VERMONT

AGENCY OF HUMAN SERVICES

Report to the Vermont Legislature

Delivery System Reform Report: 2018

Act 113, Section 12; Act 82, Section 7

Submitted by the Agency of Human Services to Senate Health and Welfare, House Health Care, House Human Services.

1-15-2019

CONTENTS

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 third of five reports required by Act 113.

STATUTORY CHARGE:

(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.

This report also incorporates the work contemplated by Section 7 of Act 82 of 2017, which required a plan to integrate multiple sources of payment for mental health and substance abuse services to the designated and specialized service agencies (DAs and SSAs).

FULL TEXT

Act 82, Sec. 7. PAYMENTS TO THE DESIGNATED AND SPECIALIZED SERVICE AGENCIES
The Secretary of Human Services, in collaboration with the Commissioners of Mental Health and of Disabilities, Aging, and Independent Living; providers; and persons who are affected by current services, shall develop a plan to integrate multiple sources of payments for mental and substance abuse services to the designated and specialized service agencies. In a manner consistent with Sec. 11 of this act, the plan shall implement a Global Funding model as a successor to the analysis and work conducted under the Medicaid Pathways and other work undertaken regarding mental health in health care reform. It shall increase efficiency and reduce the administrative burden. On or before January 1, 2018, the Secretary shall submit the plan and

any related legislative proposals to the Senate Committee on Health and Welfare and the House Committees on Health Care and on Human Services.

This is the third annual report required by Section 12 of Act 113 of 2016. 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

EXECUTIVE SUMMARY

The State of Vermont continued to make progress on payment and delivery system reform in 2018. Specifically, health care providers, regulators, and policymakers continue the slow and steady work of creating an integrated system of care that spans the entire care continuum. 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).[1]

The APM is Vermont's first-in-the-nation pilot payment model where a network of hospitals and providers use an ACO to take on the fiscal responsibility for the care and health of their patients. The goal is to create incentives to change the way care is delivered in pursuit of better health, higher quality health care, and more sustainable costs. The APM made significant progress in 2018:

- adding additional payers to join Medicaid in the APM,
- increasing the number of people and providers in the APM across all participating payers,
- having Medicaid complete an entire program year, including financial reconciliation and quality measurement, and;
- progress on Medicaid's payment and delivery 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.

Medicaid payment and delivery system reform is the focus of this report, per the statutory charge.

The report attempts to demystify payment and delivery system reform by describing the process and daily work that occurs within AHS and with our stakeholders. Specifically, the report will consist of two basic elements. First, a description of the payment reform process, which is typically facilitated by the Payment Reform team at the Department of Vermont Health Access (DVHA). Second, the report

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

provides an update on completed and in-progress payment 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 completed or in-progress in 2018:

- Vermont Medicaid Next Generation (VMNG) ACO program
- Applied Behavior Analysis (ABA)
- Children's and Adult's Mental Health
- Residential Substance Use Disorder (SUD) Program
- Developmental Disabilities Services
- Pediatric Palliative Care

SECTION 1: PAYMENT REFORM AS A PROCESS

PLANNING

Payment reform is a multi-step and iterative process co-produced by staff with relevant expertise, providers, and stakeholders. At AHS, the Payment Reform team at DVHA serves as the primary facilitators of this process. 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 identify if, and how, payment reform can be a mechanism to make progress towards that long-term goal.
2. Identify and gather 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 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 learn the advantages and disadvantages of the current process and to learn how payment reform would be of value to the beneficiaries, providers, and Vermonters.
5. Engage in quantitative research and data analysis, looking at claims data to evaluate historic utilization, population variations, service trends, etc.

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 generally focus on whether payments will be made fee for service, in a bundled payment, or in a population-based (or capitated) payment. These options 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 (for example, inpatient admission, or 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 (for example, 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 (for example, 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 process. Figure A demonstrates the series of steps typical to most rate development processes.

Figure A. General Rate Development Process

The last step in the design phase is to identify the performance metrics by which to evaluate the performance of both the program and the model itself. When available, the payment reform unit uses nationally endorsed performance measures and benchmarks. When those measures are not available, the payment reform unit uses results-based accountability to identify performance measures. Performance 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 performance measures and targets 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.

IMPLEMENTATION

The next phase in the payment reform process is implementation. Most payment reform models share similar objectives during the implementation phase, which are: 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; 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 can be made to providers as designed for a new payment model and to allow the system to continue accepting claims. Providers are still required to submit claims for all services that are zero-paid, which are often referred to as “shadow claims.” These shadow claims are then used to monitor the services delivered and to calculate the value of those services (according to the Medicaid fee-for-service fee schedule) that were covered by the payment.

