# Report to

# The Vermont Legislature

## Delivery System Reform Report: 2019

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| **In Accordance with** | Act 113 of 2016, Section 12; Act 52 of 2019, Section 1 |
| **Submitted to:** | House Committee on Health Care<br>House Committee on Human Services<br>Senate Committee on Health and Welfare |
| **Submitted by:** | Michael K. Smith<br>Secretary, Agency of Human Services |
| **Report Date:** | January 15, 2020 |

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## STATUTORY CHARGE

Section 12 of Act 113 of 2016 requires the Secretary of the Agency of Human Services to embark upon a multi-year process of payment and delivery system reform for Medicaid providers that is aligned with the Vermont All-Payer Accountable Care Organization Model and other existing payment and delivery system reform initiatives. This report is the fourth of five reports required by Act 113.

### STATUTORY LANGUAGE:

Act 113, Sec. 12.

(a) The Secretary of Human Services, in consultation with the Director of Health Care Reform, the Green Mountain Care Board, and affected providers, shall create a process for payment and delivery system reform for Medicaid providers and services. This process shall address all Medicaid payments to affected providers and integrate the providers to the extent practicable into the all-payer model and other existing payment and delivery system reform initiatives.

(b) On or before January 15, 2017 and annually for five years thereafter, the Secretary of Human Services shall report on the results of this process to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services. The Secretary's report shall 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.

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This report also incorporates the work contemplated by Section 1 of Act 52 of 2019, which requires the development of a plan to coordinate the financing and delivery of Medicaid mental health services and Medicaid home- and community-based services with the all-payer financial target services, including future plans for the integration of long-term care services with the accountable care organization on or before January 1, 2021. The statute requires AHS to provide an interim status presentation on or before January 15, 2020. This update is included in Section 2.

### STATUTORY LANGUAGE:

Act 52, Sec. 1. Report; Integration of Social Services

(a)(1) On or before January 1, 2021, the Agency of Human Services, in collaboration with the Green Mountain Care Board, shall submit to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare a plan to coordinate the financing and delivery of Medicaid mental health services and Medicaid home- and community-based services with the

all-payer financial target services, including future plans for the integration of long-term care services with the accountable care organization.
(2) In preparing the report, the Agency shall consult with individuals receiving services and family members of individuals receiving services.
(b) On or before January 15, 2020, the Agency shall provide an interim status presentation to the House Committees on Health Care and on Human Services and the Senate Committee on Health and Welfare, including an update on the Agency's progress, the process for the plan's development, and the identities of any stakeholders with whom the Agency has consulted.

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The first annual report detailing progress on delivery system and payment reform for Medicaid providers can be found here:

- First Annual Report Filed 1/3/2017: http://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-12-Medicaid-Pathway-Report-12-30-16.pdf

The second annual report detailing progress on delivery system and payment reform for Medicaid providers can be found here:

- Second Annual Report Filed 1/15/2018: https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Reform.Medicaid-Pathways-Report-1.15.18.pdf

The third annual report, outlining the payment reform process and summarizing progress on each of the projects, can be found here:

- Third Annual Report Filed 1/15/19: https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Report-2019.pdf

This fourth annual report updates progress on Medicaid payment reform initiatives during the last year.

## EXECUTIVE SUMMARY

The State of Vermont continued to make progress on payment and delivery system reform in 2019. Specifically, health care providers, regulators, and policymakers have continued the slow and steady work of creating an integrated system of care that spans the entire care continuum and a broad range of services. Vermont continues this work through the expansion of current value-based payment models and the creation of additional value-based payment models, each aligned with the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement (APM) by incorporating characteristics such as predictability in payments, flexibility for providers, movement away from fee-for-service, and accountability for health care quality and cost.[1]

The APM is Vermont's first-in-the-nation payment model where Medicare, Medicaid and commercial health payer(s) use the same payment structure in contracts with a network of hospitals and providers that have formed an ACO to take on the responsibility for the cost of care and the health of their patients. The goal is to create incentives to change the way care is delivered in pursuit of better health,

[1] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.

higher quality health care, and more sustainable costs. ACOs are provider-led and -governed organizations, with a substantial regional clinical leadership role. Vermont Medicaid was the first payer to implement a program that met the requirements of the APM, starting in 2017. The APM made significant progress in 2018 and 2019 by:

- Adding Medicare and BlueCross BlueShield of Vermont programs for both Performance Year 1 (2018) and PY2 (2019) of the APM.;
- Increasing the number of people and providers in the APM across all participating payers;
- Completing two years of program analysis for the Medicaid program, including financial reconciliation and quality measurement;
- Continuing to make progress on Medicaid's payment and delivery system reform efforts, which seek to use value-based payments to better align Medicaid services with the APM in order to strengthen the entire care continuum.

The last area of activity, Medicaid payment and delivery system reform, is the focus of this report, as indicated in the statutory language.

Section 1 of the report contains a description of the payment reform process. As the Payment Reform Unit at the Department of Vermont Health Access (DVHA) and its AHS partners have gained experience with this innovative work, lessons have been learned and improvements have been made, and that is reflected in the description.

Section 2 of the report describes progress on several Medicaid payment and delivery system reform activities, using the enumerated statutory criteria:

- Medicaid payments to affected providers;
- Changes to reimbursement methodology and the services impacted;
- Efforts to integrate affected providers into the APM and with other payment and delivery system reform initiatives;
- Changes to quality measure collection and identifying alignment efforts and analyses, if any; and
- The interrelationship of results-based accountability initiatives with the quality measures referenced above.

The following payment and delivery system reform initiatives were either implemented or were in progress in 2019:

- Vermont Medicaid Next Generation ACO program
- Child and Adult Mental Health
- Residential Substance Use Disorder Treatment
- Applied Behavior Analysis
- Developmental Disabilities Services
- Children's Integrated Services

Section 2 of the report also provides an interim progress update on the development of a plan to coordinate the financing and delivery of Medicaid mental health services and Medicaid home- and

community-based services with the all-payer financial target services, including future plans for the integration of long-term care services with the ACO.

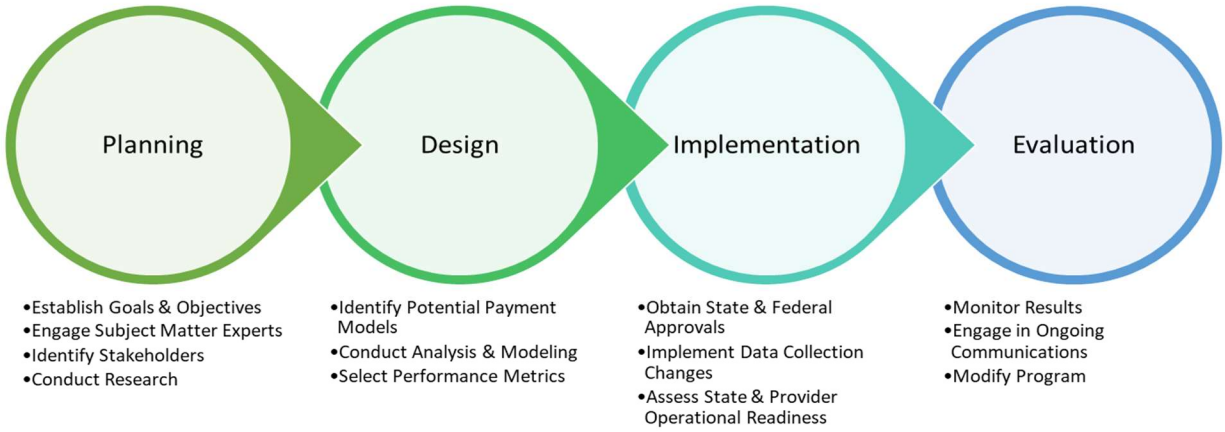
## SECTION 1: PAYMENT REFORM AS A PROCESS

### INTRODUCTION

The objective of payment reform is to support and provide incentives for delivery system reform, in order to address the State's overarching goals of improving quality of care (including the person's experience of care), improving the health of Vermont's population, and reducing growth in the cost of care (known collectively as the Triple Aim[2]), as well as the goal of integrating care and services. Medicaid payment reform is a multi-step and iterative process co-produced by AHS staff with relevant expertise from the program that is the subject of the initiative, staff from DVHA's Payment Reform Unit, providers, and other stakeholders. At AHS, the Payment Reform Unit at DVHA serves as the primary facilitator of this process. The high-level phases of the payment reform process are shown in Figure A. Several Medicaid programs are in various phases of this process, including the Vermont Medicaid Next Generation ACO program, Child and Adult Mental Health, Residential Substance Use Disorder Treatment, Applied Behavior Analysis, Developmental Disabilities Services, Children's Integrated Services. These programs and initial outcomes such as program expansion, operational improvements, and successful data exchange and quality measurement will be further discussed in Section 2.

