VERMONT

AGENCY OF HUMAN SERVICES

Report to the Vermont Legislature

Medicaid Pathway 2016 Report

Act 113, Section 12

Submitted by the Agency of Human Services and in consultation with the Agency of Administration, the Green Mountain Care Board, and Affected Providers

12-30-2016

Act 113 Sec. 12—Medicaid Pathway Report

Contents

Executive Summary

Section 12 of Act 113 of the Acts of 2016 requires the Agency of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers to create a process for payment and delivery system reform for Medicaid providers and services. The process must address all Medicaid payments to affected providers and integrate providers to the extent practicable into the All-Payer Model and other existing payment and delivery system reform initiatives.

The Agency of Human Services (AHS), in collaboration with the Agency of Administration (AOA), launched the Medicaid Pathway in the Fall of 2015. The Medicaid Pathway supports Medicaid payment and delivery system reforms, with the goal of moving away from traditional fee-for-service payment models in alignment with the All-Payer Model. The Medicaid Pathway is designed to systematically review payment models and delivery system values identified in Vermont's Model of Care[1] across AHS to refine State and local operations to better support the integration of physical health, long-term services and supports, mental health, developmental disabilities, substance use disorder treatment, and children's service providers.

The Medicaid Pathway process seeks to develop provider-led reforms, and emphasizes public-private partnerships through intensive dialogue with providers, consumers and consumer advocates, and other stakeholders. It is based on the premise that through payment and delivery system reform the State can enable Medicaid providers to better serve Vermonters by providing higher quality, more efficient care that is better integrated into the broader health system.

No formal recommendation for a specific reform is included in this report; instead, the report provides detailed information about activities and progress over the first year of the Medicaid Pathway process, including:

- Goal-setting, stakeholder engagement, and information gathering (Introduction).
- Identification of two initial provider cohorts and review of current payments to those providers (Section I).
- Proposed changes to payment methodologies for one cohort of providers, and the process by which the State, consultants, and stakeholders developed the proposed methodology (Section II and Appendix F). Initial financial analyses have been conducted, though they are still being vetted by departments and providers. The proposed model is iterative and continues to evolve.
- Integration and alignment with the All-Payer Model and other reforms (Section III).
- Initial efforts to develop a quality measure set that meets federal and Legislative requirements, supports provider accountability to the State, and minimizes provider burden (Section IV).
- Appendices provide additional background and documents developed for and in partnership with providers and other stakeholders.

Financial analyses, vetting of data, and discussions with departments and affected providers are ongoing.

[1] Vermont's Model of Care is more fully described in the Medicaid Pathway Overview found in Appendix A.

Introduction

Section 12 of Act 113 of the Acts of 2016 requires the Agency of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers to create a process for payment and delivery system reform for Medicaid providers and services. The process must address all Medicaid payments to affected providers and integrate providers to the extent practicable into the All-Payer Model and other existing payment and delivery system reform initiatives. The Agency of Human Services must submit a report on the progress of this process to the Senate Committee on Health and Welfare and to the House Committees on Health Care and Human Services. The report is to address:

(1) all Medicaid payments to affected providers;

(2) changes to reimbursement methodology and the services impacted;

(3) efforts to integrate affected providers into the all-payer model and with other payment and delivery system reform initiatives;

(4) changes to quality measure collection and identifying alignment efforts and analyses, if any; and

(5) the interrelationship of results-based accountability initiatives with the quality measures in subdivision (4) of this subsection.

AHS, in collaboration with AOA, launched the Medicaid Pathway in the Fall of 2015. The Medicaid Pathway is a process that supports Medicaid payment and delivery system reforms. AHS and OAO have engaged in innovative Health Care Reform with the recognition that:

- Health care cost growth is not sustainable;
- Health care needs have evolved since the fee-for-service system was established more than fifty years ago;
- More people are living today with multiple chronic conditions;
- The Center for Disease Control reports that treating chronic conditions accounts for 86% of our health care costs;
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health; and
- Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

One overarching goal of moving away from traditional fee-for-service payment models is to allow for providers to have a greater focus on wellness and prevention, health promotion, early detection, and intervention. The Medicaid Pathway focuses on Medicaid funded programs across the AHS such that the social determinants of health can be addressed in balance with the traditional health care system.

The Medicaid Pathway is a planning process led by AHS in partnership with AOA. These planning efforts are designed to:

- Systematically review payment models and delivery system expectations across the AHS Medicaid program to refine State and local operations to better support the integration of Physical Health, Long Term Services and Support, Mental Health, Developmental Disabilities, Substance Use Disorder Treatment, and Children's Service providers;
- Develop a financially healthy and sustainable system of care;

- To streamline payments to providers and reporting back to the State; and
- To create flexibility to meet need.

The Medicaid Pathway work is aligned with the planning efforts around the All-Payer Model. Both of these frameworks build towards a more integrated health care system in Vermont.

Current discussions and planning efforts relative to All-Payer Model and Accountable Care Organization development offer the opportunity to more fully realize the values identified in Vermont's Model of Care.[2] This is consistent with the All-Payer Model agreement provisions that require a Vermont to report on the feasibility of adding additional services to Vermont Total Cost of Care over time and as part of a future waiver renewal.[3]

The Medicaid Pathway advances payment and delivery system reform for those services not subject to the additional caps and regulation that is expected under the State's All-Payer Model. The ultimate goal of Medicaid's multi-year planning efforts is the alignment of payment and delivery system principles that support a more integrated system of care for all Medicaid supported services and enrollees.

Implementing alternatives to fee-for-service payment can also provide an opportunity for the State and providers to more fully support wellness and early intervention. Establishing alternative payment approaches may provide greater flexibility to support:

- Health Promotion and Prevention;
- Early Intervention and a Reduction of Client Risk Factors;
- Provider and Consumer Flexibility to Decide on Necessary Services;
- Reduced Incentives for Volume; and
- Home and Community Based Services based on a Person's Unique Treatment and/or Support Plan Needs and Social Determinants of Health.

High-Level Goals for Health Reforms

The State's high-level goal for all health reforms is to create an integrated health system able to achieve the Triple Aim goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost. This goal is supported by both the All-Payer Model and Medicaid Pathway.

As delivery system and payment reforms mature under the All-Payer Accountable Care Organization Model, services that support home- and community-based service and address the social determinates of health must also be integrated into an organized and accountable system of care. Physical health care, long-term services and supports, and mental health and substance use disorder treatment systems cannot work in isolation.

Through the Medicaid Pathway, the State seeks to provide efficient, effective care to all Medicaid beneficiaries through an organized delivery system, and to ensure that care is patient-centered/directed and meets the criteria described in the Vermont Model of Care.

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[2] Vermont's Model of Care is more fully described in the Medicaid Pathway Overview found in Appendix A.
[3] See sections 11 and 12 of the Vermont All-Payer Accountable Care Organization Model Agreement: http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.

AHS has identified goals for care delivery, payment model and quality framework, and administration to support this.

Care Delivery Goals

- Support primary and secondary prevention, including early intervention to reduce risk factors.
- Support flexibility to allow individuals and providers to decide on necessary services based on a person's unique treatment and/or support plan needs and social determinants of health, including use of home-and community-based services.
- Foster integrated service delivery for Medicaid beneficiaries across the care continuum.

Payment Model and Quality Framework Goals

- Expressly move from fee-for-service payments to population-based payments, increasing accountability and risk to impacted providers.
- Incentivize high quality, efficient services and reduce incentive for high service volume.
- Increase flexibility in payment to support more efficient delivery of services.
- Reduce payment silos and fragmentation across provider and service types.
- Connect payments with quality in service delivery and health of Medicaid beneficiaries.
- Align measurement and reporting with values, principles, and goals.
- Provide data and feedback to providers delivering care to support accountability for quality and cost.

Administrative Goals

- Create a foundation for program oversight; provider monitoring; provider reporting; corrective action and quality improvement planning that assesses accountability for delivering contracted services; appropriateness of care based on best practice and State standards; and outcomes.
- Reduce administrative burden to providers and AHS.
- Standardize payment structures and quality measurement for similar services across AHS.
- Allow for seamless oversight and monitoring across AHS.
- Improve data collection to support future policymaking.
- Transition payments in a manner that is operationally feasible for both the State and providers.

Transformation Elements & Work Plan Steps

To address comprehensive planning, the Medicaid Pathway process has defined five planning domains. These domains include: organized delivery system expectations, including supporting changes in State contracting and oversight practices; defined value-based purchasing methodologies to support desired changes in delivery; payment model alignment and consistent approaches to rate development across programs; and unified quality oversight and outcome monitoring across AHS Medicaid Programs. Lastly, but critically, the State examines the resources needed for technical assistance and any staff, budget, and business process changes to support and sustain necessary modifications in operation. Key areas of planning and sample design questions are summarized below.

<u>1. Delivery System Transformation (Model of Care and Population Health Activities)</u>

- What will providers, consumers and the state do differently?
- What is the scope of the transformation?
- How will transformation support integration?

