Wyoming Department of Health

Community Mental Health and Substance Abuse

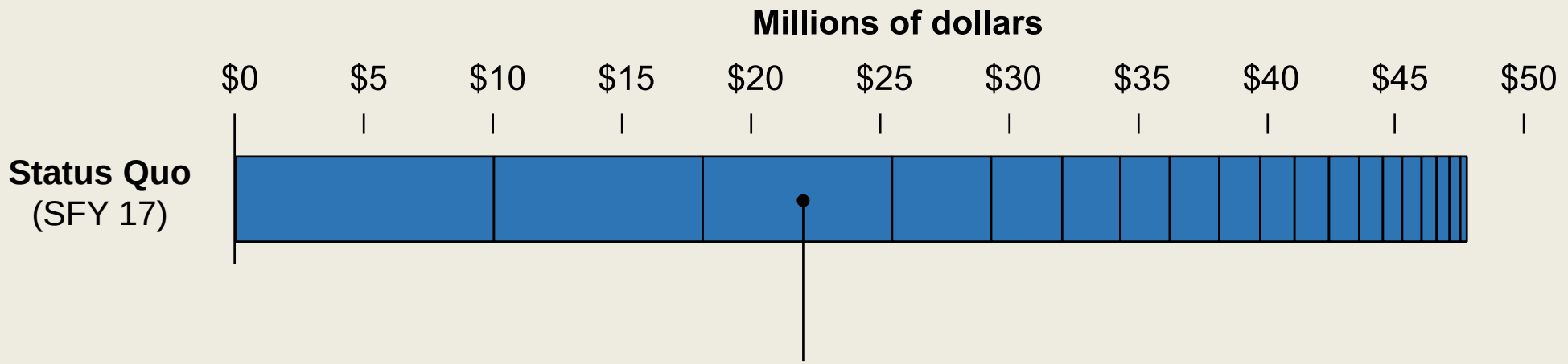
Collaborative Approach to Payment Reform

Phase I & II

Wyoming Department of Health

Commit to your health.

MHSA Payment Reform – Status Quo



Current MH/SA contracts (~$47.8M per year)

What

- Each block represents one center (e.g. the first block is Peak Wellness)
- 1/12 (monthly) payments paid in exchange for required quota of service hours
- 1 hour of service ≈ $87.00

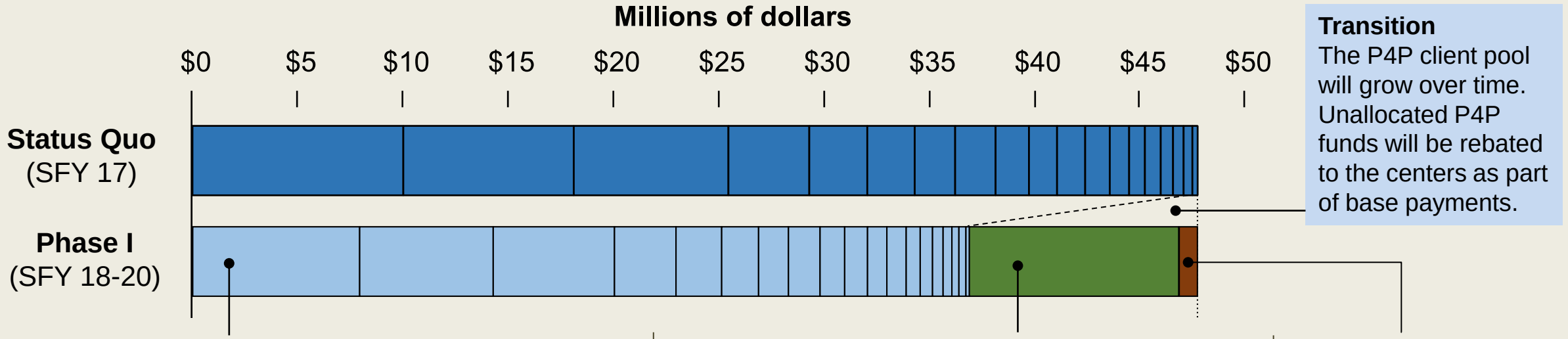
For whom

- General access, on a sliding fee schedule

Why

- System designed to support access throughout State, when MH/SA services were rarely covered by insurance.

MHSA Payment Reform – Phase I



Transition
The P4P client pool will grow over time. Unallocated P4P funds will be rebated to the centers as part of base payments.

Capped fee-for-service (FFS)

What

- Each center allowed to bill up to cap.
- At end of year, center receives unbilled balance.
- Each service priced according to cost (≠ $87/hr).
- Claims processed automatically by MMIS.

For whom

- Eligible clients (later slides)

Why

- Collect accurate utilization data for priority populations in support of actuarial analysis for Phase II implementation.

Pay for performance (P4P)

What

- Tiered monthly payments conditional on clients achieving outcomes, to include:
  - Prevention of hospitalization;
  - Competitive and integrated employment;
  - Independent housing.
- Diversion reward (outpatient commitment).
- Paid as performance bonus, not for services.