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 the business process 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 and providers to identify unforeseen operational challenges and to develop solutions. These relationships continue throughout implementation as a part of continuous process improvement.

EVALUATION

The final phase in the payment reform process is evaluation. During the evaluation phase the short, medium, and long-term outcomes are reviewed to measure the overall performance. A primary goal of payment reform is to use flexible, value-based payment as an incentive for providers to provide services, which are often not "billable" under a fee-for-service model, but which have a significant impact on a member's health outcomes (such as coordination of care and preventative care outreach). Consequently, the impacts of payment reform are frequently not immediate. Therefore, it is important to approach evaluation cautiously and with a focus on the long-term goals and objectives.

The 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; fidelity to the design; effectiveness at achieving the policy objectives; and health outcomes of the reform. Data analysis will also include monitoring for new problems and/or unintended consequences of the design or implementation. Revisions and corrective action plans are employed as needed.

During the evaluation phase, the 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. The 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 are used as indicators of overall performance.

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

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 other Medicaid-enrolled providers and other Medicaid-covered services. Section 2 of this report provides a description of six active payment reform projects:

- Vermont Medicaid Next Generation (VMNG) ACO Program
- Applied Behavior Analysis (ABA) Payment Reform
- Children's and Adult Mental Health Payment Reform
- Residential Substance Use Disorder (SUD) Treatment Payment Reform
- Developmental Disabilities Payment Reform
- Pediatric Palliative Care Payment Reform

These efforts are discussed in the remainder of Section 2.

VERMONT MEDICAID NEXT GENERATION (VMNG) ACO PROGRAM

The Vermont Medicaid Next Generation (VMNG) ACO Pilot program represents the initial phase of 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 Pilot 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 the DVHA to partner with a risk-bearing ACO. Together, DVHA and OneCare are piloting a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health, and lower costs. 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 future.

The 2017 program results indicate sufficient, incremental progress that warrants cautious optimism and a continued commitment to the program.

RESULT 1: DVHA AND ONE CARE LAUNCHED THE PROGRAM SUCCESSFULLY.

- In 2016, DVHA issued a Request for Proposals (RFP) for a new ACO program based on Medicare's "Next Generation" ACO Program. OneCare Vermont was selected as the Apparently Successful Bidder.
- DVHA conducted a readiness review prior to the launch of the 2017 program year. OneCare Vermont satisfied the majority of requirements before January 1, 2017 and completed all outstanding Readiness Review items prior to the end of the first quarter of 2017.
- DVHA worked with DXC Technologies to change Medicaid payment systems to make fixed prospective payments to OneCare Vermont.
- Processes for ongoing data exchange between DVHA and OneCare have been implemented and are regularly evaluated for potential improvements.
- DVHA and OneCare prepare and maintain an operational timeline to ensure contractually required data sharing and reporting occurs in a timely manner.
- OneCare and DVHA have established a forum for convening operational teams on a weekly basis, and for convening subject matter experts monthly. These forums have allowed the teams to identify, discuss, and resolve multiple operational challenges, and have resulted in several process improvements to date.
- DVHA and OneCare have worked together to monitor and report on program performance on a quarterly basis.

RESULT 2: THE PROGRAM IS GROWING.

Additional providers and communities have joined the ACO network to participate in the VMNG program for the 2018 performance year, and more are expected to do so for the 2019 performance year.

	2017 Performance Year	*2018 Performance Year*	*2019 Performance Year*
Hospital Service Areas	4	10	13
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs
Unique Medicaid Providers	~2,000	~3,400	~4,300
Attributed Medicaid Members	~29,000	~42,000	~79,000

RESULT 3: THE ACO PROGRAM SPENT LESS THAN EXPECTED ON HEALTH CARE IN 2017.

DVHA and the ACO agreed on the price of health care upfront, and the ACO spent approximately $2.4 million less than the expected price. Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members are entitled to save those dollars.

RESULT 4: THE ACO MET MOST OF ITS QUALITY TARGETS.

The ACO's quality score was 85% on 10 pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to diabetes control and engagement with alcohol and drug dependence treatment. Examining quality trends over time will be important in order to understand the impact of changing provider payment on quality of care.