2. Payment Model Reform (Reimbursement Method, Rate Setting)

- What is the best reimbursement method to support the criteria in the Model of Care for a given service (e.g. fee for service, case rate, episode of care, capitated, global payment)?
- Rate setting to support the reimbursement method, control State costs and support beneficiary access to care.
- Incentives to support practice transformation.

3. Quality Framework (including Data Collection, Storage, and Reporting)

- What quality measures will mitigate any risk inherent in a preferred reimbursement model (e.g. support accountability and program integrity) while allowing the State to assess provider transformation (e.g. structure and process) and assure beneficiaries' needs are met?

4. Outcomes

- Is anyone better off?

5. Readiness, Resources, and Technical Assistance

- What resources are necessary to support the desired change and/or fund the delivery system?

Information Gathering Process and Stakeholder Engagement

As part of this work, the State released an Information Gathering Document (see Appendix B) in September 2016. This document put forth proposed reforms for the payment and delivery of mental health, substance use disorder treatment, and developmental disabilities services. The State received comment in October 2016 and as a result of this feedback is in the process of revising the initial proposal.

In addition to this formal information gathering, AHS convened stakeholders for over a year to discuss potential delivery and payment reforms. These meetings focused on several areas including: the Vermont Model of Care (see Appendix B); organization of the delivery system and governance expectations aligned with integrated delivery models; payment models that support value-based and population health approaches; quality and performance measurement to support value-based payments; and alternative payment models for services delivered by Designated and Specialized Service Agencies and Preferred Providers. More detail about these meetings is found at Appendix A.

Section I: Medicaid Payments to Affected Providers

Scope and Services Potentially Impacted in SFY 18: Cohort 1

Starting in December of 2015, the Medicaid Pathway began with a review of the services provided by Designated Agencies, Specialized Service Agencies, and ADAP Preferred Providers. This review began by looking at all specialized Medicaid programs and services with an emphasis on AHS Mental Health, Developmental Disabilities Services, and Substance Use Disorder Treatment programs. Figure 1, below, provides a list of those services and the current reimbursement model for those services.

Figure 1: Services Reviewed for Inclusion in Cohort 1 (Specialized Medicaid Programs and Services within AHS Mental Health, Developmental Disabilities Services, and Substance Use Disorder Treatment Services)

Service Area	Program	Medicaid Fund Source	Provider(s)	Current Reimbursement Model(s)
MH	Emergency Mental Health (MH) Services (Basic)*	DMH; DVHA	DA/SSA	Fee-for-Service (FFS); Capacity Grant
MH	Emergency MH Services (Act 79 Enhanced)	DMH	DA/SSA	FFS; Capacity Grant
MH	Children's MH Community Services (JOBS*, Autism*, Youth in Transition*, Non-categorical*)	DMH; DVHA	DA/SSA	FFS; Monthly Case Rate
MH	Children's ISB and WrapArounds*	DMH	DA/SSA	Person-centered Budget
MH	Enhanced Family Treatment*	DMH	DA/SSA	Person-centered Budget
MH	Adult MH Outpatient	DMH	DA/SSA; Private Practice; FQHC	FFS
SUDT	Alcohol and Drug Abuse Outpatient Programs*	DMH; ADAP	DA/SSA; ADAP Preferred Providers (PP)	FFS
LTSS	Developmental Disabilities HCBS Services*	DAIL	DA/SSA	Person-centered Budget and Self-Managed
LTSS	Bridge Program (Case Management)*	DAIL	DA/SSA	Monthly Case Rate
LTSS	Flexible Family Funds*	DAIL	DA/SSA	Capacity Grant
LTSS	Flexible Family Respite	DAIL	DA/SSA	Capacity Grant
LTSS	Developmental Disabilities Clinical Services*	DAIL	DA/SSA; Private Practice	FFS
Other	Children's Integrated Services*	CDD; DVHA	DA/SSA; Parent Child Center (PCC); Home Health Agency	Case Rate
MH	Community Rehabilitation and Treatment	DMH	DA/SSA	Global Budget
MH	Children's Respite	N/A	DA/SSA	Capacity Grant
MH	Children's MH Outpatient*	DMH	DA/SSA	FFS
Other	Family Services Division – Treatment Services IFBS*	DCF	DA/SSA; PCC; Other	Capacity Grant
SUDT	ADAP Residential Programs	ADAP; DVHA	ADAP PP	FFS

Service Area	Program	Medicaid Fund Source	Provider(s)	Current Reimbursement Model(s)
SUDT	ADAP Recovery Centers	ADAP	ADAP PP	Capacity Grant
SUDT	ADAP Medication Assisted Treatment (Health Home Hubs)	ADAP	ADAP PP	Monthly Case Rate
SUDT	ADAP Medication Assisted Treatment (Outpatient Spokes)	DVHA	Blueprint Community Health Teams; ADAP PP	FFS; Case Rate
LTSS	Traumatic Brain Injury Services	DAIL	DA/SSA; TBI Approved Providers	FFS; Case Rate
Other	Family Services Division – Runaway and Homeless Youth Programs	DCF	DA/SSA; PCC; Youth Service Bureaus	Monthly Case Rate
LTSS	Children's Personal Care	DVHA	DA/SSA; Other	FFS; Self-Managed
LTSS	Choices for Care (all services)	DVHA	DA/SSA; AAA; HHA; Residential; Adult Day; NF	FFS; Self-Managed
LTSS	Attendant Services	DAIL	Self-Managed	Self-Managed
LTSS	Day Health Rehabilitation Services	DAIL	Adult Day	FFS
MH	Inpatient Psychiatric Treatment	DMH; DVHA	Hospitals	FFS
MH	Success Beyond Six	LEA	DA	FFS; Monthly Case Rate
MH	Residential - Private Non-Medical Institution (PNMI)	All	DA/SSA; PNMI	FFS
Other	Family Services Division – Targeted Case Management	DCF	DCF	FFS
Other	School Health Services (IEP - Local Educational Administration)	LEA	LEA	Level of Care (Case Rate)
MH	Adult MH Outpatient	DVHA	DA/SSA; Private Practice; FQHC	FFS
MH	Children's MH Outpatient*	DVHA	DA/SSA; Private Practice; FQHC	FFS
SUDT	Alcohol and Drug Abuse Outpatient Programs*	DVHA	DA/SSA; ADAP PP; FQHC; Private Practice	FFS
SUDT	Inpatient Hospital Detox	DVHA	Hospitals	FFS
LTSS	Children's Palliative Care (Including MH counseling)	DVHA	HHA; Hospitals	Bundled

* IFS Related Program

Over the course of several months, AHS worked with public and private stakeholders to evaluate whether these services should be included or excluded from the first phase of reforms for this cohort. Stakeholders identified the following considerations for discussion in determining scope:

- The feasibility of inclusion of the program in the near-term versus phased in over the long-term.
- The extent to which the delivery system is already organized to:
    - Support adoption of Model of Care, including advancement of integrated care.
    - Engage in service delivery reform.
    - Create a pathway to the All-Payer Model.
- The extent to which:
    - Medicaid is identified as the primary payer for the program or service.
    - The program currently adopts some or all elements of the Model of Care.
- Broad inclusion of programs may be more desirable in promoting a comprehensive System of Care approach (prevention to intervention).
- Specialized programs (e.g., Community Rehabilitation and Treatment (CRT), Developmental Services (DS), etc.) must be considered but should not be the sole focus of the planning efforts.
- The scope may change overtime based on model discussions and findings.

The final determination to include or exclude a service relies on several factors: whether the service was paid for by AHS, whether federal funding rules were a barrier, and operational feasibility. As of the submission date of this report, AHS has not yet finalized plans for which services would be reformed. AHS is planning on phasing the roll-out of value-based payment reforms for this cohort. This is to ensure feasibility, alignment with the proposed Substance Use Disorder Global Commitment to Health Demonstration waiver amendment, and alignment with the All-Payer Model.

