Report to the Vermont Legislature

Delivery System Reform Report: 2021

Act 113, Section 12; Act 52, Section 1

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

1-14-2022

CONTENTS

Statutory Charge 3

Executive Summary 4

SECTION 1: background on Vermont's all-payer Model 5

SECTION 2: important themes in payment and delivery system reform 6

SECTION 3: MEDICAID PAYMENT AND DELIVERY SYSTEM REFORM 10

- Vermont Medicaid Next Generation ACO Program 10
- Adult and children's Mental Health payment reform 14
- Residential Substance Use Disorder Treatment payment reform 16
- Applied Behavior Analysis payment reform 18
- Developmental Disabilities Services delivery system and payment reform 21
- High-Technology Nursing Services payment reform 25

SECTION 4: integration of reform initiatives and conclusions 28

APPENDIX - Payment Reform Process 31

- Introduction 31
- Planning 31
- Design 32
- Implementation 33
- Evaluation 34

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 is the sixth 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
- Fifth Annual Report filed 1/06/2021: https://legislature.vermont.gov/assets/Legislative-Reports/Delivery-System-Reform-Report-2021-to-Leadership-2021-01-06-002-v2.pdf

EXECUTIVE SUMMARY

For more than a decade, starting with the Blueprint for Health advanced primary care program and continuing with the first-in-the-nation Vermont All-Payer ACO Model (APM) Agreement with the federal Centers for Medicare and Medicaid Services, Vermont has engaged in ambitious and concerted Medicaid and multi-payer payment reform efforts. The overarching goals are 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"), as well as improving integration of care and services for Vermonters.

Section 1 of this report provides background on Vermont's APM Agreement with CMS, which has served as a catalyst for Medicaid payment reform in the state. Specifically, Vermont's Medicaid payment reform efforts seek to develop advanced alternative payment models for Medicaid services that provide incentives for delivery system reform and support value-based care.

As experience with complex payment and delivery system reform has been gained over the past several years, important themes have emerged, including the following:

- There continues to be strong federal and state interest in payment and delivery system reform.
- Vermont is a national leader in advanced alternative payment models for Medicaid.
- There are often common goals across initiatives.
- Vermont has developed a systematic process for engaging in delivery system and payment reform.
- As experience has increased, key learnings have been used to improve model design and implementation and to standardize approaches when appropriate.

Section 2 of this report summarizes those themes.

Section 3 provides updates on the specific Medicaid payment and delivery system reform programs that are underway and in various stages of development, including the following initiatives or services:

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

Section 4 of the report summarizes 2021 progress on integration of various providers and individual programs into broader payment and delivery system reform, and alignment of approaches to quality measurement and accountability between payment and delivery system reform initiatives.

Because of its complexity, payment and delivery system reform benefits from a systematic process. AHS and DVHA have developed and refined such a process, fostering consistent and effective approaches to payment reform. The Appendix of this report describes that process.

SECTION 1: BACKGROUND ON VERMONT'S ALL-PAYER MODEL

The overarching goals of Vermont's payment and delivery system reform programs are to improve quality of care (including the person's experience of care), improve the health of Vermont's population, and reduce growth in the cost of care (known collectively as the "Triple Aim"[1]). An additional goal is to create an integrated system of care and services for Vermonters that spans the entire care continuum.

To support achievement of those goals, in 2016 the State of Vermont and the Centers for Medicare and Medicaid Services (CMS) entered into the six-year Vermont All-Payer Accountable Care Organization Model (APM) Agreement.[2] The APM is a public-private partnership between CMS, the State of Vermont, and Vermont health care providers that allows providers to be paid in a different way than through fee-for-service payments. A significant percentage of Vermont's hospitals and community providers have chosen to participate. They have organized as an Accountable Care Organization (ACO) to receive more stable and flexible payment, and by working closely together they are taking responsibility for the cost and quality of care and the health of their patients. The APM creates incentives that are intended to change the way care is delivered in pursuit of the Triple Aim and an integrated system of care.

Vermont is the first state to attempt this type of ambitious and comprehensive reform on a statewide basis. Such a large-scale effort is challenging; to maximize opportunities for success it requires adjustments and improvements during implementation. To that end, on November 19, 2020, AHS released the "Implementation Improvement Plan: Vermont All-Payer Accountable Care Organization Model Agreement." The report outlines findings, issues, and recommendations intended to support Vermont in achieving success on the scale targets, financial targets, and quality of care and health outcomes targets that are important elements of the APM. The report can be found here.

