Arkansas Payment Improvement Initiative
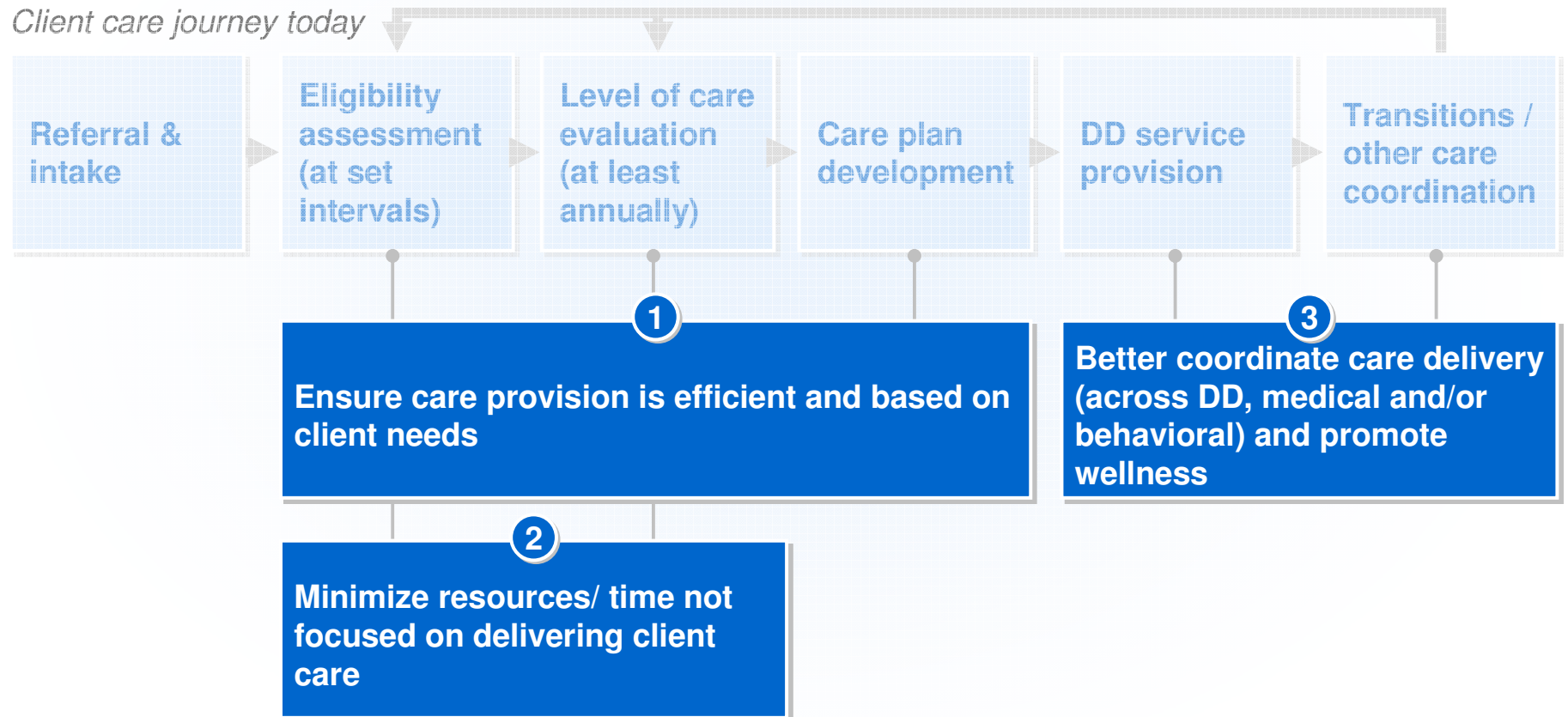
DD Working Session