[2]For more information on the Institute of Healthcare Improvement's Triple Aim, see http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.

FIGURE A: Payment Reform Process




## PLANNING

The first payment reform activity is planning, which generally contains five specific steps.

1. Establish the long-term goals of the health care service or initiative and determine if, and how, payment reform can be a mechanism to make progress towards those long-term goals.
2. Identify and engage subject matter experts to acquire a comprehensive understanding of the current process and workflow from start to finish. A thorough examination will include identifying all internal and external units and individuals that interact with the process; business or policy rules associated with the process; reporting requirements (both State and Federal); as well as any timeline or budgetary restraints.
3. Conduct research about other payment reform efforts, rate comparisons, quality measures and standards, shared challenges, and innovative solutions emerging in other states and nationally.
4. Convene stakeholders to identify the advantages and disadvantages of the current process and to learn how payment reform would be of value to beneficiaries, providers, and Vermonters.
5. Engage in quantitative research and data analysis, looking at claims and/or other data to evaluate historic utilization, population variations, service trends, etc.

***Key Takeaways:*** During the planning phase of a potential payment reform project, it is important to clearly identify the goal(s) or problem(s) to be resolved, communicate what payment reform can and can't do, and determine whether payment reform is the best mechanism for achieving the desired change. Goals that tend to be common across most payment reform projects include predictability in payments; flexibility in tailoring services based on individual needs and service delivery; and promotion

of reliable data collection to support monitoring of payment reform implementation and impact, accountability for use of public funds, and performance measurement.

## DESIGN

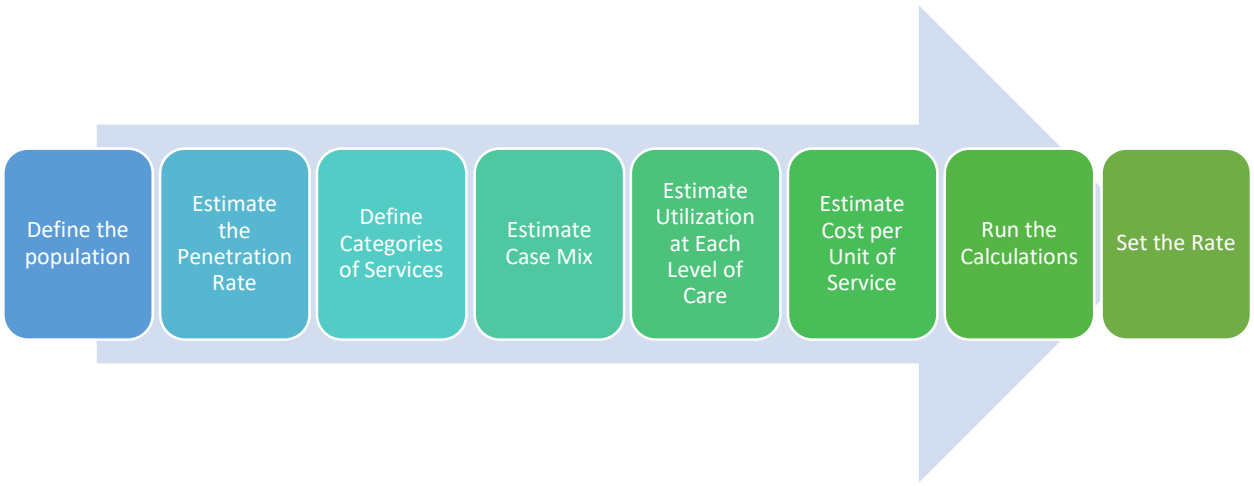
Vermont is not alone in pursuing payment reform. There are several existing payment model options, and the first step in the design phase is to identify which of the available options may further the goals and objectives of a particular project. These options, described in the table below, generally focus on whether payments will be made fee-for-service, in a bundled payment, or in a population-based (or capitated) payment. They can, and frequently are, customized and combined.

| | |
|---|---|
| **Fee-for-Service Options** | |
| *Revise Rates* | Maintains the fee-for-service framework but revises the rates to adjust to practice and service changes. |
| *One-time Incentive* | Maintains the fee-for-service framework but provides an upfront one-time, flexible incentive payment for meeting a specific objective. |
| *Ongoing Add-on Incentive* | Maintains the fee-for-service framework but provides an ongoing payment for meeting an objective or series of objectives. |
| **Bundled Rate Options** | |
| *Per Diem Rate* | Multiple units of a single service or category of services to be included in a single price per day. |
| *Monthly Case Rate* | Multiple units of a single service or category of services to be included in a single price per month. |
| *Episodic Rate* | Multiple units of a single service or category of services to be included in a single episode of care. Requires a clearly identifiable start and end to process (e.g., inpatient admission for a particular condition, pregnancy). |
| *Single-factored Tiered Rate* | A system of rates that include multiple payment ranges. Appropriate for when you have a single variation/population that needs to be stratified or if you want to incentivize a single criterion. |
| *Multi-factored Tiered Rate* | A system of rates that include multiple payment ranges. Appropriate for when you have a single variation/population that needs to be stratified or if you want to incentivize multiple criteria. |
| **Population-Based Options** | |
| *Condition-specific Rate* | Payment is not directly triggered by service. Clinicians and organizations are instead paid and accountable for all the care of a beneficiary for an agreed upon time period through a fixed and predictable payment (e.g., a payment per member per month) for a sub-set of services required by that member. |
| *Comprehensive Rate* | Payment is not directly triggered by service. Clinicians and organizations are instead paid and accountable for all the care of a beneficiary for an agreed upon time period through fixed and predictable payment (e.g., a payment per member per month) for all services required by that member. |

The next step in the design phase is to develop potential rates, to understand the mechanism for payment, and to consider the budgetary impact. This must include a review of implementation costs,

ongoing operational costs, and any expected cost savings from efficiencies made to the process. Figure B demonstrates the series of steps typical for most rate development processes.

FIGURE B: General Rate Development Process




A final step in the design phase is to identify the metrics by which to evaluate the performance of both the program and the model itself. When available, the Payment Reform Unit and program staff identify nationally endorsed performance measures and benchmarks. When those measures are not available, the project team uses results-based accountability to identify performance measures. Performance measures and targets are typically developed in collaboration with providers, and efforts are made to align performance measure requirements across programs and initiatives to the extent possible. Once potential performance measures have been identified, they are vetted through AHS leadership and Medicaid stakeholders (via standing committees and workgroups) to ensure the alignment of goals and objectives and the identification of appropriate performance targets.

***Key Takeaways:*** Design is an ongoing process that involves specification, modeling, testing, feedback, and refinement. As a result, it regularly overlaps with other phases of the payment reform process. For example, implementation and the various operational aspects of a payment reform initiative should be considered during the design phase. Similarly, while final selection of performance measures and targets might occur after payment model design and initial implementation, potential measures should be considered during initial design work.