Scope and Services Potentially Impacted in SFY 18: Cohort 2

In June of 2016, AHS convened a second group of stakeholders focused on Long Term Services and Supports offered through the DAIL Adult Service Division including Choices for Care and other Medicaid funded supports. This group used a process to define scope which was similar to the Cohort 1 process, described above. Following a review of LTSS and other services, the LTSS/CFC group narrowed its focus to those services and supports provided through the Choices for Care program at DAIL. An overview of DAIL's Long-Term Services and Supports programs initially reviewed by this group are provided in Figure 2:

Figure 2: Services Reviewed for Inclusion in Cohort 2 (DAIL Long-Term Services and Supports and Choices for Care Programs)

Service Area	Program	Medicaid Fund Source	Provider(s)	Current Reimbursement Model
LTSS	Choices for Care (CFC) Case Management	DVHA	Home Health Agency (HHA); Area Agency on Aging (AAA)	FFS
LTSS	CFC Personal Care/Attendant Care	DVHA	HHA; Independent Direct Support Workers	FFS
LTSS	CFC Adult Day	DVHA	Adult Day Providers	FFS
LTSS	CFC Respite	DVHA	HHA; Independent Direct Support Workers; Adult Day; Residential	FFS

Service Area	Program	Medicaid Fund Source	Provider(s)	Current Reimbursement Model
LTSS	CFC Companion	DVHA	HHA; Independent Direct Support Workers; Senior Companion Programs	FFS
LTSS	CFC Assistive Devices/Home Modifications	DVHA	HHA; AAA	FFS
LTSS	CFC Personal Emergency Response Systems (PERS)	DVHA	PERS providers	FFS
LTSS	CFC Adult Family/Foster Care	DVHA	DA/SSA; TBI Approved Providers	FFS
LTSS	CFC Flex Choices (Individual Budgets)	DVHA	Independent Direct Support Workers	FFS
LTSS	CFC Residential Care (ACCS and ERC)	DVHA	Residential; Assisted Living Residences	FFS
LTSS	CFC Nursing Facilities	DVHA	Nursing Facilities	FFS
LTSS	CFC Homemaker	DVHA	HHA	FFS
LTSS	Traumatic Brain Injury	DAIL	TBI Approved Providers	FFS; Case Rate
LTSS	Developmental Disabilities Services	DAIL	DA/SSA	Person-Centered Budget (Daily)
LTSS	Money Follows the Person (MFP)	DVHA & DAIL	HHA; DA/SSA; AAA	Capacity Grant
Additional LTSS programs at DAIL were discussed (e.g., Older Americans Act, Support and Services at Home (SASH) and Aging and Disability Resource Centers), however focus for the current planning effort includes Medicaid funded delivery and payment reform.				

Following the decision to focus initial Medicaid Pathway work on the Choices for Care (CFC) program, the LTSS/CFC Stakeholder group reviewed a variety of performance and outcome information currently collected through DAIL and/or other AHS initiatives. Through an informal voting process, the group identified the "Top Ten" indicators that DAIL should consider to guide project work. These indicators provide the foundation for quality oversight and serve as a pool of potential areas to consider should the State seek to create a value-based incentive payment in the Choices for Care program. The top ten indicators are provided below:

1. Participants involvement in plan of care development and decision making;
2. Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need;
3. Participant's medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed;
4. A reduction in avoidable hospital admissions/re-admissions for program participants;
5. A reduction in emergency room visits for program participants;
6. Proportion of people who have transportation to get to medical appointments when needed;
7. Participants report that their quality of life improves;
8. Participants have stable community living situation and/or a reduction in homelessness;
9. Participants report satisfaction regarding care coordination and access; and
10. Participants receive support during care transitions.

A summary of the top ten LTSS/CFC performance and outcome indicators, their relationship to the Model of Care and opportunities for improvement in the CFC program is provided in Appendix D.

Consumer feedback from several focus groups, interviews, and survey projects was also reviewed and summarized in support of the Long-Term Services and Supports/Choices for Care (LTSS/CFC) Medicaid Pathway planning. Sources of information included:

- *Vermont Dual Eligible Focus Group Project Summary* (Feb 2012): A report detailing the results of focus groups held with Vermonters dually eligible for Medicaid and Medicare (prepared by Lisa Horn, Finch Network LLC);
- *The Adequacy of Choices for Care Provider System* (Oct 2015): Department of Disabilities, Aging and Independent Living Report to the Vermont Legislature in accordance with 2013 Acts and Resolves No. 50 (prepared by Megan Tierney-Ward); and
- *What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review* (June 2016): Frail Elders Project (prepared by Brian Costello, Vermont Medical Society Education, and Research Foundation).

Consumer feedback was sorted into categories based on the Medicaid Pathway Transformation Elements outlined starting on page 5 of this document. Many of the identified themes related to the desire for improved care coordination and adoption of increased interdisciplinary teams, comprehensive planning, prevention, and early intervention to support persons with disabilities and seniors in aging in place at home. The feedback reviewed showed strong alignment with Medicaid Pathway goals and the core elements of the Model of Care. Because of this alignment, DAIL solicited additional feedback from work group members related to how the Choices for Care program could improve performance related to the key elements of the Model of Care (See Appendix D for detailed Choices for Care program feedback by Model of Care element and reform opportunity). From this analysis, four priority areas for delivery and payment reform were identified. DAIL staff identified related activities to improve program operations and enhance the Choices for Care alignment with the Vermont Model of Care, with the intent to engage staff, providers, stakeholders and Advisory Boards in further discussions:

<u>Cohort 2: Priority Areas for Delivery and Payment Reform</u>

1. *Improve Early Options Counseling and Assessment:* Support early Aging and Disability Resource Connections (ADRC) Options Counseling, holistic screening, and assessment for specialized needs in all settings (e.g., PCP, hospital admission, Nursing Facilities, Blueprint screening, referral and/or co-location agreements for ADRC and other CFC staff in non-CFC settings). (Model of Care Elements 1, 2, 7, 11);
2. *Enhance Service Delivery Flexibility:* Increase program flexibility for providers to match service and staffing to the person-centered plan, including regional funding allocations for moderate needs group services through the approval of overall budget or package of services for homemaker, respite, companion, PCA (e.g., eliminate hourly service limits) and other enrollee services and supports. (Model of Care Elements 1, 4, 5, 8, 11);
3. *Support Interdisciplinary and Integrated Care:* Implement interdisciplinary teaming and improve coordination of in-home care (e.g., PCA, respite staff), ancillary support needs (e.g., heat, food, housing, transportation) and increase support during care transitions. (Model of Care Elements 1, 3, 5, 7, 8, 9, 10, 11, 12); Improve more formal linkage and seamless services between CFC case management agencies and mental health, substance use and other disability service providers to address specialized health needs. (Model of Care Elements 1, 4, 5, 6, 8, 9, 10, 11, 12);

The LTSS/CFC Stakeholder group met approximately every three weeks from June 8th through December 19, 2016. Broad Priority recommendations from this group include the following items:

Cohort 2: Recommendations for Delivery and Payment Reform

1. *Preserve and strengthen the successes of the Choices for Care program*. Choices for Care has been nationally recognized for its innovation in LTSS. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full consumer choice in when, where, and from whom to receive services. Unlike traditional LTSS programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, home care, day health rehabilitation services, and adult family care in any given eligibility period. The seamless nature of services and strong support for participant-directed care and service delivery must be preserved.
2. *Foster on-going meaningful input into the reform process* through continued consumer, stakeholder and provider dialogue.
3. *Ensure informed consent, privacy, confidentiality, and appropriate release forms* regarding information sharing, and especially among interdisciplinary team members.
4. *Support the alignment of Model of Care and Choices for Care* through the creation of common Model of Care contract standards, program and policy guidance, and/or rules across all health care systems.

Additional recommendations specific to various aspects of the Choices for Care program operations are detailed in Appendix A (Medicaid Pathway Overview).

From these discussions and emerging recommendations, AHS staff at DAIL have identified several priorities to explore with staff, providers and Advisory Boards for improving program operations and enhancing Model of Care and Choices for Care alignment.

Cohort 2: Priority Areas for Continued Exploration

1. *Exploring stable funding and ACO/APM alignment with Aging and Disability Resource Center (ADRC) services*, including opportunities to bridge gaps between acute/primary care and long-term services and supports.
2. *Creating a new LTSS person-centered assessment and care planning tool* for use by all LTSS programs, that can be used in the DAIL Social Assistance Management Software (SAMS) and preferably linkable to the ACO platform.
3. *Exploring integration of LTSS information into health care records*, including ACO records and information sharing protocols with LTSS providers.
4. *Analyzing the viability of developing a per-member per-month case management payment* paid directly to the case management provider for all CFC participants (i.e., moderate, high, highest).
5. *Analyzing the viability of developing a per-member per-month personal care, respite, companion payment* for agency directed services, to the provider chosen by the CFC participant.
6. *Determining if there are existing regional healthcare teams that can be charged with monitoring/contributing to the personal's LTSS person-centered plan*.

Section II: Changes to Reimbursement Methodology and Services Impacted

AHS reviewed numerous reimbursement methodologies related to Cohort 1. As of this writing, those analyses are ongoing and there is no recommendation for changes. Cohort 2 initiated later in 2016 and has not yet completed a full reimbursement methodology review. Appendix F includes additional information about the reimbursement methodologies that were reviewed for cohort 1.

While there are many variations of provider payment models and reimbursement mechanisms, they all stem from three predominate payment methodologies: fee-for service (FFS), bundled payments, and population-based payments. When developing payment models and reimbursement mechanisms, payers have a choice of creating the base payment model (i.e., the overall approach to paying for services) without value-based enhancements, incentives or other goal oriented performance tools, or a payment structure in concert with Value-Based Purchasing elements. For mature payment models already in operation, value-based purchasing elements can be added to it, or the program can be restructured to promote and reward service system change and quality.[4]

In Vermont's planning efforts, the following definition of Value-Based Purchasing has been adopted:

> Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.

This definition was derived from two primary sources: the Centers for Medicare and Medicaid Services (CMS) Roadmap for Implementing Value Driven Healthcare[5] and comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP.[6]

One step in developing a value-based purchasing program is to understand the base payment model, its potential unintended consequences and effects on provider service delivery, and its relationship to the goals of the desired change.[7,8] Each payment model has its own type of financial risks that are assumed by the payer and /or provider. FFS payments can create financial incentives for volume. Bundled payments put slightly more risk on the provider since it is unknown at the beginning of the "episode"

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[4] Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf

[5] Ibid.

