Report to
The Vermont Legislature

Medicaid Delivery System Reform Report

In Accordance with Act 113 of 2016 and Act 52 of 2019

Submitted to: The Senate Committee on Health and Welfare
The House Committee on Health Care
The House Committee on Human Services

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VERMONT
AGENCY OF HUMAN SERVICES

CONTENTS

STATUTORY CHARGE

Section 12 of Act 113 of 2016 requires the Secretary of the Agency of Human Services (AHS) 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 fifth report 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.

The annual reports 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
- Second Annual Report filed 1/15/2018: https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Reform.Medicaid-Pathways-Report-1.15.18.pdf
- Third Annual Report filed 1/15/2019: https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Report-2019.pdf
- Fourth Annual Report filed 1/15/2020: https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Reform-Report-2020-Finalv2.pdf

EXECUTIVE SUMMARY

Any analysis of 2020 results of Vermont's Medicaid payment and delivery system reform would be incomplete if it did not consider the impacts of the COVID-19 public health emergency. The impacts varied by program. A number of programs with fully implemented payment reforms offered significant revenue stability for providers during a time when demand for services was plummeting. That revenue stability was augmented by health care provider stabilization grants that AHS was able to offer providers using Coronavirus Relief Funds. However, some programs that were in payment reform design or early implementation phases were delayed because of the public health emergency. Overall, AHS and DVHA continued to make steady progress on payment and delivery system reform in 2020. That progress could not have occurred without the commitment and collaborative efforts of health care providers, people who receive services, advocates, regulators, and policymakers. The goal remains the same: to create an integrated system of care that spans the entire care continuum. Vermont's focus is on the expansion of existing value-based payment models and the creation of additional 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 a network of hospitals and providers organize as part of 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, higher quality health care, and more sustainable costs. Vermont is the first state to attempt this type of comprehensive reform on a statewide basis, which is complex and ambitious. Naturally, large-scale reform efforts can be challenging and may require corrections during implementation. On November 19, 2020, AHS released the "Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement." The report outlines primary findings, issues, and recommendations intended to support the State of Vermont in achieving success on the scale targets, financial targets, and quality of care and health outcomes targets in the APM. It can be found here.

The APM continued to make progress in 2019 and 2020 by:

- Adding additional payers to join Medicaid in the APM (Vermont Medicaid was the first payer to implement a program that met the requirements of the APM, starting in 2017);
- Increasing the number of people and providers in the APM across all participating payers;
- Completing the third year of implementation for the Medicaid program (2019), including financial reconciliation and quality measurement;
- Completing the second implementation year for the Medicare and BlueCross BlueShield of Vermont programs (2019); and
- 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.

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

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 this report summarizes COVID-19 provider stabilization programs implemented to date by AHS, along with other flexibilities that were introduced to ensure continued access to services for Vermonters. Further information is available in Section 4, which includes a summary for each project of how reform efforts in the design and implementation phases were impacted by COVID-19, including how existing reforms supported Vermont providers and preserved health care capacity for the people they serve during the public health emergency.

Section 2 summarizes a renewed focus by the federal Centers for Medicare and Medicaid Services (CMS) on value-based care, describes the framework that CMS uses to assess progress toward targets for value-based care, and shows the extent to which Vermont's Medicaid payment and delivery system reform results exceed the national average.

Section 3 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 4 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 fully implemented or were in progress in 2020:

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

SECTION 1: AHS RESPONSES TO COVID-19 PUBLIC HEALTH EMERGENCY

AHS and its departments have been engaged since mid-March in developing and implementing provider financial relief and health care system stabilization payments to ensure that Vermont's provider network remained open throughout the COVID-19 public health emergency (including the period of system shutdown) and available to meet Vermonters' health care and human service needs. In the March and April timeframe, a variety of provider financial relief opportunities were implemented, including:

1. April Retainer Payments for Medicaid Providers
2. Sustained Monthly Payments to Medicaid Providers (for May, June, and July)
3. Payments to Hospitals in financial distress
4. Designated Agency (DA)/Specialized Services Agency (SSA) financial relief
5. Financial relief for Children's Integrated Services (CIS) and Private Non-Medical Institutions (PNMI)
6. Expedited Extraordinary Financial Relief for Nursing Homes

In accordance with Act 136 of 2020, AHS launched the Health Care Provider Stabilization ("HCS") Grant Program on July 17, 2020. A broad spectrum of health and human service provider types, spanning self-employed practitioners to peer services providers to hospitals were eligible for the grant program. The process was intentionally designed to award funding only after all grant applications for an application cycle had been received. This ensured that awards were made in accordance with the total need demonstrated by eligible applicants, subject to available funding, rather than on a first-come, first-served basis. AHS administered two application cycles: one beginning in July (for the time period March 1, 2020 – June 15, 2020), and one beginning in October (for the time period March 1, 2020 – September 15, 2020).

The Health Care Provider Stabilization Grant Program was authorized to utilize funds from the federal Coronavirus Relief Fund to provide direct cash grants to eligible health care and human service providers who experienced lost revenue and/or observed increased expenses due to the COVID-19 public health emergency. The program was administered in accordance with the requirements of Act 136 of 2020, as well as with the Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act that governs the permissible use of Coronavirus Relief Funds.

These various AHS-administered provider stabilization programs resulted in substantial amounts of funding being distributed to health care and human services providers in Vermont's delivery system. These funds, in combination with additional funds issued by the federal government and other non-governmental sources, enabled provider organizations to keep doors open and continue serving Vermonters even when facing significant business disruption as a result of COVID-19 during the 2020 calendar year.

Beyond implementing these provider stabilization programs, AHS departments also worked to implement a variety of other flexibilities for patients and providers to ensure Vermonters' continued access to services throughout the public health emergency. These efforts included (but were not limited to):

- Telehealth, telemedicine, and telephonic coverage for certain services

- Waiver of prior authorization requirements
- Temporary waivers of some premiums and co-payments for Medicaid members
- Cessation of coverage redeterminations for Medicaid members during the public health emergency

Additional information on these initiatives can be found at: https://dvha.vermont.gov/covid-19.

SECTION 2: FEDERAL FOCUS ON VALUE-BASED CARE

On September 15, 2020 the federal Centers for Medicare and Medicaid Services (CMS) released a 33-page policy document to State Medicaid Directors entitled "Value-Based Care Opportunities in Medicaid."