For whom

- Designated high-risk (T25) clients.

Why

- Provide incentive for diversions.
- Reduce ALOS at the State Hospital and DHs.

Base payments

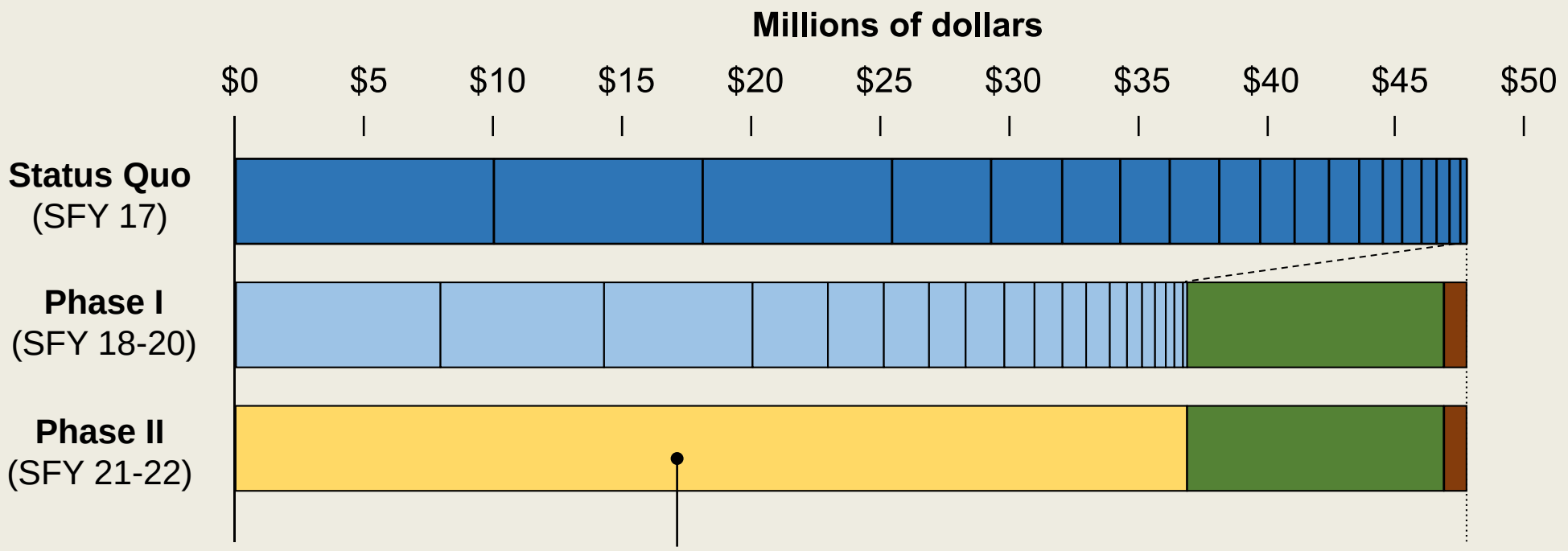
What

- Flat $100,000 per center per year.

Why

- Help smaller centers keep the doors open.

MHSA Payment Reform - Phase II



Capitated priority population payments

What

- Actuarially-sound capitated (monthly) payments for priority populations.
- Percentage of payment conditional on treatment outcomes.

For whom

- Priority populations (see previous slide)

Why

- Pay providers for treating clients based on need, without the volume incentives created in a fee-for-service system

MHSA Payment Reform – Eligibility

Higher PMPM

Level	Description			
	Eligibility	Risk of harm to self/others	Physical health	Crisis management
5	**Clinical need**	High	Unmanaged	Recent
4		Moderate	Marginally	Occasional
3		Minimal	Managed	None
2	**Lack of coverage**	None	N/A	N/A
1				

Notes

- Eligibility for Levels 3 – 5 is based on clinical need, not income.
- Eligibility for Levels 1 – 2 is based on lack of affordable insurance coverage (i.e., <100% FPL).
- Clients provided services will be assessed for eligibility (next slide) and assigned an eligibility group in the MMIS to track utilization.

MHSA Payment Reform – Eligibility

Higher PMPM

Level	Clinical Eligibility				Income Eligibility
	GAF	ASAM	CASII	LOCUS	
5	≤ 35	3.2D – 3.7D	4-5	4-5	None
4	≤ 45	2.1 – 3.5	3-4	3-5	
3	≤ 55	1.0 – 2.1	2-3	2-3	
2	55+	1.0	2	1-2	≤ 100% FPL
1	55+	0.5 – 1.0	1-2	1	

In addition to the levels, certain specific populations will be tracked by eligibility group

- Adults with Severe Mental Illness (SMI)
- Diversions from ER / jail / hospital
- Women with dependent children
- Veterans
- Persons transitioning from Title 25, corrections, or residential services
- Children with Serious Emotional Disturbance (SED)
- Pregnant women
- Intravenous drug users
- Outpatient commitments
- Severe Substance Use Disorder (SUD)