



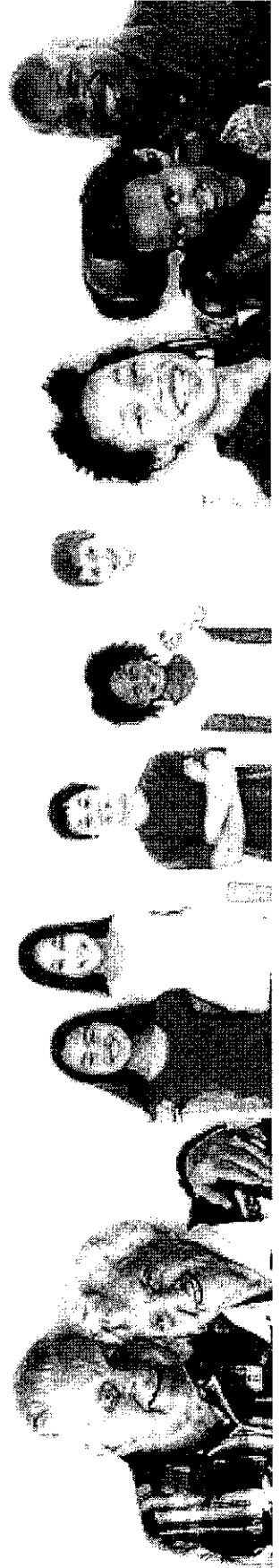
Preliminary working draft; subject to change

DRAFT

Arkansas Payment Improvement Initiative

DD Working Session

March 6, 2012



Agenda for today's discussion

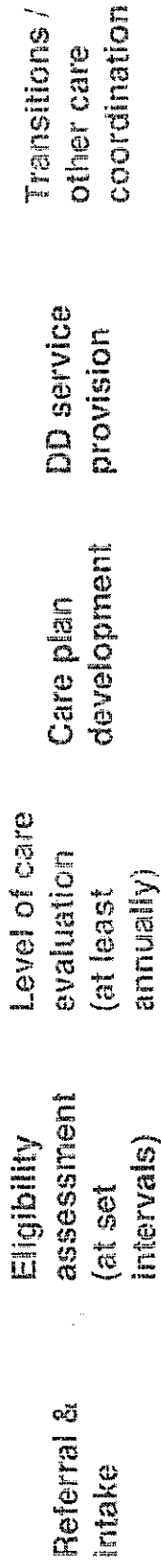
- **Review objectives of DD payment improvement initiative**
- Review emerging perspective on version 1.0 DD episode
- Review emerging perspective on version 1.0 care coordination within health home
- Discuss potential quality metrics
- Timetable going forward – what to expect

Approach to initial stages of payment improvement

- This document represents the emerging perspective on the DD payment improvement initiative
- Initial launch will represent Version 1.0
 - Launch initially applies to adult DD clients ages 18+, not enrolled in school
 - Goal is to roll-out over time to all DD clients
- Initial phase of DD payment improvement is not meant to change current DD eligibility criteria outlined in statute A.C.A. § 20-48-101 et seq.

Recap from Workgroups #1 & 2: Opportunities to improve quality of care, client experience, and cost efficiency of care provision

Client care journey today



Transitions / other care coordination

DD service provision

Care plan development

Level of care evaluation (at least annually)

Eligibility assessment (at set intervals)

Referral & intake

3

Better coordinate care delivery (across DD, medical and/or behavioral) and promote wellness