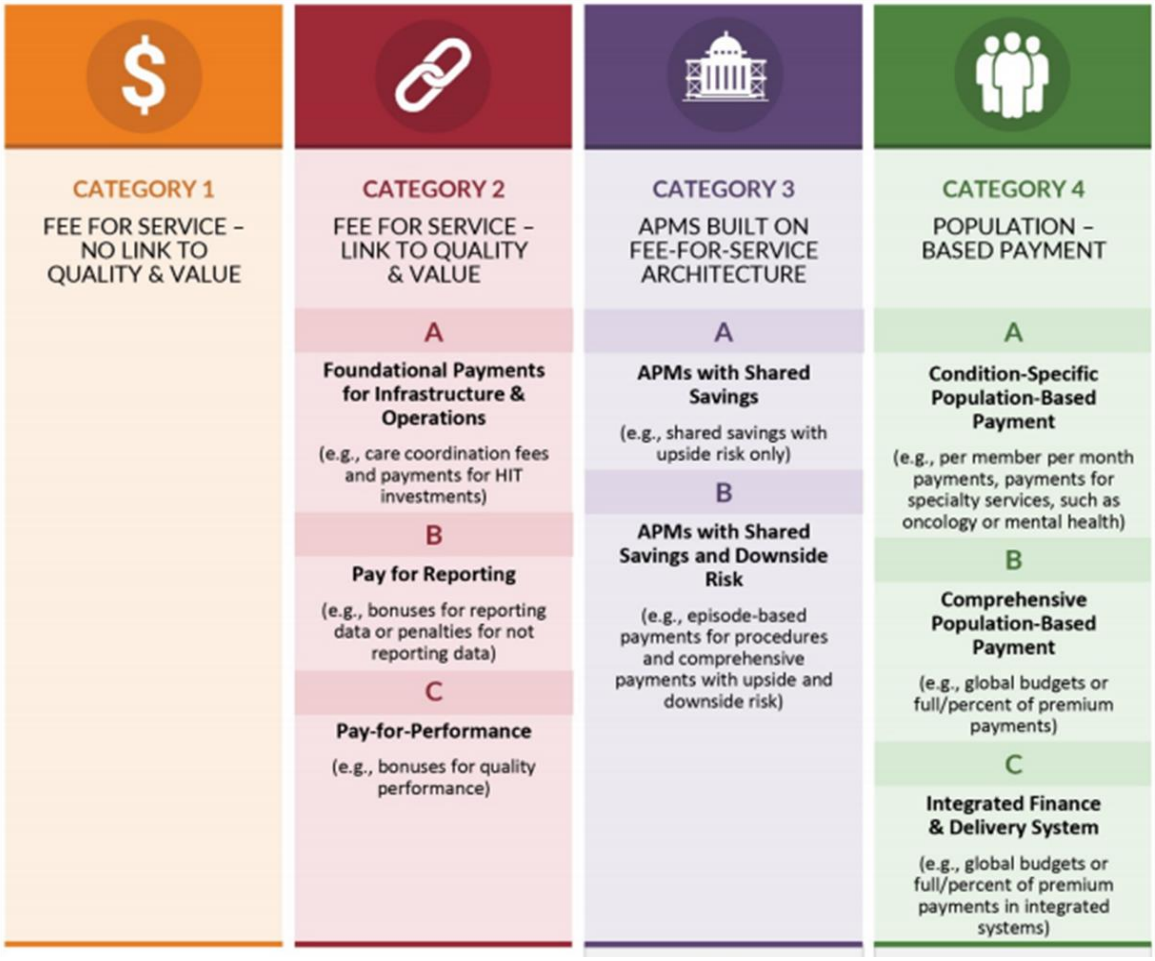
Key concepts from the document include the following:

1. There is continued very strong support and encouragement at the federal level for state Medicaid programs to engage in value-based care and value-based payment.
2. Vermont's APM is specifically called out as one of the most advanced models in the nation. The relationship between value-based care and value-based payment is clearly outlined. The opening paragraph of the document states: "The purpose of this letter is to provide information on how states can advance value-based care (VBC) across their healthcare systems, with a particular emphasis on Medicaid populations, and to share pathways for adoption of such approaches with interested states. VBC seeks to hold providers accountable for providing high quality care, and can also be a part of the solution to reduce health disparities in the healthcare system, to maximize benefits to patients, and to eliminate unnecessary procedures. Under VBC arrangements, providers are rewarded – based on specific evidence of performance on quality measures – for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives, as part of a larger healthcare system effort. The Centers for Medicare & Medicaid Services (CMS) believes that value-based payment (VBP) is a key driver of VBC. Value is more likely to improve across the larger healthcare system when provider incentives are aligned across payers."
3. Among other things, CMS is seeking provider assumption of downside risk, multi-payer participation, and a focus on sustainability.
4. As a result of Vermont's extensive portfolio of Medicaid payment reform initiatives (see Section 4, below), the state has deep experience with the VBP operational criteria that CMS outlines in the document, including:
    - Data, payment, and claims tracking;
    - Mechanics of advanced payment methodologies;
    - Attribution of Medicaid members to advanced payment models;
    - Financial reconciliation processes; and
    - Quality measures, reporting processes, and incentives resulting in better care and value.

Several years ago, CMS established the Health Care Payment Learning and Action Network (HCP-LAN) to help establish and measure states' progress in implementing Advanced Alternative Payment Models. The framework in Figure A below describes different types of Alternative Payment Models, from least to most advanced.

Key Takeaways: In 2018, the most recent year of data, the national average of the percentage of Medicaid payments in the most advanced models (Categories 3 and 4) was 23.3%. **Vermont Medicaid's result of 52.7% was more than twice the national average, and all of Vermont's payments were in the most advanced Category 4, compared to 5.9% nationally.** This strong result is primarily due to the Vermont Medicaid Next Generation ACO program, the Medicaid component of Vermont's APM (see Section 4, below).