[6] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

[7] Ibid.

[8] Miller HD. (2007). *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund. Can be found at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2007/sep/creating-payment-systems-to-accelerate-value-driven-health-care--issues-and-options-for-policy-refor/miller_creatingpaymentsystemsvalue-drivenhltcare_1062-pdf.pdf

exactly what services may be needed. Population-based payments create incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner, but can also put providers at risk if they treat populations that are sicker than average.

Proposed Changes to Reimbursement Methodology: Cohort 1

This report section describes analyses performed to date regarding Phase 1 of payment reforms related to Cohort 1 of the Medicaid Pathway. The first phase of payment reform targets the Designated Agency and Specialized Service Agency networks. AHS considers the development of an alternative payment methodology to be an iterative process at this time and is currently evaluating several alternative models.

AHS, through its contractor, has been performing a series of financial analyses of DA and SSA data. These financial analyses include consolidating the majority of payments made to DAs and SSAs into an Excel analytic model. Using this analytic file, the State is able to model alternative payment design and policy options. The information contained in the model is a compilation of most recent available sources of data, including: audited financials of DAs and SSAs; claims data; financial transaction data; and the DMH-managed MSR data repository. A series of validation exercises with AHS department staff and DA fiscal experts are ongoing to ensure data integrity. At this time, analyses include data from SFY14 and SFY15. AHS has the opportunity to add in SFY16 data in the future.

This exercise has resulted in a standardization of financial and utilization data from nearly 30 disparate programmatic sources. This is a key step towards value-based payments for providers: once the data are standardized, AHS can determine the impact of specific reimbursement changes to inform policy-making.

Assessments Phase

Three key assessments were conducted at the start of the project:

1. A review of the available data upon which to support alternative, value-based payment model design;
2. A financial review of DA and SSA system financing across AHS; and
3. The feasibility of including of substance use disorder treatment preferred providers in initial implementation of Cohort 1.

These assessments yielded the following key findings with regard to DA and SSA payment reform:

- There is not uniformity across DAs and SSAs in the types and intensity of services provided.
- Financing is not uniform and can be provided by over 100 disparate funding streams.
- The adequacy of financing (known as “cost coverage”) is not uniform and incents DAs to shift costs between programs to cover expenses.
- Data reported into the State-managed “MSR” database lacks consistency in how it is collected between programs and agencies.
- Billing guidelines and requirements lack consistency across departments, leading to non-regular encounter data. Some programs lack claims-based encounter data entirely, including the Community Rehabilitation and Treatment (CRT) program. Encounter data for CRT and some Development Disabilities Services is available through the MSR.
- Claims data limitations result in limited information upon which to determine case-mix independently among programs and DAs and SSAs.

- Traditional risk adjustment scores are meant to predict differences in future medical benefit expenditures, and do not predict DA and SSA spending accurately.
- While the DA and SSA network is broadly in support of reform, they have, through their specialty association (Vermont Care Partners), maintained that current financing is inadequate to ensure providers can be held accountable under value-based alternative payment methodologies.
- There is not yet agreement on a "preferred" alternative payment model among providers or the State; moreover, there is not yet agreement on the extent to which a DA and SSA provider would or should be held accountable for outcomes of some or all clients under a new payment model. The DAs and SSAs and AHS are moving toward agreement on a methodology.
- A system of sharing audited financial data between the State and providers exists; however, the current reporting tool may require new functionalities to meet the needs of alternative value-based payment models.
- Both among providers and within State programs, there is room for improvement in reporting of standardized financial, utilization, and outcomes data. There needs to be additional collaboration between DAs and SSAs and AHS around eligibility, services, and reporting requirements.

Given the diversity of services, the current financing, and the focus of the new Substance Use Disorder 1115 Waiver, inclusion of substance use disorder (SUD) preferred providers—primarily the Hubs, Spokes, and Recovery Centers— would be challenging. Additional time is needed to determine the best path forward for the majority of services.

Model Development Phase

Successful adoption of population-based alternative payment models – whereby providers share financial risk for a defined population – require certain minimum elements and competencies in place to ensure feasibility. An essential designated community network provider, whose margins and financial stability are largely dependent on AHS funding, require careful consideration before making broad payment reforms that have re-distributional impact. The findings of the assessments described above clearly highlight barriers to success under value-based models. In light of these findings, the AHS recommends phasing in elements of the alternative value-based models which specifically address challenges identified in the assessments.

AHS intends for this work to lay the foundation for these provider types and services to successfully integrate into a capitated model in the future. Whether that capitated model be in addition to beneficiaries' medical benefit spending or a set of enhanced services assessed as an "add-on" upon the beneficiaries' medical spend is still under consideration. There is also continued ongoing discussion to ensure that any new capitated arrangement would conform to requirements under the Substance Use Disorder (SUD) 1115 Waiver demonstration authority which, in essence, provides guidelines for defining an enhanced SUD benefit for a defined eligible population. The State's goal is to ensure that work done to prepare for implementation will directly support this goal.

Focus on DA and SSA Network

The State identified a number of benefits to focusing on the DA and SSA network. The benefits directly address the issues identified in the assessments, including:

- Creation of a framework to:

    - Consolidate program, quality, and billing activities across at least four AHS departments for services and sub-populations; and
    - Consolidate and systematize data collection and rate-setting functions across at least four AHS departments to produce higher quality data for monitoring and rate setting activities.
- Establishment of a transparent process to systematically address funding to DAs and SSAs both globally and specific to core sets of defined services or populations.
- Establishment of a system to adjust payments to include value-based incentives and/or penalties.
- Improvements in the data upon which actuaries would set any future capitation rates for services covered.

Alternative Payment Model Designs

An Excel model and reporting package, which simulates the impact of various alternative payment designs on providers, is being used to explore different alternative payment models. Based on preliminary findings, as described in more detail in Appendix F, the State has modeled different scenarios for using a global budget which has a bundled prospective monthly payment rate for a sub-set of services to a defined cohort of beneficiaries. The scenarios modeled have included a variety of options, such as:

- Defining the inclusion or exclusion of specific departmental or programmatic spending and services;
- The cohort groupings upon which different payments are made; and
- Payment model options (i.e., setting payments at the provider[9] level vs. based on the average of all providers).

The following analyses were conducted to support development of this model:

- An extensive baseline state fiscal year (SFY15) mapping of DA and SSA audited financials to various sources for use in global budget development using independently gathered audited financial statements. These mappings were also used to:
    - Develop a benchmark model upon which to track any funding source and program expenditure to be included in various bundled model scenarios;
    - Track targeted inclusion and exclusion of certain funding source and program expenditures to be included in various bundled model scenarios; and
    - Validate the electronic financial data currently collected by the State.
- An extensive mapping of historic (SY14 and SFY15) claims data to program cost centers. These enable:
    - Modeling of various bundled model scenarios and impact on global budget; and
    - Computation of cost coverage under different scenarios.
- Development of “mock” encounter claims for expenditures related to the CRT program (currently paid as financial transactions and for which encounter claims submission to the MMIS are not currently required, although they are required as part of their MSR data submission).
- Assessment of the impact of a common risk adjustment score to adjust payments under an alternative payment system.

[9] Provider is set at the individual DA and SSA level for this exercise.

- Collection of charges data from the DAs in order to perform "costing" analysis of bundled payment scenarios and validate findings.

The financial model is under-going extensive peer review by internal subject matter experts at the State and members of the provider community. Regular feedback was also obtained through meetings with staff from relevant departments, held twice a month during the last half of 2016. Provider and consumer feedback was obtained during a separate twice monthly meeting during that same time period. Representative groups of subject matters experts from the State and provider community continue to meet to finalize the validation of data upon which future rates could be set.

Changes to Reimbursement Methodology: Cohort 2

As noted at the start of this section, cohort 2 started later in 2016 and as of this time has not completed a full reimbursement methodology review. The group initiated its work with a focus on the Model of Care and the CFC service delivery reforms that would more fully implement and embrace the Vermont Model of Care. This was intended to create a foundation for future payment reform discussions, such that CFC payment reforms would be conspicuously intended to support CFC service delivery reforms and the Model of Care.

Reimbursement analysis and payment reform for the second Medicaid Pathway cohort will require a different approach than for the first cohort due to some of the following factors:

- A significant majority of CFC participants (approximately 97%) are dually eligible for Medicaid and Medicare and receive services reimbursed by both payers. This requires additional consideration and analysis to maximize integration of service delivery and payment reform across payers.
- CFC program design includes consumer choice of several HCBS delivery and financial models (traditional fee for service, bundled flexible choices budgets, consumer and surrogate directed services) across independently operating provider agencies.
- Many CFC participant move across settings (home, residential care, assisted living, nursing facility, hospital) and payment sources (Medicaid, Medicare, hospice) during the course of a given year.

