Think Tank – Day Two

LISTENING TOUR THEMES AND VISION STATEMENTS WITH SUPPORTING STRATEGIES

COMMUNITY BASED LEVEL OF CARE: *FUNDING AND PARITY*

<table>
<tr><th>LISTENING TOUR THEME</th><th colspan="3">VISION STATEMENT WITH SUPPORTING STRATEGIES IDENTIFIED</th></tr>
<tr><td rowspan="3">ACCESS & CARE

FOCUS ON MANIPULATING THE HC SYSTEM FOR FREEING UP FUNDS FOR THE SYSTEM, NEED TO THINK ABOUT OTHER APPROACHES.
NEED TO THINK ABOUT BREAKING DOWN SILOS WITHIN AHS. FEDERAL FUNDING.
BUNDLED RATES- 65% OF DA RATES IS BUNDLED, NOT SUFFICIENT, NO ADMINISTRATIVE</td><td colspan="3">A system that:
- Supports Vermonters on their path to recovery without penalizing them monetarily.
- Incentivizes recovery and mental wellness.
- Is local and accessible and allows options.</td></tr>
<tr><td>Short-Term</td><td>Mid-Term</td><td>Long-Term</td></tr>
<tr><td>Short term Strategies
1. inventory and analysis of resources.
○ Payer
○ Services including- case-management reimbursement
○ Region
○ Cost
2. Provider internal resource analysis
3. Evaluate options for a system of services vs. regional access.
○ Analyze existing resources- timeliness and adequacy.
Short/Mid-term Strategies-
• Needs assessment- to include demographics, trends in Dx.
• Understand the population needs</td><td>Mid-term Strategies:
1. Address Commercial insurance expectations-concern with aligning with other healthcare approaches.
a. Reimbursement rates
b. Covered services
i. Case management
ii. Person-centered Care
c. Choice of case manager (BCBS- they are both CM and provider)
d. Community teams
2. Implement multi-year budgeting
3. Fund multi-year innovative pilots using payment reform models that</td><td>Long-term Strategies-
1. Start reinvesting resources using analyses in step 1 and pilot results from step 2.</td></tr>
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SUPPORT. LIMITS ON FUNDING AVAILABLE FOR ADMINISTRATION. *VBP- SUPPORT OF QUALITY MEASURES AND FUNDING THAT CAN PAY FOR QUALITY AND SUPPORT REINVESTING RESOURCES SUCH AS REDUCTIONS IN INPATIENT.* *PAY EQUITY ACROSS PROVIDERS- RATES OF PAYMENT ACROSS COMMERCIAL* *MEDICARE PAYMENT WOULD EFFECT WORKFORCE AND ACCESS TO SERVICES.*		can span community and inpatient/ED levels of care.	

LISTENING TOUR THEME	VISION STATEMENT WITH SUPPORTING STRATEGIES IDENTIFIED		
WORKFORCE AND PAYMENT *Comments around secondary education that does not necessarily support people that need services.* *Higher rates of SED prevalence than in other states. Should we thinking about it differently.* .	**Reimbursement rates: we have a system that adequately compensates for work regardless of where the work is provided.**		
	Short-Term	Mid-Term	Long-Term
	1. Analyze the need. Perform provider internal resource analysis (same as short term strategy #2 at first end state in prior table) a. Look at independent providers and DAs 2. Short term- work with the independent provider trade associations a. Individuals that are private- are they billing what they are able? They may need support with this.	1. Increase "system-ness" a. Create reimbursement for care coordination for private providers ○ Across payers	1. Create an equivalence of the SDOH and in terms of financial support prevention and community. 2. Historically- idea of system of care in vt considering MH in connection with the Social Services system. Need to maintain this vision as we work to collaborate and strengthen more with healthcare.

LISTENING TOUR THEME	**VISION STATEMENT WITH SUPPORTING STRATEGIES IDENTIFIED**		
PAYMENT REFORM	- ***Focus on identifying successful collaboration models*** - ***fund the system of care differently for innovations above and beyond the basic charges.***		
	Short-Term	Mid-Term	Long-Term
	1. Evaluation of overall spend (all health) ○ Assess overlaps with Inpatient/ED	1. Evaluate budgets/spending- GMCB review of DA budgets? This is a question. 2. Hospital and community Agreements that allow for reinvestment and resource sharing. Concern about losing connection to social determinants of health. Is there a parallel of the PCP investment. 3. Implement pilots and multi-year budgets (same as mid-term strategy around access and care, above) 4. Implement payment model pilot that focuses on DA quality and reimbursement of costs- CCBHC/FQHC style	1. Long-term- Implement proven pilots statewide.

- **Insurance and funding** end-states from the listening tour notes:
  - Invest in step-down resources
  - Parity in resources- treat MH like PH in terms of access and parity of resources.
  - Prevention is funded.

- Community based services are appropriately funded.
- People talking about losing benefits and the cliff of losing benefits- is this an insurance issue? Can't we support employment and the results.
- We need a system that pays for mental wellness.

FEEDBACK FROM STRATEGY PREVIEW

Group D

Supports VT-ers on path to recovery. Local, accessible. Discussed insurance- how to open opportunities on insurance side. Need to pay across regions. Inventorying the resources. Multi-year budgets. Acknowledging the important role of government- fund state government to promote this work. Address workforce issues. Payment Reform. Biggest bang for buck in investments- prevention vs intervention. Need to shift money to prevention. Not how system is set up. Can GMCB play a role? Workforce and payment- how often do we look at cost of living in terms of what we pay people. Salary/wage needs to be compared to cost of living. Discussed that different parts of the system are poaching off other parts. Not enough people willing to do the work, not paying people enough to keep them doing the work. Need a livable wage. Same is true for clients- need a living wage. How is shifting priority to prevention in the charts currently? Coordinating with the dept of education- is this included in the plan? Where does the funding come from? Special education budget? Have populations of kids that need tier two support. Also need general, tier one support. VT has higher rate of IEP/504 on emotional/behavioral needs than surrounding states- is that we have more needs or are better at identifying the needs? We are willing to provide students what they need but not change what's not working. Need to change the education system to meet students where they are at- wouldn't need special education systems if it was more individualized. Paying for education system twice. Successful alternative programs exist. Census based funding is supposed to address this? Teachers are being trained to provide different services. Need to address population needs. Consider what is already out there and how to shift the system. When we wait until people are in crisis. The process of getting an individual into services has ripple effects of the whole family. Instead of providing services to one, we need to then serve multiple people. Need to focus on education instead of crisis.

Cheryle's Group

Looking at eh private sector-looking at the community, private sector etc. Looking at the state payment to ensure MH is a priority in the budget- by continuing level funding someone is going to get cut.

Creating more of a system to enhance payment reform

Long term reimbursement- advanced payment model perspective like a bundled rate strategy. Basing the outcome measures to drive the intervention. As opposed to the FFS model.

The DA's are currently doing the bundled rate- over 65% or more. It is bundled and not FFS

We are currently doing bundled rates, but the rates are not enough. We do agree with the Multi-year agreements to allow projections down the line. We need to look at the state funding as a system and the impact our work is having on others to offset costs broadly, not just AHS.

Ensuring that RBA and outcome measures are a part of this structure