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

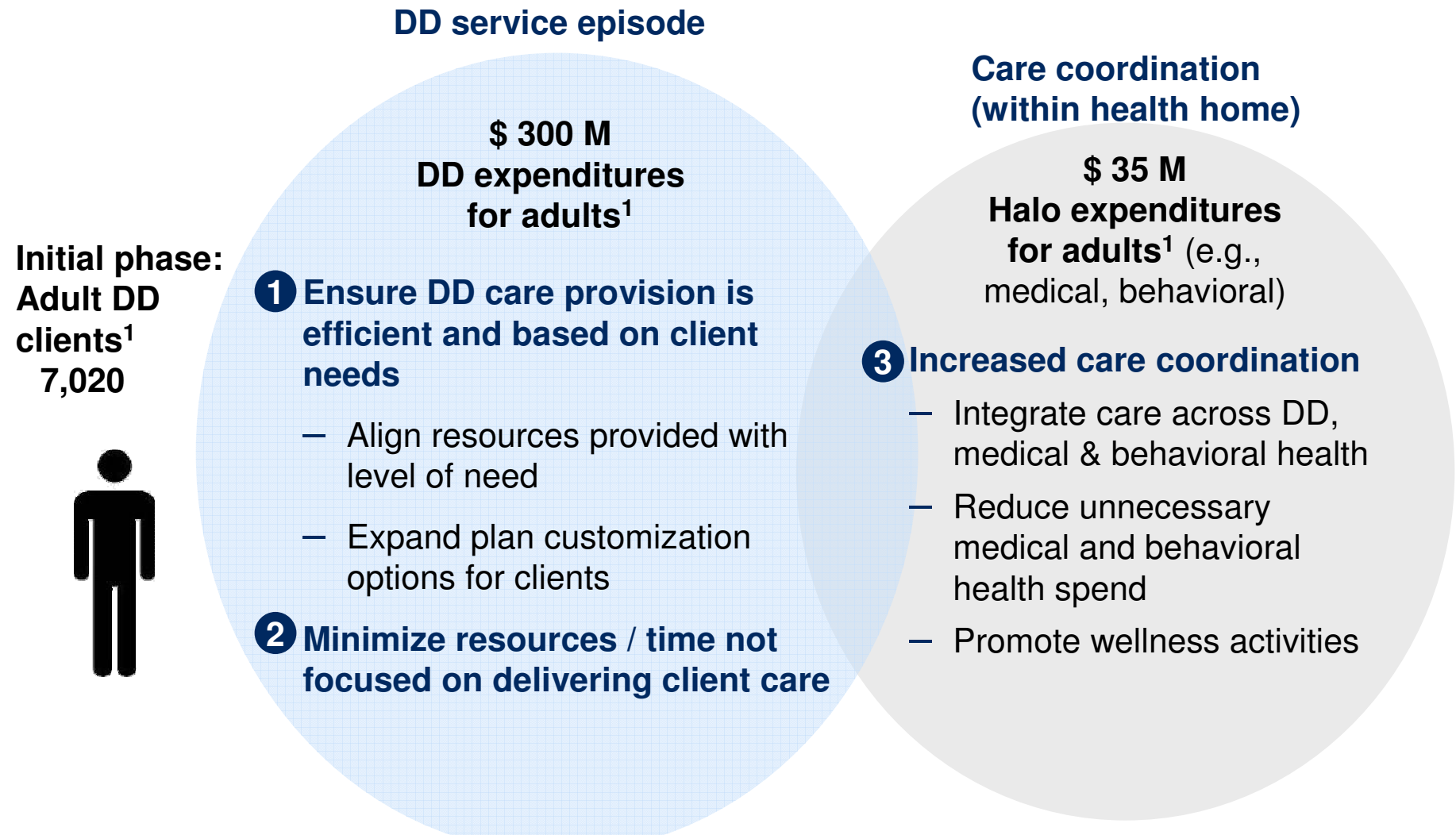# Approach to initial stages of payment improvement

- 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

Referral & intake	Eligibility assessment (at set intervals)	Level of care evaluation (at least annually)	Care plan development	DD service provision	Transitions / other care coordination

①

Ensure care provision is efficient and based on client needs

③

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

②

Minimize resources/ time not focused on delivering client care

Payment improvement initiative aims to address these opportunities

PRELIMINARY

DD service episode

Care coordination (within health home)

Initial phase: Adult DD clients[1] 7,020

$ 300 M DD expenditures for adults[1]

$ 35 M Halo expenditures for adults[1] (e.g., medical, behavioral)

❶ Ensure DD care provision is efficient and based on client needs

- Align resources provided with level of need
- Expand plan customization options for clients

❸ Increased care coordination

- Integrate care across DD, medical & behavioral health
- Reduce unnecessary medical and behavioral health spend
- Promote wellness activities

