Information Gathering Process

Mental Health, Substance Abuse Treatment and Developmental Disability Services

Vermont Medicaid Pathway
Delivery and Payment Reform
Request for Feedback

Release: September 16, 2016

Feedback Requested by: *October 17, 2016*

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1. INTRODUCTION AND BACKGROUND

1.1. Document Overview and Provider Instructions

The Vermont Agency of Human Services (AHS) is engaged in broad based planning to review its Medicaid program and determine what opportunities exist for creating a cohesive and organized delivery system across traditional health care and specialized health needs programs including long term services and supports. To support planning, better understand the readiness of the delivery system and encourage innovative ideas from participants and agencies not involved in regular planning meetings, the AHS has created a statewide information gathering process.

Specifically, AHS is seeking to gather information and feedback on proposed payment and delivery system reforms that would impact mental health, substance abuse treatment, and developmental services. Sections 1-6 and the Appendices of this document provide background materials, and describe delivery models and payment model designs currently under review. Section 7 includes a feedback tool that we are asking interested stakeholders to complete. Also included are links to other resources on integrated care models and additional background material.

Throughout the document you will find "Feedback Requested" boxes. These questions align with sections of the feedback tool that can be found in Section 7. Please review these materials and provide us with your thoughts ***by October 17, 2016,*** using the tool found in Section 7.

Responses will be accepted from all interested stakeholders; we welcome your ideas and input on how to improve the proposed payment reform and delivery system. Stakeholders are welcome to submit responses jointly or individually. We have categorized questions into two categories: those for all interested stakeholders, and those for providers who deliver the services targeted in this payment reform.

Information obtained through this process will be reviewed by AHS and with the larger stakeholder planning team and help refine final delivery system and payment reform designs for the Medicaid program.

1.2. Overview of Vermont Medicaid Pathway

There is a growing national recognition that fee-for-service (FFS) payment to providers (whether through direct contracts with the state or through Medicaid managed care organizations) has been responsible for the development and maintenance of a delivery system which does not adequately address the needs of the most complex Medicaid beneficiaries. The elderly, persons with disabilities, those with severe mental illness, and children with complex medical needs all constitute some of the most vulnerable and costly Medicaid members. Many of them are still served by fragmented delivery systems which are driven by historically siloed funding streams and a lack of financial incentives to coordinate or improve care. Hospitals, long-term care facilities, behavioral health providers, home and community-based care agencies, substance use treatment providers, and agencies serving those persons with disabilities – as well as physicians, federally qualified health centers, and rural health centers – are all part of a complex and fragmented Medicaid delivery and payment system.[1]

Vermont recognized this challenge in 2011, passing Act 48 of the Acts of 2011, which supports a transition away from fragmented care towards an integrated delivery system supporting the whole person. Through a federally-funded State Innovation Models Testing Grant, Vermont has spent the past three years designing, testing, and implementing alternatives to FFS payments. Vermont has also engaged in efforts to support practice transformation for our providers, as well as enhancements to our health data infrastructure.

In 2014, Vermont began exploring the possibility of an All Payer Model based on Medicare's Next Generation Accountable Care Organization (ACO) model with federal partners at the Centers for Medicare & Medicaid Innovation. An All-Payer Model would include an agreement between the State and the federal government to target a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers, and would build on past programs like Vermont's Medicaid and commercial Shared Savings Programs. If implemented, this model will focus on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services). The agreement would include strict quality and performance measurement and Medicare waivers if needed for restructuring payments, and would be structured using Next Generation's value-based payment models, such as capitation or global budgets.

[1] National Association of Medicaid Directors, "Value-Based Purchasing in Medicare and Medicaid: Areas of Intersection and Opportunities for Future Alignment" (June 2016). Available at: http://medicaiddirectors.org/wp-content/uploads/2016/06/FINAL-ISSUE-BRIEF_Medicaid-VBP-and-MultiPayer-Alignment.pdf.

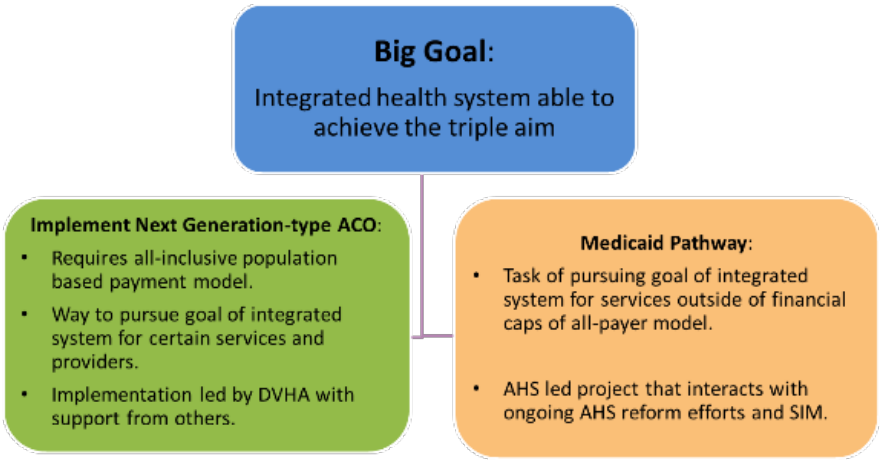
As ACO-focused delivery reforms mature under the All Payer Model they must begin to integrate with providers that support Community-Based Services in Vermont and address the social determinants of health in order to realize a fully organized and accountable system of care. Vermont's physical health care, disability and long-term services and supports (DLTSS), mental health, and substance abuse treatment systems cannot work in isolation. Reform objectives must include the development of an organized delivery system for serving individuals and promoting integration across services for:

- Mental Health;
- Substance Abuse Treatment;
- Physical Health; and
- Long-Term Services and Supports for,
    - Individuals with physical disabilities,
    - Older Vermonters, and
    - Individuals with developmental disabilities.

