Reducing Duplication of Services

In Accordance with:
Act 54 Section 25 - Reducing Duplication of Services

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Submitted by: Hal Cohen, AHS Secretary

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The following individuals, listed in alphabetical order, contributed to the development of this Legislative Report:

Ashley Berliner, Director of Healthcare Policy and Planning, Agency of Human Services

Daljit Clarke, Clinical Operations Director, Department of Vermont Health Access

Paul Dragon, Deputy Secretary of the Agency of Human Services

Emma Harrigan, Quality Management Director, Department of Mental Health

Selina Hickman, Director of Healthcare Operations, Compliance and Improvement, Agency of Human Services

Bard Hill, Director of Policy, Planning and Analysis, Department of Disabilities, Aging and Independent Living

Megan Mitchell, Quality Improvement Director, Department of Vermont Health Access

Cynthia Thomas, Division Director, Vermont Department of Health

VERMONT
AGENCY OF HUMAN SERVICES

Act 54 Section 25 - Reducing Duplication of Services

Introduction

Section 25 of Act 54 of 2015 requires the Agency of Human Services (AHS/Agency) to evaluate the services offered by each entity licensed, administered, or funded by the State, including the designated agencies, to provide services to individuals receiving home- and community-based long-term care services or who have developmental disabilities, mental health needs, or a substance use disorder. The legislation asks that AHS determine areas in which there are gaps in services and areas in which programs or services are inconsistent with the Health Resource Allocation Plan or are overlapping, duplicative, or otherwise not delivered in the most efficient, cost-effective, and high-quality manner. The legislation also requires AHS to develop recommendations for consolidation or other modifications to maximize high-quality services, efficiency, service integration, and appropriate use of public funds.

AHS has adopted the Institute for Healthcare Improvement's Triple Aim of simultaneously improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. The adoption of these three objectives supports appropriate utilization of health services, quality health care, better coordinated care, and demands avoidance of duplication. The Agency's ultimate goal is to provide the beneficiary with high quality, easily accessible, holistic services at the most optimal level, and to make the system as efficient and cost-effective as possible. This Agency goal informs and provides a framework for this report.

This report is based in part on an inventory provided by the Pacific Health Policy Group[1] to AHS and supplemented by individual program data. This inventory provides a description of all AHS health-related Specialized Programs (*Medicaid and non-Medicaid*), their data reporting systems, and use of the data to support Specialized Programs and Medicaid operations. In addition, this report draws information and recommendations from a September 2015 report prepared for the Vermont Health Care Innovation Project's Care Models and Care Management Work Group by Bailit Health, which summarizes gaps and duplication in care management services and makes recommendations on how to address gaps and duplication of services.[2] As part of its work, the Care Models and Care Management Work Group surveyed organizations providing care management services to collect information on existing activities, perceived barriers to doing their work, and obtain recommendations on improving care management in Vermont. There were

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[1] On March 31, 2015 PHPG submitted to the State the Final Task 2 Report titled: *Preliminary Inventory of Data Reporting Systems that Support Programs within the AHS and Medicaid-Funded Programs within the AoE.* The Report was finalized and accepted April 14, 2015. This report should be considered a preliminary and not final inventory.

[2] Bailit Health has summarized gaps and duplication in care management services drawing on information collected from surveys completed by Vermont organizations providing care management and has also summarized recommendations from presenters on how to address gaps and duplication.

42 organizations that responded to the survey. In addition, 13 organizations volunteered to present more detail to the Work Group regarding their care management programs.

Scope of this Report

AHS and its Departments operate and oversee numerous programs designed to directly or indirectly address Vermonters' health needs. This report is specifically evaluating the services offered and or financed by the Departments for Disability Aging and Independent Living (DAIL); Mental Health (DMH); Health's Division of Alcohol and Drug Abuse Program (ADAP); and Vermont Health Access (DVHA). See Table 1 below for service and target population by Department. This report does not include a variety of AHS services provided under other federal authority such as Vocational Rehabilitation, Older Americans Act, Child Welfare Services, McKinney-Vento Homeless Assistance Grants, mental health block grants and health promotion competitive grants. In addition, this report does not include other services that may be necessary to support Vermonters, such as housing, transportation, fuel assistance, food assistance, medical services, medication, and guardianship services.