FIGURE A: Health Care Payment Learning and Action Network Advanced Alternative Payment Model Framework

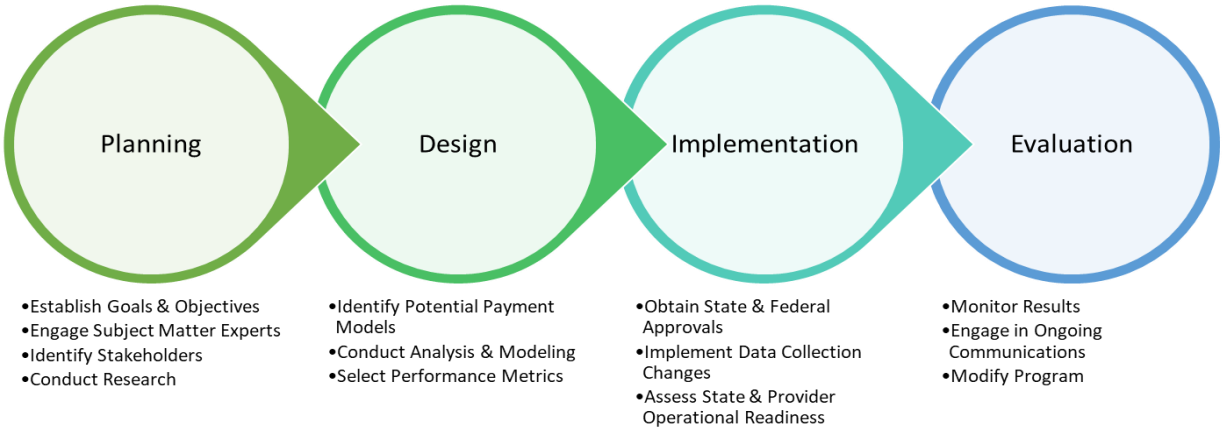


SECTION 3: PAYMENT REFORM PROCESS

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. 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 B.

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

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

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 Table 1 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.

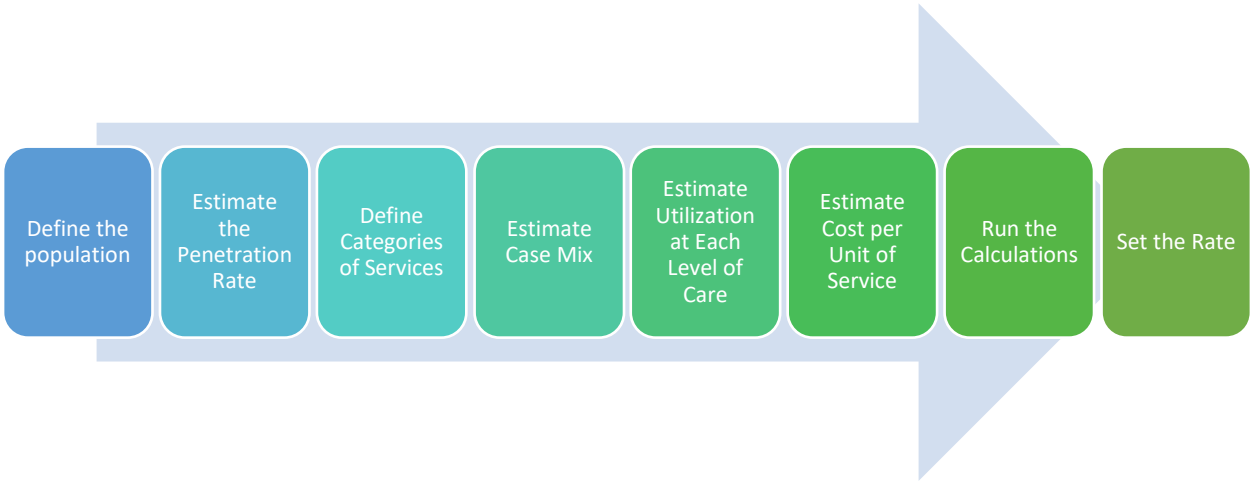
Table 1: Payment Model Options

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 C demonstrates the series of steps typical for most rate development processes.

FIGURE C: 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. Project teams also rely on the results-based accountability framework 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 work groups) 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 Gainwell Technologies, the Medicaid claims processing contractor, 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 Gainwell Technologies 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 Gainwell 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 amounts 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 4: MEDICAID PAYMENT AND DELIVERY SYSTEM REFORM

Multiple AHS departments are using the process described in Section 3 to develop and implement payment reform projects that impact various Medicaid-enrolled providers and Medicaid-covered services. This section describes seven active payment reform projects:

- Vermont Medicaid Next Generation ACO Program
- Children's 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
- High-Technology Nursing Services Payment Reform

VERMONT MEDICAID NEXT GENERATION ACO PROGRAM

Program Background:
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 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 goal of the ACO model 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 ACO 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.

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

Impact of COVID-19 Public Health Emergency:
As the health care system curtailed elective visits and procedures to reduce the risk of virus transmission in the spring of 2020, revenue for these procedures fell away. However, Vermont providers in alternative revenue models who received prospective payments for some portion of their business were better positioned to weather the loss of fee-for-service revenues. This was particularly true for hospitals and other practices receiving broader, prospective, population-based payments from OneCare Vermont. The pandemic has demonstrated that prospective payments can create stability for the health care system and preserve access to care in light of changes in health care utilization. Also, as a result of the COVID-19 public health emergency, DVHA worked with OneCare to adjust certain financial methodology and quality measurement components of the VMNG ACO program to hold providers harmless for COVID-19-related impacts to costs, quality, and utilization during the 2020 performance year.

These adjustments align with COVID-19-related changes to the 2020 performance year of the Medicare Next Generation ACO program as announced by the Centers for Medicare and Medicaid Innovation (CMMI)[4] and included a reduction in provider financial risk for months in which the public health emergency was in effect, adjusting performance measures to be for reporting only and removal of COVID-19 episodes of care from the calculation of ACO financial performance because these costs were not contemplated when originally establishing payment rates for 2020. Performance measures were adjusted to reporting only in recognition that many preventive services were delayed or foregone during the period of system shutdown.

Progress to Date:
The 2019 program results indicate continued progress that warrants cautious optimism and a continued commitment to the program.

Result 1: The program is growing.
Additional providers and communities joined the ACO network to participate in the VMNG ACO program for the 2019, 2020, and 2021 performance years, as shown in the following table. Beginning in 2020, an "Expanded Attribution" model was implemented and will be continued in the 2021 VMNG contract between DVHA and the ACO. This model allows 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.