1

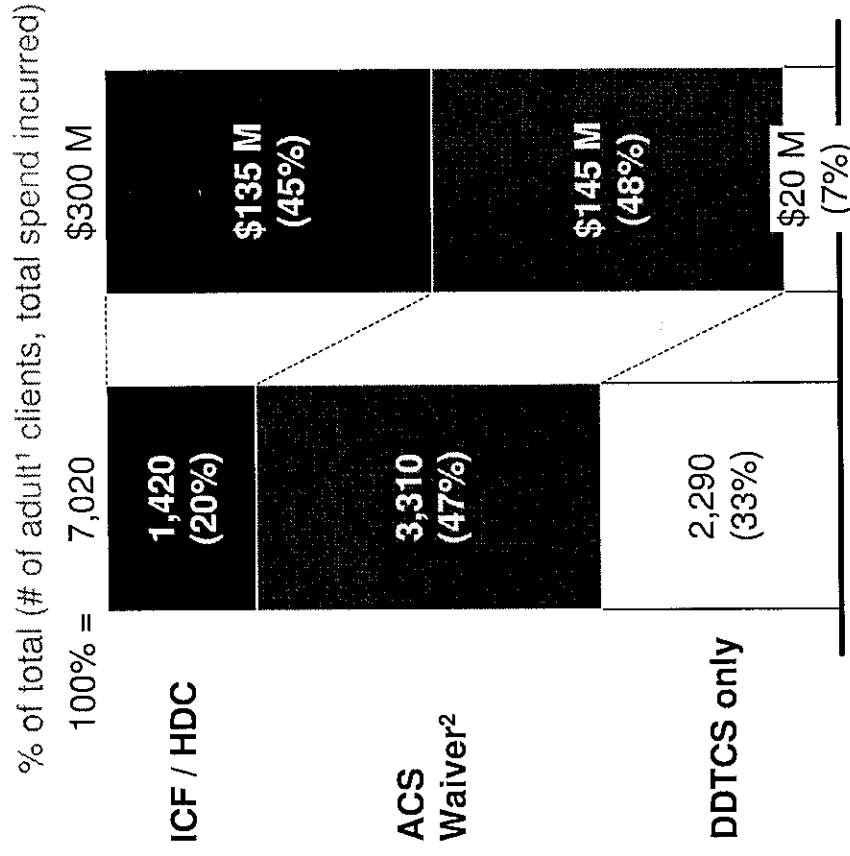
Ensure care provision is efficient and based on client needs

2

Minimize resources/ time not focused on delivering client care

PRELIMINARY

Context: Current adult DD clients and expenditures



Note: over time, model to expand to include all DD clients

NOTE: Clients / providers attributed to State Category of Service based on primary source of spend

¹ Initial episode design will include clients ages 18+, not currently enrolled in school

² Includes all services covered under ACS waiver, including DDTCS

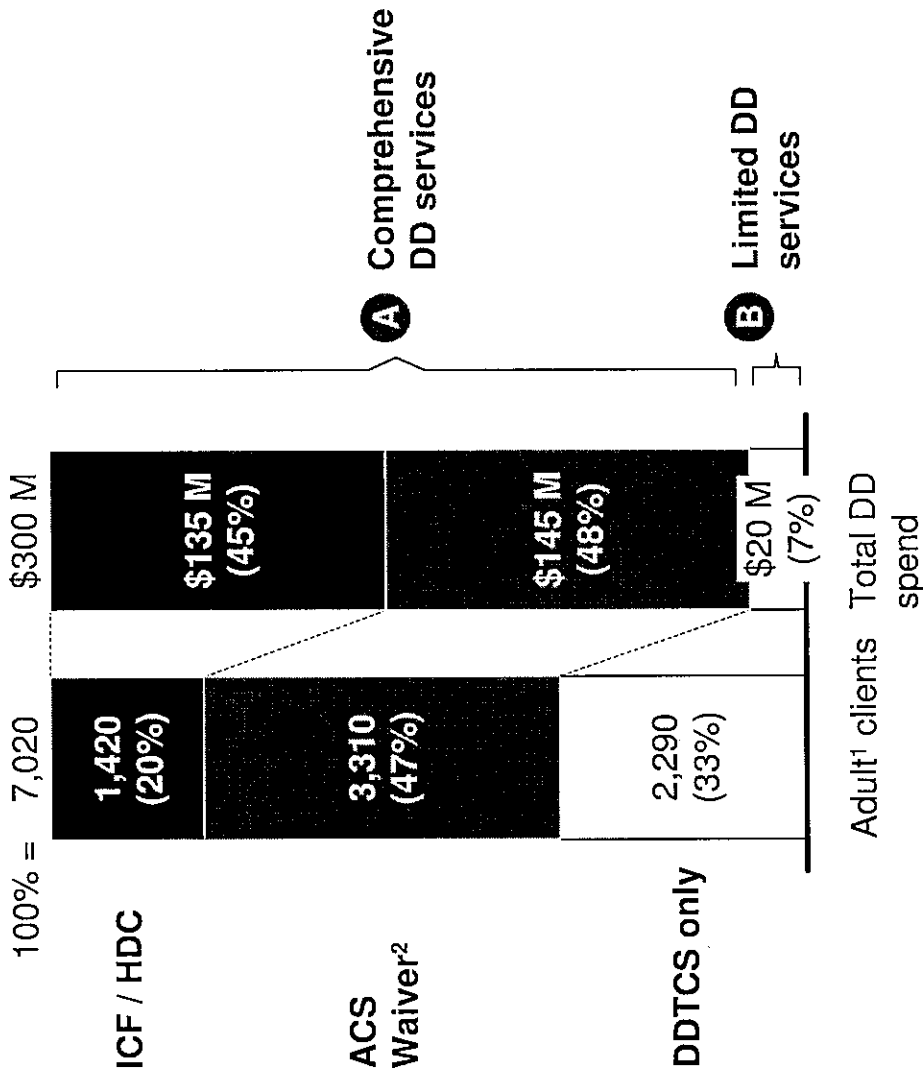
SOURCE: Medicaid claims data for claims incurred in SFY 2010