Table 1

Department	Program	Service
DAIL	Older people and adults with physical disabilities	- Attendant Services Program - Day Health Rehabilitation (adult day) services - Choices for Care includes home, residential, and institutional settings: - CFC 'Enhanced residential care' licensed settings include residential care homes and assisted living facilities. - CFC Home and community based services include: ➢ Case Management ➢ Personal Care ➢ Respite ➢ Companion ➢ Adult Day ➢ Assistive Devices and Home Modifications ➢ Adult Family Care ➢ Personal Emergency Response System ➢ Flexible Choices

		• CFC Moderate Needs Group services include: ➢ Case Management ➢ Homemaker, Adult Day, and Flexible Funding CFC Institutional settings include ➢ Nursing homes
DAIL	People with developmental disabilities	Home and community based services include: ➢ Service Planning & Coordination ➢ Community Supports ➢ Employment Services ➢ Home Supports ➢ Respite ➢ Clinical Interventions ➢ Crisis Services Licensed residential settings ➢ Include therapeutic community residences. Institutional settings ➢ Include one small Intermediate Care Facility, and specialized support services provided to a small number of people residing in nursing homes.
DAIL	People with traumatic brain injury	Home and community based services include: Case Management ➢ Rehabilitation Services ➢ Community Supports ➢ Environmental and Assistive Technology ➢ Crisis Support ➢ Respite ➢ Employment Supports ➢ Special Needs (ongoing
DVHA	Vermont's Medicaid program to meet the needs of low income Medicaid eligible Vermonters	Full spectrum of physical and behavioral Medicaid covered healthcare services to meet the medically necessary needs of enrolled Medicaid members.

DMH	Required populations: ➤ CRT[3] ➤ Children with a Serious Emotional Disturbance (SED) ➤ Adult and Children outpatient Services	Includes Medicaid state plan services that are provided by Designated Agencies or waiver services provided by DAs and SSAs. Services include MCO Investment Services like special service funding for non-Medicaid reimbursable items and respite.
ADAP	Serves all Vermonters	Include Medicaid and non-Medicaid services provided by Preferred Providers. Services include ➤ Screening ➤ Assessment ➤ Case Management ➤ Counseling ➤ Therapy ➤ Medication Management

Areas of Potential Duplication

This report categorizes the services provided to Vermonters by AHS and AHS-funded providers into several categories: case management and care coordination; mental health therapy; medication management; diagnostic assessment and evaluations; and treatment plans. These are described in more detail below.

Case Management and Care Coordination[4]

The largest area of potential duplication of services is in case management and care coordination, which includes a wide range of services such as employment services and crisis services. Case management is often a specialized service delivered by a case manager with specific skills that are relevant to the condition which makes an individual eligible for specialized services. These

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[3] People with severe and persistent mental illness receiving Community Rehabilitation and Treatment (CRT) services.

[4] The terms "case management" and "care coordination/management" are used widely across the agency and not always with the same meaning or intention. More clarity around definition would be use for future work resulting from this report.

services occur in numerous programs within AHS. For example, a case manager in the CRT program oversees care and coordinates the needs of an adult who has severe and persistent mental illness, while a case manager in the Vermont Chronic Care Initiative (VCCI) program oversees and coordinates the care of an adult who has high Medicaid costs and utilization. Both CRT and VCCI are considered case management; a service delivered to individuals who meet the eligibility requirements for the respective specialized program and concomitantly, have specific plans of care, but the program rules and the services delivered vary greatly. Vermonters served under the Global Commitment waiver cannot access more than one case management service at the same time as the Centers for Medicaid and CHIP Services considers that case management services must assist an individual to gain access to all needed medical, social, educational and other services. The result of this is that no federal financial participation is allowed for these beneficiaries to access more than one case management service at a time within AHS. The challenge with this restriction is that many people have multiple complex needs. For example, the VCCI program beneficiaries with the highest costs for Medicaid services can overlap with specialized population waivers for mental health, developmental disabilities, or services for the elderly. In this somewhat restrictive environment it is important that case managers from different programs who are involved with the same person are coordinating their services and plans to ensure a comprehensive and integrated approach, rather than disconnected and perhaps duplicative plans for people with complex needs.

Mental Health Therapy (individual, group, family).