[4] https://www.cms.gov/files/document/covid-innovation-model-flexibilities.pdf

	2017 Performance Year	*2018 Performance Year*	*2019 Performance Year*	*2020 Performance Year*	*2021 Performance Year*
Health Service Areas	4	10	13	14	14
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs				
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000	~4,800
Attributed Medicaid Members	~29,000	~42,000	~79,000	~114,000 (~86,000 traditional attribution and ~28,000 expanded attribution)	~111,000 (~84,000 traditional attribution and ~27,000 expanded attribution)

Result 2: The ACO program spent more than expected on health care in 2019.
DVHA and the ACO agreed on the price of health care up front, and spending for ACO-attributed members was approximately $13.5 million more than the expected price. Because financial performance exceeded the agreed-upon price, the ACO is liable for the full amount within the 4% risk corridor. After the application of other necessary adjustments, the ACO will issue payment to DVHA of $6.7 million.

Result 3: The ACO met most of its quality targets.
The ACO's quality score was 95% on 10 pre-selected measures linked to payment. Notably, its performance exceeded the national 90th percentile on measures related to diabetes mellitus hemoglobin A1c poor control and 30-day follow-up after discharge from Emergency Departments for alcohol and other drug dependence treatment. The ACO's performance exceeded the national 75th percentile on measures relating to developmental screening in the first three years of life and engagement of alcohol and other drug dependence treatment. Also, the ACO demonstrated significant improvement over prior year performance for measures relating to adolescent well care visits, diabetes mellitus hemoglobin A1c poor control, developmental screening in the first three years of life, 30-day follow-up after discharge from Emergency Departments for mental health and for alcohol and other drug dependence, and screening for clinical depression and follow-up plan. Examining quality trends over time is important in understanding the impact of changing provider payment on quality of care.

Result 4: The ACO is supporting integration of care and services.
As noted earlier in this section, an important goal of the VMNG ACO 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 2020, the ACO promoted integrated, team-based care by continuing to offer 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.

Result 5: The program is on track.

- DVHA and the ACO successfully implemented a third year of the VMNG ACO 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 regular 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.
- The DVHA Payment Reform Unit continued to work extensively throughout 2020 with the DVHA Business Office and Gainwell 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.

On November 19, 2020, AHS released the "Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement." The report outlines primary findings, issues, and recommendations intended to support the State in achieving success on the scale targets, financial targets, and quality of care and health outcomes targets in the APM. It contains 22 recommendations in four areas: Federal/State Partnership, AHS Prioritization and Reorganization, Regulation, and Strengthening ACO Leadership Strategy. The report can be found here.

CHILDREN'S AND ADULT'S MENTAL HEALTH

Program Background:
The Department of Mental Health (DMH) and DVHA have collaborated during the past three years on a payment reform project that has changed the Medicaid payment model for the state's Designated Agencies (DAs) and Pathways Vermont (a Specialized Services Agency or SSA) for a wide array of mental health services. In January 2019, after extensive planning and design work, the payment model for children's and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service) to a monthly case rate.

Performance year 2020 saw a continuation of the case rate model under which agency-specific case rates are calculated for each agency's unique child and adult populations, based on the agency's mental health allocation from DMH and its 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 during the month, as monitored through encounter data submissions.

Value-based payments for this program are made through a separate quality payment. During each measurement year, DMH withholds 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* to assess health and access to care of populations and/or catchment areas. Monitoring measures do not impact the distribution of value-based payments.
- *Reporting Measures* 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* to 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.

The key goals of mental health payment reform, including increasing provider flexibility to meet the needs of Vermonters and increasing predictability and stability of payment, remain unchanged. As DMH and DVHA close out 2020 and move into the third year of the case rate model, the experience of both AHS and providers in operating the model continues to grow and program operations continue to be routinized. Initial implementation of the case rate model represented a significant shift in operational protocols for DMH. Impacts to core business functions (ranging from the merging of multiple discrete program and policy manuals into a single unified mental health provider manual, to the marrying of paid and encounter claims in a single claims processing system, to shifts in historical accounting and reconciliation practices) affected staff across nearly every unit within DMH. While these changes require hard work and dedication from all involved, they also represent opportunities for strategic improvements to long term program and payment operations.

Impact of COVID-19 Public Health Emergency:
COVID-19 had an impact on the case rate model in 2020, and the impact is likely to continue into 2021. Some activities were delayed (such as financial reconciliation and implementation of payments for performance), and operational questions remain, including how to understand and address the impact of the pandemic on shifts in service utilization and quality performance. Nonetheless, the pandemic provided an unexpected proof of concept for the prospective payment model. As providers across Vermont, including DAs and SSAs, were seeing steep declines in their fee-for-service reimbursements, the case rate model offered a consistent and reliable revenue stream to carry providers through some of the most uncertain times. Additionally, DVHA and DMH took advantage of CMS flexibilities related to service modality across the system to meet the changing needs of Vermonters. The two departments worked together to identify and ensure coverage of services appropriate to be delivered by telehealth in order to enable some service delivery to continue during the period of system shutdown. DAs and SSAs also worked with AHS departments on several provider stabilization funding opportunities throughout 2020 to ensure organizations continued to be available to serve Vermonters throughout the public health emergency despite new COVID-related costs and revenue losses.

Progress to Date:
Despite the impacts of COVID-19, 2020 program results indicate a continued commitment on behalf of both AHS and providers to continue to successfully operate and improve upon the case rate model. Progress was informed by lessons learned from an additional year of program operations, and 2020 results include the following:

Result 1: The prospective payment model supported mental health services through the first year of the COVID-19 public health emergency.
At a time when Vermonters needed them most, funding for mental health services under the case rate model was maintained at rates established prior to the public health emergency, despite drops in utilization that subsequently occurred.

Result 2: Providers successfully submitted service delivery information; as a result, core Medicaid operations are better equipped to support human services programming.

Providers successfully shifted from submitting service delivery information to a stand-alone state-operated database (the Monthly Service Report or MSR) to submitting the information to the Medicaid Management Information System (MMIS). This was not without challenge; in a year when many DAs rolled out new Electronic Medical Records, claims processing issues arose. Nonetheless, the dedication of both AHS and providers to successful operation of the case rate model led to stronger relationships between DMH, the providers, and the state's MMIS vendor and resulted in an MMIS that is better equipped to meet the needs of human services programs across AHS. Migration of service delivery information (known as "encounter data") from the MSR to the MMIS has provided an opportunity for AHS and its claims processing vendor (Gainwell Technologies) to better understand and support human services, including home and community-based services.