RESULT 5: DVHA IS SEEING MORE USE OF PRIMARY CARE AMONG ACO-ATTRIBUTED MEDICAID MEMBERS.

Based on preliminary analyses of utilization, the cohort of attributed members has had higher utilization of primary care office-visits than the cohort of members who are eligible for attribution but not attributed. As further information about utilization becomes available, DVHA will conduct more robust analyses to determine whether differences between cohorts are statistically significant, and to understand the impact of the program on utilization patterns over time.

The APM Agreement's initial focus is on hospital and physician services. Yet, the APM also calls out the need to include other services necessary to achieve the population health and quality outcomes over the period of the agreement. These services include mental health, substance use disorder, home- and community-based services, and long-term institutional services. Expanding services will involve strategic planning and collaboration. By December 31, 2020, the state must have developed two plans: one involves coordinating financing and delivery of Medicaid mental health and substance use disorder services with the APM Agreement financial and quality targets; the second involves coordinating 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. While these deadlines are still several years away, initial planning and preparation has already begun.

APPLIED BEHAVIOR ANALYSIS (ABA)

"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. 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.

Therefore, Vermont Medicaid will transition from traditional fee-for service reimbursement to a single-factored tiered rate. As a result of this reform, providers will no longer be 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 restrictions placed on codes when delivering ABA services. Going forward, utilization management and clinical integrity will instead be monitored through chart audits, site visits, and the standardization of tools and reporting.

Payments to providers will become more predictable and timely. The payment for each client will be delivered prospectively each month and will not be 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 rate. The DVHA Quality and Clinical Integrity unit will monitor claims data monthly and review with providers (as needed) to ensure that utilization and payments are closely aligned. Once yearly, 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 is expected to go 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 review population indicators and to develop performance measures.

Summary Overview: Applied Behavior Analysis Payment Reform	
Program:	Applied Behavior Analysis
Impacted Providers:	• Designated Agencies • Kingdom Autism and Behavioral Health • Keene Perspectives • BEL Center • Benchmark • Seeds of Change • SD Associates • Independent practicing, licensed clinicians
Anticipated Impacted Beneficiaries:	~160
Estimated funds allocated for new payment model (SFY2020)	~$3,900,000[2]
Type of Payment Reform:	Fee for Service to a monthly case rate
Implementation Date:	July 1, 2019

CHILDREN'S AND ADULT'S MENTAL HEALTH

The Department of Mental Health (DMH) and DVHA are collaborating on a payment reform project that transitioned Vermont Medicaid payments to all Designated Agencies (DA) and 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. Although the scope of services is narrower, the new payment model relies heavily on prior experience through the Integrating Family Services pilot and expands the case rate approach to child and adult populations statewide. Each child and adult case rate is unique to the individual Agency's child and adult population, comprised of their mental health allocation from DMH and their historical DVHA fee for service expenditure. Under the new model, Agencies are paid a fixed amount prospectively at the beginning of each month and are expected to meet established case load targets by delivering at least one qualifying service to an individual in a given month.

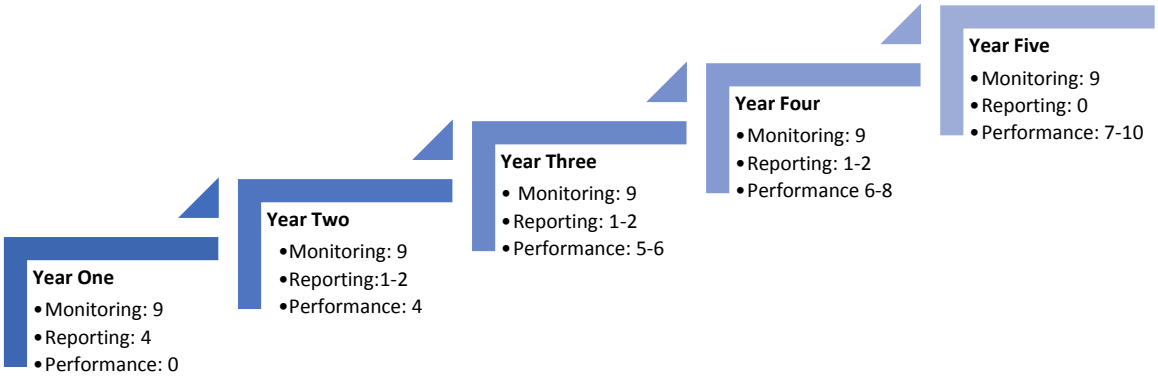
Value-based payments are made through a separate quality payment. During each measurement year, DMH will withhold a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model uses three types of performance metrics to assess the quality and value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

[2] The estimated funds allocated for the new ABA payment model may be affected by multiple transitions taking place for ABA in Calendar Year 2019 including: the adoption of new CPT codes; the transfer of ABA from Northwestern Counseling and Support Services (NCSS) IFS funds to the new ABA payment reform; and uncertainty regarding utilization.