❷ Minimize resources / time not focused on delivering client care

1 Includes DD clients ages 18+, not currently enrolled in school, excludes 22 clients receiving therapy only
2 Includes all medical and behavioral spend, in-patient, out-patient and pharmacy spend

SOURCE: Medicaid claims data for claims incurred in SFY 2010

4

Context: Current adult DD clients and expenditures

% of total (# of adult[1] clients, total spend incurred)

100% =   7,020 $300 M

ICF / HDC   1,420 (20%)

$135 M (45%)

ACS Waiver[2]   3,310 (47%)

$145 M (48%)

DDTCS only   2,290 (33%)

$20 M (7%)

Adult[1] clients   Total DD spend
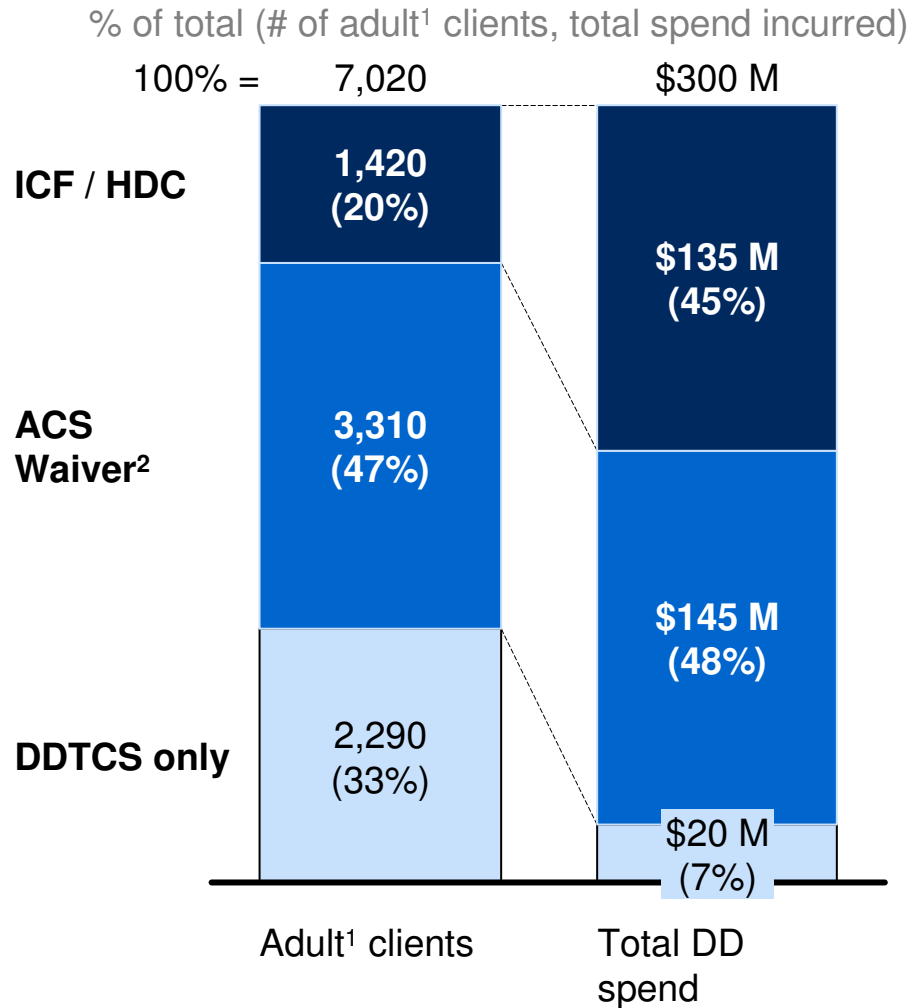
Note: over time, model to expand to include all DD clients

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)

Future approach will vary by level of DD services

% of total (# of adult[1] clients, total spend incurred)

100% =   7,020 $300 M

ICF / HDC   1,420 (20%)

$135 M (45%)

ACS Waiver[2]   3,310 (47%)

Ⓐ Comprehensive DD services

$145 M (48%)

DDTCS only   2,290 (33%)

$20 M (7%)