The APM continued to make progress in 2020 and 2021 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 fourth year (2020) of implementation for the Medicaid program, including final reporting, financial reconciliation, and quality measurement. The Medicaid program's 2021 implementation is on track.
- Completing the third implementation year for the Medicare and BlueCross BlueShield of Vermont programs (2020), with 2021 implementation underway.
- Continuing to make progress on Medicaid's payment and delivery system reform efforts, which seek to use value-based payments to better align Medicaid services with the APM in order to strengthen the entire care continuum.

The AHS focus in recent years has been on expanding existing value-based payment models and creating additional models that cover a wide variety of Medicaid services and providers. These models are designed to be aligned with the 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] For more information on the Institute of Healthcare Improvement's Triple Aim, see http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.

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

SECTION 2: IMPORTANT THEMES IN PAYMENT AND DELIVERY SYSTEM REFORM

Medicaid payment reform is a complex, multi-step, and iterative process led by DVHA's Payment Reform Unit, AHS staff from various Departments who have relevant expertise in the program that is the subject of the initiative, providers, recipients of services, and other stakeholders. As experience with payment and delivery system reform has been gained over the past several years, important themes have emerged:

Theme 1: There continues to be strong federal and state interest in payment and delivery system reform.

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." This document outlines a vision for value-based care, specifically calls out Vermont's APM as one of the most advanced models in the nation and outlines important design and operational elements needed to realize that vision. Vermont's longstanding efforts in payment and delivery system reform have provided valuable experience in incorporating these elements.

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 (VBC) and value-based payment: "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."
2. There is particular emphasis on Medicaid reform: "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."
3. CMS is also seeking multi-payer participation, provider assumption of downside risk, and a focus on sustainability.
4. As a result of Vermont's extensive portfolio of Medicaid payment reform initiatives (see Section 3, below), the state has deep experience with the 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.

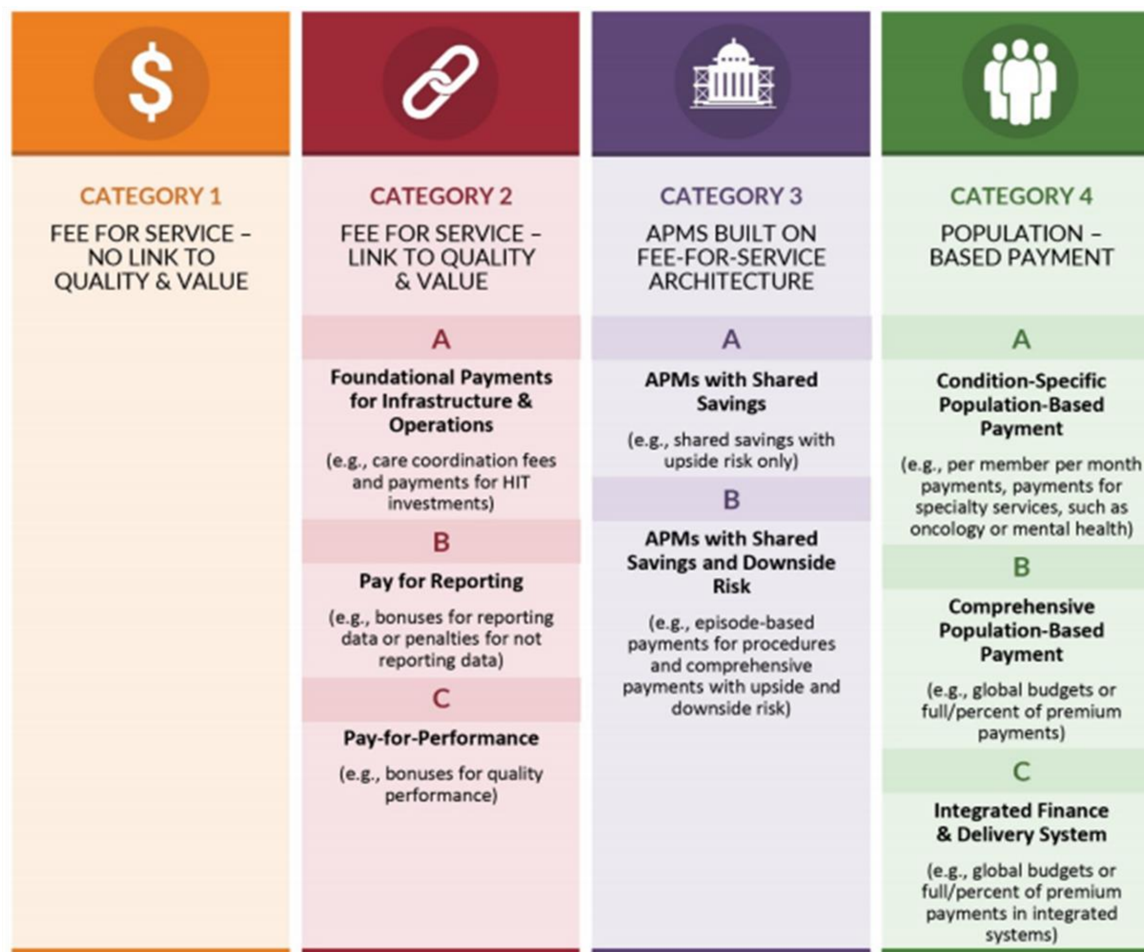
Theme 2: Vermont is a national leader in advanced alternative payment models for Medicaid.