- *Monitoring Measures* are those measures that are used to assess the health and access to care of population 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 a Designated 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 Designated Agency's ability to meet specific targets and/or outcomes.

In the first year, providers will earn their value-based incentive for the reporting of complete, accurate, and timely information. Agencies will also use the first year to gather baseline data. In subsequent years, the incentive will be earned for performance on certain quality measures, and the baseline data will be used to set performance targets. DMH has established a *Mental Health Payment Reform Scoring and Metrics Advisory Committee* to make recommendations to DMH on the development of new measures and the establishment of performance targets. The committee consists of 14 members, with equal representation from the State and provider networks. The value-based payment model is expected to reach maturity in year five (see Figure B; however, the performance measures and targets may continue to evolve over time as program priorities shift and as necessary to support continuous quality improvement.

Figure B. Payment Reform Five-Year Plan



Key goals of the mental health payment reform are 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. Successful implementation 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. As opportunities arise, DVHA and DMH

will continue to improve upon this foundation, to decrease the limitations of the fee-for-service model and move towards increased provider flexibility and accountability.

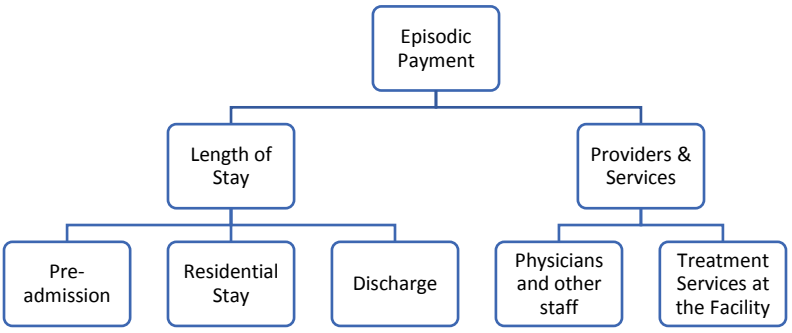
The payment change went into effect for all mental health services delivered on or after January 1, 2019 for Medicaid beneficiaries receiving treatment at all Vermont DAs and one SSA (Pathways). In the next phase of work on the mental health payment model, DMH and DVHA will continue to collaborate with providers and member recipients to develop performance measures, transition to "pay for performance," and to increase transparency and accountability by transitioning information about additional services and client populations into the Medicaid Management Information System (MMIS).

Summary Overview: Children's and Adult's Mental Health Payment Reform	
Program:	Children's and Adult's Mental Health
Impacted Providers:	• Designated Agencies • Pathways
Anticipated Impacted Beneficiaries:	~16,900 (8,300 kids and 8,600 adults)
Estimated funds allocated for new payment model (CY2019)	~$98,000,000 (~$40,000,000 for the child case rates and ~$58,000,000 adult case rates)
Type of Payment Reform:	Fee for Service to a monthly case rate
Implementation Date:	January 1, 2019

RESIDENTIAL SUBSTANCE USE DISORDER (SUD) PROGRAMS

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 treatment providers from a per diem rate to an episodic payment. 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.

Figure C. Residential 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)).

In year two 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 value-based payments through demonstration of improved outcomes in the following areas:

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

The change went into effect for all episodes of care beginning on/after January 1, 2019 for Medicaid beneficiaries at all residential treatment providers in Vermont (Valley Vista: Vergennes, Valley Vista: Bradford, and Serenity House). VDH and DVHA will begin work on the second phase of this payment reform, implementing the value-based component, at the end of January 2019.

