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 Vermonters 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	Core Adult Case Rate	
• Emergency Services (ACCESS) • MH Waiver (EFT) • JOBS • All FFS (DMH) • Outpatient Services (DVHA)	• 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	• 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.

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Vermont Mental Health Payment Reform

VERSION LAST UPDATED APRIL 12TH, 2018

Mental Health Payment Reform Background & Current Status

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:
  - Improving the effectiveness and coordination of mental health programs and services around the State;
  - Simplifying payment structures to increase flexibility and predictability of provider payments; and
  - Shifting to Value-Based payment models that reward outcomes and incentivize best practices.

Value-Based Payment Framework

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

Guiding Principles of Payment Reform

Healthier People (Improved outcomes and value)

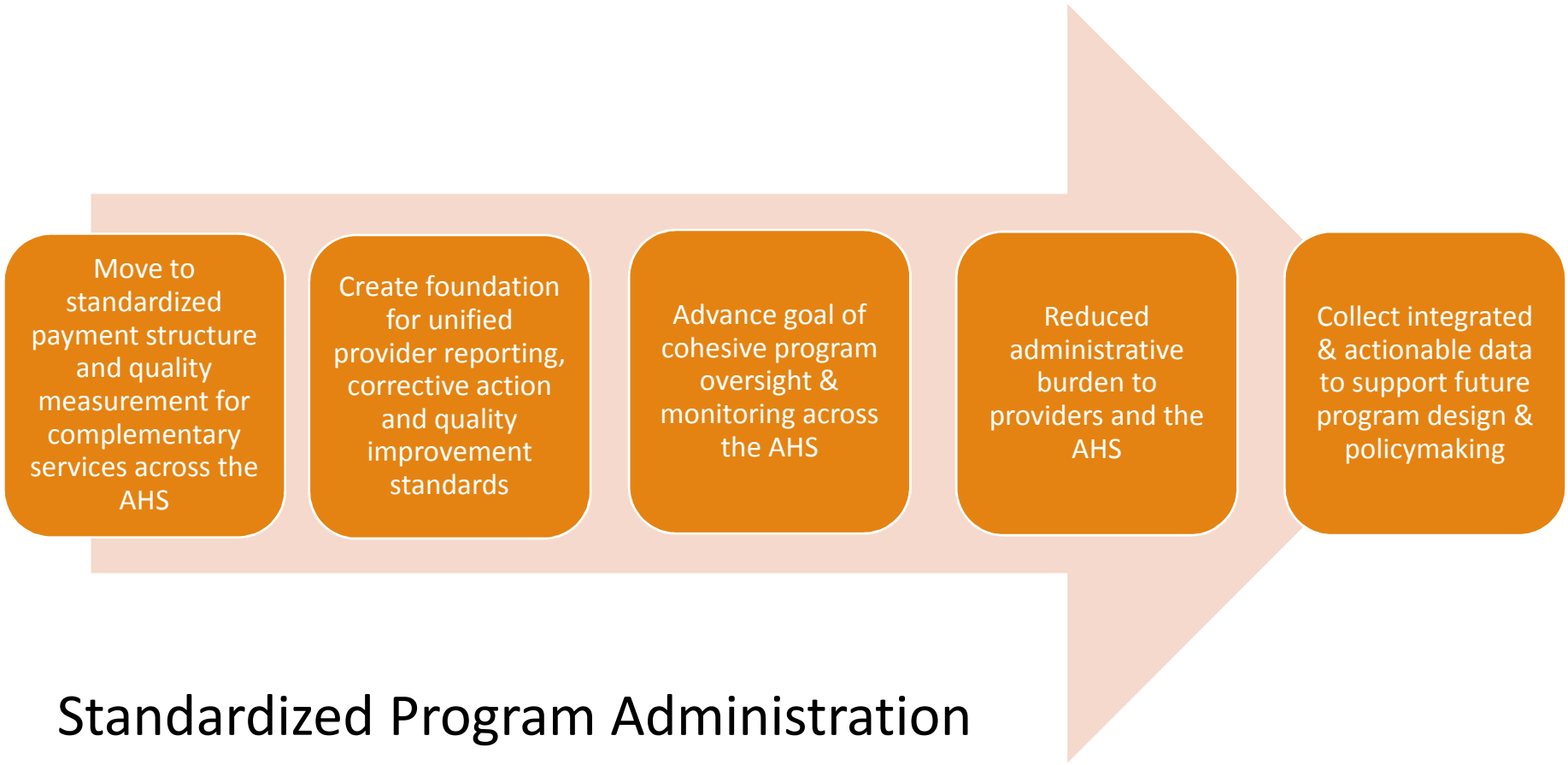
- Population health focus
- Increase capacity for prevention and early intervention
- Efficient quality review and program evaluation processes
- More standardized tracking of outcomes across programs and populations