Even in the face of an unprecedented public health emergency, Vermont's state and local leaders, health and community service providers, and recipients of services have continued to work together on existing and new payment and delivery system reform initiatives.

Several years ago, CMS established the Health Care Payment Learning and Action Network (HCP-LAN) to support and measure state 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.

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



To support care for Medicaid members that links payment to value, the federal government has established a target for 2025 that 50% of Medicaid payments will be in the form of advanced alternative payment models with quality components. In calendar year 2020, the most recent year of data, CMS received information from states and payers representing 64% of covered lives in the Medicaid market. That information indicated that the percentage of reported national Medicaid payments in the more advanced models (Categories 3 and 4) was 35.5%. **Vermont Medicaid's result of 61.2% was more than one and one-half times the reported national average and already exceeds the 2025 Medicaid payments target.** All of Vermont's payments were in the most advanced Category 4, compared to 6.4% for reported national Medicaid payments.[3] This strong result is primarily due to the Vermont Medicaid Next Generation (VMNG) ACO program, the Medicaid component of Vermont's APM (see Section 3 below for a detailed description of the VMNG program). It also reflects the breadth of Vermont's delivery system and payment reform initiatives, and the willingness of various providers to engage in this groundbreaking work.

---

[3] Caballero, Andrea (December 15, 2021). *2019-2020 APM Measurement Results: Looking in the rear-view mirror and down the road for APM adoption.* Conference presentation, 2021 LAN Summit (virtual event).

Theme #3: There are often common goals across initiatives.

Providers, recipients of services, and leaders of state programs often articulate common goals when embarking on payment and delivery system reform. Those common goals include a desire for greater flexibility in how services are provided; improved access to needed care; predictability in payment; and support for structured reporting of utilization, financial, and quality data.

DVHA's innovative payment reform models are often characterized by predictability of payment independent of the volume of in-person services, with subsequent financial reconciliation to ensure accountability. The VMNG and Adult and Children's Mental Health Case Rate programs are two examples of initiatives characterized by predictable payments. Both programs have been cited as providing critical and essential stability to Vermont's health care system during the COVID-19 public health emergency (PHE).

Theme #4: Vermont has developed a systematic process for engaging in delivery system and payment reform.

Payment and delivery system reform is extremely complex work, and it benefits from a systematic process and approach. DVHA's process consists of several phases:

- Planning (including an assessment of whether payment reform would be effective in supporting the desired delivery system changes),
- Payment model design,
- Implementation,
- Performance measurement and monitoring, and
- Program evaluation.

This process has been refined over the years and is used in all DVHA-led payment reform initiatives, fostering consistent and effective approaches to payment reform. It is outlined in detail in the Appendix of this report.

Theme #5: As experience with delivery system and payment reform has increased, key learnings have been used to improve model design and implementation and to standardize when appropriate.

With each new project, DVHA's Payment Reform Unit and the various partners in payment and delivery system reform continue to gain valuable experience and improve upon the payment reform process. While tailoring of payment models is important to address the unique characteristics of each program that is the subject of reform, DVHA has developed a menu of potential payment model options and gained experience with each of those options. These options are described in Table 1, below:

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.

In addition, much has been learned about the system requirements and available mechanisms for implementing complex and intricate payment changes, including the collection of detailed encounter data to permit reliable assessment of services being delivered. DVHA and its partners have also developed a consistent approach to create effective performance measurement frameworks that evaluate the impact of new payment models across several performance domains, such as access to care, intensity of services, quality of care, and outcomes of care.