There is potential for duplication as mental health therapies are state plan services that can be provided by any willing eligible provider, which includes private providers and Designated Agencies for any Medicaid-enrolled person. Similar to most medically necessary services, these therapies are not program or waiver-specific and are therefore accessible to any Medicaid client as necessary for treatment.

Medication Management.

There is a risk of duplication and lack of coordination in prescribing of therapeutic medications due to members seeing more than one provider[5] for management of chronic and/or acute illnesses. This can be costly and have potentially harmful side effects when medications are prescribed having similar action, or when specific combinations of medications are contra-indicated.

Diagnostic Assessments and Evaluations

Psychological assessments are performed by providers in the Designated Agency system, in private practice, and in schools. One example for potential duplication is Individual Education Plan (IEP) evaluations. The potential for duplication may occur as a result of a lack of

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[5] For example a specialist and a primary care provider or a psychiatrist and addictionologist or any combination of providers

communication and collaboration between the providers. The providers in the Designated Agency and private practices do not currently have access to a management system or electronic health record system that is capable of sharing evaluations and assessments when appropriate.

<u>Treatment Plans</u>

Data analysis demonstrates overlapping rehabilitation therapy service (physical, occupational, and speech therapies) between the Department for Children and Families and the Department for Vermont Health Access. One example is that some beneficiaries receive certain services through Children's Integrated Services Early Intervention (CIS-EI) while at the same time receiving other services through Medicaid via DVHA. Many of the children receiving both types of services are Medicaid eligible. Because the services are not reviewed together, and the type and level of review differ, there is room for duplication and gaps in services.

Another example is that people may be receiving substance abuse treatment from more than one provider and because that provider is typically providing substance abuse treatment within the scope of their own practice this may lead to duplication in treatment planning.

Reasons for Potential Duplication

There are several reasons why duplication may occur. These are organized into the following categories:

<u>Funding Silos</u>

The current funding structures can be a barrier to flexibility as they are predominately fee-for-service, which pays for each service individually. This funding structure causes significant fragmentation and can be a barrier to integration. The existing funding streams with AHS departments are generally designed to support a specific purpose and provider, leading case managers to act separately based on their specific focus and expertise. Some programs have limited funding and/or low reimbursement rates, creating incentives for providers to shift people or costs to other programs and providers. Consumers, providers, and other stakeholders often advocate for funding for specific programs leading to reluctance to consolidate funding into more flexible models that may represent a loss in revenue to an individual provider or provider sector. In addition, due to the complexity of multiple programs and funding streams there is often a lack of clarity regarding what is covered in different programs.

<u>Technology – Data Systems</u>

Departments within AHS have different data systems. There is a lack of an AHS-wide unified and integrated technology system that collects real-time data in order to communicate and

coordinate across programs including the lack of a unified member management system. Because departments have different data systems there is no clear and consistent expectation and process to exchange information and coordinate care across the departments. The current Health Services Enterprise (HSE) initiative is intended to improve coordination and collaboration among AHS departments through new information management systems. This will include a revised governance process that creates clear expectations around information sharing. Outside of AHS departments, Vermont is seeking to improve connections among different service providers through the Vermont Health Care Innovation Project and other state health data infrastructure investments.

Documentation and Reporting

At this time there is a lack of uniform and consistent coding, different documentation and reporting requirements and different definitions and composition of funding case rates and other more aggregated payment methodologies across the Agency. However, the Agency recently implemented a centralized and coordinated process for building edits, audits and opening new codes in the Medicaid Management Information System (MMIS). This process will help to prevent errors as new edits, audits and codes are implemented moving forward.

Monitoring and Oversight

There are different quality standards, expectations for providers, requirements and oversight across the Agency that tend to be the result of separate funding streams and concomitant expectations. This can result in a duplication of auditing, reporting and quality monitoring processes.

Organizational Culture and Development

Programs that are designed, due to funding streams and requirements, to serve a specific specialized need, may not easily or adequately address the complex and overlapping needs of some individuals. For example, an individual may have both a developmental disability and a severe and persistent mental illness, or a person with a traumatic brain injury may have substance use challenges or multiple medical conditions. Medicaid funding was initially designed to address a specific set of conditions or circumstances rather than 'the whole person', resulting in barriers to coordination for people with multiple, complex needs. In addition, some federal and state privacy laws provide both real and perceived barriers to communication and coordination of care. Due to data and technology limitations there is a limited understanding among State staff of what services people are receiving through different AHS departments' programs and this limitation may impede coordination of care. Also, high caseloads for many State staff tend to restrict their ability to coordinate and effectively create teams to assist individuals with multiple needs. In sum, these systemic and structural barriers may foster a narrow or restrictive view of a

person whose needs are multiple and complex, which further embeds a "silo" approach within the organizational culture.

