MENTAL HEALTH PAYMENT REFORM

DEPARTMENT OF MENTAL HEALTH/DEPARTMENT OF VERMONT HEALTH ACCESS

APRIL 2018

WHY:

As a state we contract out a large percent of our mental health services to non-profit community partners (Designated Mental Health Agencies). We set their budgets, so they function in a capped system. We don’t ask community partners what it costs to provide the services, instead we give them a set amount to meet the diverse needs of their clients. State funded mental health Programming is complex and currently resides across 6 Departments and 11 Divisions within the Agency of Human Services, and each silo operates independently. This lack of coordination has resulted in a system of care that can be fragmented, inefficient, and difficult to navigate. Payment structures often vary across programs, and can require complex, confusing and restrictive eligibility requirements and billing practices that limit providers’ flexibility to deliver needed services.

Mental Health Payment Reform will begin to address these challenges and support the goal of promoting and improving the mental health of Vermoneters by: Improving the **efficiency and coordination** of mental health programs and services around the State; simplifying payment structures to **increase flexibility and predictability of payments**; and shifting to Value-Based payment models that **reward outcomes and incentivize best practices**.

WHAT:

Mental Health Payment Reform supports a cultural shift in the way State funded mental health providers do business. We are moving the focus from counting how much we are doing to looking at how well we are doing. This shift is enabled by giving communities more flexibility with funding and decision-making, so agencies can focus on the needs of the children, youth, adults and families they serve; and provide the right supports and services, at the right time.

Payment for a large portion of existing state funded mental health services will be “bundled” into two core monthly case rates - Child and Adult. Providers will be paid a monthly case rate per client served based on a single service included in the bundled case rate until the agency’s annual allocation is met. Payment reform is not about adding new money to the system; it is about reducing barriers and increasing flexibility to meet the needs of individuals and families. Payments will be “Value Based” meaning that they will be linked to quality and performance on a selected set of measures and will incentivize outcomes based on clinical best practice of care.
### Core Children’s Case Rate
- Emergency Services (ACCESS)
- MH Waiver (EFT)
- JOBS
- All FFS (DMH)
- Outpatient Services (DVHA)

### Core Adult Case Rate
- Outpatient Services (DMH)
- Outpatient Services (DVHA)
- CRT (Community Rehab and Treatment)
- Intensive Residential Recovery Facilities
- Emergency Support Fund (for CRT)
- Other DA specific CRT related programs

### Core Adult Case Rate
- Emergency Services
- SFI (Severely Functionally Impaired)
- CSIP (Collaborative Systems Integration Project)
- Staff Secure Transportation
- Eldercare (DAIL/DMH)
- Substance Use (DMH)

### HOW:
Payment reform will support the goal of promoting and improving the mental health of Vermonters by:
- Decreasing administrative burden;
- Eliminating complex and varying programmatic requirements;
- Delivering more predictable payments;
- Providing flexibility that supports comprehensive, coordinated care; and
- Standardizing an approach for tracking population indicators, progress, and outcomes.

### GLOSSARY OF ACRONYMS
- CRT: Community Rehab and Treatment
- DAIL: Department of Disabilities Aging and Independent Living
- DMH: Department of Mental Health
- DVHA: Department of Vermont Health Access
- EFT: Enhanced Family Treatment

### FOR MORE INFORMATION: CONTACT THE DEPARTMENT OF MENTAL HEALTH
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INTRODUCTION TO STAKEHOLDER ENGAGEMENT MATERIALS

The enclosed stakeholder engagement materials are designed to assist users when communicating about mental health payment reform in a clear and consistent manner across diverse stakeholder groups such as:

- Mental Health Providers
- Individuals & Families
- State Government Agencies

Materials can be drawn from as the user sees fit, and may be useful when communicating with:

- Staff across the Agency of Human Services and Designated Mental Health Agencies;
- Local community groups such as the Local Program Standing Committees, Local Interagency Teams, the Integrating Family Services Core Teams, the Accountable Communities for Health Teams, and any other community organizations or partners;
- Consumer advocacy groups such as the DS Standing Committee, the State Program Standing Committee (Children’s Mental Health & Adult Mental Health), the Act 264 Advisory Board, the Department of Disabilities Aging and Independent Living Advisory Board, the Vermont Family Network, the Vermont Federation of Families for Children’s Mental Health, and the Medicaid Exchange Advisory Board;
- Legislative committees, and all other interested parties.