SECTION 3: MEDICAID PAYMENT AND DELIVERY SYSTEM REFORM

The COVID-19 PHE continued to have a significant impact on Medicaid payment and delivery system reform during 2021. As was the case in 2020, the impacts varied by program. While some programs that were in design or early implementation were delayed, steady progress was made in other programs due to the efforts of health care providers, people who receive services, program staff from AHS and its Departments, advocates, regulators, and policymakers.

Multiple AHS departments are using the process described in the Appendix of this report to develop and implement payment reform projects that impact various Medicaid-enrolled providers and Medicaid-covered services. This section describes eight active payment and delivery system reform projects:

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

VERMONT MEDICAID NEXT GENERATION ACO PROGRAM

Program Overview:

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.[4] 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.

Impact of COVID-19 PHE:

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

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 declined. However, Vermont providers in alternative revenue models who received prospective payments for some portions 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 PHE, 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 (the program's performance years are based on calendar years).

These adjustments continued into the 2021 performance year. They align with COVID-19-related changes to the 2020-2021 performance years of the Medicare Next Generation ACO program as announced by the Centers for Medicare and Medicaid Innovation (CMMI).[5] They include:

1) A reduction in provider financial risk for months in which the PHE has been in effect,
2) Adjusting performance measures to be reporting only in recognition that many preventive services have been delayed or foregone during the period of system shutdown, and
3) Removing 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 and 2021.

Progress to Date:

The 2020 program results show a significant impact on cost, utilization, and quality for the VMNG ACO program due to the COVID-19 pandemic and associated PHE, which should be taken into account when drawing conclusions around program performance.

Result 1: The program is stable.

The number of providers and communities participating in the ACO network for the VMNG ACO program has remained stable for the 2020 and 2021 performance years and is expected to grow slightly in 2022, as shown in Table 2, below. Beginning in 2020, an "Expanded Attribution" model was implemented and was 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.

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

Table 2: VMNG Provider Participation and Member Attribution, 2017-2022

	2017 Performance Year	*2018 Performance Year*	*2019 Performance Year*	*2020 Performance Year*	*2021 Performance Year*	***2022 Performance Year***
Health Service Areas	4	10	13	14	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	~5,000
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)	~126,000 (~96,000 traditional attribution and ~30,000 expanded attribution)

Result 2: The ACO program spent less than expected on health care in 2020.

DVHA and the ACO agreed on the price of health care up front and spending for ACO-attributed members was approximately $16.8 million less than the expected price. Because the ACO shares financial risk with Medicaid, the ACO and its provider network are entitled to the difference between the total spending and the agreed-upon price that is within the program's 4% risk corridor. After the application of other necessary adjustments, DVHA will issue payment to the ACO of $15.4 million.

Result 3: Fixed Prospective Payments created stability in the health care system during the COVID-19 PHE.

The COVID-19 PHE negatively impacted provider revenue in the spring of 2020 as the health system curtailed elective procedures and visits to minimize the spread of the virus. Alternative payment models, such as the fixed prospective payment model through the VMNG ACO program, provided a measure of financial stability for providers during that time, and better positioned them to weather the loss of fee-for-service revenue associated with the PHE.

Result 4: Quality results declined from 2019 to 2020; the COVID-19 PHE was a key factor.

As noted above, the COVID-19 PHE had a significant impact on the delivery of health care in Vermont (and nationally) as elective visits and procedures were curtailed to reduce transmission of the virus. One of the many tragic consequences of the pandemic is that important care had to be deferred. Health care providers' quality results in the VMNG program declined for 9 out of 10 measures from 2019 to 2020. This phenomenon was not limited to Vermont. The CMMI decided to link payment to reporting rather than performance in 2020, in recognition that care was delayed or forgone during the pandemic. Vermont aligned its approach with CMMI.

Prior to 2020, quality results in the VMNG program were very encouraging. In 2019, OneCare was evaluated on the same 10 measures as in 2020. There were national Medicaid benchmarks for 8 of those measures.

- For 3 of the 8 measures, OneCare provider performance exceeded the national 90th percentile, which is considered the highest achievable benchmark.
- For 1 additional measure for which there was no national 90th percentile, OneCare provider performance exceeded the multi-state 75th percentile, the highest benchmark available.
- For 1 other measure, OneCare provider performance was between the national 75th and 90th percentiles.
- For 2 more measures, OneCare provider performance was between the national 50th and 75th percentiles.
- For the remaining measure with a national benchmark, OneCare provider performance was between the 25th and 50th percentile.