The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model. The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care for all Vermonters, including integrated physical health, long-term services and support, mental health, substance abuse treatment, developmental disabilities services, and children's service providers. The *Medicaid Pathway Goals* document, found here, provides more information about AHS' goals for the VMP.

The Medicaid Pathway is a planning process facilitated by AHS in partnership with the Agency of Administration. These planning efforts are designed to systematically review payment models and delivery system expectations across AHS and the Medicaid program, and to refine State and local operations to support new payment and delivery system models. As part of this process, AHS has convened a stakeholder group to focus on mental health, substance use, and developmental services.

The following figure illustrates how the All Payer Model and Medicaid Pathway support Vermont's goal of an integrated health system able to achieve the Triple Aim.



The VMP is guided by the following set of principles:

- *Ensure Access to Care for Consumers with Special Health Needs*
  - This principle seeks to ensure that the State's most vulnerable populations have access to high-quality, comprehensive care.
  - Access includes sustainability of specialized providers.

- *Promote Person- and/or Family-Centered and -Directed Care*
  - This principle 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 include 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 siloed decision-making that could result in unintended negative consequences.

- *Create a Structural Framework to Support Integration*
    - Organizational structures must support accountability and efficiency of operations at both the State and provider levels.
    - Health Care Reform efforts should align with State and provider short-term and long-term goals.
    - Any proposed change should be goal-directed and promote meaningful improvement.

The Medicaid Pathway process requires development of new provider and State processes to support comprehensive planning and implementation of reforms. This includes defining delivery system expectations and how those expectations may change the local delivery system as well as State contracting and oversight practices. Along these lines, the movement away from fee-for-service payment models to more clearly defined value-based purchasing methodologies will require changes in payment models, rate development, quality oversight and outcome monitoring. Lastly, the State will need to examine the resources needed for technical assistance and the impact on staffing and budgeting to support and sustain necessary changes in operation.

Through this information gathering process, AHS hopes to receive information developed by providers and communities to inform State policy and planning efforts around the VMP. AHS is sharing information about design and development work completed to date through the VMP process focused on delivery and payment reform for providers of mental health services, substance abuse treatment, and developmental disabilities services.

1.3. Purpose of Information Request

The proposed reforms, described in more detail in Sections 3 and 4, represent an unprecedented and unique opportunity for Vermont to promote integrated, comprehensive, coordinated, person-and family-centered and directed care as outlined in the Vermont Model of Care (described in Section 2) and to strengthen community-based mental health services, substance abuse treatment, and developmental services. Vermont is seeking feedback from interested stakeholders and in particular, those providers who would participate in VMP reforms, in order to inform final program design decisions prior to the launch of this new payment and delivery model. The reforms are initially focused on Designated Agencies and Specialized Service Agencies, with the opportunity to expand to other providers in future phases.

2. VERMONT MODEL OF CARE

The following section provides a summary overview of the Vermont Model of Care (more detail can be found in Section 7: Resources) as conceptualized in current AHS' discussions. Highlights of this model are presented below. These elements are expected to serve as the foundation for delivery system modifications in support of a more organized and consistent delivery system.

1. *Person/Family Centered and/or Directed Services and Supports:* 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. *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.

5. *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.

6. *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.

7. *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).

8. *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.

9. *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).

10. *Use of Technology for Information-Sharing:* Ultimate goal: A technological infrastructure that would:
    - House a common case management database/system.
    - 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.
    - Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options.
    - Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent.

Table 1 provides an overview of the Model of Care elements in comparison to other national frameworks. Vermont's Integrated Model of Care is fully aligned with the CMS and National Committee for Quality Assurance (NCQA) Disability and Long-Term Services and Supports Framework that was created for persons who are dually eligible for Medicare and Medicaid services.

Table 1: Vermont's Model of Care Comparison with Other National Frameworks

COMPARISON OF NATIONAL EVIDENCED-BASED MODELS				
Core Elements of Vermont Model *	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**				

Current discussion and planning efforts relative to All Payer Model and ACO development offer the opportunity to more fully realize Vermont's Integrated Model of Care throughout the entire

health care system including long-term services and supports, mental health and addictions treatment services. 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.