Section III: Integration Efforts between All-Payer Model, Medicaid Pathway, and Other Reform Initiatives

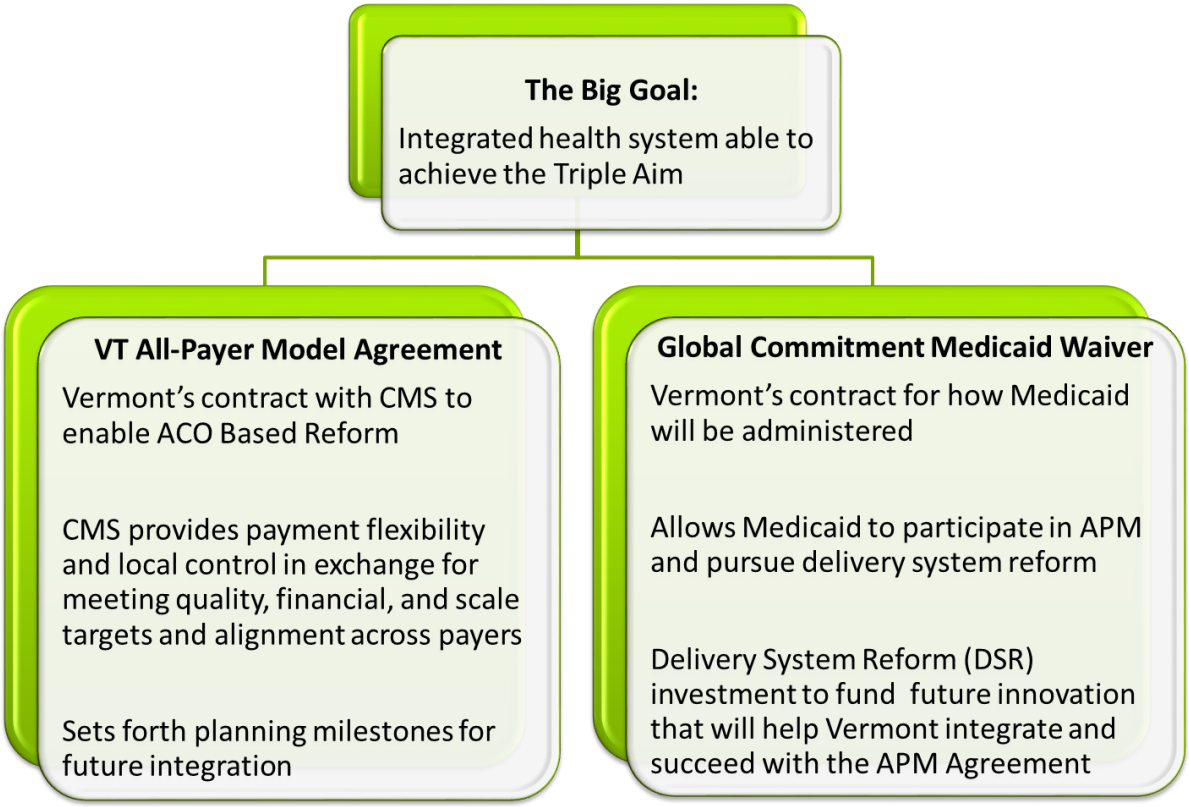
Planning and Timeline Documents

AOA has taken the lead to ensure that there is alignment between the All-Payer Model, Medicaid Pathway, and other efforts. This work is being done collaboratively with the Green Mountain Care Board and AHS and involves significant input from Vermont's provider community.

The goal of both the All-Payer Model and Medicaid Pathway frameworks is to create an integrated health system that achieves the Triple Aim of better care, lower cost growth, and healthier Vermonters. Figure 3 below describes how these two frameworks work together in support of that goal.

In 2016, Vermont signed two agreements with the federal government that support this complementary reform effort. The All-Payer Model Agreement and Global Commitment Medicaid Waiver allow Vermont to take a one-model approach to payment reform and integration.

Figure 3: Creating an Integrated Health System to Achieve the Triple Aim



The All-Payer Model allows Medicare to participate in health care reform that is customized for Vermont and provider-led. Specifically, Medicare, through CMS, will pay in a different way and provide a prospective growth trend, shifting from FFS to an All-Inclusive Population Based Payment (AIPBP) for certain services. In exchange for this payment flexibility, and the continuation of Medicare funding for Vermont's existing Blueprint for Health and SASH program, Vermont is expected to achieve certain

quality, financial, and scale goals. The Global Commitment Medicaid Waiver expressly allows Vermont Medicaid to continue innovating and supporting value-based payment.

There are several examples of specific alignment efforts, which are described below:

1. *Service Alignment:* The All-Payer Model Agreement provides that certain mental health services (including substance use disorder treatment services) are included in the Total Cost of Care payment made to an ACO. These are identified below.

Included in ACO Total Cost of Care	**Excluded from ACO Total Cost of Care**
Mental health and substance use disorder services funded by the Department of Vermont Health Access (DVHA) and not funded by other State Departments	• HCPCS codes H0001 – H2037 (mental health and substance use services) when paid by DVHA • Level 1 (involuntary placement) inpatient psychiatric stays in any hospital when paid for by DVHA • Psychiatric treatment in a state psychiatric hospital • Services paid by DVHA to Designated Agencies (DAs) and Specialized Service Agencies (SSAs) • Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by State Agencies other than DVHA • Services administered and paid by the Vermont Department of Mental Health • Services administered and paid by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network

2. *Timelines:* The All-Payer Model implementation timeline is on a calendar year basis. The Medicaid Pathway reforms are aligned to ensure they also start on a calendar year. Additionally, the All-Payer Model requires Vermont to develop a plan for Medicaid services not initially included in the Total Cost of Care payment by the end of 2020. Aligning implementation timelines supports this planning effort.
3. *Communication:* The All-Payer Model and Medicaid Pathway are complementary efforts. The AOA and AHS work jointly on presentations, materials, and other communications to ensure this is communicated clearly.
4. *Population-Based Payment Approach:* The All-Payer Model Agreement requires that payers move away from fee-for-service payment models towards all-inclusive, population-based payment models (AIPBPs) to ACOs that are aligned across the major payers (Medicare, Medicaid, and commercial). The Medicaid Pathway process supports providers in increasing their readiness for alternative payment models and supports the State in its move toward population-based monitoring and measurement.
5. *Substance Use Disorder (SUD) Treatment Demonstration Application:* In July 2015, CMS offered states the opportunity to apply for demonstration projects approved under Section 1115 of the Social Security Act to ensure that a continuum of care is available to individuals with SUD. Vermont is currently drafting application materials for a Global Commitment to Health Medicaid demonstration project amendment which would allow Vermont to receive federal financial participation for costs not otherwise matchable. The strategies proposed for this waiver align with the Medicaid Pathway to ensure a full continuum of services, focusing on integration with primary care and mental health treatment, and work to deliver services which are consistent with evidence-based models and industry standards or are considered promising practices.

Section IV: Quality Measure Alignment Efforts and the Interrelationship of Results-Based Accountability and Quality Measures

Performance measurement is critical to ensuring appropriate monitoring and oversight of Medicaid. The performance measurement framework currently used by AHS is described below. The development of this system was guided by – and intentionally incorporates – many of the principles associated with Results Based Accountability to ensure synergy with the State's roll-out.

Within this framework are specific quality measures used to hold individual providers accountable for the services they deliver and for the outcomes of the population they are serving. As AHS implements more value-based payment programs, it will shift towards outcome-based measures.

Quality Measure Alignment

Currently, the various departments utilize different types of measures to ensure that providers are delivering appropriate care to individuals who receive Medicaid services. The State's measurement strategy must balance federal and Legislative requirements, the State's ability to monitor and evaluate providers and ensure beneficiaries are receiving care that is efficient and high-quality, and providers' reporting burden.

AHS believes that quality measurement and performance measurement should be aligned across all departments. In addition to aligning within AHS, there is a need to align with other payers of similar services. Seeking to minimize unnecessary measurement and create greater alignment across programs and departments, AHS engaged in an alignment activity in 2015-2016 to improve the efficiency of the AHS Master Grant, a written agreement between AHS and DAs and SSAs. Although this process was fruitful, more alignment work is necessary for the measures that impact these providers. Written agreements with ADAP preferred providers mirror DA and SSA AHS master grants when the services delivered are identical, other Substance Use Disorder Treatment Services not aligned with DA and SSA operations are addressed outside of the master grant and thus not in scope for the group.

AHS Master Grant Alignment Process

In October 2015, AHS convened an Outcomes Work Group,[10] comprised of quality management representatives from State, provider, and stakeholder entities. The Outcomes Work Group was initially tasked with developing a standardized template for Attachment A of the SFY17 Master Grant, which included developing standardized performance measure and monitoring activity tables. The group initially identified approximately 150 "measures" in the SFY16 master grant that the DAs and SSAs were required to report to AHS. While the group was developing the tables, they reviewed their SFY16 "measures". During the process, some departments dropped performance measures or monitoring activities that were no longer required or determined redundant, while others developed performance measures or monitoring activities where none existed previously. Using the standardized tables, the group split performance measures and reporting activities. At the end of the activity, a total of 100 measures, 50 performance measures and 50 monitoring activities, across all programs and providers

[10] The various departments of AHS use different contracts, grants, and other payment processes to reimburse DAs, SSAs, and Preferred Providers. A subset of these services is codified in Master Grants between the State and the DAs. The Master Grants cover approximately 90% of a DA's budget.

were agreed upon for the SFY17 Master Grant. An aggregate table of all measures and monitoring activities for all DAs and SSAs was included in the SFY17 Master Grant as an appendix.

