Vermont Mental Health Payment Reform

Version last updated April 23rd, 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

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.

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

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.

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 [tool TBD]

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

Other changes:

- Streamline documentation for one of the most commonly provided service
- Cut critical data fields for reporting in half reducing IT impact and need to correct data files
- Reduce the number of manuals and combine many of the manuals into one child and adult provider manual
- Reduce performance measures in master grant from 2-5 measures per program (11 programs) to those in slides 10 & 11