Ⓑ Limited DD services

Adult[1] clients   Total DD spend
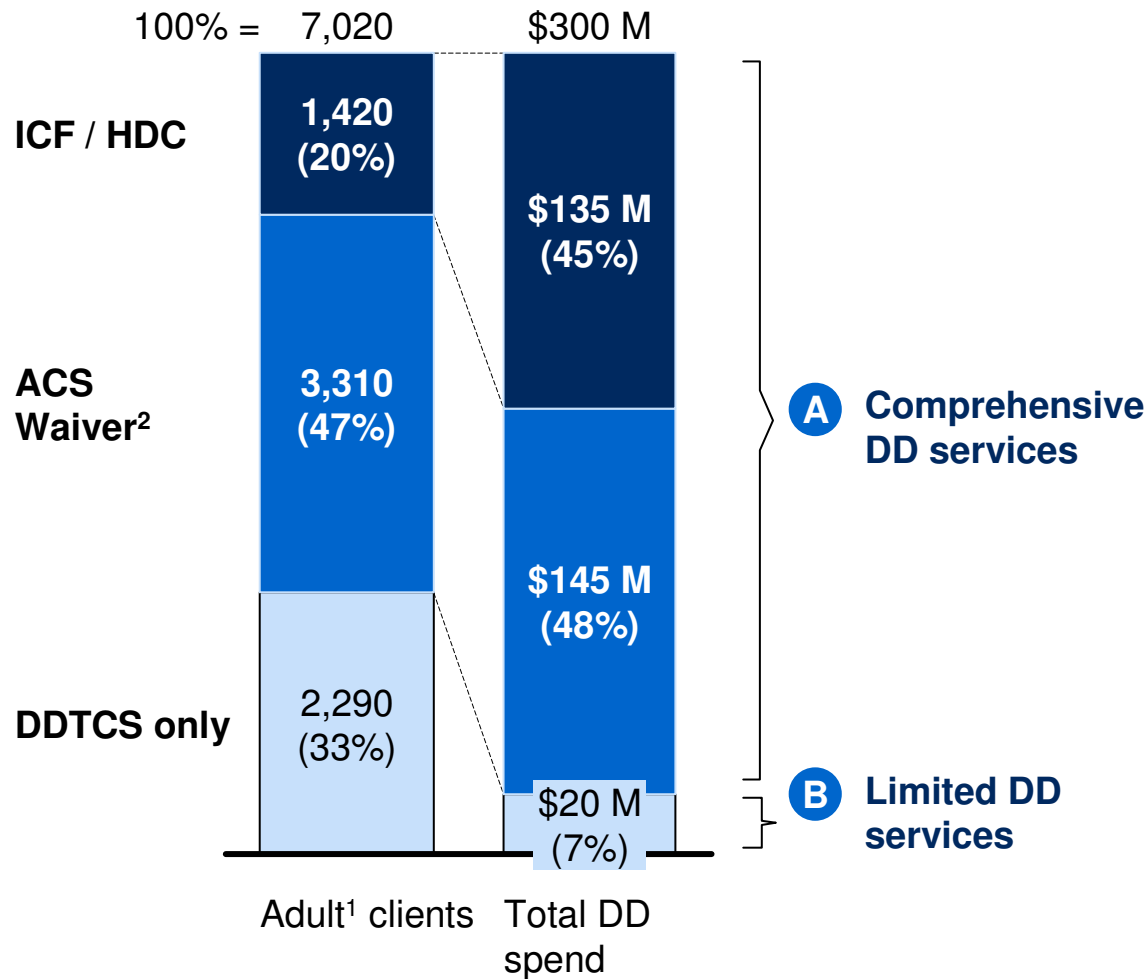
Ⓒ Family support option

— 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**
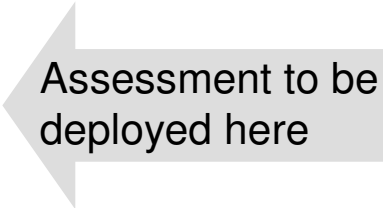
- Adults currently receiving care through ICF / HDC or ACS Waiver, who are not enrolled in school

Assessment to be deployed here

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

—

Proposed payment improvement plan addresses each source of value

Episode model	**1** Efficient care provision matched to client need	**2** Minimize time / resources not focused on client care	**3** Better coordinated care delivery
A **Comprehensive DD services**	▪ Level of care based on assessment	Current requirements largely replaced with: ▪ Annual care plan ▪ Billing at episode level ▪ Refined review / tracking mechanisms	**Health home care coordination**
B **Limited DD services**	▪ Access to broader set DD categories of service		
C **Family support**	▪ Ability for family to customize and execute plan	▪ Appropriate reporting to protect clients	▪ Families assume responsibility for care coordination activities