## IMPLEMENTATION

The next phase in the payment reform process is implementation. Most payment reform models share similar objectives during the implementation phase, such as increasing or maintaining the accountability and transparency of services delivered; streamlining multiple program-specific budgets and cross-departmental funding sources into a single payment; delivering payments in a more timely and

predictable manner; supporting flexibility in tailoring services according to a person's needs; and aligning with the APM.

A new payment model may require obtaining timely State and/or Federal approvals. The State also works closely with DXC Technologies, the Medicaid claims processor, to ensure payments for the new payment model can be made to providers as designed and to allow the system to continue accepting claims. Generally, providers are required to continue, revise, or begin submission of claims for all services provided. These claims are often zero-paid (referred to as "shadow claims"), and are used to monitor the services delivered and to calculate the value of those services (e.g., according to the Medicaid fee-for-service fee schedule) that were covered by the payment.

Preparation for claims (encounter data) submission is detailed and complex work with multiple internal and external partners. It follows the same general approach for all projects:

1. Establish minimum requirements for encounter data submission (through fee-for-service or shadow claims submissions), ensuring coordination across DVHA units and AHS departments and collaboration with providers.
2. Develop a timeline for submission of encounter data.
3. Share information with all impacted provider organizations.
4. Work with provider organizations to understand systems and workflow implications.
5. Provide written guidance on encounter data submission.
6. Work with provider organizations and Medicaid claims processing contractor to phase in encounter data changes over time.

In the final phase of implementation, all affected parties collaborate to develop a transition strategy and ensure operational readiness. This may include training staff; setting up new reporting queries; changing business processes and workflows; providing proper public notice; and adopting any IT changes and systems upgrades. During the early phases of implementation, the State continues to work closely with DXC Technologies and providers to identify unforeseen operational challenges and to develop solutions. These relationships continue throughout implementation as a part of continuous process improvement.

***Key Takeaways:*** Even with comprehensive planning, implementation of new models is characterized by unanticipated questions, needs, and activities. In addition to planning, clear role delineation supports successful implementation. The Payment Reform Unit's experience with implementation has increased over time, and it uses that experience to support State staff and providers in developing new workflows and troubleshooting issues as they arise. A key component of implementation involves building program staff capacity to lead operations for the payment reform initiative.

## EVALUATION

The final phase in the payment reform process is evaluation. During the evaluation phase, short, medium, and long-term outcomes are reviewed to monitor results, measure overall performance, and assess progress toward goals. A primary goal of payment reform is to use flexible, value-based payment as an incentive for providers to deliver services that might not always be "billable" under a fee-for-service model, but which over the long term have a significant impact on a member's health outcomes (such as coordination of care and preventative care outreach).

Evaluation considers data collected in a variety of areas, most commonly:

- Program and/or provider performance;
- Delivery system impacts;
- Process improvements;
- Member experience and improvements to quality of life;
- Quality of care and services provided;
- Fidelity to program design;
- Effectiveness at achieving policy objectives; and, ultimately,
- Health outcomes of the reform.

Data analysis also includes monitoring for new problems and/or unintended consequences of the payment model's design or implementation. Revisions and corrective action plans are employed as needed.

During the evaluation phase, shadow claims allow the State to assess how much would have been paid under the fee-for-service model. Those expenditures are compared to the amount that was actually paid under the new payment model. Shadow claims also provide the State with information on the type and amount of services provided to the member, which is used to monitor changes to service delivery. These comparisons can be used as indicators of overall performance.

An important step in the evaluation process is communication. Clear and effective communication ensures that Vermonters have the information needed to assess and understand changes to Medicaid payment and delivery system reforms. This communication often happens through reports and information briefs, and in presentations to stakeholder groups.

***Key Takeaways:*** The impacts of payment reform are frequently not immediate. Therefore, it is important to approach evaluation cautiously and with a focus on short, medium, and long-term goals and objectives.

## SECTION 2: MEDICAID PAYMENT AND DELIVERY SYSTEM REFORM

Multiple AHS departments are using the process described in Section 1 to develop and implement payment reform projects that impact various Medicaid-enrolled providers and Medicaid-covered services. Section 2 of this report provides a description of six active Medicaid payment reform projects, in chronological order based on project implementation dates:

- Vermont Medicaid Next Generation ACO Program
- Child and Adult Mental Health Payment Reform
- Residential Substance Use Disorder Treatment Payment Reform
- Applied Behavior Analysis Payment Reform
- Developmental Disabilities Payment Reform
- Children's Integrated Services Payment Reform

### VERMONT MEDICAID NEXT GENERATION ACO PROGRAM

The Vermont Medicaid Next Generation (VMNG) ACO program represents Medicaid's participation in the integrated health care system envisioned by the Vermont APM Agreement with the Centers for Medicare and Medicaid Services (CMS). ACOs are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care. The model's goal is an integrated health care system that has aligned incentives to improve quality and reduce unnecessary costs. The VMNG ACO program pursues this goal by taking the next step in transitioning the health care revenue model from Fee-for-Service payments to Value-Based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

The VMNG program allows DVHA to partner with a risk-bearing ACO. Together, DVHA and OneCare Vermont, the ACO participating in the program, are testing a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim.[3] Primary goals of the program are to increase provider flexibility and support health care professionals to deliver the care they know to be most effective in promoting and managing the health of the population they serve. This will contribute to improving the health of Vermonters and moderating health care spending growth in the future.

The 2018 program results indicate sufficient, incremental progress that warrants cautious optimism and a continued commitment to the program.

**Result 1: The program is on track.**

- DVHA and the ACO successfully implemented a second year of the VMNG program.
- Implementation addressed the full range of program activities, including contracting, member attribution and communications, data sharing, financial performance assessment and reconciliation, periodic reporting, quality measurement, and assessment of reporting and results.
- DVHA and the ACO prepare and maintain an operational timeline to ensure contractually required data sharing and reporting occurs in a timely manner and continue to convene weekly operational team meetings. These forums have allowed the teams to identify, discuss, and resolve multiple operational challenges, and have resulted in several process improvements to date.
- The DVHA and ACO medical directors meet monthly to discuss clinical topics, and there is a quarterly meeting at which clinical and analytics staff from both entities review utilization information.
- Quality improvement staff from DVHA and the ACO also meet quarterly, to discuss performance measures and quality improvement initiatives.

[3] http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

- The Payment Reform Unit continued to work extensively throughout 2019 with the DVHA Business Office and DXC Technologies to ensure that Medicaid data systems contain information to support robust financial monitoring and reporting.
- Processes for ongoing data exchange between DVHA and the ACO have been implemented and are regularly evaluated for potential improvements.
- DVHA and the ACO work together to monitor and report on program performance.

**Result 2: The program is growing.**

Additional providers and communities joined the ACO network to participate in the VMNG program for the 2019 and 2020 performance years, as shown in the following table. In addition to another health service area projected to join the VMNG program in 2020, an innovative "Expanded Attribution" model has been incorporated into the 2020 VMNG contract between DVHA and the ACO. This model will allow for additional Medicaid members to be attributed based on their type of Medicaid coverage rather than where they receive care. It supports a population-wide focus within each health service area and is based on a pilot project that was successfully implemented in the St. Johnsbury Health Service Area in performance year 2019.