Recommendations

1. Payment and Delivery System Reform

Vermont has been engaged in payment and delivery system reform for several years. Building on earlier reforms, Vermont's Blueprint for Health Patient-Centered Medical Home Initiative provides significant care coordination within Vermont's primary care system. Vermont's ACO Shared Savings Program builds on this by expanding care coordination activities to a broader network of providers. More recently, AHS has been developing payment reforms for children's mental health services, adult mental health services, and substance abuse treatment. All of these reforms are working to transition from fee-for-service payment and other payments that do not include quality measurement, to those that do. Vermont can continue with these reforms and use them to help to reduce service duplication and service gaps. AHS should continue to pursue payment reforms to support more integrated services, improved outcomes, and the efficient use of resources. These reforms should be designed and implemented in the context of Vermont's multi-payer reform efforts.

2. Integrated Services and Teams

Integrated services and teams can help to reduce service duplication and service gaps. AHS should continue to encourage an internal organizational structure and process that supports integrated or interdisciplinary community case or care management teams. The Agency should increase training for case and care managers to strengthen their team-building skills and provide a structure for them to share best practices. The Agency should also improve partnerships with those providing care management and case management outside the Agency, building on the Integrated Family Services model and the Blueprint for Health Initiative.[6] AHS should continue to support pilot initiatives to provide interdisciplinary and interagency team case management in home and community based services. AHS should continue its commitment to building co-occurring capacity and capabilities within mental health and substance abuse programs such as the current initiative to screen and refer for substance abuse across all AHS programs. AHS should develop a process to increase collaboration between DVHA and VDH clinical personnel. AHS is working on and should finalize a universal release form to support initiatives like these. AHS should support the creation of a single, unified services plan for individuals and families in order to coordinate care and ease access to services for customers, while improving outcomes.

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[6] These include SASH teams, the Unified Community Collaborative, VHCIP learning collaborative, Accountable Health Communities, and Accountable Care Organizations.

3. Oversight and Monitoring

AHS needs to expand and improve the consistent use of performance measures and performance improvement activities across AHS. AHS should also continue and expand current efforts to minimize the reporting burden on providers and align performance measurement targets across programs. AHS should leverage passive reporting as much as possible and increase the quantity and quality of performance reports to providers delivering services to Medicaid beneficiaries. There should be a process for greater collaboration between the Agency of Education (AOE) and DVHA to improve clinical oversight and reduce gaps and duplication of services for those students supported by IEPs. This should include greater coordination of clinical personnel to ensure integrated clinical oversight of school based services, including instruction for therapists, special educators, auditors, and Medicaid clerks. This would mean greater oversight of the non-primary care providers who are making medical necessity determination within the fee-for-service system.

4. Information Systems Development

Information systems can provide tools to support payment reform and integrated care. AHS should increase the development and use of integrated information technology to coordinate care management activities. AHS will continue to support the strategies and recommendations of the Vermont Health Information Technology Plan and increase the use of a shared data to coordinate care and measure effectiveness. AHS is moving to implement a new Medicaid Management Information System under a current procurement project with a unified data system for all claims including service level data for bundled payments and case rates made across AHS. AHS will work to improve the system for edits on codes and services within this new system.

AHS should continue to implement the new Care Management System to support a single treatment plan and effective communication across the AHS[7].

AHS should reduce the duplication or lack of coordination in prescribing of therapeutic medications and ensure that all prescribing providers consult the Vermont Prescription Monitoring System (VPMS) tool before prescribing medications. Additionally, Case Managers providers and pharmacists will be able to utilize the new Care Management system in the near future to verify member's medications. Currently, the pharmacy management system, to which Case Managers have access, has flags to identify known potential contra-indications for medications, but the utilization of the VPMS and the Care Management system would provide additional tools.

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[7] Include Designated Agencies, Specialized Service Agencies, Home Health, hospitals and FFS providers.