DDTCS – Developmental Day Treatment Clinic Services; ICF – Intermediate Care Facility; HDC – Human Development Centers (HDCs)

PRELIMINARY

Future approach will vary by level of DD services

% of total (# of adult¹ clients, total spend incurred)



C Family support option

- Adults currently receiving comprehensive DD services may switch to a family support option
- May provide additional flexibility outside of existing models

NOTE: Clients / providers attributed to State Category of Service based on primary source of spend

¹ Initial episode design will include clients ages 18+, not currently enrolled in school

² Includes all services covered under ACS waiver, including DDTCS

SOURCE: Medicaid claims data for claims incurred in SFY 2010

Clients included in each level of DD services

High level description

- A Comprehensive DD services**
 - Adults currently receiving care through ICF / HDC or ACS Waiver, who are not enrolled in school
 - B Limited DD services**
 - Adults receiving DDTCS services only including
 - Adults not enrolled in school
 - Adults on waitlist for receiving comprehensive DD services
 - C Family support**
 - Adults currently receiving comprehensive DD services may switch to a family support option
- Assessment to be deployed here

Proposed payment improvement plan addresses each source of value

- 1 Efficient care provision matched to client need
- 2 Minimize time / resources not focused on client care
- 3 Better coordinated care delivery

Episode model

A Comprehensive DD services

- Level of care based on assessment

Current requirements largely replaced with:

- Annual care plan
 - Billing at episode level
- Health home care coordination**

- Access to broader set DD categories of service

- Refined review / tracking mechanisms

B Limited DD services

- Ability for family to customize and execute plan

- Appropriate reporting to protect clients

- Families assume responsibility for care coordination activities

C Family support

An effective assessment is required for payment improvement

- Inter-RAI ID assessment tool has been selected for use in DD payment improvement
 - Core components tested and verified over the past 20 years
 - Recently selected by NY for use in the People First Waiver

- Opportunity to develop Arkansas-specific methodology & create consistency across application in DD, behavioral health and long-term care

- Independent 3rd party to perform initial assessment to achieve unbiased baseline

Assessor

- Initial phase will include DD clients age 18+, currently receiving comprehensive supported care (i.e., ICF / HDC or ACS Waiver services)

Clients to be assessed

- Initial assessments for adults receiving comprehensive DD services to begin in second half of 2012

Timing

- Ongoing frequency of assessment may vary by age, condition, severity

Next steps

- Collaborate with stakeholders in DD community to develop Arkansas-specific methodology
- Develop launch plan for initial assessment of DD clients

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Episode design dimensions

1 Target client population

2 Episode definition/
scope of services

3 Lead provider

4 Pricing

5 Provider level
adjustments

6 Payment mechanics

Emerging perspective: version 1.0 for adult DD episode

	A Comprehensive DD services	B Limited DD services	C Family support
1 Target client population	<ul style="list-style-type: none">▪ Clients ages 18+, currently receiving care through HDC/ICF or ACS waiver (not enrolled in school)	<ul style="list-style-type: none">▪ Clients ages 18+, receiving DD/TCS services only (not enrolled in school)	<ul style="list-style-type: none">▪ Clients ages 18+, currently receiving comprehensive DD services who choose to switch to family support
2 Episode definition/ scope of services	<ul style="list-style-type: none">▪ Assessment /annual review▪ 12 months of services, though assessment frequency may vary▪ All DD services▪ Defined triggers for reassessment	<ul style="list-style-type: none">▪ Annual review▪ 12 months of services▪ Broad set of DD services▪ Defined triggers for redetermination / care plan review	<ul style="list-style-type: none">▪ Annual review▪ 12 months of services▪ All DD services▪ Defined triggers for reassessment
3 Lead provider	_____ [see next page] _____		
			▪ Client and /or legal guardian