FIGURE C: Vermont Medicaid Next Generation ACO Program Attributed Medicaid Members by Year

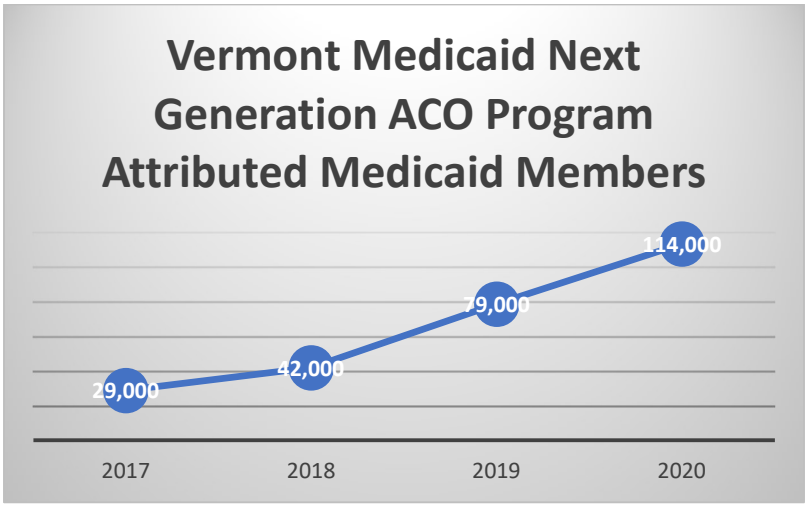


FIGURE D: Vermont Medicaid Next Generation ACO Program Health Service Areas by Year

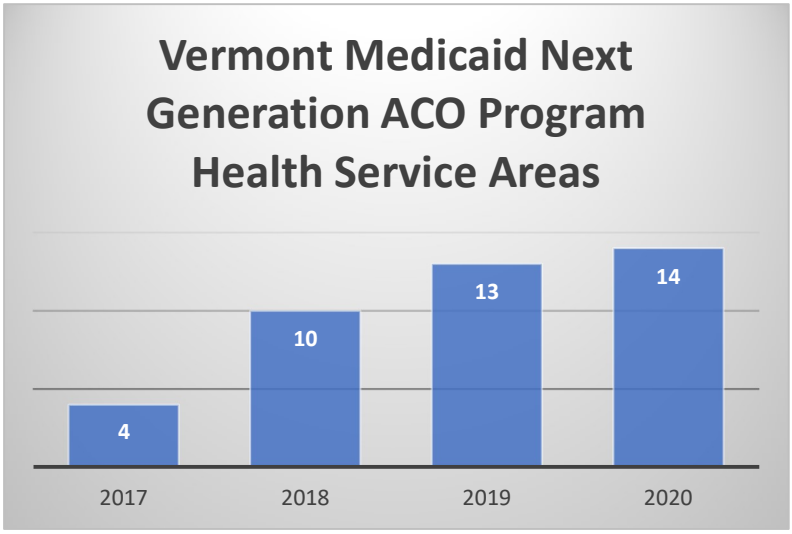
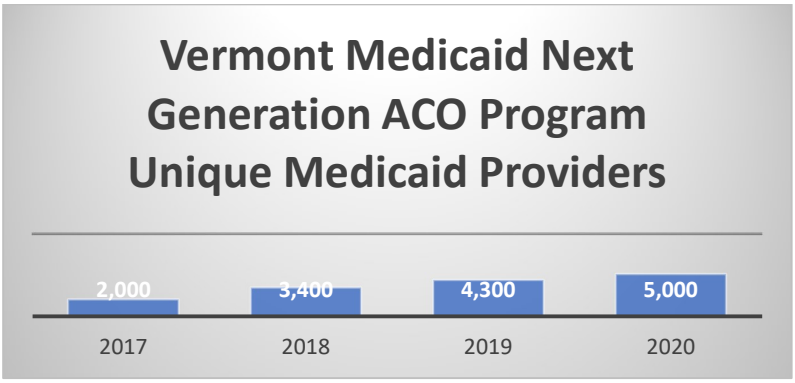



FIGURE E: Vermont Medicaid Next Generation ACO Program Unique Medicaid Providers by Year




| | *2017 Performance Year* | *2018 Performance Year* | *2019 Performance Year* | *2020 Performance Year* |
|---|---|---|---|---|
| Health Service Areas | 4 | 10 | 13 | 14 |
| Provider Entities | Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs | | | |
| Unique Medicaid Providers | ~2,000 | ~3,400 | ~4,300 | ~5,000 |
| Attributed Medicaid Members | ~29,000 | ~42,000 | ~79,000 | ~114,000 (~86,000 traditional attribution and ~28,000 expanded attribution) |

**Result 3: The ACO program spent more than expected on health care in 2018, but Medicaid did not pay more than the agreed upon price.**

DVHA and the ACO agreed on the price of health care up front, and the ACO spent $1.5 million more on care than the expected price. Because the ACO shares financial risk with Medicaid and the amount is within the ±3% corridor (spending was 1.31% more than expected), the ACO and its provider network must pay for this spending over the agreed upon price. The ACO spent less than expected on care in 2017; there are not yet enough data points to identify a financial performance trend.

**Result 4: The ACO met most of its quality targets.**

The ACO's quality score was 85% on 10 pre-selected measures linked to payment. Notably, OneCare's performance exceeded the national 75$^{th}$ percentile on two measures: 30-Day Follow-Up after Discharge from the Emergency Department for Alcohol and Other Drug Dependence Treatment, and Developmental Screening in the First 3 Years of Life. It exceeded the national 90$^{th}$ percentile for one measure: 30-Day Follow-Up after Discharge from the Emergency Department for Mental Health. For the remaining 7 measures, two do not have national benchmarks and four showed performance that exceeded the national 50$^{th}$ percentile. One measure (Initiation of Alcohol and Other Drug Dependence Treatment) showed performance that exceeded the national 25$^{th}$ percentile, indicating that this is a particular area with opportunity for improvement. Examining quality trends over time is important in understanding the impact of changing provider payment on quality of care.

**Result 5: The ACO is supporting integration of care and services.**

As noted earlier in this section, an important goal of the VMNG program is integration of the health care system. The ACO has developed a care model, clinical and financial mechanisms, and information system tools and infrastructure that support integration. The care model uses a nationally recognized tool to stratify members into four risk categories. Interventions by the ACO's participating providers are then tailored to members' risk categories and needs. Care is coordinated for the highest risk members through selection of a lead care coordinator, development of a multi-disciplinary care team consisting of primary care and other providers, access to a shared care plan using an online tool from the ACO, and provision of educational resources, all with the goal of providing the member with well-coordinated care that supports positive health outcomes. In 2019, the ACO's model to promote integrated, team-based care offered training and financial support for Vermont's area agencies on aging, designated mental health agencies, and home health agencies serving as lead care coordinators and/or participating on members' care teams.

This work helps to address the goals of the APM Agreement. The APM Agreement's initial focus is on hospital and physician services, but the APM also emphasizes the need to integrate with other services necessary to achieve the population health and quality outcomes over the period of the agreement. These services include mental health and substance use disorder services, home- and community-based services, and long-term institutional services. Expanding financial accountability for services for either the ACO or the state will involve continued strategic planning and collaboration. By December 31, 2020, the state must have developed a plan to coordinate the financing and delivery of Medicaid mental

health and substance use disorder services with the APM Agreement financial and quality targets and to coordinate the financing and delivery of Medicaid home- and community-based services with APM Agreement targets. Beginning on January 1, 2021, Medicaid Long-Term Institutional Services will be included in the APM Agreement as financial target services. Initial planning and preparation for this work is underway.

## CHILD AND ADULT MENTAL HEALTH PAYMENT REFORM

The Department of Mental Health (DMH) and DVHA continue to collaborate on a payment reform project that transitioned Vermont Medicaid payments for a wide array of mental health services to all Designated Agencies (DA) and Pathways Vermont (a Specialized Services Agency or SSA), from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service) to a monthly case rate. Under the new model, which went into effect for all covered services delivered on or after January 1, 2019, agency-specific case rates are calculated for each agency's unique child and adult populations, based on their mental health allocation from DMH and their historical DVHA fee-for-service expenditure. Agencies are paid a fixed amount prospectively at the beginning of each month and are expected to meet established caseload targets by delivering at least one qualifying service to an individual in a given month as monitored through service encounter data submissions.