After the execution of the SFY17 AHS Master Grants, the Outcomes Work Group reviewed the monitoring activities to determine if there were any opportunities for further consolidation/reduction. If such a determination was made, the group agreed to recommend an amendment to the current grant. Since both Federal regulations and the Vermont Legislature via Act 186 require the collection of certain data elements, special attention was placed on activities required by AHS Departments – as opposed to those required by our Federal partners or the Vermont Legislature. Questions considered include:

- Does the activity support AHS priorities?
- Are we getting what we need from the activity?
- Are we asking for this information in other ways?

This process sought to identify inefficiencies (e.g., can activities be minimized, eliminated, combined, etc.). While the group identified several DMH, ADAP, and DDSD monitoring activities that would benefit from additional Department/VCP follow up, they did not think that a formal grant amendment was necessary. As a final task the group agreed to recommend a process for reviewing measures using Results Based Accountability moving forward with future AHS Master Grant negotiations.

All-Payer Model Measure Alignment

In October 2016, the State of Vermont signed an "All-Payer Accountable Care Organization Model Agreement" with the Centers for Medicare and Medicaid Services. The five-year Agreement contains a comprehensive quality framework that has the potential to improve quality of care and the health of the entire Vermont population, including people benefiting from Medicaid services and providers.

The Agreement's quality framework establishes a clear focus for Vermont's quality efforts for the foreseeable future. It consists of 20 measures related to the following overarching population health goals:

- Improving access to primary care
- Reducing deaths from suicide and drug overdose
- Reducing prevalence and morbidity of chronic disease (specifically Chronic Obstructive Pulmonary Disease, Diabetes, and Hypertension)

Some of the measures in the Agreement that are particularly relevant to Medicaid providers and beneficiaries have been considered by the Medicaid Pathway Outcomes Subgroup (Appendix A, Page 20 of the Medicaid Pathway Overview) as it reviews measures already in use in Vermont.

Appendix A: Medicaid Pathway Overview

An overview of the Medicaid Pathway planning process, goals, workgroup descriptions and detail on efforts to date can be found at this link: http://dvha.vermont.gov/global-commitment-to-health/medicaid-pathway-planning-overview-12.19.16-update.pdf

Appendix B: Medicaid Pathway Information Process

AHS engaged in an information gathering process regarding a potential alternative payment model for Cohort 1 in September 2016. The request for information is found here: http://healthcareinnovation.vermont.gov/content/vt-medicaid-pathway-information-gathering-september-2016.

AHS then responded to the feedback in November 2016. The response is found here: http://healthcareinnovation.vermont.gov/content/medicaid-pathway-information-gathering-process-stakeholder-feedback-and-state-response.

Appendix C: LTSS/CFC Top Ten Performance and Outcome Indicators for CFC Planning

LTSS/CFC Stakeholder Discussion: August 2016		
Performance and Outcome Indicator(s)	**Model of Care Element**	**Opportunity for Improvement**
1. Participants involvement in plan of care development and decision making.	• Person Centered and Directed Process for Planning and Service Delivery	• Improved flexibility for providers to match services to person-centered needs could improve enrollee involvement, engagement, and decision-making.
2. Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.	• Access to Independent Options Counseling & Peer Support • Person Centered and Directed Process for Planning and Service Delivery	• Delivery system improvements that support early options counseling and holistic screening and assessment for specialized needs could support improved and earlier access through co-location and/or other integration agreements.
3. Participant's medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed. 4. A reduction in avoidable hospital admissions / re-admissions for program participants. 5. A reduction in emergency room visits for program participants.	• Actively Involved Primary Care Physician • Provider Network with Specialized Program Expertise • Integration between Medical & Specialized Program Care • Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services	• Supporting an interdisciplinary team approach and enhanced care coordination between medical and specialized providers could improve utilization of potentially avoidable services.
6. Proportion of people who have transportation to get to medical appointments when needed.	• Single Point of Contact for person with Specialized Needs across All Services • Integration between Medical & Specialized Program Care • Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services	• Enhanced teaming and care coordination could improve communication and identification of scheduling needs to lessen gaps in transportation.
7. Participants report that their quality of life improves. 8. Participants have stable community living situation and/or a reduction in homelessness.	• Standardized Assessment Tool • Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services	• Improvements in comprehensive assessment, person-centered planning and service delivery could result in improved quality of life, including improved stability of living situations.
9. Participants report satisfaction regarding care coordination and access.	• Care Coordination and Care Management • Interdisciplinary Care Team	• Improvements in care coordination and interdisciplinary teaming could result in increased satisfaction and improved access to necessary care.
10. Participants receive support during care transitions.	• Coordinated Support during Care Transitions • Use of Technology for Sharing Information	• Improvements in communication and information sharing and early support for transitions could result in improved stability.

Appendix D: Detailed Choices for Care Program Feedback by Model of Care Element and Reform Opportunity

LTSS/CFC Stakeholder Discussion: September 2016				
Model of Care Area	**Areas for LTSS/CFC Improvement** *Four CFC Priority Areas (Highlighted)**	**Potential Reform Area**		
		State Policy (P) or Resource (R)	*Local Delivery (D) or Payment (P) Model*	*Medicare/ ACO Alignment*
1. Person-Centered and -Directed Process for Planning and Service Delivery	Consistent and timely access to person-centered planning during hospital or nursing facility discharge.		D, P	✓
	Enhancement of person-centered planning.	P	D	
	Development and implementation of person-centered planning tools.	P	D	✓
	Training for Case Managers and other staff (e.g., hospital social workers, transition II advisors, AFC service coordinators) in person-centered care.	R	D	✓
	Improve assessment and certification processes for determining who is eligible to self-manage.	P, R	D	
	Improve support to self-managed participants (e.g., respite, caregiver support, employer roles).	R		
	Re-examine fiscal intermediary in self-managed care (e.g., pass-through) role for improvements across all populations.	P	D	
	Improve training and support for individual and families who self-manage paid caregivers.	R		
	Improve access to care provider resources for persons who self-manage care, e.g., improved the functionality of the care giver registry.	R		
2. Access to Independent Options Counseling & Peer Support*	Consistent and timely access to independent Options Counseling (ADRC) during hospital and/or short term rehabilitation nursing facility stays.		D	✓
	Improve access to plan of care/person-centered information gathered during ADRC options counseling and potential for incorporation into Independent Living Assessment (ILA) and other planning.		D	✓
	Expansion of ADRC Options Counseling in all settings (prior to CFC and/or other application processes).	R	D	✓
3. Actively Involved Primary Care Physician	Expand and improve PCP involvement in overall care plan.	P, R	D	✓
	Develop health and wellness standards (similar to DDS guidelines) for CFC providers to use to monitor primary care needs.	P	D	✓
	Increase access to preventive care, wellness programs, nutritional services and exercise options to support health and independence.	R	D, P	✓
	Home visits by PCP and team approach to health and well-being.	P, R	D, P	✓
4. Provider Network with Specialized Program Expertise	Increase training and certifications for in-home providers.	P, R		
	Improve out of home respite options.	R		
	Improve staffing for home based care.		D, P	
	Explore training options to enhance care-giver skills and support to prevent burnout.	R		
	Consider expanded access to non-medical personal care services.	R	D	
	Enhance options for customized community programming in addition to adult day.	R		

LTSS/CFC Stakeholder Discussion: September 2016				
Model of Care Area	**Areas for LTSS/CFC Improvement** *Four CFC Priority Areas (Highlighted)**	**Potential Reform Area**		
		State Policy (P) or Resource (R)	*Local Delivery (D) or Payment (P) Model*	*Medicare/ ACO Alignment*
	Explore specialized adult day programming (e.g., supporting people with dementia care needs, psychiatric management needs and/or challenging behaviors).	R		
	Improve access to mental health and substance abuse services including medication-assisted treatment.	R	D, P	✓
	Provide Mental Health consultation in Nursing Facilities.	R	D, P	✓
	Explore how to address and/or develop resources for specialized care needs (bariatric, dementia, behavioral health care).	R	D, P	✓
	Integrate and improve options for persons with a TBI within the CFC program.	P	D, P	
5. Integration between Medical & Specialized Program Care	Opportunity to identify potential CFC enrollees and assist persons to maintain independence through PCP coordination and early assessments.	P, R	D, P	✓
	Support earlier application for specialized programs (e.g., on hospital admission).		D	✓
	Discharge processes that allows for timely identification of Adult Family Care and/or in home support needs to allow for community-based staff recruitment and training.		D	✓
	Increase access to preventive care and health promotion (public health, wellness, nutritional and exercise support) and support services that allow people to age in place (transportation, PCP home visits, heat, food, and housing).		D, P	✓
6. Single Point of Contact for Persons with Specialized Needs Across All Services	Support for caregivers who are unable to find respite.	R	D	✓
	Improve coordination of in-home care (e.g., PCA, respite staff).		D	✓
	Increase assistance with ancillary support needs (e.g., heat, food, housing, transportation).		D	✓
7. Standardized Assessment Tool*	ILA tool is outdated, new tool that more effectively addresses person-centered planning and specific challenges such as dementia, substance abuse, mental illness, cognitive impairments are needed.	P, R	D	✓
	Consider risk mitigation tools and negotiated risk agreements.	P	D	
	Standardized electronic tools need to easily convert information into usable format for data collection, storage, and reporting (e.g., outcome tracing and plan of care performance measures).	P, R	D	✓
8. Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services*	Choices for Care plan typically include service authorization but not comprehensive inclusion of all needs and supports and person-centered goals.	P	D, P	
	Improve budget flexibility for self-directed participants.	P	D, P	
	Moderate Needs Group funding is fragmented and not always conducive to person-centered planning or early intervention for persons at risk NF placement.	P	D, P	
	Medicare and commercial coverage policies exclude LTSS.			✓
	Mental and Substance Abuse Treatment service is not well coordinated; screening and access to service and formal linkages could be improved.	P, R	D, P	