An effective assessment is required for payment improvement

Tool

- 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

Assessor

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

Clients to be assessed

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

Timing

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

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

Episode design dimensions

1 **Target client population**

2 **Episode definition/ scope of services**
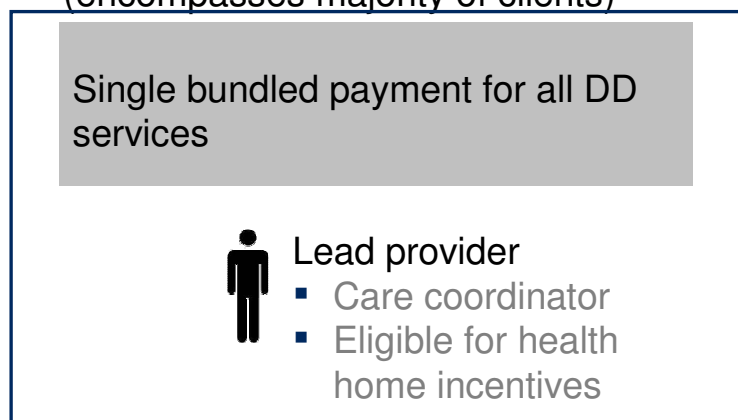
3 **Lead provider**

4 **Pricing**

5 **Provider level adjustments**

6 **Payment mechanics**

Emerging perspective: version 1.0 for adult DD episode

	Ⓐ Comprehensive DD services	**Ⓑ Limited DD services**	**Ⓒ Family support**
❶ Target client population	▪ Clients ages 18+, currently receiving care through HDC/ICF or ACS waiver (not enrolled in school)	▪ Clients ages 18+, receiving DDTCS services only (not enrolled in school)	▪ Clients ages 18+, currently receiving comprehensive DD services who choose to switch to family support
❷ Episode definition/ scope of services	▪ Assessment /annual review ▪ 12 months of services, though assessment frequency may vary ▪ All DD services ▪ Defined triggers for reassessment	▪ Annual review ▪ 12 months of services ▪ Broad set of DD services ▪ Defined triggers for redetermination / care plan review	▪ Annual review ▪ 12 months of services ▪ All DD services ▪ Defined triggers for reassessment
❸ Lead provider	———————— [see next page] ————————		▪ Client and /or legal guardian

12

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

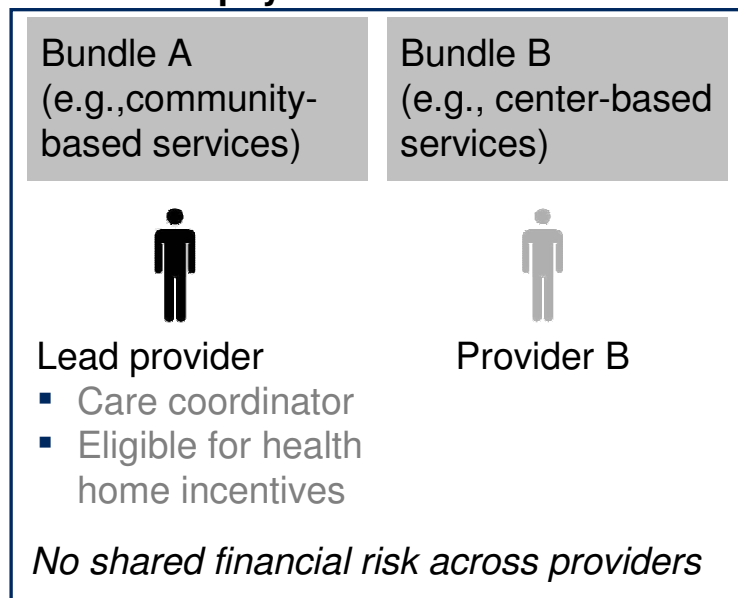**I** **Single lead provider / payment**
(encompasses majority of clients)

Single bundled payment for all DD services

Lead provider
- Care coordinator
- Eligible for health home incentives

Description

- Clients choose to receive care through one provider

Lead provider responsibilities

- 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

II **Single lead provider / split bundled payment**

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

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

No shared financial risk across providers

Description

- Client choose separate providers for center-based and community-based services
- Client chooses lead provider as provider delivering the most services

Lead provider responsibilities

- Delivery of select DD services in line with client need
- Responsibility for performing or providing access to:
  - 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?