Result 3: The foundation for future payment model improvements has been established.

While the short-term goals of payment reform include increasing predictability and stability of provider payments and increasing provider flexibility to meet the needs of Vermonters, a longer-term AHS goal is to move to a model that includes standardized and equitable reimbursement rates for the same services delivered by DAs and SSAs statewide. To do this, baseline encounter data needs to be available to compare service delivery with current case rate payments. The work of the first two years of payment reform to capture and normalize the flow of encounter data represents a significant first step towards this longer-term goal.

Result 4: Payment reform changes resulted in delivery system improvements.

To prepare for upcoming value-based payment measures on access to care, some agencies redesigned their intake processes and provider schedules to allow for same day walk-in or next day appointments. All agencies reported on access to care using the same metrics for the first time in calendar year 2020, allowing DMH to work toward a reliable baseline for this important quality measure that will inform value-based targets in years to come. Agencies continued to work with DMH to improve documentation efficiencies, such as embedding the Child and Adolescents Needs and Strengths (CANS) assessment tool into the intake assessment, and prepared for the implementation of the adult assessment tool, the Adults Needs and Strengths Assessment (ANSA),, to begin July 1, 2021. 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 5: DMH, DVHA and providers continued on the path to value-based payment.

As noted above, a key component of the program is a framework for value-based payment based on selected reporting and performance measures. In 2019 and 2020, agencies earned the value-based incentive if they were able to report complete, accurate, and timely information for the selected performance measures. During 2020, 100% of the agencies have reported their data thus far, with around 70% of those agencies meeting the guidelines for submitting in a complete, accurate, and timely fashion. In addition to earning the value-based payment for reporting in 2020, 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 other activities in 2020 related to value-based payment, agencies began training their providers on the ANSA, a standardized assessment tool for the adult system of care. 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. The CANS tool, which has been in use to some extent since 2015, was adopted across all providers in 2020.

Result 6: DVHA, DMH and impacted providers remained committed to continuous improvement and evolution of mental health payment reform.

Throughout 2020, DMH and DVHA continued to convene a monthly Mental Health Payment Reform Implementation work group, which served as a forum to refine existing program operations and plan for the future. During the public health emergency this work group has offered a valuable venue for

information sharing and dissemination, to more closely examine the impacts of COVID-19 on program operations, and to explore lessons learned and potential program improvements.

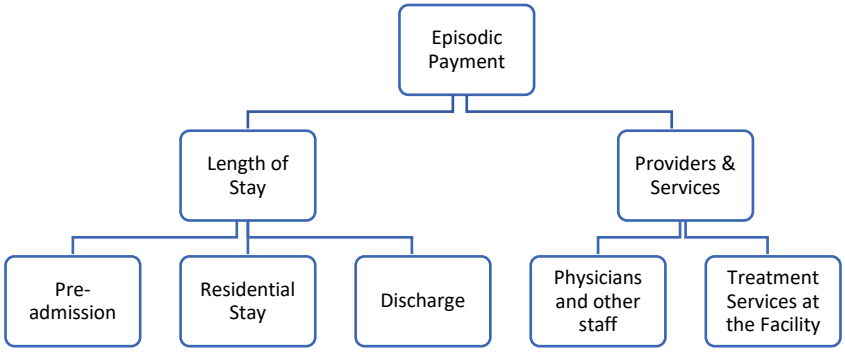
In the next phase of work on the mental health payment model, DMH and DVHA will continue to collaborate with providers and member recipients to evolve aspects of the payment model and rate setting methodologies, with an eye toward further increasing accountability, transparency, and equity in payments.

Summary Overview: Children's and Adult's Mental Health Payment Reform	
Program:	Children's and Adult's Mental Health
Impacted Providers:	• Designated Agencies • Pathways (Specialized Services Agency)
Impacted Beneficiaries:	~13,700 (~6,500 in child program and ~7,200 in adult program)
Funds allocated for new payment model (CY2020)	~$97,100,000 (~$40,300,000 for child case rates and ~$56,800,000 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

Project Background:
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 D, 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.

FIGURE D: 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 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)).

Impact of COVID-19 Public Health Emergency:

Because this payment reform initiative was implemented in January 2019, the public health emergency did not impact the project start date. However, it resulted in a delay in the implementation of the value-based payment component of the project as providers prioritized delivering residential services safely during the pandemic. Providers reduced admissions and maintained lower census during the pandemic along with incurring additional costs. These factors have contributed to challenges with gathering comparable data in order to effectively adjust rates and set outcome measures.

Progress to Date:

Residential SUD payment reform program implementation continued as expected in 2020, with monitoring of results on key program indicators underway. An analysis of data since the start of the program indicates that length of stay is declining. Since the baseline year of 2018, the residential treatment program has seen a 23.8% reduction in the average length of stay (see Table 3 below for provider-level and statewide results). DVHA and VDH believe that this result can be at least partially attributed to the introduction of the new payment model; reduction in administrative burden (e.g., removal of the requirement for concurrent review) allowing more time for direct care by clinical staff; improved discharge planning at the facilities; and better access to outpatient services, including medication assisted treatment. The rate of 30-day readmissions increased slightly from calendar year 2019 (5.6%) to 2020 (6.7% for discharges through October). The goal is for length of stay to continue at clinically appropriate levels while readmission rates remain steady or decline. Length of stay and readmission results should be interpreted with caution, particularly for 2020. It is quite possible that COVID-19 changed the way that people decided to access services, in terms of timing, type of service, or whether they chose to access services or not.

Table 3: Average Length of Stay by Calendar Year (CY) and Provider

	CY2018	CY2019	CY2020 (as of December 21st)
Provider	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*
Recovery House	14.51	12.39	12.49
Valley Vista: Vergennes	19.56	16.01	14.07
Valley Vista: Bradford	18.12	16.03	14.70
Statewide	17.97	15.03	13.69

In 2020, VDH and DVHA paused efforts to refine and implement a value-based payment component due to the COVID-19 public health emergency, as noted above. In future years, the intent is to create an opportunity for residential treatment providers to earn value-based payments by demonstrating improved outcomes in certain areas. Measures under consideration include:

- 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.