Key goals in the first performance year (2019) of mental health payment reform were to improve the predictability of payments to providers of mental health services and to increase their flexibility to meet the needs of the Vermonters they serve, while also monitoring for statewide and agency-specific shifts in service delivery trends. Successful implementation and operation of mental health payment reform represents a strong commitment on behalf of both the AHS and the Designated Mental Health Agency network to support movement towards population-based payments. The new payment model shares many characteristics of other value-based payment models that the State is implementing or considering for future implementation; such alignment contributes to both State and provider readiness for an increasingly integrated health care delivery system and aids the State in developing a strategy for inclusion of additional services in All-Payer financial targets in the future.

For the mental health payment reform project, value-based payments are made through a separate quality payment. During each measurement year, DMH will withhold a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model uses three types of performance metrics to assess the quality and value of services:

- *Monitoring Measures* are those measures that are used to assess the health and access to care of populations and/or catchment areas. Monitoring measures do not impact the distribution of value-based payments.
- *Reporting Measures* are those measures that are used to establish a baseline and/or gather data. Reporting Measures do impact the distribution of value-based payments according to an agency's ability to meet specific reporting criteria.

- *Performance Measures* are those measures that assess an agency's work and/or outcomes of work. Performance Measures do impact the distribution of value-based payments according to the agency's ability to meet specific targets and/or outcomes.

In 2019, agencies were able to earn their value-based incentive for the reporting of complete, accurate, and timely information. Agencies also used the first year to gather baseline data. A comparison of the first four months of 2019 against the first four months of 2018 (see Figure F, below) showed a marked improvement in reporting performance; only one agency failed to meet both requirements for reporting complete, accurate, and timely data. The improvement trend continued throughout 2019 and DMH anticipates ending the year with approximately 95% of data reported in a complete, accurate, and timely fashion.

FIGURE F:

CY 2018

| DA | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|
| A | 1 | 2 | 2 | 2 |
| B | 1 | 1 | 1 | 2 |
| C | 1 | 2 | 2 | 2 |
| D | 2 | 2 | 1 | 1 |
| E | 2 | 1 | 2 | 2 |
| F | 1 | 0 | 1 | 0 |
| G | 1 | 2 | 2 | 2 |
| H | 0 | 1 | 1 | 0 |
| I | 0 | 1 | 0 | 1 |
| J | 1 | 1 | 1 | 1 |
| K | 1 | 1 | 1 | 1 |
| L | 0 | 1 | 1 | 0 |

CY 2019

| DA | Jan-19 | Feb-19 | Mar-19 | Apr-19 |
|---|---|---|---|---|
| A | 2 | 2 | 2 | 2 |
| B | 2 | 2 | 2 | 2 |
| C | 2 | 2 | 2 | 2 |
| D | 2 | 2 | 2 | 2 |
| E | 2 | 2 | 2 | 2 |
| F | 2 | 2 | 2 | 1 |
| G | 2 | 2 | 2 | 2 |
| H | 2 | 2 | 2 | 2 |
| I | 2 | 2 | 2 | 2 |
| J | 2 | 2 | 2 | 2 |
| K | 2 | 2 | 2 | 2 |
| L | 2 | 2 | 2 | 2 |

**Key**

0 = Reporting met no requirements (neither timely nor complete)

1 = Reporting met one requirement (timely or complete)

2= Reporting met both requirements (timely and complete)

2019 accomplishments also include the selection of the Adults Needs and Strengths Assessment (ANSA), a standardized assessment tool for the adult system of care that complements the CANS assessment tool for children (which has been in use since 2015, but will be adopted across all providers in 2020), providing opportunity for a longitudinal view of progress and needs across the life span. The ANSA is a strengths-based, recovery-focused multi-purpose tool that provides a comprehensive assessment of needs and strengths, including specific psychological symptom functioning and social determinants of health, and allows for the monitoring of outcomes of services.

In 2020, agencies will begin training their providers on the ANSA with the intention that agencies will earn a portion of their value-based incentive for complete, accurate, and timely reporting of data from the assessment by 2021. Also in 2020, in addition to earning the value-based incentive for reporting, agencies will earn a portion of the incentive for performance on four client experience quality measures, and baseline data will be used to set performance targets.

In the next phase of work on the mental health payment model, DMH and DVHA will continue to collaborate with providers and member recipients to evolve aspects of the payment model and rate setting methodologies to further increase accountability, transparency, and equity in payments. Key to this work will be continuing to improve the quality of service delivery cost and utilization data.

The 2019 program results indicate sufficient, incremental progress that warrants a continued commitment to the program.

**Result 1: The program launched on time with manageable operational issues.**

Providers were paid predictable monthly payments, Medicaid recipients received their mental health services, and the State received detailed encounter data on services delivered under the mental health case rates. While various operational challenges arose in the first year of mental health payment reform, as tends to be common in any new payment reform project, they have largely been resolved. One example of an operational challenge is working with the DXC Technologies to update claims processing rules that resulted in some unanticipated claims denials in the first year of payment reform.

**Result 2: Caseload forecasting is largely on track.**

Drawing from data from the first six months[4] of performance year 2019:

- The number of unique children served statewide is 3.8% above aggregate estimates;
- The number of unique adults served statewide is 0.2% above aggregate estimates;
- Only 2 child programs (out of 11) are below their unique caseload target (both by 3% or less); and
- Only 1 adult program (out of 11) is below its unique caseload target (by 2.5%).

**Result 3: Payment reform changes resulted in delivery system improvements.**

In preparation for upcoming value-based payment measures on access to care, some agencies have redesigned their intake processes and provider schedules to allow for same day walk-in, or next day appointments. Agencies have also collaborated with DMH to develop efficiencies for documentation, such as embedding the CANS assessment tool into the intake assessment to capture both sets of information at one time. Changes in concurrent billing rules have also removed a barrier to developing discharge plans throughout the client's stay in inpatient or residential treatment.

**Result 4: Payment rates and methodologies for mental health services were aligned across the AHS.**

Prior to the launch of mental health payment reform, DVHA and DMH had varying payment rates, methodologies, and policies for the same or similar mental health services. Developing a unified rate

[4] At the time of this report's creation, the full 2019 performance year was not complete. Additionally, encounter data claims lag contributes to an incomplete picture of utilization data for the second half of 2019.

supported by a common provider program manual[5] has improved mental health programming operations by clarifying expectations for both the State and providers.

**Result 5: DVHA, DMH and impacted providers remained committed to continuous improvement and evolution of mental health payment reform.**

DMH and DVHA have convened a monthly Mental Health Payment Reform Implementation work group throughout the first performance year with the goal of establishing a forum for collaborative dialogue to address refinement to existing program operations and planning for the future. This work group is expected to continue to convene as long as relevant discussion topics exist.

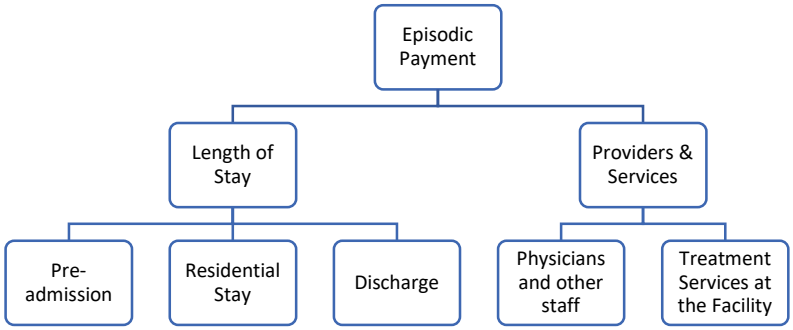
| **Summary Overview: Child and Adult Mental Health Payment Reform** | |
|---|---|
| **Program:** | Child and Adult Mental Health Payment Reform |
| **Impacted Providers:** | • Designated Agencies<br>• Pathways |
| **Impacted Beneficiaries:** | ~16,100 (~7,700 for child program and ~8,400 for adult program) |
| **Funds allocated for new payment model (CY2019)** | ~$93,300,000 (~$39,300,000 for child case rates and ~$54,000,000 adult case rates) |
| **Type of Payment Reform:** | Fee-for-Service to a monthly case rate |
| **Implementation Date:** | January 1, 2019 |

## RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT

The Vermont Department of Health (VDH) and DVHA are collaborating on a payment reform project that transitioned Vermont Medicaid payments to residential substance use disorder (SUD) treatment providers from a per diem rate to an episodic payment (see visual depiction in Figure G, below). An episodic payment was selected as it would: provide a framework to pay for outcomes rather than discrete services; incentivize innovation and cost-containment through increased provider flexibility; and ensure financial stability through the delivery of more predictable payments.