FOR MORE INFORMATION ON MENTAL HEALTH PAYMENT REFORM PLEASE CONTACT THE DEPARTMENT OF MENTAL HEALTH

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Beginning in August 2017, the Department of Mental Health, Department of Vermont Health Access, Vermont Care Partners, and Designated Agencies began a collaboration to design and implement payment reform for children and adult mental health services.

Multiple work groups have been meeting on a bi-weekly basis to design, plan for, and prepare to implement the new payment model.

The first year of payment reform will offer an opportunity to oversee, observe, and evolve payment model operations. More AHS partners, programs and services are expected to join overtime – likely beginning with DAIL and DCF funded programs.
Current Issues

• A large percent of mental health services in Vermont are provided by non-profit community partners (Designated Mental Health Agencies). Funding for the Mental Health System is capped, the State pays a set amount to each agency.

• State funded mental health programming is complex and currently resides across 6 Departments and 11 Divisions within the Agency of Human Services. Lack of coordination has resulted in a system of care that can be fragmented, inefficient, and difficult to navigate.

• Payment structures often vary across programs, and can require complex, confusing and restrictive eligibility requirements and billing practices that limit providers’ flexibility to deliver needed services.

How Can Payment Reform Help?

• Decreases administrative burden;

• Delivers more predictable payments;

• Provides flexibility that supports comprehensive, coordinated care;

• Standardizes an approach for tracking population indicators, progress, and outcomes; and

• Supports AHS’s goal, moving away from FFS to a more value-based approach to payment.

Long Term Goals

• To promote and improve the mental health of Vermonters by:
  o Improving the effectiveness and coordination of mental health programs and services around the State;

  o Simplifying payment structures to increase flexibility and predictability of provider payments; and

  o Shifting to Value-Based payment models that reward outcomes and incentivize best practices.
<table>
<thead>
<tr>
<th>Simple</th>
<th>Expressly move from siloed programmatic payment streams to more population-based payments, increasing accountability and risk to impacted providers over time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficient</td>
<td>Incentivize high quality, efficient services and reduce incentive for high service volume.</td>
</tr>
<tr>
<td>Flexible</td>
<td>Increase flexibility in payment to support more efficient delivery of services.</td>
</tr>
<tr>
<td>Integrated</td>
<td>Reduce payment silos and fragmentation across provider and service types.</td>
</tr>
<tr>
<td>Value-Based</td>
<td>Connect payments with quality in service delivery and health of Medicaid beneficiaries.</td>
</tr>
<tr>
<td>Standardized</td>
<td>Align measurement and reporting with values, principles and goals.</td>
</tr>
<tr>
<td>Accountable</td>
<td>Provide data and feedback to providers delivering care to support accountability for quality and cost.</td>
</tr>
</tbody>
</table>
Healthier People (Improved outcomes and value)

- Population health focus
- Increase capacity for prevention and early intervention
- Efficient quality review and program evaluation processes
- More standardized tracking of outcomes across programs and populations

Better Care (Improved customer experience)

- Improved access to care
- Increased integration and collaboration throughout the care planning and delivery process
- Improved satisfaction
- System of Care is strengthened

Smarter spending (Increased fiscal sustainability)

- Simplify funding streams
- Move from siloed payments streams towards population based payments
- Increase payment predictability
- Increase provider flexibility
Create foundation for unified provider reporting, corrective action and quality improvement standards.

Advance goal of cohesive program oversight & monitoring across the AHS.

Reduced administrative burden to providers and the AHS.

Collect integrated & actionable data to support future program design & policymaking.

Standardized Program Administration Drives Service Integration
What Does Payment Reform Mean For....