Summary Overview: SUD Residential Treatment Payment Reform	
Program:	SUD Residential Treatment
Impacted Providers:	• Valley Vista: Vergennes • Valley Vista: Bradford • Serenity House
Impacted Beneficiaries (CY2020)	~1050
Funds allocated for new payment model (CY2020)	~$4,060,000
Type of Payment Reform:	Per diem rate to episodic payment
Implementation Date:	January 1, 2019

APPLIED BEHAVIOR ANALYSIS

Project Background:

"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 childhood developmental disabilities. The practice 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.

Vermont Medicaid transitioned from traditional fee-for service reimbursement to tiered rates (with 14 tiers) on July 1, 2019 for members with Vermont Medicaid as primary insurance. Providers are no longer required to complete prior authorization requests, nor must they wait for approvals of changes to treatment plans. The tiered rates allow 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 submission of Medicaid claims data. Each of the tiers has a "monthly floor," a minimum number of hours required to validate the monthly payment rate. DVHA's Quality and Clinical Integrity Unit reviews monitoring results with providers as needed to ensure that utilization and payments are closely aligned. The program includes an annual financial reconciliation after allowing the providers adequate time to submit encounter data.

Impact of COVID-19 Public Health Emergency:

The payment reform initiative was implemented in July 2019, so COVID-19 did not impact the project's timing. However, it did impact service delivery. Most ABA services are provided in-person, so providers had to adjust tiers when services were reduced as a result of the pandemic. The program's structure allowed for rapid adjustments to the tiers, and DVHA worked to identify services appropriate for delivery via telemedicine or audio-only. As noted in Section 1 of this report, AHS also developed health

care provider stabilization programs to further support providers that applied and qualified for the programs.

Progress to Date:

For this program, efforts in 2020 focused on supporting and educating providers regarding the new model and conducting the initial financial reconciliation for services provided from July 1, 2019 through December 31, 2019.

Reconciliation examined the difference between:

- Payments each ABA provider should have received for services delivered from July 1, 2019 through December 31, 2019 (based on hours of services actually provided), and
- The amount each ABA provider was actually paid from July 1, 2019 through December 31, 2019 (including payments for assigned tiers plus any fee-for-service payments).

For each provider, those differences were summed across members served. Providers that were paid more than they should have repaid DVHA. Providers that were paid less than they should have received additional payments from DVHA.

Because this was the first reconciliation for the new ABA payment model, providers were afforded additional time to submit encounter data in the form of claims, ask questions, and review information related to reconciliation. As is the case with any initial implementation, lessons were learned along the way. Those learnings are being used to refine the reconciliation process for January 1, 2020 through December 31, 2020 (that reconciliation will occur during the third quarter of 2021, after allowing adequate time for providers to submit encounter data).

An important goal of this program is to increase access to direct services for Medicaid members by giving providers the flexibility to innovate and to use staff more efficiently. To assess progress toward this and other goals, DVHA has established a monitoring framework that includes measures of access, utilization, service intensity, quality, and cost. Early data for some of these measures shows promising results. For example, since the implementation of the payment reform program, it appears that a higher proportion of services are in the form of direct services to members rather than assessments.

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 monitoring results, and identify performance measures (likely drawing from the existing monitoring framework) to use for value-based payment.

Summary Overview: Applied Behavior Analysis Payment Reform	
Program:	Applied Behavior Analysis
Impacted Providers:	• Applied Behavioral Analysis • Autism Advocacy & Intervention • Autism Bridges • BEL Center • Benchmark Behavioral Solutions • Clara Martin Center • Counseling Services of Addison County • Green Mountain Behavioral Counseling • Howard Center • Keene Perspectives • Kingdom Autism and Behavioral Health • Lamoille County Mental health • Northwest Counseling and Support Services • Rutland Mental Health Services • SD Associates • Independent practicing, licensed clinicians
Impacted Beneficiaries (CY2020):	~235
Funds allocated for new payment model (CY2020):	~$3,800,000
Type of Payment Reform:	Fee-for-service to a monthly case rate
Implementation Date:	July 1, 2019 for members with Vermont Medicaid as primary insurance

DEVELOPMENTAL DISABILITIES SERVICES

Project Overview:

The Department of Disabilities, Aging and Independent Living (DAIL) and DVHA have been 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) payment model 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.

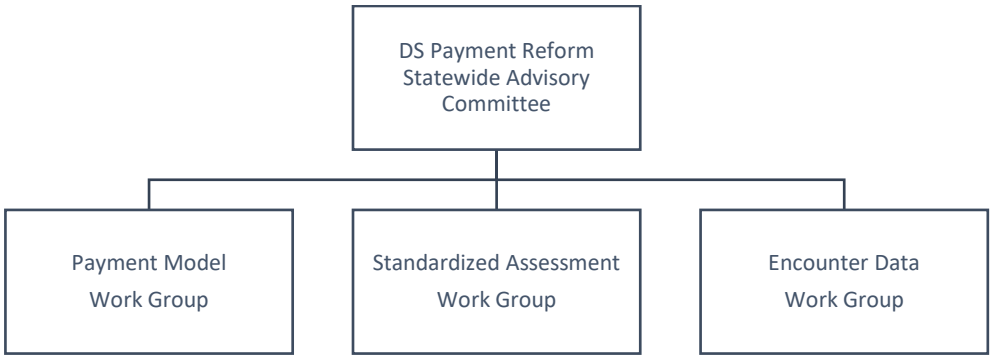
This project has several objectives:

- Align with and inform a potential 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 State Auditor's Report to improve the State's oversight of Designated Agencies;
- Improve the validity and reliability of needs assessments through use of a standardized assessment tool;
- Ensure submission of encounter data to the Medicaid Management Information System (MMIS) 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 within a structure that consists of three work groups and an advisory committee, as shown in Figure E.

FIGURE E: DS Payment Reform Work Group Structure



Impact of COVID-19 Public Health Emergency:

The COVID-19 public health emergency has had a significant impact on this project. The COVID-19 response effort was DAIL's most critical priority during most of 2020, and that prioritization will persist into 2021. Work on the project was paused for about six months. Nonetheless, progress has been made on the standardized assessment and encounter data workstreams during 2020, as noted below.