Feedback Requested
Section 2: Model of Care

For Providers and Stakeholders

1. Do current programs incorporate Model of Care elements? *If possible, provide additional detail and/or examples.*
2. Are there circumstances where the Model of Care or certain elements are not necessary to support person-centered and integrated care? *If possible, provide additional detail and/or examples.*
3. What indicators would you suggest to measure the extent to which providers are using the Model of Care? *Please provide specific measures or measure tools if possible.*

For Providers

4. Are improvements or enhancements to your current agency operations and practices necessary to fully implement the model of care in your region? *If possible, provide additional detail and/or examples.*

3. DELIVERY SYSTEM

As noted in Section 1, the objectives of delivery system transformation include the development of a more organized delivery system for serving all Medicaid beneficiaries and promoting integration across Mental Health and Substance Abuse Treatment; Physical Health Care; and Long-Term Services and Supports for Individuals with physical disabilities, older Vermonters, and Individuals with developmental disabilities. To date, planning efforts have defined a continuum of integration that ranges from a "Coordinated Model" at its most basic level, progresses to "Integrated Community Model" which contemplates locally designed regional partnerships and a fully integrated, regional or statewide "ACO-like" model. Brief descriptions of these models and their characteristics are provided below.

Service Coordination Model: 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.***

Integrated Community Delivery System – 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 staffs 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.***

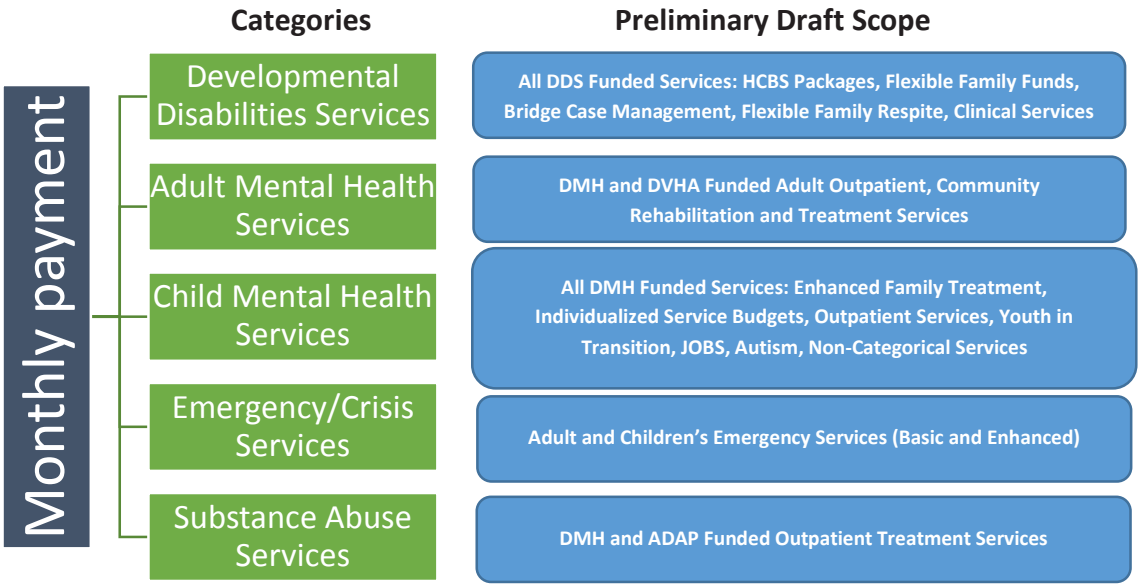
Full Integration ACO-Like Model: Separate entities develop a formal and/or unified governance structure that oversees a defined set of services and providers for a region or statewide. Structure is developed through contract agreements, corporate relationships (e.g., LLC, merger) or other legally recognized 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.

Discussions to date have acknowledged that, for the specialized AHS programs targeted in this reform effort, regional provider-led partnerships are best suited to support integration and be responsive to unique opportunities, gaps and challenges for each community they serve. Each of Vermont's 14[2] health service areas has unique characteristics and providers within these regions are actively engaged in identifying the best way to organize to meet the needs of Vermonters within their region.

AHS is encouraging entities that provide mental health, developmental and/or substance use disorder services to develop more integrated delivery models, focused on implementing the Vermont Model of Care (Section 2) and supported through payment reform.

The AHS is interested in understanding current levels of integration and hearing from providers and interested stakeholders ideas for expanded models of collaboration such as larger expanded regional and/or statewide delivery approaches based on demonstrated collaboration with willing partners. Please see below for a list of programs and services Vermont intends to include in the first year of delivery and payment reform:



[2] There are 11 Designated Agencies and 5 Specialized Service Agencies that provide services within these 14 HSAs.

Feedback Requested
Section 3: Delivery System

For Providers and Stakeholders

1. AHS is seeking provider-led reform. Does your organization support this principle? *If possible, provide additional detail about how you would operationalize this principle: How would providers optimally organize within your region to provide the integrated and person-centered care? Please provide a description of the organizational model and provider relationships that you would propose.*
2. Are there services and supports that you believe are critical to promoting more integrated care that are not currently available due to billing, coverage policies or provider restrictions? *If possible, provide additional detail about services and current barriers and/or provide examples*.