Individuals & Families

Providers

Agency of Human Services

ALIGNED GOALS SUPPORTED BY CLEAR AND CONSISTENT MESSAGES
Mental Health Payment Reform gives communities more flexibility with funding and decision-making, so agencies can focus on the needs of the children, youth, adults and families they serve; and provide the right supports and services, at the right time. This will enable individuals & families to:

- Access primary and secondary prevention, including early intervention to reduce risk factors;
- 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; and
- Navigate service delivery across the care continuum.
<table>
<thead>
<tr>
<th>Before IFS</th>
<th>After IFS</th>
<th>What does this mean for families?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual/client focus</td>
<td>Focus on healthy children, family, schools, child and family environments including communities</td>
<td>Offer a parenting support/education group in Bristol – made possible by using flexible funding for staff to facilitate the group.</td>
</tr>
<tr>
<td>Eligible only when circumstances became bad enough to qualify for services</td>
<td>Early intervention, treatment and support</td>
<td>“John” – a young man with an extensive history of hospital and residential placement – was supported with a skills worker. As a result, he has been able to remain at home with his mother for the last two years, has successfully attended the Teen Center and is now able to move towards greater independence. Prior to IFS, skills workers were only available to 1-3 youth annually who received Medicaid Waiver services. Through IFS, 34 youth received this service during FY 14.</td>
</tr>
<tr>
<td>Multiple individual providers with separate systems and standards, intakes, budgets based on separate expectations from each AHS division/department</td>
<td>Unified local network/continuum for direct services Multi-disciplinary team approach available with consistent guidelines in each region</td>
<td>Prior to IFS, services were limited to case management supports for children not on developmental services (DS) waivers. IFS has enabled families to receive full wraparound supports if needed, including home-based services, Applied Behavior Analysis (ABA) consultation, and respite care</td>
</tr>
</tbody>
</table>
The Agency of Human Services and Designated Agencies are partnering to support the mission of operating an integrated, high quality care delivery system by designing and implementing payment reform that:

- Transitions Designated Agencies away from historically siloed programmatic funding systems to an alternative payment model that rewards high-quality, cost-effective care;

- Shifts accountability for the quality, cost, and experience of care to Designated Agencies in exchange for increased flexibility and predictability in payments; and

- Enables Designated Agencies to focus on meeting needs of the individuals and families they serve, not eligibility and program requirements.
Goals of Payment Reform

The Agency of Human Services and Designated Agencies are partnering to develop new value-based payment models for reforming mental health service reimbursement. The goal is to support the mission and vision of the Department of Mental Health and Agency of Human Services by creating value-based payment models that:

- Build on past experiences of Integrating Family Services and Medicaid Pathway projects;
- Include other AHS Departments over time;
- Align with alternative and value-based payment approaches and the All-Payer Model; and
- Support providers to have the flexibility they need to implement effective service delivery approaches.
Scope of Payment Reform

Payment reform is not about adding new money to the system; it is about reducing barriers and increasing flexibility to meet the needs of individuals and families.

**Current State**
Multiple discreet payments supported by varying programmatic requirements, indicators & outcomes.

**Future State**
One bundled payment supported by aligned programmatic requirements, indicators & outcomes.

1 Monthly Bundled Case Rate Payment
How Will Payment Reform Impact Providers?

Current

Providers are required to fit clients into program eligibility requirements and don’t always have the flexibility to structure a plan based on the individual’s needs.

Future

Providers are paid a monthly case rate based on a single service included in the bundled case rate. This allows providers more flexibility to manage the needs of individuals.

Current

Service billing and clinical documentation requirements are structured to account for discreet time spent with a client.

Future

Service billing and clinical documentation shifts to more meaningful indicators such as progress on a client’s goals, plan of care or some other outcome.
An Incremental Approach

Mental Health Payment Reform will begin with services paid for by the Department of Mental Health and the Department of Vermont Health Access, as well as a small amount of services paid for by the Department of Disabilities Aging and Independent Living and the Department for Children and Families, and will seek to include additional departments and services in future years.
Two separate work groups were convened to design the payment model & methodology for Child and Adult programs. Both work groups recommended that Designated Agencies receive a separate bundled payment for each case in each month (a case rate) for child and adult services, and have focused on:

- Defining what programs and services are included in the child & adult case rates
- Methods for constructing the case load and case rate
- Methods for addressing risk
- Methods for constructing value based payments
Payment Model & Methodology
Children’s Case Rate

Core

- Emergency Services (ACCESS)
- MH Waiver (EFT)
- JOBS
- Outpatient Services (DMH)
- Outpatient Services (DVHA)
- Micro-residential (DMH- WCMHS)
- “Low-level” Individual Service Budgets (DCF)

Future Consideration

DMH Funded Programs Including:
- PNMI
- Success Beyond 6

DAIL Funded Programs Including:
- Family Flexible Funding
- Bridge
- Family Managed Respite
- DS Waiver

DCF Funded programs
Payment Model & Methodology
Adult Case Rate

Core

- Outpatient Services (DMH)
- Outpatient Services (DVHA)
- CRT (Community Rehabilitation and Treatment)
- Intensive Residential Recovery Facilities
- Emergency Support Fund (for CRT)
- Other DA specific CRT related programs
- Emergency Services
- SFI (Severely Functionally Impaired)
- CSIP (Collaborative Systems Integration Project)
- Staff Secure Transportation
- Eldercare (DAIL/DMH)
- Substance Use (DMH)

Future Consideration

- Reach Up
- Traumatic Brain Injury
Two separate work groups were formed to select diverse measures for child and adult programs and design a value based payment model that is linked to quality and performance on selected measures that:

- **Focus on outcomes**;
- **Increase the quality and the value** of the programs and services provided;
- **Are feasible to collect** and;
- **Produce meaningful data** for CQI efforts.
Value-Based Payment Overview & Expectations

**Year One: Focus on Reporting**
- Reporting compliance
- Standardization
- Evolve/Identify new measures

**Year Two: Focus on Performance**
- Select a portion for Value-Based Payments
- Continue the “pay for reporting” other measures
- Evolve/Identify new measures

**Year Three: Value-Based Payments**
- Responsible for all Year-One measures
- Continued evolution...
Value Based Payment Five Year Plan

Year One
- Reporting: 10
- Identify: 1-2

Year Two
- Performance: 5
- Reporting: 5-7
- Identify: 1-2

Year Three
- Performance: 10
- Reporting: 2-5
- Identify: 1-2

Year Four
- Performance: 12
- Reporting: 1-3

Year Five
- Performance: 15
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Pregnant women and young children are thriving</th>
<th>Families/Communities are safe, stable, nurturing, and supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Indicators</td>
<td>a. Demonstrates Resilience / Flourishing</td>
<td>a. Family Strengths</td>
</tr>
<tr>
<td></td>
<td>b. Prevalence of Emotional, mental or behavioral conditions</td>
<td>b. Child involvement in Community Activities</td>
</tr>
<tr>
<td></td>
<td>c. Level of severity of Emotional, mental or behavioral conditions</td>
<td>c. Parent’s physical health, mental/emotional health</td>
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<tr>
<td></td>
<td>d. How often have these conditions affect child’s ability to do things, severity of impact</td>
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### Performance Measures proposed for Payment Reform – Children’s Mental Health

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<tr>
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<tbody>
<tr>
<td><strong>Delivery System Measure</strong></td>
<td><strong>Process Measure</strong></td>
<td><strong>Patient Experience Measure</strong></td>
</tr>
<tr>
<td>- # of children/youth (0-17) served</td>
<td>- % of clients offered a face-to-face contact within five days of initial request</td>
<td>- Array of Services</td>
</tr>
<tr>
<td>- # of eligible children/youth (0-17) served [per 1,000 children residents]</td>
<td>- % of clients seen face-to-face within 14 calendar days of intake assessment</td>
<td>- % of clients indicate services were right for them</td>
</tr>
<tr>
<td>- SED prevalence for 0-17*</td>
<td>- % of clients with a CANS update recorded within the last 6 months</td>
<td>- % of clients indicate they received the services they needed</td>
</tr>
<tr>
<td>- SED prevalence for 18-22*</td>
<td></td>
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</tr>
<tr>
<td>*SED determination based on diagnosis, duration, and functional impairment (using CANS)</td>
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4/23/2018
### Performance Measures proposed for Payment Reform – Adult Mental Health

