Vermont’s Mental Health Service Delivery and Payment Reform Path to Value-Based Payment

Pennsylvania’s Value-Based Purchasing: Supporting Whole Person Care
Melissa Bailey, MA, Senior Fellow
Welcome & Introductions

Vermont’s Story and Progress to Date
Welcome and Introductions
Overview of the MH system in VT – setting the stage
Initial Efforts – Integrating Family Services
Current Effort – the Entire Community Mental Health System
Lessons Learned
Next Steps
Q&A
Today’s Presenter

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About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Select CHCS Initiatives

**Delivery System and Payment Reform**
- Advancing Implementation of CDC’s 6|18 Initiative
- Advancing Primary Care Innovation in Medicaid Managed Care
- Value-Based Payment Technical Support for the Medicaid Innovation Accelerator Program

**Services for People with Complex Needs**
- Community Management of Medication Complexity Innovation Lab
- Complex Care Innovation Lab
- Helping States Support Families Caring for an Aging America
- Promoting Integrated Care for Dual Eligibles

**Medicaid and Cross-Sector Leadership Capacity**
- Medicaid Leadership Institute
- State Medicaid Academies
  - California
  - Massachusetts
  - New Hampshire
  - New Jersey
  - Rhode Island
  - Vermont
Better outcomes for the people served is the first priority

This is an evolutionary process

Must be a win/win/win situation

If the state focuses on outcomes providers will be able to focus on outcomes

To achieve a value-based payment model that works there are flexibilities the providers will need

Need to use a phased-in approach

Need to give some new structures time to work

Move the system from reactionary only to include early intervention and prevention
10 Designated Mental Health Agencies — established by statute and designated by the Department of Mental Health

Designated Agencies provide mental health services to children and adults, community crisis services, developmental disability services and seven of the ten provide substance abuse services

VT does not have MCOs, it has one ACO and Designated Agencies are managed and paid by the Department of Mental Health for Medicaid mental health services

VT is implementing an All Payer Model in conjunction with the ACO model

VT has a Global Commitment waiver that allows for some additional flexibilities

VT’s population is about 620,000 — the size of some small counties in other states
Multiple “doors” and processes = lack of comprehensive services
Competing, redundant or unavailable services
Disconnected system, lack of timely services and poor outcomes
Service providers were tripping over each other and frustrated
Different expectations from AHS departments regarding similar services or the same state plan authority
Children needing high level services often did not meet eligibility requirements because teams worked hard to prevent hospitalization
Data requirements different within each department
Different eligibility requirements make holistic integrated care a challenge
Focus – mental health, developmental disabilities, child welfare, substance abuse, early childhood and other Medicaid funded services for ages birth - 21
First Effort to Reform the What

- Establish **common goals** and **outcomes** for the system change
- **Streamline** intake process, create a **common** assessment process and elements for a **single plan of care**
- **Increase teamwork** and case/care coordination across care and service providers and state Departments/Divisions.
- Support mechanisms to **increase bundled** and/or **outcome- and value-based payments** that increase service **flexibility** and focuses accountability on **results**.
- Use data and mutual accountability to **drive decision making**, establish **priorities**, and **fill service gaps**. Promoting prevention and population health strategies.
- Support **diverse, inter-disciplinary** community teams to address population health for children, youth, and families.
First Effort to Reform the How, Where and When

- Establish **team** of state representation, providers and families to develop goals, processes, and oversight structure
- Move from fee-for-service to case rate type of payment to create **flexibility**, support **creativity** and more upfront services
- Assess provider for **readiness for change**
- Fiscal and program mapping to **understand the scope**
- Took **over a year** for the first contract – implement, monitor, improve and repeat
- LOTS AND LOTS of meetings – but **strong commitment** and **trust** between provider and state – a little less from the families
- Started in 2011 with one DA children’s program, moved to
- two and now an **adjusted model being implemented state-wide** and for adult and child DA mental health services
Initial Lessons and Successes