For the two measures in 2019 with no national benchmarks, OneCare's 2019 performance was compared to its 2018 performance. For both measures, performance improved in 2019. Perhaps most encouraging, for 5 of the 10 total measures there was statistically significant improvement from 2018 to 2019.

There is hope that as the PHE abates, as providers can return their focus to preventive care and chronic disease management, and as Vermonters feel more comfortable accessing important care, quality results will return to previous levels. DVHA will continue to assess OneCare's performance carefully in the coming years.

Result 5: 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 2021, the ACO promoted integrated, team-based care by continuing to offer training and financial support for Vermont's area agencies on aging, designated agencies, and home health agencies serving as lead care coordinators and/or participating on members' care teams.

Result 6: The program is on track.

- DVHA and the ACO successfully completed implementation of the fourth year of the VMNG ACO program in 2020 and are on track with 2021 implementation.
- Implementation addresses 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.

- Quality improvement staff from DVHA and the ACO meet quarterly, to discuss performance measures and quality improvement initiatives.
- The DVHA Payment Reform Unit continued to work extensively throughout 2021 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.

ADULT AND CHILDREN'S MENTAL HEALTH PAYMENT REFORM

Program Overview:

In 2019 the Department of Mental Health (DMH) and DVHA implemented an alternative Medicaid payment model for the state's Designated Agencies (DAs) and Pathways Vermont (a Specialized Services Agency) for a wide array of mental health services. Most notably, the payment model for children's and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service payments) to a monthly case rate model. The mental health case rate model is one of the more mature alternative Medicaid payment models implemented by AHS, completing the third performance year on December 31, 2021. The foundational goals and principles driving mental health payment reform have remained unchanged throughout the life of this program. Those goals include:

- Encouraging flexibility in service delivery that supports comprehensive, coordinated care.
- Standardizing the approach to tracking population indicators, progress, and outcomes.
- Simplifying payment structures and improving the predictability of provider payments.
- Improving accountability, equity, and transparency; and
- Shifting to value-based payment models that reward outcomes and incentivize best practices.

Progress to Date:

Performance Year 3 (calendar year 2021) 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 allocation from DMH. Agencies are paid a fixed amount at the beginning of each month and are expected to meet established adult and child caseload targets. At least one qualifying service must be delivered during the month for an adult or child to be considered part of the agency's caseload.

An important program accomplishment is that providers are now successfully submitting encounter claims to the Medicaid Management Information System (MMIS), which allows the state to monitor service delivery and other aspects of performance.

Value-based payment to support quality improvement and accountability is an important component of this model. During each measurement year, DMH withholds a percentage of each agency's approved adult and child case rate allocations for these payments. Three types of performance metrics are used 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. Examples of monitoring measures include "Number of Children/Youth (0-17) Served" and "Number of Adults Served."
- *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. An example of a reporting measure is "Percentage of Clients with an Assessment Who Have Been Screened for Depression."
- *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 performance targets and/or outcomes. An example of a performance measure is "Percentage of Clients with a Completed Child and Adolescent Needs and Strengths (CANS) Assessment Within the Past Six Months of Receiving Services."

The COVID-19 pandemic, beginning in early 2020 and continuing through 2021, introduced additional and novel challenges for advancing the mental health system of care. Vermont's mental health care system has adapted to changing utilization patterns, economic shifts, service delivery guidelines, and workforce capacity fluctuations as it has become necessary to ensure a public-health-informed response for all Vermonters. While some COVID-19 impacts are short term in nature, others may persist over the longer term. Factors such as changes in caseload, the intensity of individual needs and the cost of delivering mental health services are evolving and have the potential to influence future iterations of the payment model.

Proposed Valuation Model:

Based on the experience and lessons of the first three years of the mental health case rate payment model, an updated model (referred to as the "valuation model") is under development for 2023 implementation. Preliminary discussions are underway in the Payment Reform Advisory Group (PRAG), a forum for AHS and provider representatives to jointly review and consider model design and operations. Building upon the core principles established in current and past performance years, including caseload and quality targets, the proposed valuation model seeks to incorporate additional elements into the payment model, such as case mix, utilization, quality, and adequacy of rates. Incorporation of these additional elements supports the foundational goals of mental health payment reform by accommodating more flexible service delivery models built on transparent and equitable payments. AHS aims to conduct all necessary model design and pre-implementation activities during 2022 in collaboration with relevant stakeholders, to support a shift to the valuation model on January 1, 2023.