[5]The mental health provider manual can be found at: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Manuals/Mental_Health%20_Provider_Manual_10-29-2019.pdf

FIGURE G: Residential Treatment Episodic Payment

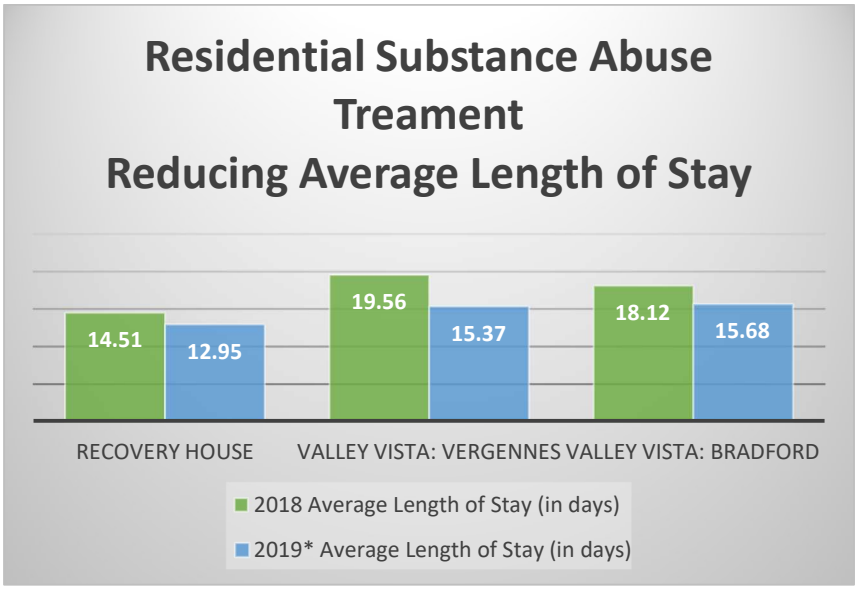



The episodic payment covers the entire episode of care which includes both the residential detoxification and the residential treatment, with pharmaceutical benefits continuing to be billed separately. The payment covers the full length of stay, from pre-admission through discharge, and all providers and services utilized for treatments at the facility.

The payment model includes eight potential episodic payment rates. The amount of the payment is determined by two factors: the primary diagnosis and, if present at intake, a co-morbidity. This multifactored episodic rate was designed to incentivize providers to admit only those patients that need the full resources of residential care and only for a medically-necessary length of stay, thereby promoting the good stewardship of public resources and ensuring people receive appropriate types and levels of care. Prior to January 1, 2019, Vermont Medicaid reimbursed SUD residential providers based on rates separately negotiated by each provider, resulting in three different per diem rates for the same services. Through payment reform change, Vermont Medicaid now accounts for variations in populations and acuity in a way that is consistent throughout the state and across providers and better aligns with federal requirements that State Medicaid agencies pursue payment structures in which all payment rates are "consistent with efficiency, economy, and quality of care," (42 CFR §447.200, Payments for Services, Payment Methods: General Provisions) and that the payment is (a) based on the utilization and delivery of services, and (b) directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract (42 CFR § 438.6(c)(2)).

Although it is too early to draw definitive conclusions, early monitoring of the SUD payment reform effort has been encouraging. In the first year, the residential treatment program has seen a 21% reduction in the average length of stay per-person (see Figure H below), and it appears that Medicaid beneficiary 30-day readmission rates have gone down from 4.3% in 2018 to 3.5% in 2019. DVHA and VDH believe that these improvements to the program can be attributed to: the introduction of the value-based payment model; the reduction of administrative burden, such as the removal of the requirement for concurrent review thus allowing more time for direct care by the clinical staff; improved discharge planning at the facilities; and better access to outpatient services including medication assisted treatment (MAT) available across the state.

FIGURE H: Average Length of Stay by Calendar Year and Provider




| | CY2018 | CY2019 (*as of 10/21/2019) |
|---|---|---|
| **Provider** | *Average Length of Stay (in days)* | *Average Length of Stay (in days)* |
| ***Recovery House*** | 14.51 | 12.95 |
| ***Valley Vista: Vergennes*** | 19.56 | 15.37 |
| ***Valley Vista: Bradford*** | 18.12 | 15.68 |

In CY2019, the residential treatment providers received an overall 19% increase in revenue per person across the program. In CY2020, Vermont Medicaid will adjust the payments to maintain a 3% increase in the program over CY2018. DVHA and VDH intend to use the 3% for the value-based incentive. In year three of this payment reform initiative, a portion of the episodic payment will be withheld for value-based payments. The residential treatment providers will be able to earn the value-based payments through demonstration of improved outcomes in the following areas:

- clients initiating outpatient treatment within seven days of discharge;
- reducing readmissions (90 and 180-day); and
- clients visiting a Primary Care Physician within 30 days of discharge.

VDH and DVHA will begin work on the second phase of this payment reform, implementing the value-based component, at the end of January 2020.

| Summary Overview: SUD Residential Treatment Payment Reform | |
|---|---|
| **Program:** | SUD Residential Treatment |
| **Impacted Providers:** | • Valley Vista: Vergennes<br>• Valley Vista: Bradford<br>• Serenity House |
| **Impacted Beneficiaries (CY2019)** | ~1,250 |
| **Funds allocated for new payment model (CY2019)** | ~$5,800,000 |
| **Type of Payment Reform:** | Per diem rate to Episodic Payment |
| **Implementation Date:** | January 1, 2019 |

## APPLIED BEHAVIOR ANALYSIS

"Applied behavior analysis" (ABA) consists of the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. ABA includes a wide variety of evidence-based strategies to impact behaviors for individuals with core impairments in behavior and skills associated with autism and other developmental disabilities. The term includes direct observation, measurement, and functional analysis of the relationship between environment and behavior.

The Social Security Act requires state Medicaid programs to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to all Medicaid eligible individuals under age 21, which includes ABA services when medically necessary. However, a national shortage of licensed ABA providers has impacted Designated Agency and independent practices' ability to secure enough staff to meet all the medically necessary needs of Vermont Medicaid members. The payment reform initiative for this project came in response to providers' feedback that the administrative components of ABA, namely the prior authorization process and the complexity of the billing codes, interfered with their ability to deliver services to clients.

After extensive planning and design work, Vermont Medicaid transitioned from traditional fee-for service reimbursement to a single-factored tiered rate on July 1, 2019 for members with Vermont Medicaid as primary insurance. As a result of this reform, providers are no longer required to complete prior authorization requests, nor must they wait for approvals of changes to treatment plans. The tiered rate allows providers to determine the appropriate treatment type and to adjust and respond immediately to changes in their patients' medically necessary service needs. Providers are no longer limited to Vermont Medicaid imposed restrictions placed on codes when delivering ABA services. DVHA's Quality Improvement and Clinical Integrity Unit monitors utilization and clinical services through claims data, chart audits, site visits, and standardized tools and reporting.