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<tbody>
<tr>
<td><strong>Delivery System Measure</strong></td>
<td><strong>Process Measure</strong></td>
<td><strong>Patient Experience Measure</strong></td>
</tr>
<tr>
<td>· # of adults served</td>
<td>· % of clients offered a face-to-face contact within five days of initial request</td>
<td>· Array of Services</td>
</tr>
<tr>
<td># of adults served [per 1,000 residents]</td>
<td>· % of clients seen face-to-face within 14 calendar days of intake assessment</td>
<td>· % of clients indicate services were right for them</td>
</tr>
<tr>
<td></td>
<td>· The agency screens for substance use.</td>
<td>· % of clients indicate they received the services they needed</td>
</tr>
<tr>
<td></td>
<td>· The agency screens for psychological trauma history.</td>
<td>· Client Interactions</td>
</tr>
<tr>
<td></td>
<td>· The agency screens for depression.</td>
<td>· % of Clients indicating they were treated with respect</td>
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A policy and Procedure work group is updating State “documentation,” including policies, rules and regulations that are impacted by the designed payment reform. Key activities include:

- Update existing provider manuals (DMH and DVHA FFS, EFT) & develop a single merged provider manual.
- Update DVHA/DMH Intergovernmental Agreement
- Update all impacted State rules (invoke State rulemaking process as needed)
- Update DVHA Grievances and Appeals Manual
- Update all DA Master Agreements
- Submit all needed federal approvals
- Initiate PBR process as needed
An accountability work group is meeting to operationalize changes to monitoring and reporting structures in order to meet program integrity, and State audit compliance. Key activities include:

- Discussing changes to minimum documentation standards (for example frequency of clinical chart notes)
- Updating DA to State reporting processes as needed
- Updating State to Federal reporting processes as needed
- Reviewing MSR specifications to identify necessary, feasible and desirable edits
- Reviewing program integrity standards and updating as needed
# Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABA</td>
<td>Applied Behavioral Analysis</td>
</tr>
<tr>
<td>AHS</td>
<td>Agency of Human Services</td>
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<tr>
<td>ANSA</td>
<td>Adult Needs and Strengths Assessment</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
</tr>
<tr>
<td>CANS</td>
<td>Child and Adolescent Needs and Strengths</td>
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<tr>
<td>CRT</td>
<td>Community Rehabilitation and Treatment</td>
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<tr>
<td>CSIP</td>
<td>Collaborative Systems Integration Project</td>
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<tr>
<td>DA</td>
<td>Designated Agency</td>
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<tr>
<td>DAIL</td>
<td>Department of Disabilities Aging and Independent Living</td>
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<tr>
<td>DCF</td>
<td>Department for Children and Families</td>
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<tr>
<td>DMH</td>
<td>Department of Mental Health</td>
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<tr>
<td>DVHA</td>
<td>Department of Vermont Health Access</td>
</tr>
<tr>
<td>DS</td>
<td>Developmental Services</td>
</tr>
<tr>
<td>EFT</td>
<td>Enhanced Family Treatment</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee For Service</td>
</tr>
<tr>
<td>IFS</td>
<td>Integrating Family Services</td>
</tr>
<tr>
<td>MSR</td>
<td>Monthly Service Report</td>
</tr>
<tr>
<td>PBR</td>
<td>Policy Budget Reimbursement</td>
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<tr>
<td>PNMI</td>
<td>Private Non-Medical Institution</td>
</tr>
<tr>
<td>VBP</td>
<td>Value Based Purchasing</td>
</tr>
<tr>
<td>VCP</td>
<td>Vermont Care Partners</td>
</tr>
<tr>
<td>SED</td>
<td>Severe Emotional Disturbance</td>
</tr>
<tr>
<td>SFI</td>
<td>Severely Functionally Impaired</td>
</tr>
<tr>
<td>SFY</td>
<td>State Fiscal Year</td>
</tr>
<tr>
<td>SSOM</td>
<td>Self Sufficiency Outcome Matrix</td>
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