LTSS/CFC Stakeholder Discussion: September 2016				
Model of Care Area	**Areas for LTSS/CFC Improvement** *Four CFC Priority Areas (Highlighted)**	**Potential Reform Area**		
		State Policy (P) or Resource (R)	*Local Delivery (D) or Payment (P) Model*	*Medicare/ ACO Alignment*
	Coverage policies will not allow concurrent NF and Specialized community provider services (DA/SSA, TBI, ADAP) services.	P, R	D, P	✓
	Coverage policies limit companion/respite hours per calendar year; many participants with dementia, psychiatric, behavioral, or other high needs require more hours.	P, R		
	Assistive Device/Home Modifications Assisted Technology needs are determined by case manager, however low Medicare rates for DME discourage providers from accepting Medicare and create a need for CFC funds to be used for DME.		D, P	✓
	Lack of PCAs to staff total hours called for in care plans.	R	D, P	✓
	Eligibility for personnel emergency response system (PERS) service and cost of service.	P, R	D, P	✓
	Access to reliable transportation.	R	D, P	✓
	Increase access to programs that provide skill-building for independence in the community (functional capacity and daily living support).	R	D, P	✓
	Increase utilization of hospice care (e.g., increase VT utilization to national average).		D	✓
9. Care Coordination and Care Management	DAIL approved activities are limited.	P	D	
	Annual limit of 48 hours per calendar year unless variance requested restricts services for enrollees with more complex needs.	P, R	D, P	
	Training in specialized care issues is needed (e.g., dementia, psychiatric and behavioral challenges).	R	D	✓
	Improve more formal linkage and seamless services between CFC case management agencies and other disability services (e.g., DA/SSA and TBI).		D	✓
	Allow nurse monitoring between Medicare episodes of care to assist persons to maintain independence and safely at home.		D	✓
	Add a Targeted Case Management option for Medicaid enrollees who may be at risk but not yet part of the CFC program.	R	D, P	✓
10. Interdisciplinary Care Team*	Develop CFC team approach to support more comprehensive care planning to address individual needs.	P	D, P	
11. Coordinated Support during Care Transitions	Improve provider coordination between care transitions.		D, P	
	Staffing shortages often delay transitions in from facility based care to in-home or AFC settings.		D, P	
	Enrollees who choose ERC & AFC services do not have case management services outside of all-inclusive daily rate; this can be a barrier to seamless transition from nursing facility or hospital.		D, P	✓
	Medications are not reconciled post discharge from hospital or NF due to staff shortages and Medicare delegation rules.		D, P	✓
12. Use of Technology for Sharing Information	Better communication between providers and readily accessible records information across providers.		D	✓
	SAMS does not support sharing of information with hospitals and primary care or internal DAIL connection to LTSS Eligibility files.	R		

Appendix E: Medicaid Pathway 2016 Report (Act 113 Sec. 11)

Posted online at this link: http://legislature.vermont.gov/reports-and-research/find/2016

Appendix F: Additional Information Regarding the Cohort 1 Proposed Payment Model and Feedback Received

In September 2016, AHS released an Information Gathering Document which proposed a specific value-based alternative payment model framework for the DA and SSA network that consisted of two components:

1. A *global budget* target and monitoring and adjustment process; and
2. A *bundled payment* – a monthly, prospectively-set, case-mix adjusted bundled rate for a pre-defined population cohort and set of services. The payment model is modeled after the federal Certified Community Behavioral Health Center (CCBHC)'s Prospective Payment System 2 (PPS2).

As discussed above, AHS received significant feedback on this proposal and is in the process of additional analyses that will inform the final decisions. See Appendix B, Medicaid Pathway Information Gathering Process, for more detail on the specific proposal presented at that time. The reviewed services were summarized in Figure 1. A detailed description of those services included in the initial implementation of the global budget and the prospective payment system can be found in Figure 4, below. Note that all payments (i.e., revenue) refer only to those of the DA and SSA network, and does not extend to other providers who may be providing similar services at this time (e.g., substance use treatment disorder preferred providers and FQHCs).

It is important to note that the DAs and SSAs already manage to an annual budget. Across all revenue sources, their expenses equal their revenues each year. So, when looking at any subset of services or populations, it is probable that some payments (i.e., revenue) are found to be in excess of cost and some are reimbursed at rates lower than cost (i.e., expense). Caution, therefore, should be exercised before reducing funding for cost coverage findings alone under a new model initially as this could de-stabilize programs or services outside the scope of the that new reimbursement model. Revenue in excess of expenses (i.e., >100% cost coverage) is attributable to one or more of the following reasons:

1. The data quality may be poor and in need of adjustments;
2. DAs and SSAs are "cost-shifting" to other services outside of the services contained with a given model;
3. Some DAs and SSAs are more efficient and/or higher volume; and/or
4. The underlying case mix is different from that on which rates were set.

Figure 4: Proposed Services for Inclusion in New Payment Model

Service Area	Program	Medicaid Fund Source	Provider(s)	Current Reimbursement Model(s)	Global Budget	PPS2 Monthly Bundle
MH	Emergency Mental Health (MH) Services (Basic)*	DMH; DVHA	DA/SSA	Fee-for-Service (FFS); Capacity Grant	YES	YES
MH	Emergency MH Services (Act 79 Enhanced)	DMH	DA/SSA	FFS; Capacity Grant	YES	YES
MH	Children's MH Community Services (JOBS*, Autism*, Youth in Transition*, Non-categorical*)	DMH; DVHA	DA/SSA	FFS; Monthly Case Rate	YES	ONLY IF IFS
MH	Children's ISB and WrapArounds*	DMH	DA/SSA	Person-Centered Budget	YES	NO
MH	Enhanced Family Treatment*	DMH	DA/SSA	Person-Centered Budget	YES	NO
MH	Adult MH Outpatient	DMH	DA/SSA; Private Practice; FQHC	FFS	YES	YES
SUDT	Alcohol and Drug Abuse Outpatient Programs*	DMH; ADAP	DA/SSA; ADAP Preferred Providers	FFS	YES	YES
LTSS	Developmental Disabilities HCBS Services*	DAIL	DA/SSA	Person-Centered Budget and Self-Managed	YES	NO
LTSS	Bridge Program (Case Management) *	DAIL	DA/SSA	Monthly Case Rate	YES	NO
LTSS	Flexible Family Funds*	DAIL	DA/SSA	Capacity Grant	YES	NO
LTSS	Flexible Family Respite	DAIL	DA/SSA	Capacity Grant	YES	NO
LTSS	Developmental Disabilities Clinical Services*	DAIL	DA/SSA; Private Practice	FFS	YES	NO
Other	Children's Integrated Services*	CDD; DVHA	DA/SSA; Parent Child Center (PCC); Home Health Agency	Case Rate	YES	ONLY IF IFS
MH	Community Rehabilitation and Treatment	DMH	DA/SSA	Global Budget	YES	YES
MH	Children's Respite	N/A	DA/SSA	Capacity Grant	YES	NO
MH	Children's MH Outpatient*	DMH	DA/SSA	FFS	YES	YES
Other	Family Services Division – Treatment Services IFBS*	DCF	DA/SSA; PCC; Other	Capacity Grant	YES	ONLY IF IFS
SUDT	ADAP Residential Programs	ADAP; DVHA	ADAP PP	FFS	YES	NO
SUDT	ADAP Recovery Centers	ADAP	ADAP PP	Capacity Grant	YES	NO
SUDT	ADAP Medication Assisted Treatment (Health Home Hubs)	ADAP	ADAP PP	Monthly Case Rate	YES	NO
SUDT	ADAP Medication Assisted Treatment (Outpatient Spokes)	DVHA	Blueprint Community Health Teams; ADAP Preferred Providers	FFS; Case Rate	YES	NO
LTSS	Traumatic Brain Injury Services	DAIL	DA/SSA; TBI Approved Providers	FFS; Case Rate	YES	NO
Other	Family Services Division – Runaway and Homeless Youth Programs	DCF	DA/SSA; PCC; Youth Service Bureaus	Monthly Case Rate	YES	NO
LTSS	Children's Personal Care	DVHA	DA/SSA; Other	FFS; Self-Managed	YES	NO
LTSS	Choices for Care (all services)	DVHA	DA/SSA; AAA; HHA; Residential; Adult Day; NF	FFS; Self-Managed	YES	NO
LTSS	Attendant Services	DAIL	Self-Managed	Self-Managed	N/A	N/A
LTSS	Day Health Rehabilitation Services	DAIL	Adult Day	FFS	N/A	N/A
MH	Inpatient Psychiatric Treatment	DMH; DVHA	Hospitals	FFS	N/A	N/A
MH	Success Beyond Six	LEA	DA	FFS; Monthly Case Rate	YES	NO