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



Standardized Program Administration Drives Service Integration

What Does Payment Reform Mean For….

Individuals & Families

Providers

VERMONT
AGENCY OF HUMAN SERVICES

Agency of Human Services

ALIGNED GOALS SUPPORTED BY CLEAR AND CONSISTENT MESSAGES

Goals of Payment Reform

Individuals & Families

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.

What Does Payment Reform Mean For

Individuals & Families

Lessons From "Integrating Family Services" Communities		
Before IFS	**After IFS**	**What does this mean for families?**
Individual/client focus	Focus on healthy children, family, schools, child and family environments including communities	Offer a parenting support/education group in Bristol – made possible by using flexible funding for staff to facilitate the group.
Eligible only when circumstances became bad enough to qualify for services	Early intervention, treatment and support	"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.
Multiple individual providers with separate systems and standards, intakes, budgets based on separate expectations from each AHS division/department	Unified local network/continuum for direct services Multi-disciplinary team approach available with consistent guidelines in each region	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

Goals of Payment Reform

Providers

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

VERMONT
AGENCY OF HUMAN SERVICES

Individuals & Families

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

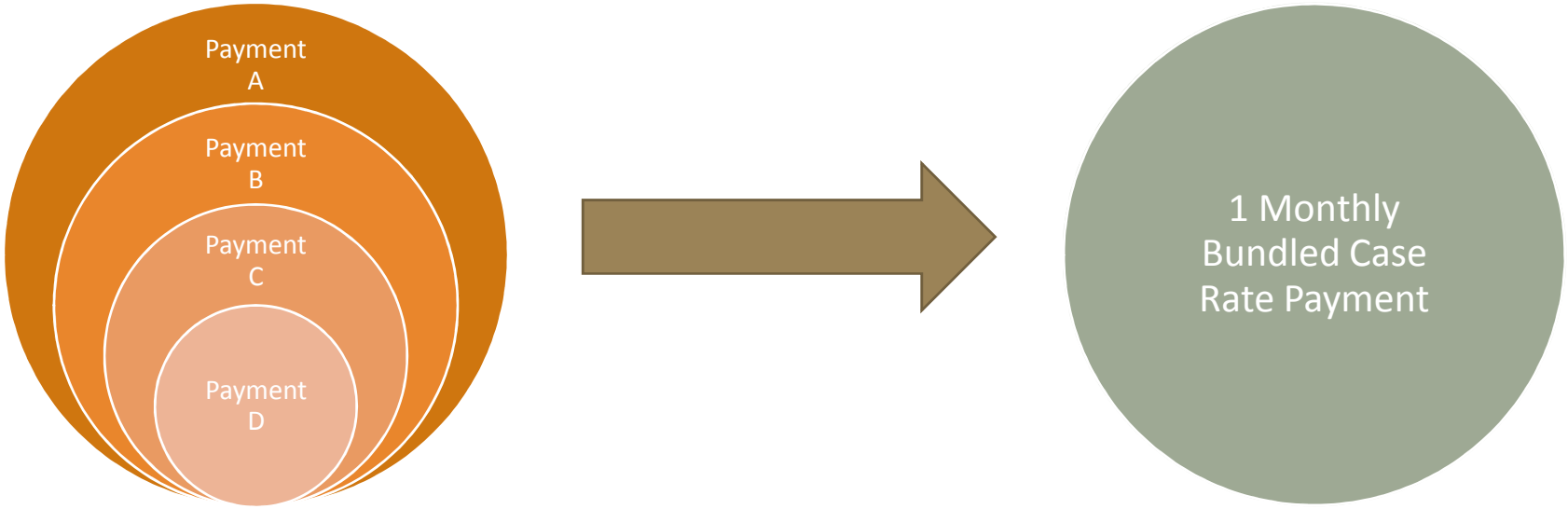
Payment reform is not about adding new money to the system; it is about reducing barriers and increasing flexibility to meet the needs of individuals and families.