For Providers

3. Does your organization have affiliation agreements or partnerships with other local providers (e.g., Primary care practices; Hospitals; Federally Qualified Health Centers, Community Health Centers or Rural Health Clinics; Providers of Long-Term Services and supports; Other community-based organizations that provide social services such as transportation, housing, employment services, financial assistance, childcare, veterans services, legal assistance, correctional institutions)? *If possible, provide additional detail and/or examples, including organizational charts as applicable. If relationships exist, but could be strengthened or fostered, please indicate this as well.*
4. Do current affiliation agreements support integrated and person centered care? *If possible, provide additional detail and/or examples of agreements.*

3.1. Governance and Collaboration Expectations

The delivery model is expected to be provider-led and assumes these providers will take accountability for integrated care delivery models and beneficiary outcomes. The model supports integration on a regional basis recognizing that health care delivery is local and there is significant regional integration underway. Local efforts for collaboration are expected to support, at a minimum, the following activities:

- Achieving the VT Model of Care;
- Addressing social determinants of health;
- Assessing community needs and gaps;

- Using community and quality data to make decisions about community services, gaps, assets; and
- Creating consensus regarding community investments to support population health and the adoption of the Model of Care.

Discussions to date have focused on the role of provider led efforts to address strategic planning and local accountability for population health, integration of health systems and person-centered/directed care, and integrated planning contemplated in the Vermont Model of Care. Recent reforms include the Unified Community Collaboratives (UCCs), which represent a partnership between Blueprint for Health, Accountable Care Organizations, medical, social and community services providers in all 14 Health Service Areas state-wide. UCCs have begun to create more formalized integrated care models amongst participants and the Blueprint for Health is currently seeking to measure delivery system integration through initiatives such as a provider facing "team-based care survey" and a community network analysis. Initial findings indicate that through the work of the Blueprint Community Health Teams, and more recently the UCCs, significant progress towards regional delivery system integration has been made.

During the first phase of the mental health, substance abuse treatment and developmental disability services reforms, providers may choose to create formal or informal structures to address collaboration and outcome monitoring. AHS expects that providers would look at participation in existing community frameworks such as the UCCs, Integrating Family Services or other Local Interagency Team structures to determine if community oversight functions may be supported through existing frameworks and identify any components that may require additional enhancements to support. The following table outlines community oversight functions or local governance roles that AHS and stakeholders have determined are critical to support desired delivery and payment reforms.

Expected Regional Oversight/Governance Functions	
Function	**Description**
1. Strategic Oversight and Goal Setting	Local entities should have shared goals, community vision and clearly defined roles (based on final State standards and contract expectations)
2. Accountability for Management of Partnership Agreements	Any formal local agreements regarding decision making and roles need unified, agreed on point of responsibility (e.g., how each provider relates to local governance structure and decision-making)
3. Designation of an Administrative Lead Agency for Shared Services (if utilized)	Shared services and administrative structures are discretionary based on local provider decisions and

Expected Regional Oversight/Governance Functions	
Function	**Description**
	agreements, if regions decide to share functions then roles and responsibilities across providers should be clearly defined
4. Consumer Voice and Involvement in Governance	Local entities should include consumer's and family members in decision-making structure
5. Community Needs Assessment and Asset Building	State should develop standards to bring separate requirements across government together across services, providers and populations; Local entities would be responsible for unified needs assessment across domains and submitting cohesive plan for addressing gaps in a collaborative fashion.
6. Monitoring of Quality Data and Community Indicators of Health (Including Consumer Experience of Care and compliance with State standards)	Local entities would share responsibility for monitoring quality and outcome data, including how well the system is complying with state and/or federal standards as outlined in contract agreements
7. Monitoring of Service Utilization and Waiting List	Local entities should monitor service use and waiting list to inform both quality improvement and resource allocation/investment decisions
8. Direct Priorities for Local Quality Improvement (QI) Efforts	Local entities should make Quality Improvement decisions based on data from items above and local discussion

Feedback Requested

Section 3.1: Delivery System – Oversight and Governance Functions

For Providers and Stakeholders

1. Is there one model of regional integration that is most feasible for your region? *If possible, provide additional detail and/or examples, including a description of your region.*

For Providers

2. Do you currently partner with any other providers around shared administrative services? Are there opportunities for shared administrative services? Are there opportunities for greater efficiencies? *If possible, provide additional detail and/or examples around service, type arrangement, and partner organization.*
3. Does your current model involve shared decision making with other agencies? *If possible, provide additional detail and/or examples around shared governance structure and decision-making processes.*
4. Is your agency currently affiliating with an Accountable Care Organization or Blueprint network? *If possible, provide additional detail around the extent of the partnership.*

4. PROPOSED DA/SSA PAYMENT MODEL

The proposed payment model below is specific to Designated Agencies (DAs) and Specialized Service Agencies (SSAs). As discussed in Section 1, AHS expects to propose successive models for other provider and service types in the future. Through implementation of an alternative payment model for these providers, AHS seeks to **provide efficient, effective care to all Medicaid beneficiaries and to ensure that care is patient-centered/directed and meets the criteria described in the Vermont Model of Care.**

The proposed alternative payment model (APM) would consist of two components:
1) A global budget target and monitoring and adjustment process.
2) A monthly, prospectively-set, case-mix adjusted bundled rate for the majority of services provided by DAs and SSAs to Medicaid beneficiaries.

