment methodology that has streamlined reporting and outcome metrics and that allows flexibility to meet need, regardless of attribution.**
- **Collaboration with regional partners to address regionally agreed upon population health goals.**
- **Incentive payments to meet population health goals and for enhanced care coordination.**
- **Whole person/family directed care is applied to total population, not just identified target groups.**
- **Balance federal rules and requirements with the unique pattern of care in Vermont**

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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)

Elements of Transitional Model….

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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 *and consumer and peer directed.* 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	***Agency specific, statewide, and regional* based on scope of services and local decisions regarding shared functions.**	**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 *additional* funds could flow to defined local entity for shared administrative and quality incentive payments. *Incentive payments for enhanced regional care coordination.***
Integrated Community Delivery System - Minimum Service Array plus additional health care partners	Same as above ; **integrated care for whole or subset of population ; Streamlining 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	Same as above ; streamlining of Medicaid fund	Supports all objectives	Required for resource decisions, priority setting and	All of the above plus budget monitoring, priority	Single Entity with shared investments

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Quality & Outcomes Framework Draft

Quality			
Level of Delivery System Integration	**Accountability**	**Outcomes**	**Reporting**
Coordinated Model	Provider specific	Provider specific	**Provider specific *and***
Specialized Delivery System Integration/Minimum Service Array (current Scope CCBHC-like model)	***Statewide and* provider specific; there could be shared community targets**	***Statewide and* provider specific; there could be shared community targets** ***Quality incentive bonus for achieving pre-defined targets and/or Integration***	**Could be shared reporting. *All dependent on payment, accountability and outcomes***
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

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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 *potential for budget review by independent authority***
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	***Uncapped bundle using budgeted costs to determine bundled rate.* Provider Specific Global Budget *delivered within a prospective payment methodology.* (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	Whole or Target	Regional Capitation	Shared Savings AND	Same as above

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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** ***Cross training opportunities (i.e. DA training to other providers on trauma, community based trainings etc.)***
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** • **Funding for increased availability of wellness prevention support and treatment *options*** • ***Funding to support enhanced care coordination*** • ***Funding to support regionally designed population health outcomes*** • **Independent evaluation of effectiveness of delivery system and outcomes** • ***Independent review of budgets*** • **Funding*/resources* for IT *and analytic platforms and staff* at State and local**	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)				

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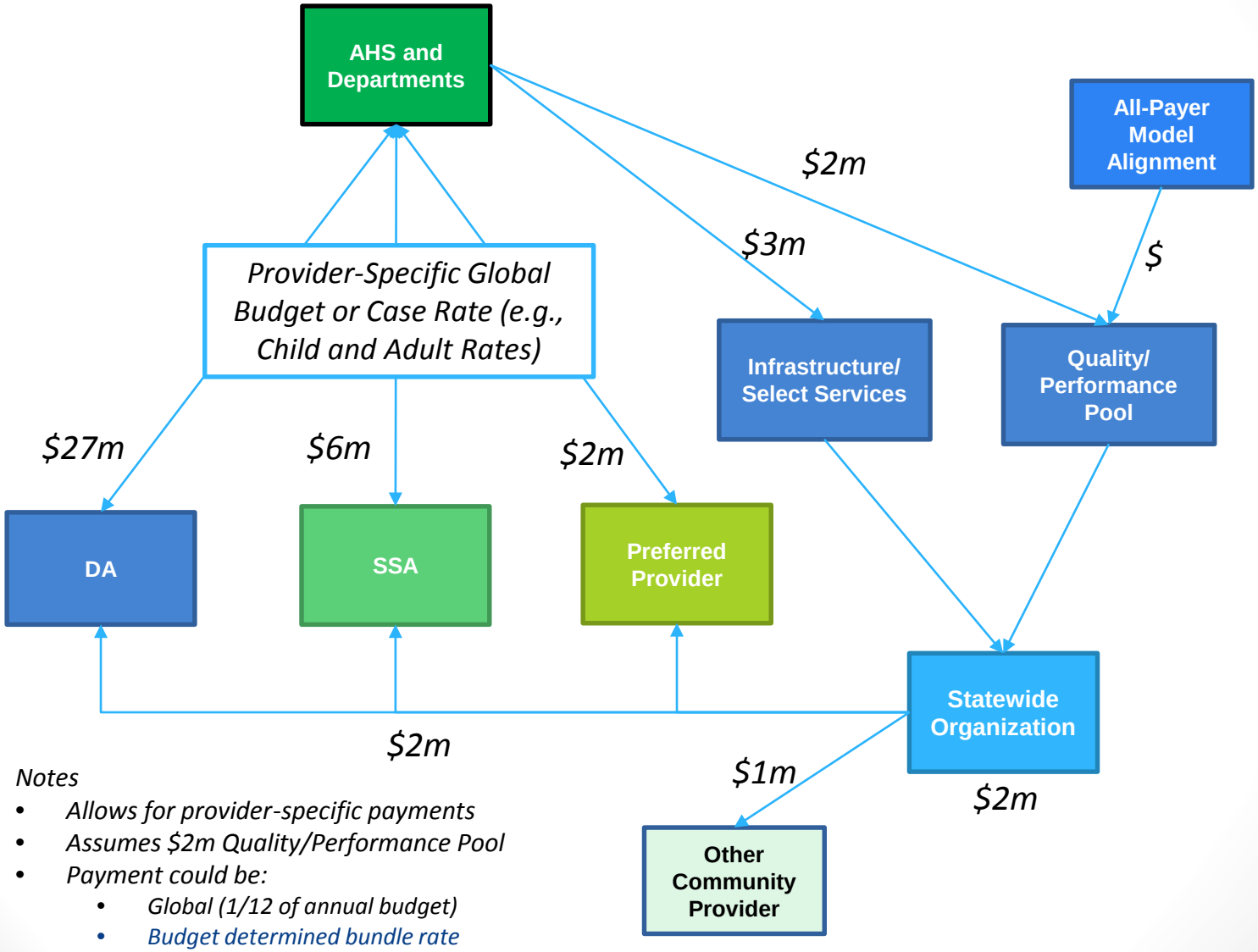
Example for Discussion: Partially Integrated Budget