13

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 historical data - Single price for all clients[1]	- 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

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

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

	Medical home	Care coordination (within health home)
	Medical provider	**DD provider**
Tailored care plan based on level of risk	▪ 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	▪ 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
Client education and communication	▪ Promote preventative care and therapeutic adherence ▪ Proactive outreach / follow-up of medical issue	▪ Tailor education to specific intellectual/behavioral needs ▪ Monitor / facilitate continued adherence to care plan and promote wellness
Specialist / in-patient care	▪ Provide (and schedule) referrals with clear indication / timing ▪ Collaborate with specialists to coordinate clinical 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	▪ Assess change in clinical status and determine change in long-standing therapeutic plan	▪ 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**

❶ 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
▪ Which provider is responsible for care coordination responsibilities?	▪ DD episode lead provider is responsible for care coordination activities and outcomes
▪ Are there infrastructure / other requirements for provider participation?	▪ DD providers must meet existing Medicaid / DDS requirements for licensure ▪ Access to internet to receive reports and submit data ▪ Additional criteria to be defined
▪ Can families fulfill the role of the health home?	▪ When families choose the family support program, they are required to assume care coordination activities

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

Questions to address	Emerging perspective

▪ What care coordination activities are required?	▪ Providers must meet responsibilities across[1]:
	
	  — Tailored care plan based on risk
	
	  — Client education & communication
	
	  — Specialist / in-patient care
	
	  — Symptom identification & triage
	
	▪ Identification of triggers for re-assessment / plan redesign
	
	(Details to be refined in coming weeks)

▪ What tools could health homes benefit from, e.g., care plan templates, training, infrastructure?	▪ Care plan execution templates ▪ Avenues for collaboration with providers (e.g., medical provider, other DD providers)