Progress to Date:

- *Standardized Assessment Work group*: This work group is focused on the selection of a uniform, valid, and reliable standardized assessment tool for determining what services and supports an individual needs. Notable areas of progress in 2020 include:
    - The selection of a standardized assessment instrument: The Supports Intensity Scale®(SIS-A). Prior to the public health emergency, the work group reviewed assessment tool options and recommended several supplemental areas for questions to add to the assessment.
    - Significant progress in the selection of a vendor to administer the SIS-A. DAIL issued an initial Request for Proposals (RFP) in late 2019. Procurement was postponed due to the COVID-19 public health emergency. The RFP was re-issued in fall 2020; bids were received and evaluated by a multi-departmental review team. An apparently successful bidder has been chosen by a review team and the contract is currently in development. The anticipated start date for conducting standardized assessments is July 1, 2021.

- *Encounter Data Work group*: This work group has developed a process by which providers will report all service delivery encounters to the MMIS. The group has designed encounter claim submission requirements for the various services, worked with the State's MMIS vendor Gainwell Technologies to implement these requirements, and contributed to the development of detailed encounter data submission guidance and training for providers. Work in 2020 included ongoing provider technical assistance, training and educational supports to support increased encounter data volume and quality, establishing a strong baseline to inform future planning. In addition to supporting the implementation and uptick of the initial encounter data reporting structure, in the second half on 2020 the work group focused on a comprehensive update to the procedure code list used to report DDS encounters, ensuring that all included services are represented in coding and that coding is up to date and compliant with national correct coding standards.

- *Payment Model Work group*: This work group is focused on designing a payment mechanism by which providers would be paid to provide services. This work group has considered several payment model options in detail. The work was paused due to COVID-19, but the plan is to resume the process of refining those options and identifying implications for providers and people receiving services. Key building blocks for the design of the payment model are having six months of comprehensive encounter data and information from 500-700 needs assessments. This information is necessary to inform the payment model design, so this work group will resume its work at a later date. Payment model options will be designed with broad stakeholder involvement and proposals will be presented for broader public feedback.

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 are intended to inform the new payment model and assist in the development of provider reimbursement rates. Initial rate study results were presented for public comment. The objective is to develop uniform rates to be paid for similar services across providers. The rates identified in 2019 will need to be updated when the new payment model is designed and prepared for implementation.

The DS Payment Reform Statewide Advisory Committee reconvened in December 2020 after a pause due to the public health emergency. The Advisory Committee will meet regularly through the remainder of the project to provide input and feedback on the direction and decisions within the project.

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 (SFY2020)	$226,161,551
Type of Payment Reform:	TBD
Implementation Date:	Encounter data collection targeted for first quarter of CY2021; standardized assessment implementation targeted for third quarter of CY2021; payment model implementation targeted for late CY2022 or early CY2023.

CHILDREN'S INTEGRATED SERVICES

Project Background:

The DVHA Payment Reform Unit has collaborated with the Children's Integrated Services (CIS) program of the Department of Children and Families (DCF) on a payment reform project. CIS serves vulnerable children prenatally through five, including those with disabilities or developmental delays. Services include early intervention, home visiting, specialized childcare 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 have been 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. Previously, rates were historically based and varied by region, with contract amounts totaling the $9.2 million statewide appropriation for the program's services that are covered in the contracts.

Impact of COVID-19 Public Health Emergency:

The new payment model was slated to take effect on July 1, 2020, after a formal public comment period and federal Centers for Medicare and Medicaid Services (CMS) approval. In part because of COVID-19, implementation was delayed until October 1, 2020.

CIS services are generally provided in-person. In response to the public health emergency, DVHA and DCF worked closely together to identify services appropriate for telehealth. The Departments also worked together on COVID-19 related provider stabilization efforts to support CIS fiscal agents and subcontractors. While this work was not directly associated with the payment reform project, the working relationships that were developed during payment reform helped to facilitate these efforts.

Progress to Date:

During the second half of 2019 and throughout 2020, DCF worked with the DVHA Payment Reform Unit to complete an analysis of CIS service provision and payment structures and obtain feedback from affected providers, with the goal of gaining an objective and data-informed understanding of service delivery costs. The process, which included conducting a provider survey, analyzing results, and identifying available funding, aimed to ensure equitable and appropriate funding allocation across regions to maximize available resources and support effective service delivery. Providers had an opportunity to review the resulting proposal for a uniform statewide rate and submit feedback. DCF and the DVHA Payment Reform Unit reviewed that feedback before finalizing the proposal for a uniform statewide rate. A significant milestone was achieved when the statewide monthly payment rate was implemented on October 1, 2020.

As in most payment reform projects, another key element of this project is to collect accurate encounter data through claims submissions from providers to inform caseload assumptions, utilization of services, contract monitoring, and ongoing programmatic analysis. DCF and the DVHA Payment Reform Unit have identified provider coding requirements for the various CIS services, worked with Medicaid's claims processing contractor (Gainwell Technologies) to ensure that the MMIS is ready to accept CIS claims, and partnered with DVHA's Provider and Member Services Unit and Gainwell Technologies to prepare data collection guidance and offer training for providers. Training occurred in October of 2020, and providers began submitting claims to the MMIS in November 2020. Ongoing technical support will be offered to providers as needed.

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) • 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)
Funds allocated for new payment model (SFY2021)	~$9,223,000
Type of Payment Reform:	Bundled Rate (updated monthly case rate)
Implementation Date:	Payment model implemented on October 1, 2020.

HIGH-TECHNOLOGY NURSING SERVICES

Project Overview:
The Vermont Department of Health (VDH) and the Department of Disabilities, Aging and Independent Living (DAIL) each manage high-technology nursing (HTN) programs: VDH for children and DAIL for recipients over the age of 21. These programs offer in-home nursing care for individuals with complex medical needs in support of their choice to remain in their homes and communities. Vermont's home health agencies and visiting nurse associations are the HTN providers at the focus of this payment reform project.

HTN services represent critical supports for the individuals and families that need these services. 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 medically necessary HTN services. Adults also rely on the HTN program to remain at home. Nursing shortages and the complexity of the services can make it challenging for home health agencies to provide staffing for all of the authorized hours.

In response to these challenges, VDH and DAIL have engaged with providers, advocates, individuals receiving services, and families to develop a multi-faceted approach to address individuals' needs for and access to HTN services. In March of 2020, the HTN Services payment reform project, a collaborative effort between VDH, DAIL, and DVHA, was initiated as one component of the broader approach.