Notes

- *Allows for provider-specific payments*
- *Assumes $2m Quality/Performance Pool*
- *Payment could be:*
  - *Global (1/12 of annual budget)*
  - *Budget determined bundle rate*

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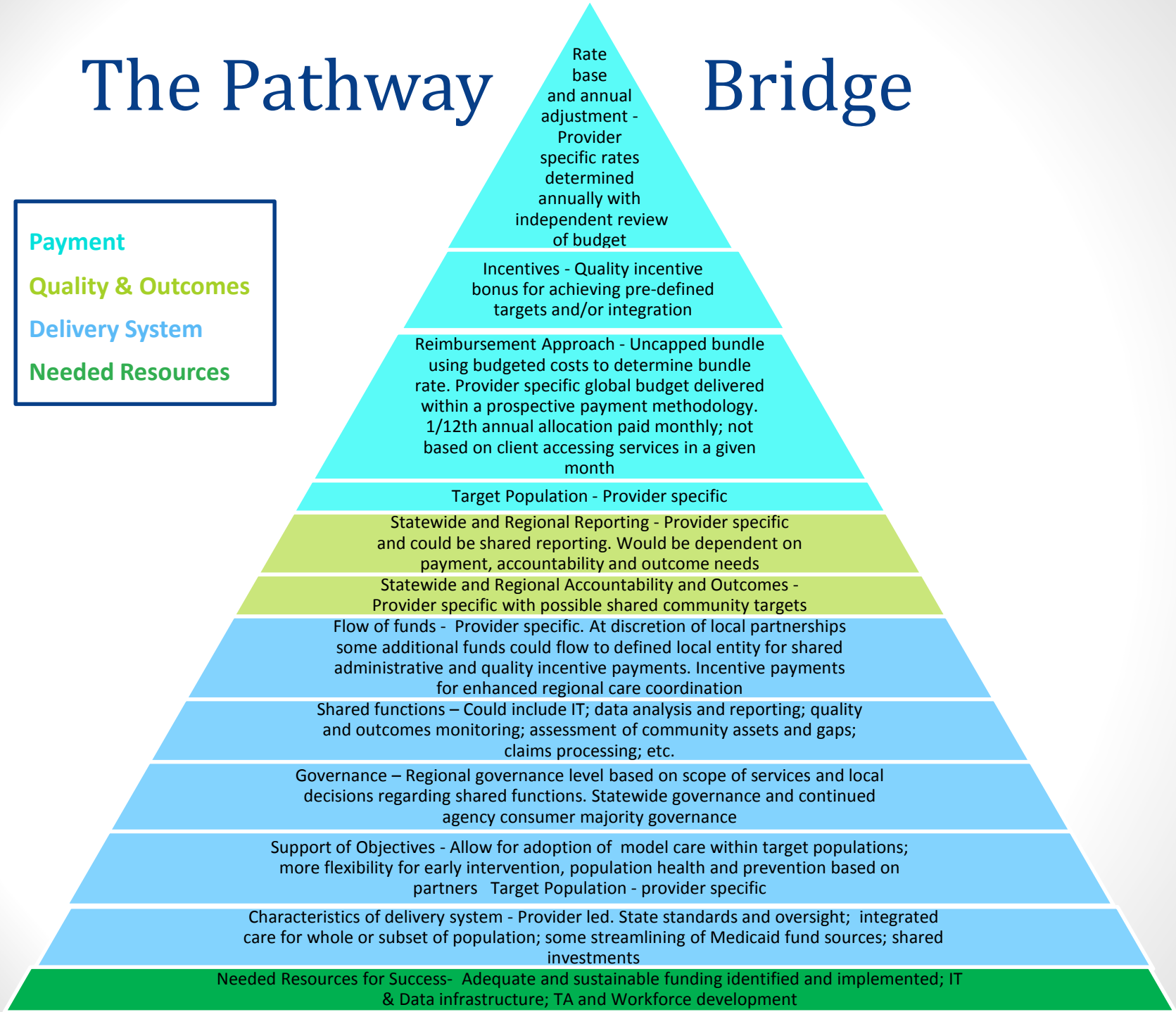
The Pathway Bridge

Payment

Quality & Outcomes

Delivery System

Needed Resources



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Questions and Next Steps

- Does this incremental model advance the long term goal?
- **What is a realistic timeline?**
- Do we want to roll this out statewide or allow providers to opt-in?
- **This is a presentation by VCP, what are the next steps for preferred providers, home health, AAAs, and others?**

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