Payments to providers are now more predictable and timely, with the amount determined by each client's tier based on needs assessment. The monthly prospective payment for each client is not tied to the submission of Medicaid claims data. Each of the tiers has a "monthly floor," or a minimum number of hours required to validate the monthly payment rate. The DVHA Quality and Clinical Integrity Unit

monitors claims data monthly and reviews results with providers (as needed) to ensure that utilization and payments are closely aligned. After the end of the performance year, Vermont Medicaid will reconcile the differences between payments delivered and services rendered at the client level.

Through this payment reform, DVHA hopes to increase access and utilization for Medicaid beneficiaries by giving providers the flexibility to innovate and to use staff more efficiently. While there is currently no value-based component, the ABA payment reform establishes a monitoring framework that could be used to pay for outcomes in the future.

The payment model change went into effect for all members for whom Medicaid is the primary payer on July 1, 2019. In the next phase of work on the ABA payment model, DVHA will collaborate with providers and member recipients to refine the reconciliation process, review population indicators, and develop performance measures.

| Summary Overview: Applied Behavior Analysis Payment Reform | |
|---|---|
| **Program:** | Applied Behavior Analysis |
| **Impacted Providers:** | • Designated Agencies<br>• Kingdom Autism and Behavioral Health<br>• Keene Perspectives<br>• BEL Center<br>• Benchmark<br>• Seeds of Change<br>• SD Associates<br>• Autism Advocacy and Intervention<br>• Independent practicing, licensed clinicians |
| **Impacted Beneficiaries:** | ~200 (July through December 2019) |
| **Funds allocated for new payment model** | ~$2,500,000 (July through December 2019) |
| **Type of Payment Reform:** | Fee-for-Service to a monthly case rate |
| **Implementation Date:** | July 1, 2019 |

## DEVELOPMENTAL DISABILITIES SERVICES

The Department of Disabilities, Aging and Independent Living (DAIL) and DVHA are collaborating on a complex and comprehensive payment and delivery system reform project to improve data on services provided, ensure consistent assessment of individuals' needs, and transition from the current Developmental Disabilities Services (DDS) home- and community-based services (HCBS) daily rates to a new form of payment for individuals with intellectual and developmental disabilities. The goal is to create a transparent, effective, and operationally feasible payment model for DDS that aligns with AHS' broader health care reform goals.

This project has several objectives:

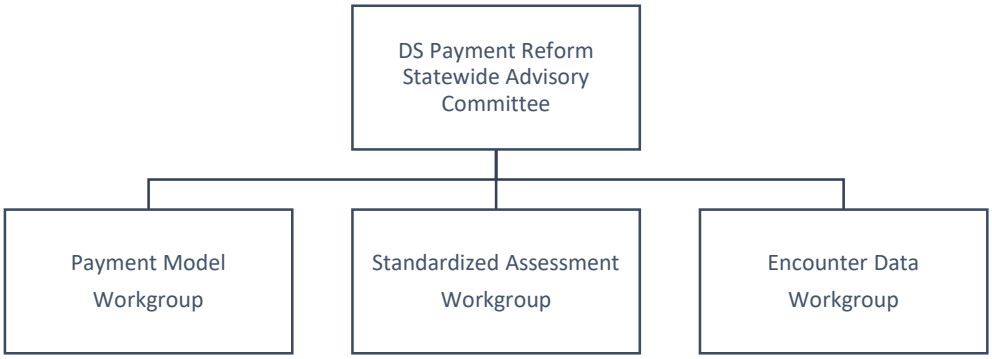
- Comply with the APM Agreement, which obligates AHS to develop a plan to coordinate payment and delivery of Medicaid HCBS with the State's delivery reform efforts for health care;
- Increase the transparency and accountability of DDS, consistent with recommendations in the 2014 State Auditor's Report;
- Improve the validity and reliability of needs assessments through use of a standardized assessment tool;
- Ensure submission of encounter data to support continued tracking of approved services;
- Provide equity and predictability, including similar budgets and services for individuals with similar needs, and consistent funding streams for providers;
- Provide flexibility in response to changes in individual needs and choices; and
- Support a sustainable provider network.

Representatives from the State, provider network, individuals, family members, and other stakeholders have been working together on this project since 2018. In the Fall of 2018, three workgroups were created:

- *Standardized Assessment*: Focused on the selection of a uniform, valid, and reliable standardized assessment tool for determining what services and supports an individual needs. This workgroup has reviewed assessment tool options, and DAIL has issued a Request for Proposals for a vendor to acquire and administer the assessment tool. The workgroup has recommended several supplemental areas for questions to add to the assessment.
- *Payment Model*: Focused on designing a payment mechanism by which providers would be paid to provide services. This workgroup has considered several payment model options in detail and is in the process of refining those options and identifying implications for providers and people receiving services. Payment model options will be presented for broader public engagement.
- *Encounter Data*: Focused on developing a process by which providers will report all service delivery encounters to the Medicaid Management Information System (MMIS). This group has designed encounter claim submission requirements for the various services, worked with DXC Technologies to implement these requirements, and contributed to the development of detailed encounter data submission guidance for providers. Work in 2020 will include further refining encounter data submission guidelines, as well as developing and implementing provider educational materials and training with the goal that encounter data volume and quality will continue to increase, establishing a strong baseline to inform future planning.

All three workgroups provide updates to the DS Statewide Advisory Committee, which was created in late 2018 to obtain ongoing input from a broad group of stakeholders. Figure I shows the workgroup structure.

FIGURE I: DDS Payment Reform Workgroup Structure




The State also engaged Burns & Associates, a consulting firm, to conduct a provider rate study to evaluate the actual cost to providers of delivering services. The study results will inform the new payment model and assist in the development of provider reimbursement rates. Initial rate study results were presented for public comment, and revisions are currently being prepared.

More detailed information on this project can be found in "Developmental Disabilities Service Payment Reform Update," submitted by DAIL in accordance with Act 72, Section E. 333.

| Summary Overview: Developmental Disabilities Services Payment Reform | |
|---|---|
| **Program:** | Developmental Disabilities Services |
| **Impacted Providers:** | • Designated Agencies<br>• Specialized Services Agencies<br>• Supportive Intermediary Service Organization |
| **Anticipated Impacted Beneficiaries:** | ~3,200 |
| **Estimated funds allocated for new payment model (SFY2020)** | ~$221,000,000 |
| **Type of Payment Reform:** | TBD |
| **Implementation Date:** | Encounter data collection targeted for first quarter of CY2020; standardized assessment implementation targeted for third quarter of CY2020; payment model implementation targeted for late CY2021 or early CY2022. |

## CHILDREN'S INTEGRATED SERVICES

The Payment Reform Unit is working on a payment reform project with the Children's Integrated Services (CIS) program of the Department of Children and Families (DCF). CIS serves vulnerable children prenatally through five, including those with disabilities or developmental delays. Services include early intervention, home visiting, specialized child care coordination, and early childhood and family mental health. The program contracts with a fiscal agent in each region to deliver or subcontract for services to eligible families. A significant portion of the services are covered through a bundled payment mechanism in the fiscal agent contracts; each fiscal agent is reimbursed up to its contract total using a monthly case rate for each client served. Rates are historically based and vary by region, with contract amounts in the current year totaling the $9.2 million statewide appropriation for the program's services that are covered in the contracts.

Over the past year, DCF has worked with the Payment Reform Unit to complete an analysis of CIS service provision and payment structure, with the goal of gaining an objective and data-informed understanding of service delivery costs. The process, which has included a provider survey and analysis of results, aims to ensure equitable and appropriate funding allocation across regions to maximize available resources and support effective service delivery. Providers have had an opportunity to review the resulting proposal for a uniform statewide rate and submit feedback. DCF and the Payment Reform Unit were reviewing that feedback at the time of this report's creation. The new rate and contract totals are slated to take effect on July 1, 2020, after a formal public comment period and contingent on federal Centers for Medicare and Medicaid Services (CMS) approval.