HTN payment reform efforts are focused on the development of a new payment model as one mechanism to help achieve the overarching goal of ensuring access to authorized services. A new payment model should:

- Support improved access to services;
- Be developed in collaboration with stakeholders;
- Be based on accurate, verifiable, and reliable data; and
- Include relevant monitoring and performance measures

Impact of COVID-19 Public Health Emergency:
The COVID-19 public health emergency has had an impact on the timing of this project. Progress has been steady, although at a slower pace than anticipated. The HTN program leads from both VDH and DAIL are heavily involved in the State's COVID-19 response effort. Nonetheless, they remained fully engaged in the payment reform project until early November, when Vermont experienced a significant surge in COVID-19 cases. Because of their strong commitment to this work, the project has continued to advance.

Progress to Date:

- *Planning:* The HTN Payment Reform project team was created in March 2020 with an immediate focus on identifying and confirming shared goals and defining project objectives.
    - By the end of June, the following steps had been achieved:
        - High level timeline, risks, and success criteria confirmed;

        - Work plan developed and stakeholders identified; and
        - Project charter written and approved.
- *Design:* The design phase has entailed review of potential HTN payment models, development of a proposed model, presentation of the model to stakeholders, and refinement of the model.
    - By the end of September 2020 the following activities had been completed:
        - Proposed payment model developed;
        - Stakeholder communication strategy outlined and initiated with presentation of the proposed model to AHS leadership group; and
        - Payment reform subcommittee created to address more detailed operational questions.
    - Progress in the fourth quarter of 2020 centered on obtaining stakeholder feedback and revising the model based on that feedback through the following steps:
        - Meetings held with advocates representing families and individuals, and with provider representatives;
        - Analysis conducted to assess impact of proposed model; and
        - Model modified in response to stakeholder feedback.

Next steps are to obtain stakeholder feedback on the revised model and, if the decision is made to move forward, to implement the model during 2021.

Summary Overview: High-Technology Nursing Services Payment Reform	
Program:	High-Technology Nursing Services
Impacted Providers:	• Addison County Home Health & Hospice • Bayada Home Health Care • Caledonia Home Health Care & Hospice • Central Vermont Home Health & Hospice • Franklin County Home Health Agency • Lamoille Home Health & Hospice • Orleans, Essex VNA & Hospice • VNA & Hospice of the Southwest Region • Visiting Nurse and Hospice for Vermont & New Hampshire • University of Vermont Health Network Home Health & Hospice
Anticipated Impacted Beneficiaries:	~33 (16 Adults, 17 Children)
Estimated funds allocated for new payment model (SFY2021)	~$2,300,000
Type of Payment Reform:	Hybrid model with fee-for-service and monthly payment components
Implementation Date:	Estimated implementation: third quarter of CY2021.

CONCLUSION: INTEGRATION OF REFORM INITIATIVES, ALIGNING QUALITY MEASURES, INTERRELATIONSHIP OF QUALITY MEASURES AND RESULTS-BASED ACCOUNTABILITY

It is clear that the COVID-19 public health emergency will continue to have significant impacts on AHS priorities and operations, including payment reform activities, well into 2021. Despite the pandemic, and perhaps in part in response to it, there continues to be strong interest in initiating new delivery system and payment reform projects. For example, discussions are underway with DMH and the Agency of Education regarding the Behavioral Intervention Services component of the Success Beyond Six program that provides services to students in Vermont's schools.

With each new project, the Payment Reform Unit continues to gain valuable experience and improve upon the payment reform process described in Section 3, fostering consistent and effective approaches to planning, payment model design, implementation, performance measurement and monitoring, and evaluation.

DVHA's Payment Reform Unit has also made significant progress in standardizing the approach across programs in collecting claims (or encounter) data from providers. This data serves as a critical source of information on services provided to Medicaid beneficiaries, and supports monitoring, evaluation, and accountability.

A theme in all payment reform projects to date is a desire to incorporate key characteristics such as predictability in payments, flexibility for providers, movement away from fee-for-service payment, and accountability for health care quality and cost. These common characteristics support integration of payment reform initiatives with the APM, which shares those characteristics.

As the statutory language suggests, alignment is important in the selection of monitoring, performance, and quality measures; it helps focus resources and provider efforts in areas that have been prioritized for quality improvement. Intentional efforts are made to identify measures that are already being collected and reported by providers, and/or that are being used by other performance frameworks and payment reform initiatives.

The APM agreement's quality framework and results-based accountability are at the forefront whenever engaging in new payment reform initiatives; they serve as guideposts in identifying measures and performance targets. For example, quality measures in the VMNG ACO program are closely aligned with the APM agreement's quality measures and with quality measures in the Medicare and Commercial ACO programs. Other payment reform initiatives have also drawn from existing measures when appropriate and feasible.

In general when developing performance frameworks for payment reform projects, measures are identified across a variety of domains (e.g., Access to Care, Utilization, Service Intensity, Quality, Person Experience, and Financial) and measure types (e.g., structural, process, and outcome measures). Ensuring measurement across domains and types addresses the three questions in the Results-Based Accountability framework:

- How much did we do?
- How well did we do it?
- Is anyone better off?

The VMNG ACO program is the largest and most visible of the payment reform projects currently underway. It represents Medicaid's participation in the integrated health care system envisioned by Vermont's APM agreement with CMS. Operational and implementation refinement in the VMNG ACO program will continue during 2021, the program's fifth year. In addition, state and ACO partners will work diligently to address the findings and recommendations contained in the Implementation Improvement Plan released in November 2020.

A graphic providing a visual overview of AHS' seven current payment reform projects is found in Figure F. The broad cross-section of programs, providers, and state agencies participating in these projects are indicative of an ambitious and conscious strategy to integrate providers into Vermont's delivery system and payment reform efforts. AHS anticipates that steady progress will continue on these seven projects, and that requests for new projects will continue to arise, even during the public health emergency. Public and private partners have experienced benefits from existing payment reform programs, not the least of which has been some level of revenue stability during the pandemic, and the federal government has demonstrated that it is fully engaged in value-based care and the payment models that serve as the engine for such care. That landscape provides significant momentum for Vermont's continuing and groundbreaking efforts in delivery system and payment reform.

FIGURE F: Payment and Delivery System Reform Project Summary (as of December 31, 2020)