Current State

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

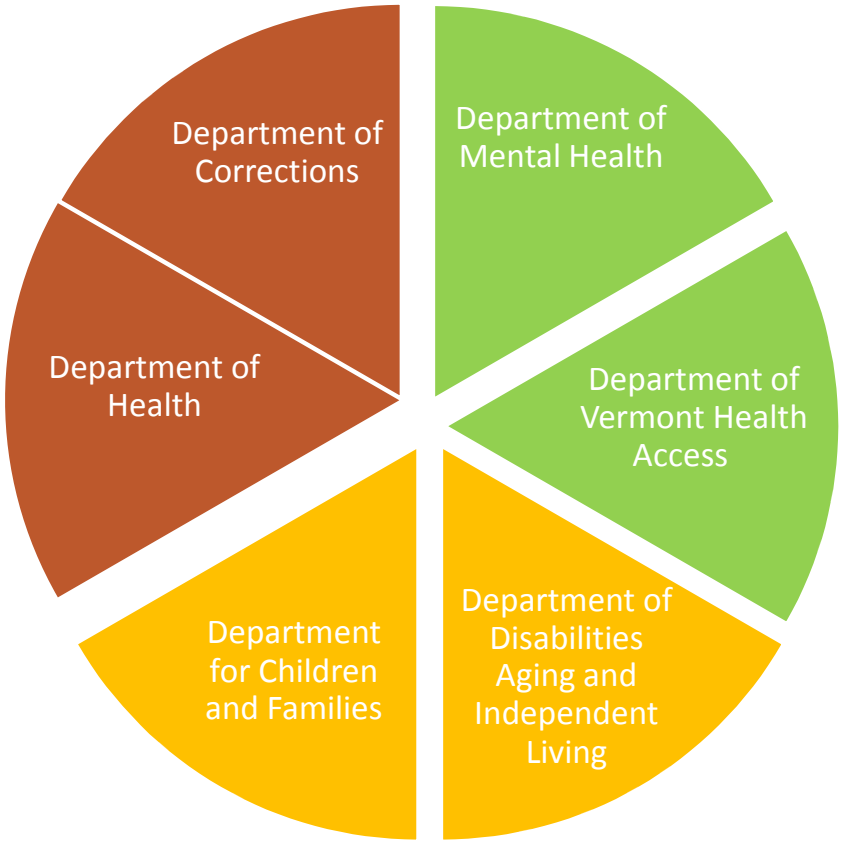
Future State

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



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.

Payment Model & Methodology Overview

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 & outlier policies
- 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