As in other payment reform projects, another key element of this project is to collect claims data to inform caseload assumptions, utilization of services, contract monitoring, and ongoing programmatic analysis. To that end, DCF and the Payment Reform Unit have designed provider coding requirements for the various services, prepared data collection guidance for providers, and initiated work with Medicaid's claims processing contractor to ensure that the system will be ready to accept CIS claims during the second quarter of 2020.

| **Summary Overview: Children's Integrated Services Payment Reform** | |
|---|---|
| **Program:** | Children's Integrated Services |
| **Impacted Providers:** | • 9 Regional Fiscal Agents (six Parent Child Centers, one Designated Agency, one Home Health Agency, one Learning Services Agency)<br>• 24 subcontracted service providers in addition to the 9 fiscal agents |
| **Anticipated Impacted Beneficiaries:** | ~5,000 – 6,000 unique beneficiaries per year (~2,500 new beneficiaries each year) |
| **Estimated funds allocated for new payment model (CY2020)** | ~$9,223,000 |
| **Type of Payment Reform:** | Bundled Rate (updated monthly case rate) |
| **Implementation Date:** | Payment model implementation targeted for July 1, 2020. |

## SECTION 1 OF ACT 52 OF 2019 INTERIM STATUS UPDATE

The Agency of Human Services (AHS), in collaboration with the Green Mountain Care Board (GMCB), will develop a plan to coordinate the financing and delivery of Medicaid mental health services and Medicaid home- and community-based services with the All-Payer Financial Target Services, as required by CMS in the Vermont All-Payer Accountable Care Organization Model Agreement.. This interim status update describes progress made, the process for the plan's development, and the identities of any stakeholders with whom AHS has consulted to date.

All-Payer Financial Target Services currently include the following categories of services: acute hospital inpatient and outpatient care, post-acute care, professional services, and durable medical equipment. These are inclusive of Medicare Part A and Part B services and similar services paid for by Medicaid and Commercial plans. Services that are also covered by Medicaid, Commercial Plans and Self-insured Plans are excluded such as dental services, Medicaid home- and community-based services and certain Medicaid mental health and substance use disorder services. Medicaid long-term institutional services will be included in Performance Years 4 and 5 only. Services delivered to Vermont residents whether provided in or outside of Vermont or by ACO or non-ACO participating providers are included in All-payer Financial Target Services.

As part of the All-Payer Accountable Care Organization Agreement with the Centers for Medicare and Medicaid Services (CMS), Vermont agreed to limit All-Payer Total Cost of Care per Beneficiary Growth on expenditures associated with All-payer Financial Target Services to 3.5 percent. Given the interest in addressing differential rates between payers, opportunities are available to adjust the calculation to reflect rate increases. CMS may require corrective action if the State is not on track to achieve growth targets based on compounded annual growth rates across multiple performance years that exceed 4.3 percent.

AHS is investigating the implications of including Medicaid mental health and substance use disorder services and home- and community-based services in the All-Payer Financial Target Services. This could include services and supports operated by the Department of Mental Health (DMH); Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP); and Department of Disabilities, Aging and Independent Living (DAIL) through specialized programs such as Community Rehabilitation and Treatment, Enhanced Family Treatment, Choices for Care, the Traumatic Brain Injury Program, and Developmental Disability Services. It also could include other Medicaid-funded services provided by Designated Agencies, Specialized Services Agencies, and Home Health Agencies.

Currently, foundational activities are underway that could support the ability to include certain services in the All-payer Financial Target Services and inform decisions regarding whether the services should be included and within what timeframe. These include payment reform efforts described above in this Section 2 such as the Child and Adult Mental Health Payment Reform, Developmental Disabilities Payment Reform, Residential Substance Use Disorder Treatment Payment Reform, and Applied Behavior Analysis Payment Reform. These efforts are expected to result in the following types of improvements: predictability of payment and risk for providers, use of standard encounter data collection to increase understanding of services delivered and costs, use of standard assessments to gather validated data on service needs, and use of new rate setting models. As these are being implemented, AHS is also engaging leaders across departments to begin work developing a plan to further coordinate the financing and delivery of Medicaid mental health services and Medicaid home- and community-based services. As an incremental step in this initiative, AHS is collecting information to create a profile of each potential program or service, including payment methodology and utilization history. AHS will develop a set of overarching objectives that align with priorities across departments. A list of activities necessary to reach these objectives, including precursor activities, will be developed and evaluated to determine how they will support AHS in reaching the agreed-upon objectives and what facilitators and barriers will impact the ability to implement and operate the activities. In addition to including certain services in the All-payer Financial Target Services, AHS will examine intersecting activities related to aligning quality measures and payment mechanisms and reducing fragmentation across the delivery system. AHS will engage key internal and external stakeholders throughout the process.

A variety of stakeholder engagement activities related to this work have occurred to date. In November 2019, the GMCB and AHS hosted a stakeholder meeting to discuss integration of social services. Outcomes of that meeting are included in the GMCB's response to Section 2 of Act 52 of 2019, in which, the GMCB evaluated the degree to which social services are integrated into ACOs. Over twenty-five participants across state government, the ACO and social service organizations debated the current

status of integration and opportunities and barriers associated with future integration.[6] In addition, stakeholder feedback was collected through public comments submitted through the ACO oversight process. The GMCB also sought feedback from individuals receiving social services from providers in OneCare VT's network to inform its report.

Foundational activities described in this report that support further coordination of the financing and delivery of Medicaid-funded mental health services and home- and community-based services with the All-Payer Financial Target Services have benefited from robust stakeholder engagement. DAIL is working with stakeholders on several payment reform design elements. Self-advocates, advocates, guardians, provider staff, and legislators participated with DAIL staff, Department of Vermont Health Access (DVHA) staff, and consultants in payment reform workgroups. These workgroups include a Statewide Advisory Committee, a Standardized Assessment Workgroup, an Encounter Data Workgroup, and a Payment Model Workgroup. In addition, related work on developing uniform statewide payment rates is based on providers' financial information and stakeholder input and a final rate proposal will be distributed for further stakeholder comment. DAIL intends to develop a future payment model on the foundation of actual assessment data and encounter data, again informed by stakeholder input. DMH led a multi-phase process of planning and design, implementation preparation, and implementation to inform all aspects of Mental Health Payment Reform. Engagement continues through a monthly Post-Implementation Workgroup, Metrics and Scoring Workgroup, and other ad-hoc groups and meetings, as needed. A wide range of affected providers, partners, consumer advisory groups, and state agency staff has participated throughout the process. Lessons learned and systems improvements from these foundational activities will continue to inform plans to further coordinate the financing and delivery of services with All-Payer Financial Target Services.

## CONCLUSION

A graphic providing a visual overview of the six Medicaid payment and delivery system reform projects is found in Figure J. As additional projects have been added, the Payment Reform Unit has gained valuable experience and focused on alignment in the approach to planning and payment model design, performance measurement, and monitoring and evaluation. Alignment with the APM is also an important goal. For example, quality measures in the Vermont Medicaid Next Generation ACO Program are closely aligned with the quality measures in the APM and with quality measures in the Medicare and Commercial ACO programs. Payment reform initiatives have also aligned quality measures across ACO programs and other payment reform projects discussed in this report, where appropriate and feasible. Alignment with the APM has also occurred across projects by incorporating characteristics such as predictability in payments, flexibility for providers, movement away from fee-for-service, and accountability for health care quality and cost. In another example of alignment, the Payment Reform Unit has standardized its approach across programs in supporting the collection of claims data (which serves as a critical source of information on services provided to Medicaid beneficiaries). In its future work, the Payment Reform Unit will continue to prioritize alignment and evaluation of Medicaid payment reform impacts across projects.

[6] Green Mountain Care Board (2019). *Evaluation of Social Service Integration with Accountable Care Organizations.*

FIGURE J: Payment and Delivery System Reform Project Summary (as of December 31, 2019)