Summary Overview: SUD Residential Treatment Payment Reform	
Program:	SUD Residential Treatment
Impacted Providers:	• Valley Vista: Vergennes • Valley Vista: Bradford • Serenity House
Anticipated Impacted Beneficiaries:	~1,500
Estimated funds allocated for new payment model (CY2019)	~$5,729,000
Type of Payment Reform:	Per diem rate to Episodic Payment
Implementation Date:	January 1, 2019

DEVELOPMENTAL DISABILITIES SERVICES

The Department of Disabilities, Aging and Independent Living (DAIL) and DVHA are collaborating on a payment reform project to 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 State has initiated this project to meet several objectives:

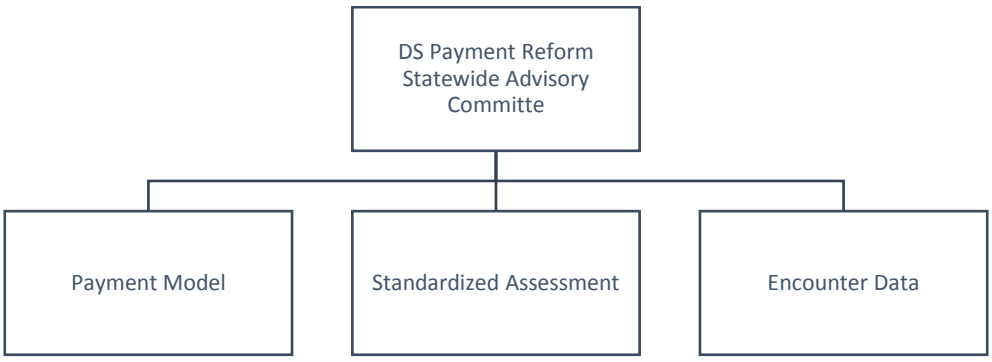
- Comply with the State's APM Agreement with the federal Centers for Medicare & Medicaid Services, which obligates the Agency of Human Services to develop a plan to coordinate payment and delivery of Medicaid Home and Community-based Services with the State's delivery reform efforts for health care;
- Increase the transparency and accountability of DD services, consistent with recommendations in the 2014 State Auditor's Report;
- Improve the validity and reliability of needs assessments;
- Improve equity and consistency in funding of individual services;
- Increase flexibility in addressing individual needs, services and outcomes, within the limits of available funding; and
- Support a sustainable provider network.

Representatives from the State, provider network, consumers, family members, and other stakeholders have begun work on the project scope and planning. In the Fall of 2018, representatives split into three initial workgroups:

- *Standardized Assessment*: focused on the adoption of a uniform, valid, reliable, standardized assessment tool for determining what services individuals need. This included a review of some assessment tool options with a preliminary recommendation. Future considerations include the details of a possible transition to a new tool, considering the broader workflow from application and eligibility through funding and service planning.
- *Payment Model*: focused on designing a payment mechanism by which providers would be paid to provide services. This workgroup is considering payment model options, including implications for providers and people receiving services.
- *Encounter Data*: focused on developing a process by which providers would report all covered services that are delivered to individuals to the Medicaid Management Information System.

All three workgroups report up to the *DS Payment Reform Statewide Advisory Committee* on a monthly basis.

Figure D. DS Payment Reform Workgroup structure



The State has also engaged Burns & Associates, as the consulting firm, to conduct a provider rate study to evaluate the actual cost to providers of delivering services which will inform the new payment model and assist in the development of provider reimbursement rates.

The payment reform has a preliminary target date of January 1, 2020.

Summary Overview: Developmental Disabilities Services Payment Reform	
Program:	Developmental Disabilities Services
Impacted Providers:	• Designated Agencies • Specialized Services Agencies • Supportive Intermediary Service Organization
Anticipated Impacted Beneficiaries:	~3,200
Estimated funds allocated for new payment model (CY2020)	~$212,000,000
Type of Payment Reform:	TBD
Implementation Date:	Targeted for January 1, 2020

PEDIATRIC PALLIATIVE CARE

In partnership with VDH, Vermont Medicaid is contemplating transition from traditional fee for service reimbursement to a new form of reimbursement. The model is currently in the design phase. A target implementation date for a new payment model will be identified pending additional input from leadership, providers, and stakeholders.

Summary Overview: Pediatric Palliative Care Payment Reform	
Program:	Pediatric Palliative Care
Impacted Providers:	• Addison County Home Health & Hospice • Caledonia Home Health Care & Hospice • Central Vermont Home Health & Hospice • Franklin County Home Health Agency • Lamoille Home Health & Hospice • Orleans, Essex VNA & Hospice • University of Vermont Health Network Home Health Hospice • VNA & Hospice of the Southwest Region • Visiting Nurse and Hospice for Vermont & New Hampshire
Anticipated Impacted Beneficiaries:	~50
Estimated funds allocated for new payment model (TBD)	~$91,000
Type of Payment Reform:	TBD
Implementation Date:	TBD