1 As described on pg 16

③ Emerging perspective: version 1.0 payment model considerations

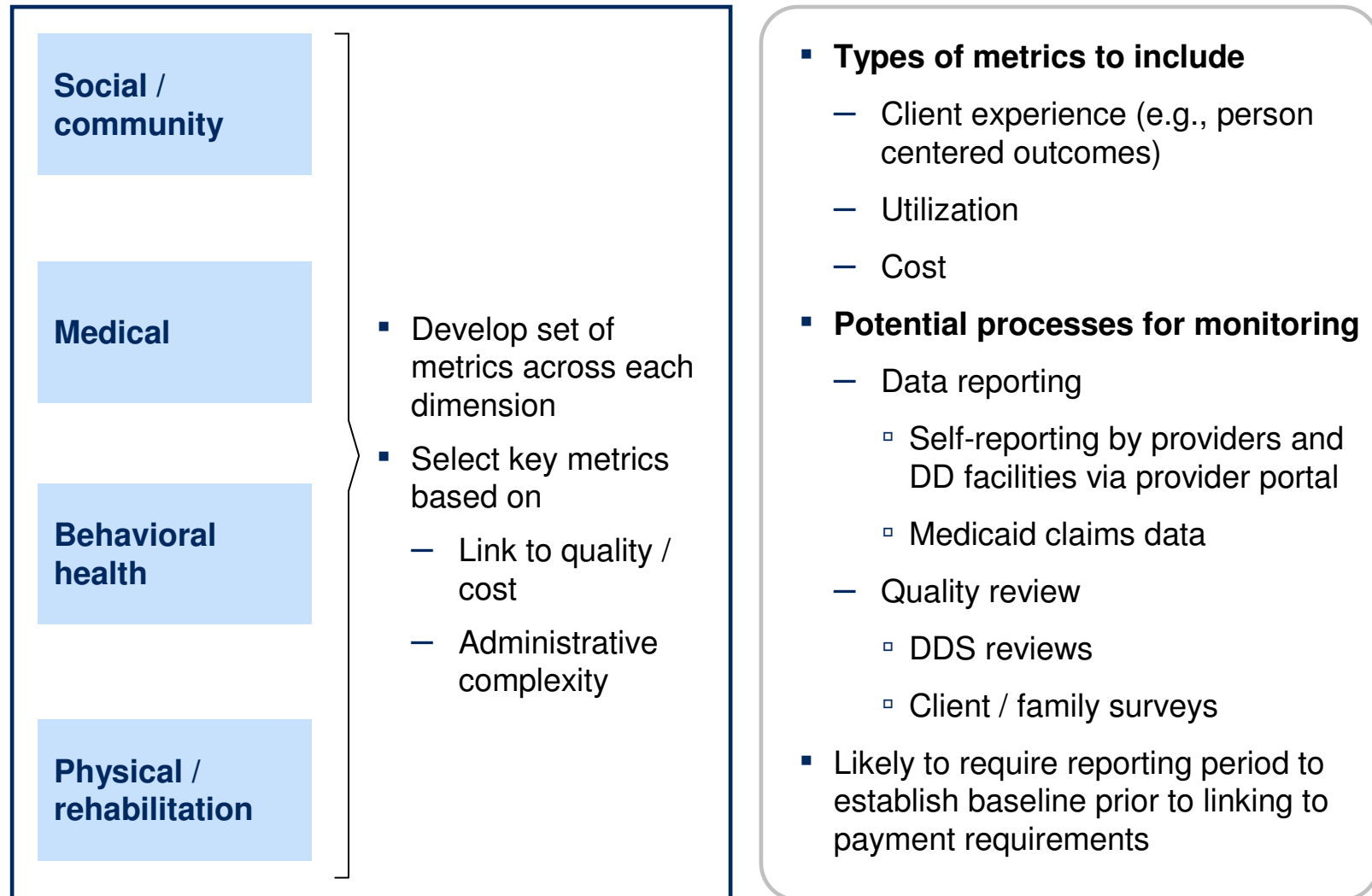|	**Potential payment streams**	**Requirements for payment**
Care coordination fees	▪ Risk-adjusted PMPM payments based on — DD severity — Level of medical / behavioral need ▪ Flat PMPM payment (Both contingent on funding)	▪ All providers must meet minimum quality requirements / care coordination responsibilities to be eligible for payment
Outcomes-based payment	▪ Based on reducing total cost and utilization of non-DD care, e.g., medical, behavioral — Incentives tied to performance, e.g., utilization / quality metrics — Shared savings ▪ Likely to begin with reporting period	▪ 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

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

Quality metrics can be assessed across four categories

Potential quality dashboard categories

Social / community		
Medical	■ Develop set of metrics across each dimension	■ **Types of metrics to include**

Social / community

Medical

Behavioral health

Physical / rehabilitation

- ■ Develop set of metrics across each dimension
- ■ Select key metrics based on
  - – Link to quality / cost
  - – Administrative complexity

- ■ **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

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

Emerging perspective: Quality metrics (1/2)

Example metrics	Source

Social / community

Health home & episode metrics
- # 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?

Health home metrics only
- # 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

Provider portal

Medical

Health home metrics only
- # 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

Claims data

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)

	Example metrics	**Source**
Behavioral health	**Health home & episode metrics** ▪ # 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 ▪ # of behavioral health assessments / year ▪ # of ER visits for behavioral reasons / year	Claims data
Physical / rehab-ilitation	**Health home & episode metrics** ▪ # of hours & type of physical activity / month ▪ # of updates from DD provider to case manager / month – 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

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

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**

Timetable going forward - what to expect

PRELIMINARY

Key milestones	Description	Timing
Announcement and education	■ Assessment process and additional design documents published ■ Educational workgroups and townhalls to answer questions	May/ June
Assessment launch	■ Initial assessments begin for adults receiving comprehensive DD services (who are not enrolled in school)	2nd half 2012
Reporting period / data collection for both episode and health home	■ Reporting begins for providers in order to establish baseline historical performance ■ Assessment data collection and refinement	2nd half 2012
Feedback period	■ Formal / informal opportunities for feedback on experience to date ■ Refinements to version 1.0 design	Q4 2012
Performance period begins	■ Episodic payment begins (design / timing may vary by level of DD services, e.g., comprehensive, limited) ■ Performance-related health home incentives introduced	Subsequently