- Having a **commitment** from all sides is important
- Having a provider **willing** to try and work through the issues and then they become an **advocate**
- Model is always **evolving** – work never completely done
- You **uncover** things you didn’t know about
- Starting with an **alternative payment model** that has measures and then moving to **value-based payment**
- **Increased** the number served and **early interventions**
- Provided ability to be **creative** in delivery of care so that **positive outcomes** could be achieved
- Providers **would not go back** to the old model
Building on the IFS efforts, attempted in 2015 to replicate model with mental health, substance use and developmental disabilities for adult services. Several reasons this did not work

In 2017 when I became commissioner, I was committed to developing a model that we could build start and then improve over time

Began work with all the DA MH providers and several workgroups
  » Payment model/methodology and business operations
  » Accountability and encounter data
  » Quality and program evaluation

In total, the Department of Mental Health, in collaboration with the Department of Vermont Health Access’ Payment Reform Unit, engaged in over 150 hours of work group meetings over 16 months

Requires a lot of talking with each other!
Alternative Payment Model

- Based on similar structure of the IFS model and including the allocation from DMH-based on legislative appropriation and additional Medicaid claims.

- Paid in monthly prospective payment lump sum at same point each month. Entire allocation received through equal distribution over 12 months.

- Entire allocation is earned if ≥90% of the annual caseload has been served.

- Funds paid back or withheld from case rate if caseload target is not met.

- Encounter claims submitted to MMIS and other data to DMH specific reporting system that will be used for value-based payment measure calculation.
Service Delivery Changes

- More **fluid services and criteria** – while still required to document that SPMI adults and SED children are served allows for **some flexibility between criteria thresholds**
- Payment structured in a way to allow for more **early intervention** and **prevention type** services
- Continued development of **creative service delivery options**
  - More supports in emergency departments
  - School-based mental health services able to support of multi-tiered system of supports implemented in schools
  - Cross systems service provision for children with co-occurring mental health and developmental needs
Accountability Changes

- Multiple provider manuals **combined into one**
- Place of service limitations were **eliminated**
- Concurrent billing issues were **alleviated**
- Set **minimum standards** for documentation for all services
- **Threshold billing parameters** set for services to qualify as a billable
Quality and Value-Based Payments Timeline

- **2016**: SIM investment in repository
- **2017**: Children and adult MH and DD payment reform design (DNF)
- **2018**: DMH payment reform design process
- **2019**: Year 1 measures – reporting & est. baseline
- **2020**: Year 2 – subset of measures now tied to value
- **2021**: Year 3 – larger amount of measures moved to value-based payments
Examples of Measures

- **Baseline work – percentage of clients:**
  - Offered face-to-face contact within 5 calendar days of initial request.
  - Seen for treatment within 14 calendar days of assessment.
  - With a CANS update recorded within the last 6 months.
  - With an assessment that have been screened for substance use.
  - With an assessment that have been screened for psychological trauma history.
  - With an assessment that have been screened for depression.

- **The following measures will be moved to performance – percentage of client indicate:**
  - Services were “right” for them.
  - They received the services they “needed.”
  - They were treated with respect.
  - Services made a difference.
Lessons, Successes, and Next Steps

- Build **trust** by working together on all components of reform from the beginning
- Be willing to **negotiate**
- Start **small** and building from there helps **change happen**
- For the same funding allocation but with a different payment model **flexibility** and room for more individuals to be served can be achieved
- Establish **new norms** for the model, will take time but is beginning to take shape
- “Softer” lines between programming allows people to get their needs-based on assessment rather than criteria
- Work on addressing 3rd **party** and **cross-over claims**
- Develop **strong data analytics** to really understand metrics and continue to set benchmarks and targets
- Consider **global budget** as next payment model
For more information

Vermont Department of Mental Health

Integrating Family Services
▪️https://ifs.vermont.gov/

Mental Health Reform
▪️https://mentalhealth.vermont.gov/about-us/department-initiatives/payment-reform
Question & Answer
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