3 Designation of lead provider for comprehensive & limited episode – 2 scenarios

I Single lead provider / payment (encompasses majority of clients)

Single bundled payment for all DD services



- Lead provider**
- Care coordinator
 - Eligible for health home incentives

II Single lead provider / split bundled payment

Bundle A (e.g., community-based services)

Bundle B (e.g., center-based services)



- Lead provider**
- Care coordinator
 - Eligible for health home incentives
- Provider B**

No shared financial risk across providers

Description	Lead provider responsibilities
<ul style="list-style-type: none"> ▪ Clients choose to receive care through one provider 	<ul style="list-style-type: none"> ▪ Delivery of all DD services in line with client need ▪ Development of integrated, comprehensive DD care plan ▪ Reporting and performance on quality metrics / outcomes for episode and health home
<ul style="list-style-type: none"> ▪ Client choose separate providers for center-based and community-based services ▪ Client chooses lead provider as provider delivering the most services 	<ul style="list-style-type: none"> ▪ Delivery of select DD services in line with client need ▪ Responsibility for performing or providing access to: <ul style="list-style-type: none"> – Development of integrated, comprehensive DD care plan – Reporting and performance on quality metrics / outcomes for episode and health home

Can we roll-out self-directed option for these clients?

Emerging perspective: version 1.0 for adult DD episode

- A** Comprehensive DD services
- B** Limited DD services
- C** Family support

4 Pricing

- Based on assessment and historical data
- Price determined for each level of need, once sufficient number of assessments have been completed to enable link of assessed level to cost in AR
- Based on assessment
- Leverage historical/on-going family support program models

5 Provider level adjustments

- For HDC/ICF need to isolate DD service / supportive living costs for pricing
- None
- None

6 Payment mechanics

- Prospective bundle, paid at set interval

¹ Over time, payment may become linked to assessment

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DD provider care coordination within health home has complementary responsibilities to medical home

Medical home

Medical provider

- Perform clinical assessment and treatment plan
- Determine medical inputs for care plan, e.g., medication regimen, diet / lifestyle modifications
- Include clients / caregiver in clinical decisions
- Promote preventative care and therapeutic adherence
- Proactive outreach / follow-up of medical issue
- Provide (and schedule) referrals with clear indication / timing
- Collaborate with specialists to coordinate clinical care
- Assess change in clinical status and determine change in long-standing therapeutic plan

Tailored care plan based on level of risk

- Engage family / client in creation of integrated care plan

Client education and communication

- Tailor education to specific intellectual/behavioral needs
- Monitor / facilitate continued adherence to care plan and promote wellness

Specialist / in-patient care

- Prepare client for specialist visit, (e.g., fasting, pre-procedure prep)
- Ensure timely attendance at visit
- Facilitate transitions of care (e.g., provide information on symptoms & clinical history)

Symptom identification & triage

- Monitor physical / behavioral changes within the home / social settings to identify potential medical issues
- Determine need for medical / behavioral attention (PCP vs. ER vs. other)

Care coordination (within health home)

DD provider

- Develop DD care plan and coordinate across DD services
- Consolidate multiple inputs into integrated care plan (MH, BH, day service, supportive living)
- Engage family / client in creation of integrated care plan
- Tailor education to specific intellectual/behavioral needs
- Monitor / facilitate continued adherence to care plan and promote wellness
- Prepare client for specialist visit, (e.g., fasting, pre-procedure prep)
- Ensure timely attendance at visit
- Facilitate transitions of care (e.g., provide information on symptoms & clinical history)
- Monitor physical / behavioral changes within the home / social settings to identify potential medical issues
- Determine need for medical / behavioral attention (PCP vs. ER vs. other)

Design choices for care coordination within health home

Design choices

1 Target client population

2 Care coordination model

3 Payment model

1 Emerging perspective: version 1.0 target client population

Questions to address

Emerging perspective

- Are all DD clients included in health home?
 - All adult clients (ages 18+, not enrolled in school) are eligible for health home, however level of care coordination may vary based episode model / level of need
- Can clients be attributed to more than one health home?
 - Clients may choose no more than one health home, although there are no restrictions on which DD service provider or PCP can be seen
- Should clients be required to select a DD provider or can they be attributed? Are there elements of both?
 - All eligible clients must select a lead DD provider at time of assessment / annual review
 - DDS should assist in selection