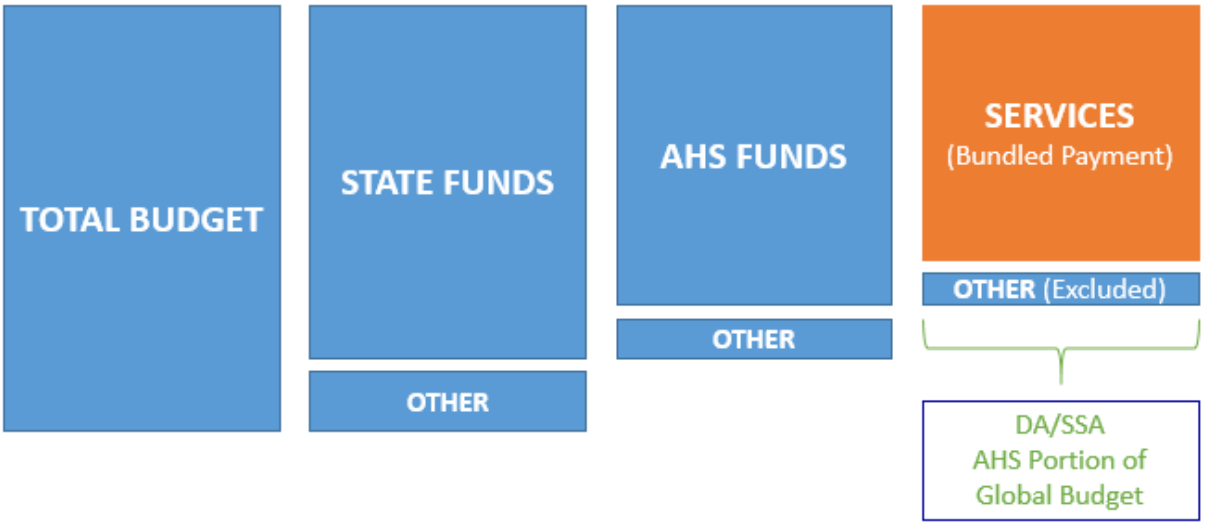
4.1. Development of a Global Budget

Global budgets are expenditure targets for health care spending. The purpose of setting an expenditure target is to constrain both the level and rate of growth of spending. The advantage of this approach is that it provides a clear incentive to operate efficiently. The downside however, is that these constraints can lead to access problems due to rationing by waiting. The monitoring and adjustment component of the global budget process will be required in order to both enforce targets and make informed decisions about the shifting of resources, particularly in response to potential access issues.

DA/SSAs received approximately 95% of their revenue from State sources in state fiscal year 2015 (SFY15). The payment model contemplated within this document is focused on setting an expenditure target for the AHS portion of the DA/SSA total budget, which represents approximately 88% of the total 95% of the revenue statewide from State sources. The State is developing a process by which targets are set and monitored against payments from the bundled payment system (described in Section 4.2) and other sources, like those from grants or specifically excluded services. Should a provider be falling behind or ahead of target, adjustments could be made either via grants, if allowable under terms of grant, or via bundled rate increases or decreases.

The figure below illustrates the subset of DA/SSA budgets this payment is intended to replace; note that non-State funds, funds from State agencies other than AHS, and some AHS funds earmarked for grants management and some other purposes are excluded. AHS has developed baseline expenditure targets by mapping revenue line details from SFY15 audited financial statements to non-State funded, State-funded, and AHS-funded portions. The AHS portion of

the DA/SSA revenue is then separated into those paid via the bundled rate described below and other, which includes specifically excluded services.



Feedback Requested
Section 4.1: Payment Model – Global Budget

For Providers and Stakeholders

1. What process or sources of information should be considered when setting future global budget targets?

4.2. Bundled Payment Model

As described in Section 4.1, the bundled payment will be supported by an overarching global budget calculation that will allow for AHS to compare regional activities and results as well as to support future integrated payment models beyond phase one of the Medicaid Pathway (see Section 6). The subset of the AHS budget and scope of services covered in this component of the model is represented by the orange box in the Figure from Section 4.1. After exclusions, AHS estimates this bundled payment would cover just less than half of the AHS targeted services (statewide) for DA/SSA providers. Currently, AHS considers the following programs to be excluded from the bundled payment system, except where they are already bundled in IFS pilot regions, and remain in the non-bundled "other" category: Self or Surrogate Managed Developmental Disability Services, Success Beyond Six (SBS), Traumatic Brain Injury (TBI), private non-medical institution (PNMI) as well services provided with Funding Sources from the Department of Child and Families, Department of Education and the non-ADAP Department of Health. Revenue related to intermediate care facilities (ICFs) were also removed from the bundled payment model.

The State is currently proposing a prospective, case-mix adjusted monthly bundled payment[3] model. Compared to fee-for-service (FFS), the advantage of a bundled payment model is that it incents efficiency of resources within the bundle, within a given month. However, the weakness of the monthly bundled payment approach is that on its own, it does not provide a direct incentive to manage how many monthly bundles are provided overall throughout the year. When paired with the global budget approach however, the model will allow for providers to respond and accrue revenue for increased utilization through the bundled payment which can be adjusted if needed when monitored against the global budget target.

The figure below describes the proposed bundles. These bundles were proposed because of similarity in characteristics represented and resources consumed. They were also proposed given their structure largely follows the current monitoring and reporting systems already in place so to minimize the transition to the bundled rate.