Service Area	Program	Medicaid Fund Source	Provider(s)	Current Reimbursement Model(s)	Global Budget	PPS2 Monthly Bundle
MH	Residential - Private Non-Medical Institution (PNMI)	All	DA/SSA; PNMI	FFS	YES	NO
Other	Family Services Division – Targeted Case Management	DCF	DCF	FFS	NO	NO
Other	School Health Services (IEP - Local Educational Administration)	LEA	LEA	Level of Care (Case Rate)	N/A	N/A
MH	Adult MH Outpatient	DVHA	DA/SSA; Private Practice; FQHC	FFS	YES	YES
MH	Children's MH Outpatient*	DVHA	DA/SSA; Private Practice; FQHC	FFS	YES	YES
SUDT	Alcohol and Drug Abuse Outpatient Programs*	DVHA	DA/SSA; ADAP PP; FQHC; Private Practice	FFS	YES	YES
SUDT	Inpatient Hospital Detox	DVHA	Hospitals	FFS	N/A	N/A
LTSS	Children's Palliative Care (Including MH counseling)	DVHA	HHA; Hospitals	Bundled	N/A	N/A

* IFS Related Program

Global Budget Development

Global budgets are expenditure targets for health care spending. The purpose of setting an expenditure target is to constrain both the level and rate of growth of spending. The advantage of this approach is that it provides a clear incentive to operate efficiently. A weakness of the model, however, is that these constraints can lead to access problems due to rationing.

DAs and SSAs received approximately 91% of their revenue from AHS sources in state fiscal year 2015 (SFY15). The global budget would set an expenditure target for the AHS portion of each DA's and SSA's total budget. The monitoring and adjustment component of the global budget process will be required in order to both enforce targets and make informed decisions about the shifting of resources, particularly in response to potential access issues.

The global budget alone however, does nothing to address the existing disparities across funding sources. It may also not address negative incentives created by the status quo or be detailed enough to identify any new unintended consequences associated with changing care delivery and financing. And finally, it does not incentivize sufficient data collection on which to base future capitation rates, improve the use of appropriate risk adjustment or attribution approaches for these provider types, or for use in population health management activities.

Reliable data is a precursor to the adoption of any value-based model. The DA and SSA system is currently managed by a decentralized State structure, and reporting and monitoring activities are not uniform. Moreover, some programs lack standardized data collection. These challenges will need to be addressed to provide State decision-makers with the information they will need to better understand the drivers of performance and access outcomes when making rate decisions. As reported in detail in the Act 113 Section 11 report (see Appendix E), the State and providers are attempting to address these issues through efforts to standardize data collection needed for rate setting purposes. Adding the a bundled payment model to this global budget, described in the next section, will facilitate stronger data collection for the subset of mental health and SUD services covered.

Monthly Prospective Payment System

As described above, adopting a monthly bundled payment model will help fill a gap in data. It will also help improve transparency in rate setting. In the Information Gathering Document, AHS proposed a first wave of services and clinical expectations – consistent with the CCBHC[11] model design and Model of Care (see Medicaid Pathway Information Gathering Document, Appendix B) – be consolidated from across DVHA, DMH, ADAP and DAIL into one pool of financing for a defined set of sub-populations and services. The Information Gathering Document proposed that the State would adopt the CCBHC PPS2 model as a starting place for more detailed discussion about alternative payment models.

In general, those services proposed for inclusion in the bundled payment are:

- Adult Mental Health Services
- Child Mental Health Services
- Community, Rehabilitation, and Treatment (CRT)
- Emergency/Crisis Services
- Outpatient and Intensive Outpatient Substance Use Disorder Services
- Developmental Services

[11] The CCBHC is a national model that focuses on integration of mental health and substance use disorder treatment services.

Under the proposed model, a subset of services, previously paid in a variety of ways across numerous departments, would now be paid in beneficiary months, meaning that for any beneficiary who received some minimum number of hours of service within a given month, the DA or SSA would receive a payment specific to that DA or SSA for the diagnostic group and/or level of care assigned to that beneficiary for that month or year. A contractor to AHS reviewed claims and DMH DA and SSA data submissions (known as the "MSR") to identify which services and AHS funding sources were feasible to include as part of the PPS2 methodology. The contractor identified approximately 93% of revenue could be included if desired by AHS. Discussion regarding what is included or excluded are ongoing.

Compared to fee-for-service (FFS), the advantage of a bundled, prospective payment model is that it incents efficient use of resources to provide services for a beneficiary within a given month. Also, unlike the current system which is spread across departments, adoption of this payment approach will streamline the rate setting component of DA and SSA administration and create a transparent process for evaluating financial needs via the alternative payment model. It will also provide a mechanism to collect information on unanticipated costs or scope of service changes.

Alternative payment models can reduce the overall need for "cost shifting" within DAs and SSAs in order to cover some services or programs that were underfunded in the past because it can smooth out unnecessary variation in payment. The State's contractor has presented some findings on an analysis of the relationship of payment to costs for the subset of services and sub-populations covered in the model. The rates would be able to more accurately distribute payment based on clinical acuity and level of need across the sub-populations being served by the DAs and SSAs for the services included.

There are some downsides to the this approach. For example, on its own, it does not provide a direct incentive to manage the months of use across a person-year. Also, if there are targeted exclusions, it poorly incents efficiency and coordination across those services and funding streams outside of the new reimbursement model. Both incentives are mitigated should more spending be included in the new model and when paired with the global budget.

Addendum: Green Mountain Care Board

MEMORANDUM

To: The House Committees on Health Care on Human Services; the Senate Committees on Health and Welfare and on Finance

From: The Green Mountain Care Board

Re: Act 113 (2016) Sec. 12, Medicaid Pathway Report Addendum

Date: December 19, 2016

Cc: Hal Cohen, Secretary of Agency of Human Services
Al Gobeille, Secretary of Agency of Human Services Designate
Trey Martin, Secretary of Administration
Susanne Young, Secretary of Administration Designate

The Vermont Agency of Human Services (AHS) Central Office, assisted by Health Care Reform staff in the Secretary of Administration's Office, has been leading a process for payment and delivery system reform for Medicaid providers and services called the Medicaid Pathway. Section 12 of Act 113 of 2016 requires that the Secretary of AHS, in consultation with the Director of Health Care Reform and the Green Mountain Care Board, report on that process and provide a Medicaid Pathway report. This addendum reflects the GMCB's perspective of the Medicaid Pathway work in the context of the Vermont All-Payer Accountable Care Organization Model Agreement (APM), signed in October 2016.[12] The Board met on December 8, 2016 to hear an update on the process from AHS staff and to discuss efforts to integrate affected providers "to the extent practicable into the all-payer model and other payment and delivery system reform initiatives." Act 113 (2016) Sec. 12(a).

By 2020, the All Payer Model Agreement provides that AHS, in collaboration with the Board, submit a plan to include Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the All-payer Financial Targets in any APM waiver renewal request. The plan shall describe a strategy for including Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the State delivery system reform efforts and for supporting the inclusion of such Medicaid services in the definition of All-payer Financial Target Services in a subsequent agreement.

The Board commends AHS for its stakeholder process and the analysis it has completed to date, and recommends that AHS continue this analysis before proposing payment changes. In particular, the financial modeling currently underway must be fully understood by the impacted providers to build confidence that the modeling provides accurate information on the potential impacts to provider organizations and to Vermonters receiving services. The Board is encouraged that this work is proceeding, but acknowledges that more work needs to be done prior to conclusive decision-making. Continuing to raise awareness and articulate how these

[12] The APM was signed October 27, 2016 by the Governor of the State of Vermont, Green Mountain Care Board, Secretary of Human Services, and Center for Medicare and Medicaid Innovation.

changes in payment methodologies will support value-based purchasing is pivotal to successful integration of these and other key providers into Vermont's changing health care system.[13]

Lastly, the Board recommends that payment reforms proposed through the Medicaid Pathway process ensure readiness to meet the for Medicaid Behavioral Health Services and Medicaid Home and Community-based Services All Payer Model Targets.

[13] One stakeholder commented at the December 8, 2016 Board meeting that moving away from fee-for-services may not be a goal unto itself.