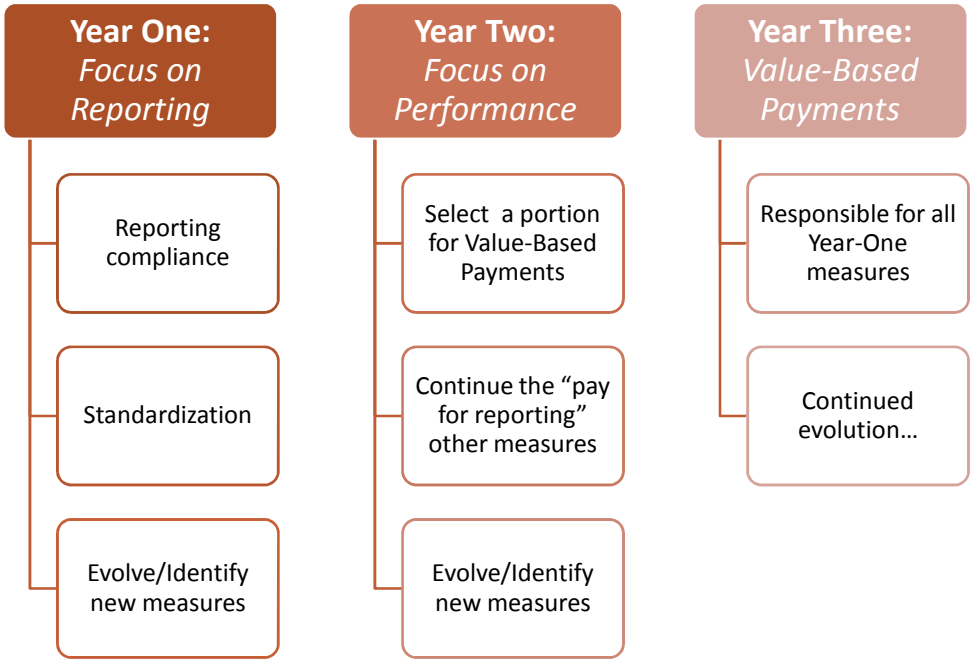
- Reach Up
- Traumatic Brain Injury

Quality & Value Component Overview

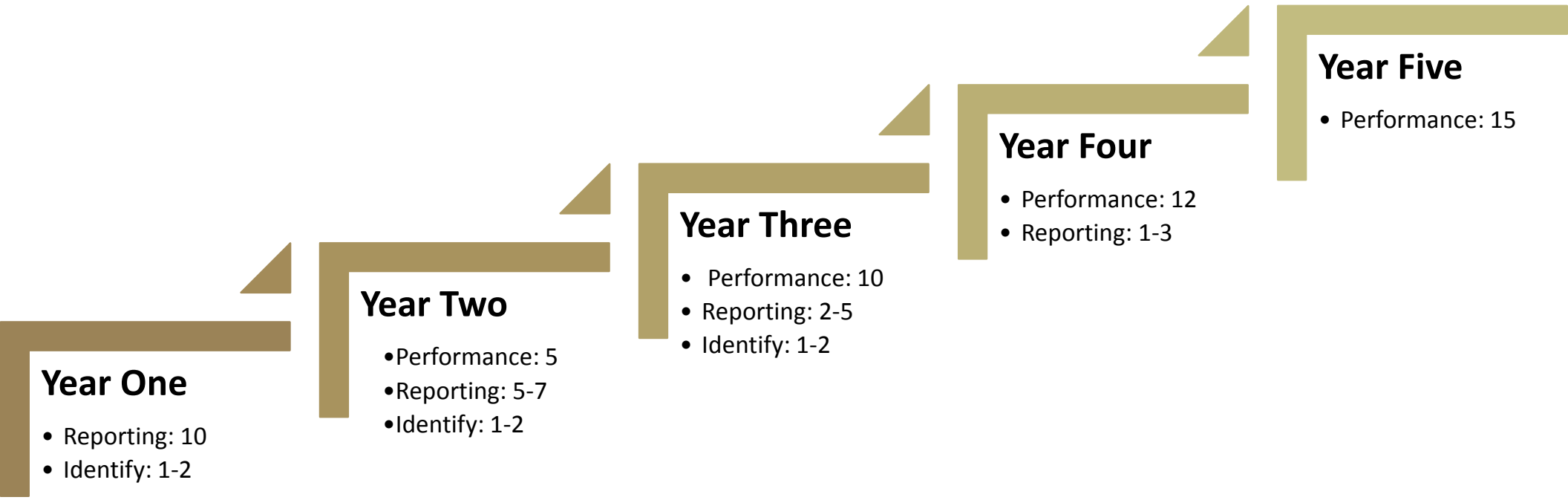
Two separate work groups were formed to select diverse measures for child and adult programs and design a value based payment model that is linked to quality and performance on selected measures that:

- **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



Value Based Payment Five Year Plan



Outcomes	Pregnant women and young children are thriving	Families/Communities are safe, stable, nurturing, and supported
Population Indicators	a. Demonstrates Resilience / Flourishing b. Prevalence of Emotional, mental or behavioral conditions c. Level of severity of Emotional, mental or behavioral conditions d. How often have these conditions affect child's ability to do things, severity of impact	a. Family Strengths b. Child involvement in Community Activities c. Parent's physical health, mental/emotional health

Performance Measures proposed for Payment Reform – Children's Mental Health

How Much?	How Well?		Is Anyone Better Off?	
Delivery System Measure	**Process Measure**	**Patient Experience Measure**		**Outcome Measure**

• # of children/youth (0-17) served
• #of eligible children/youth (0-17) served [per 1,000 children residents]
• SED prevalence for 0-17*
• SED prevalence for 18-22*
*SED determination based on diagnosis, duration, and functional impairment (using CANS)
	• % of clients offered a face-to-face contact within five days of initial request
	• % of clients seen face-to-face within 14 calendar days of intake assessment
	• % of clients with a CANS update recorded within the last 6 months
		• Array of Services
		  • % of clients indicate services were right for them
		  • % of clients indicate they received the services they needed
		• Client Interactions
		  • % of Clients indicating they were treated with respect
			• Array of Services
			  • % of Clients who indicate services made a difference
				• % of clients improved upon annual review of Plan of Care

Outcomes	All Vermonters are healthy.
Population Indicators	a. Rate of suicide deaths per 100,000 Vermonters b. % of Vermont adults with any mental health conditions receiving treatment c. Rate of community services utilization per 1,000 Vermonters

Performance Measures proposed for Payment Reform – Adult Mental Health

How Much?	How Well?		Is Anyone Better Off?	
Delivery System Measure	Process Measure	Patient Experience Measure		Outcome Measure

• # of adults served
• #of adults served [per 1,000 residents]
	• % of clients offered a face-to-face contact within five days of initial request
	• % of clients seen face-to-face within 14 calendar days of intake assessment
	• The agency screens for substance use.
	• The agency screens for psychological trauma history.
	• The agency screens for depression.
		• Array of Services
		  • % of clients indicate services were right for them
		  • % of clients indicate they received the services they needed
		• Client Interactions
		  • % of Clients indicating they were treated with respect
			• Array of Services
			  • % of Clients who indicate services made a difference
				• A comparative analysis of annual change in SSOM/ANSA

Policy & Procedure Work Group Overview

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

Accountability Work Group Overview

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

ABA: Applied Behavioral Analysis

AHS: Agency of Human Services

ANSA: Adult Needs and Strengths Assessment

CQI: Continuous Quality Improvement

CANS: Child and Adolescent Needs and Strengths

CRT: Community Rehabilitation and Treatment

CSIP: Collaborative Systems Integration Project

DA: Designated Agency

DAIL: Department of Disabilities Aging and Independent Living

DCF: Department for Children and Families

DMH: Department of Mental Health

DVHA: Department of Vermont Health Access

DS: Developmental Services

EFT: Enhanced Family Treatment

FFS: Fee For Service

IFS: Integrating Family Services

MSR: Monthly Service Report

PBR: Policy Budget Reimbursement

PNMI: Private Non-Medical Institution

VBP: Value Based Purchasing

VCP: Vermont Care Partners

SED: Severe Emotional Disturbance

SFI: Severely Functionally Impaired

SFY: State Fiscal Year

SSOM: Self Sufficiency Outcome Matrix

FOR MORE INFORMATION

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