Feedback Requested
Section 4.2: Payment Model – Bundled Payments

For Providers and Stakeholders

1. Does the proposed payment model support the Medicaid Pathway goals and level of integration contemplated in the Model of Care? *If possible, provide additional detail and/or examples around perceived opportunities or barriers.* Do you have revisions or alternatives to the payment model that would support meeting the goals and level of integration? *If possible, provide additional detail and/or examples.*

[3] AHS considers this an iterative process and alternative models may be considered.

4.3. Methodology for Developing Bundled Payment Rates

A bundled payment rate model was developed that compiled financial and claims data for a historic period. Survey data, audited financial data, claims data, and data from the State's Monthly Service Report (MSR) database were compiled into a comprehensive database of historic service financial and utilization data. The database contains data from calendar years 2013, 2014, and 2015. The State proposes to use a fiscal impact model based on State Fiscal Year 2015 data to display the impact of various bundled payment models against actual baseline or adjusted baseline cost and payments.

The State then conducted extensive financial analysis on the compiled data to assess the sample size, variability in spending, outliers and the best approach to case-mix and/or risk adjustment. The data was validated using external sources where possible. Next, the State calculated the historic cost of providing services included in the bundle. Upon reviewing the findings of the financial and costing analysis, the proposed bundles and options for outlier and case-mix adjustment were developed; see Section 4.4 for more details.

Feedback Requested
Section 4.3: Payment Model – Methodology for Developing Bundled Payments

For Providers and Stakeholders

1. In evaluating the proposed model, what additional information or data reports would be helpful?

4.4. Bundling, Case-Mix Adjustment, Outliers, and Other Considerations

AHS, with support from a contractor, reviewed several payment model methodologies. The Medicaid Pathway payment model review document, found here, describes these analyses in more detail. While AHS considered setting cost coverage targets either in the aggregate across all DAs, SSAs or other peer groupings, the proposal is to set the cost coverage targets at the individual DA or SSA provider-level. Prospective rates will be set in order to achieve an aggregate cost coverage target for a defined set of services at the provider level.

Bundling of payments by clinically meaningful service categories and case-mix adjusting help to improve predicting future spending based on historical averages. As described in Section 4.2, the proposed bundles include: Developmental Disabilities Services; Adult Mental Health Services (including CRT); Child Mental Health Services; Emergency/Crisis Services; and Substance Abuse Services. The State considered case-mix adjusting within each bundle such

that actual services received in any given month could trigger a higher bundled rate. This approach would provide additional resources when a beneficiary experienced a higher than historically recorded use of services; however, the approach has a strong incentive for providing more services to trigger an enhanced payment, referred to as up-coding in risk adjustment or in the diagnostic resource group (DRG) system. Because of this, the State is not proposing to case-mix adjust within each bundle at this time.

To avoid this incentive, AHS proposes using historic, provider-specific historic case-mix to set the prospective bundled rates. Updates to the case-mix would be reflected as future re-basing of the bundled rates occurred. Therefore, historic provider-level case-mix will be determined by using weighted bundled costs to construct a relative weight across the five bundles proportionate to their resource use and utilization for that provider in the historic data. To convert the relative weights to rates which in the aggregate, will equal a total percent of cost, a provider-specific conversion factor will be set.

To ensure that the predicted spending in the prospective rate is as accurate as possible, adjustments to historic utilization will be made for known changes in trends. An example of this is in the area of autism coverage, which is a new service being offered. If necessary, risk corridors will be set up so that the new methodology does not create significant increases or decreases in spending compared to baseline or adjusted baselines. Moreover, an outlier policy based on monthly costs in excess of two standard deviations of the mean, approximately equivalent to a total withhold in spending of approximately 2.5% across all DAs and SSAs, is proposed.

In summary, under the proposed bundled model, the total monthly payment for a beneficiary would be the sum of the provider-specific rates for those bundles triggered net of any applicable outlier payments and/or adjustments like discounting for efficiencies when multiple bundles are provided in the same month, if applicable. Bundles would be triggered based on some unique combination of services and modifiers recorded on professional services claims forms (CMS1500). The rates would reflect historic provider-specific case-mix and be set equal to a specified percent of cost target.

Feedback Requested

Section 4.4: Payment Model – Case-Mix, Outliers and Other Considerations

For Providers

1. Can your current business office and billing systems support Phase One of the proposed model? *If possible, provide additional detail and/or examples of changes that would be required to support the payment model.*

4.5. Required and Additional Services

The aim of this payment model is to provide DAs and SSAs with a predictable, responsible, and flexible revenue stream with appropriate quality measurement to support accountability to the State and individuals served. DAs/SSAs would receive monthly prospective payments, developing a standardized, comprehensive, patient/person-month administrative record of charges and services rendered.

AHS is proposing this payment model for mental health, developmental services and substance use services currently provided by DAs and SSAs including:

- Adult Mental Health Services
- Child Mental Health Services
- Community, Rehabilitation, and Treatment (CRT)
- Emergency/Crisis Services
- Substance Abuse Services

In addition to the required services, the State may consider adding additional services in the future.