2 Emerging perspective: version 1.0 care coordination model (1 of 2)

Questions to address	Emerging perspective
<ul style="list-style-type: none">▪ Which provider is responsible for care coordination responsibilities?	<ul style="list-style-type: none">▪ DD episode lead provider is responsible for care coordination activities and outcomes
<ul style="list-style-type: none">▪ Are there infrastructure / other requirements for provider participation?	<ul style="list-style-type: none">▪ DD providers must meet existing Medicaid / DDS requirements for licensure▪ Access to internet to receive reports and submit data▪ Additional criteria to be defined
<ul style="list-style-type: none">▪ Can families fulfill the role of the health home?	<ul style="list-style-type: none">▪ When families choose the family support program, they are required to assume care coordination activities

3 Emerging perspective: version 1.0 payment model considerations

	Potential payment streams	Requirements for payment
Care coordination fees	<ul style="list-style-type: none">▪ Risk-adjusted PMPM payments based on<ul style="list-style-type: none">– DD severity– Level of medical / behavioral need▪ Flat PMPM payment (Both contingent on funding)	<ul style="list-style-type: none">▪ All providers must meet minimum quality requirements / care coordination responsibilities to be eligible for payment
Outcomes-based payment	<ul style="list-style-type: none">▪ Based on reducing total cost and utilization of non-DD care, e.g., medical, behavioral<ul style="list-style-type: none">– Incentives tied to performance, e.g., utilization / quality metrics– Shared savings▪ Likely to begin with reporting period	<ul style="list-style-type: none">▪ Providers achieving higher level of performance will be eligible for outcomes-based payment

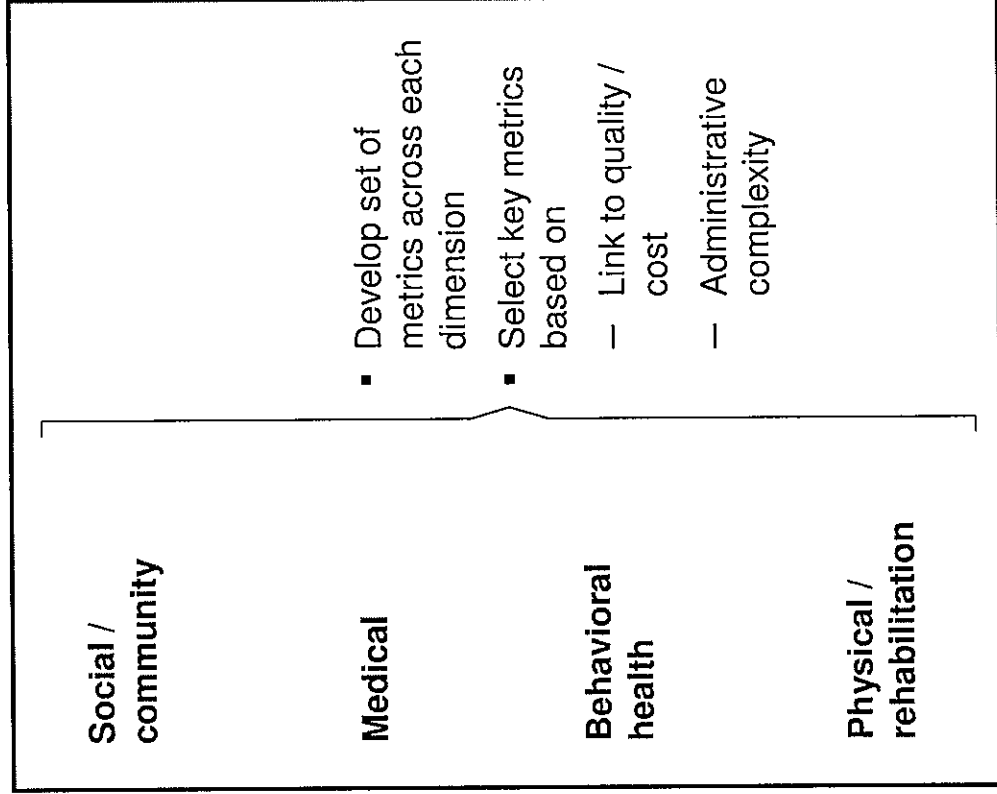
NOTE: Review underway to identify expectations that may be included in existing payments