Feedback Requested

Section 4.5: Payment Model – Required and Other Services

For Providers

1. What minimum or core set of services should be included in the payment model?
2. Are there other services or supports that you feel should be included in phase one of the proposed payment model? *If possible, provide additional detail and/or examples.*

5. QUALITY FRAMEWORK

A key component of the Medicaid Pathway work to support delivery system and payment reform is the quality framework. The overall quality and outcome framework is related to, but broader than, quality metrics that may be used to determine incentive payments. The impact of quality measures on the payment model will be only upside risk, meaning providers can increase revenue through the achievement of higher quality. This is meant to transition these providers from the current, non-risk based payment model into one where there is increased accountability. Through the quality framework, AHS will seek to achieve the following:

- Align measurement and reporting with values, principles and goals
- Create a foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning:
    - *Accountability*: Confirm that contracted services were delivered. Did the State get what it paid for?
    - *Appropriateness*: Were the services delivered based on best practice and State standards (e.g., process and clinical, Model of Care, Home and Community Based, Trauma, Recovery, Reliance, etc.)?
    - *Outcomes:* Did the services delivered produce the expected results?

Key elements of quality and outcome measurement involve quality indicators that utilize a broad measure set including structure, process and experience of care measures, examples of measures that may be considered in each area, include but are not limited to:

- Access, Structure and Process
    - Efficiency and timely access
    - Primary Care involvement in comprehensive treatment and care planning
    - Communication between the medical and specialized systems of care
    - Adherence to State standards and best practice

- Beneficiary Experience
    - Involvement in decision-making
    - Satisfaction regarding care coordination and access
    - Support during care transitions
    - Increased overall satisfaction with services and supports
    - Decreased out-of-pocket costs (e.g., fewer co-pays for ER, other services)
    - Increased early intervention options for children, adults and families

- Positive Health Outcomes that include measures of independence as well as traditional health scores

- Person and Service Related Outcomes
    - Decreased emergency room utilization

- Decreased avoidable hospital admissions / re-admissions
- Decreased nursing home utilization
- Health assessment and/or condition specific scores (asthma, diabetes, overall assessment of functioning)
- Decreased use of residential care for children, youth and adults
- Stable community living situation
- Stable employment
- Attainment of person-centered goals and objectives

Examples of potential systemic outcomes include:

- Decreased Provider Cost-shifting across Payers
  - Due to more service oversight and coordination across all of the individual's medical and specialized needs via a single point of contact, comprehensive care plan, and integrated care team
- Decreased Overall Costs for Health Care System

AHS has sponsored a Medicaid Pathway outcomes subgroup to meet between August and December of 2016. The group will propose quality measures to support implementation of the Medicaid Pathway delivery system goals and proposed payment model.

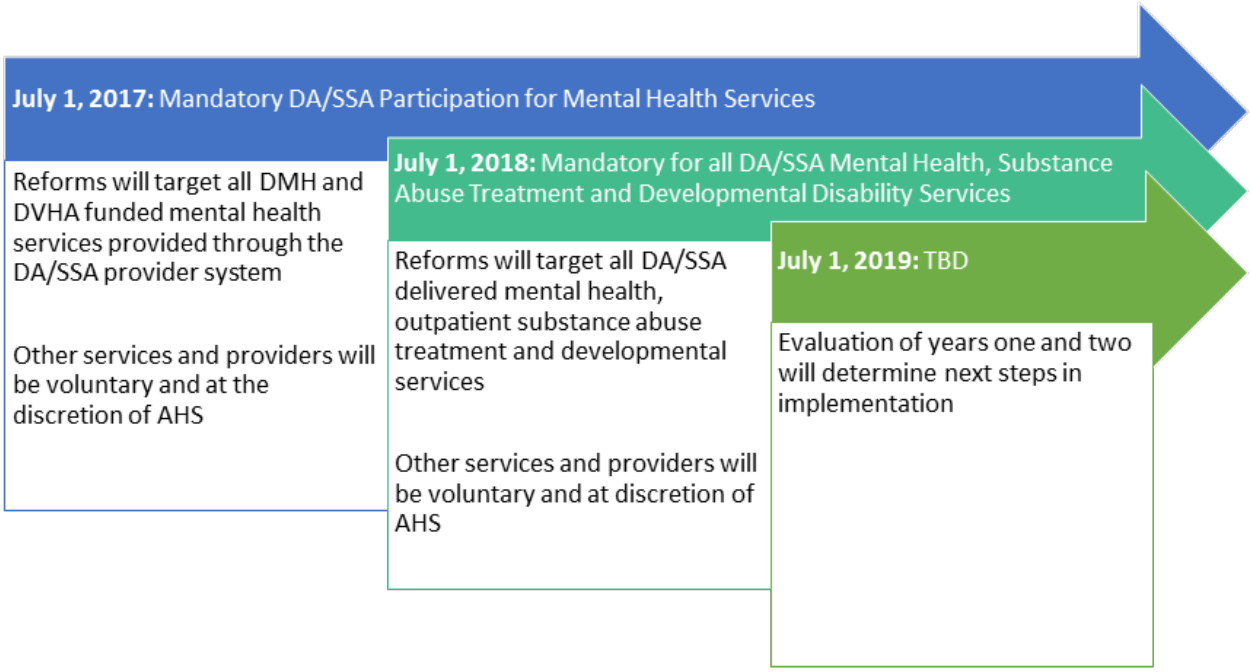
Feedback Requested
Section 5: Quality Framework

For Providers and Stakeholders
1. Are there specific quality measures that you feel should be included to ensure appropriate accountability in the payment model?

6. PHASING

The first phase one of this reform targets the Designated Agencies of Mental Health and Developmental Services (DA) and Specialized Service Agency (SSA) system of care; however broader partnerships and integration with community partners are encouraged. Providers are expected to partner with primary and acute care service providers, as well as other community providers such as home health agencies, parent child centers, area agencies on aging and others to implement the Model of Care and support better coordinated care and comprehensive care for Medicaid beneficiaries. The reform is expected to expand upon current mental health and substance use disorder capacity, promote full adoption of the Vermont Model of Care (described in more detail in Section 2) and overall improve connections between primary care, mental health, substance abuse treatment and developmental disability services.

Expected timelines for implementation are outlined on the following page.



Feedback Requested:

Section 6: Implementation Phasing

For Providers and Stakeholders

1. Is the proposed approach to phasing feasible? *If possible, provide additional detail and/or examples of alternative approaches or considerations to implementation.*

7. REQUEST FOR FEEDBACK

7.1. Contact Information

The sole point of contact for this information gathering process is:

Julie Corwin
Senior Health Policy Analyst
Department of Vermont Health Access
(802) 557-7925
julie.corwin@vermont.gov

7.2. Timetable

Written feedback is due on October 17, 2016.

7.3. Feedback Template

Please use the template below to provide feedback.

Organization Name:

Region (please list the Counties/Towns Represented):

Is this a Joint Response?

If Yes, please list partners below.

(For Joint Reponses) Partner Organizations and Partner Roles:

Person Completing Feedback Form:

Name:

Title:

Phone:

Feedback Area: Model of Care:

1. Do current programs incorporate Model of Care elements? *If possible, provide additional detail and/or examples.*
2. Are there circumstances where the Model of Care or certain elements are not necessary to support person-centered and integrated care? *If possible, provide additional detail and/or examples.*
3. What indicators would you suggest to measure the extent to which providers are using the Model of Care? What additional data or reports would be helpful? *Please provide specific measures or measure tools if possible.*
4. Are improvements or enhancements to your current agency operations and practices necessary to fully implement the model of care in your region? *If possible, provide additional detail and/or examples.*

Response:

Feedback Area: Delivery System

1. AHS is seeking provider-led reform. Does your organization support this principle? *If possible, provide additional detail about how you would operationalize this principle: How would providers optimally organize within your region to provide the integrated and person-centered care? Please provide a description of the organizational model and provider relationships that you would propose.*
2. Are there services and supports that you believe are critical to promoting more integrated care that are not currently available due to billing, coverage policies or provider restrictions? *If possible, provide additional detail about services and current barriers and/or provide examples.*
3. Does your organization have affiliation agreements or partnerships with other local providers (e.g., Primary care practices; Hospitals; Federally Qualified Health Centers, Community Health Centers or Rural Health Clinics; Providers of Long-Term Services and supports; Other community-based organizations that provide social services such as transportation, housing, employment services, financial assistance, childcare, veterans services, legal assistance, correctional institutions)? *If possible, provide additional detail and/or examples, including organizational charts as applicable. If relationships exist, but could be strengthened or fostered, please indicate this as well.*
4. Do current affiliation agreements support integrated and person centered care? *If possible, provide additional detail and/or examples of agreements.*

Response:

Feedback Area: Collaboration and Governance

1. Is there one model of regional integration that is most feasible for your region? *If possible, provide additional detail and/or examples, including a description of your region.*
2. Do you currently partner with any other providers around shared administrative services? Are there opportunities for shared administrative services? Are there opportunities for greater efficiencies? *If possible, provide additional detail and/or examples around service, type arrangement, and partner organization.*
3. Does your current model involve shared decision making with other agencies? *If possible, provide additional detail and/or examples around shared governance structure and decision-making processes.*
4. Is your agency currently affiliating with an Accountable Care Organization or Blueprint network? *If possible, provide additional detail around the extent of the partnership.*

Response:

Feedback Area: Payment Model

1. What process or sources of information should be considered when setting future global budget targets?
2. Does the proposed payment model support the Medicaid Pathway goals and level of integration contemplated in the Model of Care? *If possible, provide additional detail and/or examples around perceived opportunities or barriers.* Do you have revisions or alternatives to the payment model that would support meeting the goals and level of integration? *If possible, provide additional detail and/or examples.*
3. In evaluating the proposed model, what additional information or data reports would be helpful?
4. Can your current business office and billing systems support Phase One of the proposed model? *If possible, provide additional detail and/or examples of changes that would be required to support the payment model.*
5. What minimum or core set of services should be included in the payment model?
6. Are there other services or supports that you feel should be included in phase one of the proposed payment model? *If possible, provide additional detail and/or examples.*

Response:

Feedback Area: Quality Framework

1. Are there specific quality measures that you feel should be included to ensure appropriate accountability in the payment model?
Response:

Feedback Area: Phasing 2. Is the proposed approach to phasing feasible? *If possible, provide additional detail and/or examples of alternative approaches or considerations to implementation.*
Response:

8. RESOURCES

Vermont Model of Care
Medicaid Pathway Overview