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- **Discuss potential quality metrics**
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Quality metrics can be assessed across four categories

Potential quality dashboard categories



- **Types of metrics to include**
 - Client experience (e.g., person centered outcomes)
 - Utilization
 - Cost
- **Potential processes for monitoring**
 - Data reporting
 - Self-reporting by providers and DD facilities via provider portal
 - Medicaid claims data
 - Quality review
 - DDS reviews
 - Client / family surveys
- Likely to require reporting period to establish baseline prior to linking to payment requirements

Emerging perspective: Quality metrics (1/2)

WORKING VERSION - TO BE REFINED

Example metrics		Source
Social / community	Health home & episode metrics	Provider portal
	▪ # of hours in community setting / month	
	▪ # of hours in educational setting / month	
	▪ Can the client choose a workplace?	
	▪ Can the client control budget / finances?	
	▪ Can the client choose where they live?	
	▪ Can the client communicate needs to staff?	
	▪ # of meaningful, sustained social relationships / past year	
	▪ # of unsettled relationships (e.g., persistent hostility) / past year	
	▪ How does the staff facilitate client understanding of care plan?	
Medical	Health home metrics only	Claims data
	▪ # of updates from DD provider to family or guardian / month	
	— Detail actions taken in response	
	▪ # of hours of assistance from family supports / month	
	▪ # of hours of assistance from ALL supports / month	
	▪ # and type and cost of ER visits / past year	
▪ # and type and cost of hospitalizations & re-hospitalizations / past year		
▪ # of new co-morbidities / past 3 years		
▪ # of physician visits / year		
▪ # of specialist visits / year		
▪ Access to preventive care / wellness		

SOURCE: Expert interviews, lit. review (e.g., AHRQ Measurement of Outcomes for People with Disabilities, National Core Indicators 2009-2010)

Emerging perspective: Quality metrics (2/2)

WORKING VERSION - TO BE REFINED

Example metrics	Source
Behavioral health Health home & episode metrics <ul style="list-style-type: none"> ▪ # of behavioral incidents (e.g., physical fights) / month ▪ # of incarcerations / year ▪ # of uses of physical restraints / month ▪ Does the client have access to smoking cessation programs? ▪ Does the client have access to substance abuse programs? ▪ Is a positive behavior plan in place? ▪ Is a crisis management plan in place? 	Provider portal
Health home metrics only <ul style="list-style-type: none"> ▪ # of behavioral health assessments / year ▪ # of ER visits for behavioral reasons / year 	Claims data
Physical / rehab-ilitation Health home & episode metrics <ul style="list-style-type: none"> ▪ # of hours & type of physical activity / month ▪ # of updates from DD provider to case manager / month <ul style="list-style-type: none"> – Detail actions taken in response to updates ▪ # of falls / past month ▪ Body mass index ▪ Incidence of pressure sores / month ▪ # of hours in speech therapy / month ▪ # of hours in physical therapy / month ▪ Can the client access adaptive equipment / environmental modification? 	Provider portal

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Timetable going forward - what to expect

PRELIMINARY

Key milestones	Description	Timing
<ul style="list-style-type: none"> ▪ Announcement and education 	<ul style="list-style-type: none"> ▪ Assessment process and additional design documents published ▪ Educational workgroups and townhalls to answer questions 	May/ June
<ul style="list-style-type: none"> ▪ Assessment launch 	<ul style="list-style-type: none"> ▪ Initial assessments begin for adults receiving comprehensive DD services (who are not enrolled in school) 	2 nd half 2012
<ul style="list-style-type: none"> ▪ Reporting period / data collection for both episode and health home 	<ul style="list-style-type: none"> ▪ Reporting begins for providers in order to establish baseline historical performance ▪ Assessment data collection and refinement 	2 nd half 2012
<ul style="list-style-type: none"> ▪ Feedback period 	<ul style="list-style-type: none"> ▪ Formal / informal opportunities for feedback on experience to date ▪ Refinements to version 1.0 design 	Q4 2012
<ul style="list-style-type: none"> ▪ Performance period begins 	<ul style="list-style-type: none"> ▪ Episodic payment begins (design / timing may vary by level of DD services, e.g., comprehensive, limited) ▪ Performance-related health home incentives introduced 	Subsequently