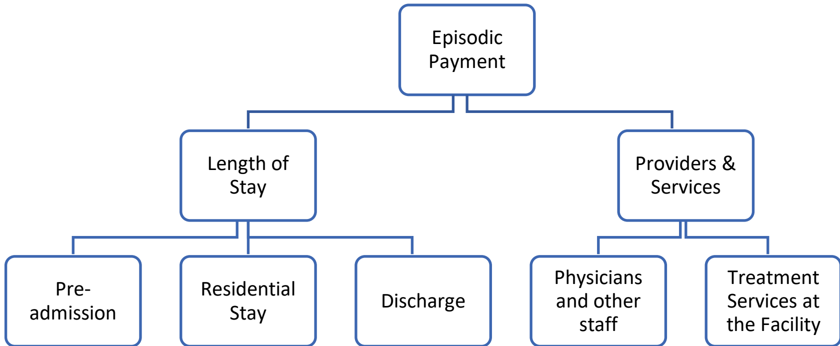
Summary Overview: Children's and Adult's Mental Health Payment Reform	
Program:	Children's and Adult's Mental Health
Impacted Providers:	• Designated Agencies • Pathways (Specialized Services Agency)
Impacted Beneficiaries (CY2021):	~13,800 (~6,200 in child program and ~7,600 in adult program)
Estimated Expenditures for New Payment Model (CY2021):	~$98,000,000 (~$40,900,000 for child case rates and ~$57,100,000 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 PAYMENT REFORM

Project Overview:

The Vermont Department of Health (VDH) and DVHA have collaborated 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 B, below). An episodic payment was selected to provide a framework to pay for outcomes rather than discrete services; encourage innovation and cost-containment through increased provider flexibility; and ensure financial stability through the delivery of more predictable payments.

FIGURE B: Residential Treatment Episodic Payment



The episodic payment covers the entire episode of care, including both residential detoxification and 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 treatment providers and services at the facility.

The payment model includes eight different episodic payment rates. The amount of the payment is determined by two factors: the primary diagnosis and clinically relevant co-morbidities. This multifactored episodic rate was designed to encourage providers to admit only those patients who need the full resources of residential care for medically necessary lengths of stay, thereby promoting 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,

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).

Progress to Date:

Residential SUD payment reform program implementation continued as expected in 2021, with monitoring of results on key program indicators underway. The goals are for people to continue to access services, and for length of stay to continue at clinically appropriate levels while readmission rates remain steady or decline.

The number of people accessing services rebounded to 2019 levels in 2021 following a decline in 2020 (possibly due to COVID-19). It appears that length of stay is declining. Since the baseline year of 2018, the residential treatment program has seen a 33.9% reduction in the average length of stay (see Table 2 below for provider-level and statewide results). Factors contributing to this reduction, in addition to the new payment model, might include:

- General impact of COVID-19 on whether and how people decide to access services. Providers have prioritized delivering residential services safely during the pandemic, by reducing admissions and maintaining lower census.
- Impact of COVID-19 outbreaks specific to residential SUD treatment facilities, which have most likely resulted in people choosing to leave sooner due to real or perceived risks of virus transmission.
- Impact of staffing challenges (including the impact of COVID-19 on workforce).
- Reduction in administrative burden (e.g., removal of requirement for concurrent review) allowing more time for direct care by clinical staff.
- Improved discharge planning at the facilities.
- Access to outpatient services, including medication assisted treatment.
- New ownership and leadership at some facilities.

The rate of 30-day readmissions increased between calendar years 2019 (5.7%) and 2021 (7.6%).

Table 3 shows results over time for Average Length of Stay. Results for 2020 and 2021 should be interpreted with caution. As noted above, it is possible that COVID-19 changed the way people decided to access services, in terms of timing, type of service, duration of service and/or whether they chose to access services or not. It also impacted staffing at residential treatment programs.

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

	CY2018	CY2019	CY2020	CY2021
Provider	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*	*Average Length of Stay (in days)*
Recovery House	14.51	12.39	12.59	11.70
Valley Vista: Vergennes	19.56	16.01	14.39	11.12
Valley Vista: Bradford	18.12	16.03	14.04	12.18
Statewide	17.97	15.03	13.66	11.90

VDH and DVHA have paused efforts to refine and implement a value-based payment component for this model due to the COVID-19 PHE. 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 • Recovery House
Impacted Beneficiaries (CY2021)	~1,100
Estimated Expenditures for New Payment Model (CY2021)	~$4,350,000
Type of Payment Reform:	Per diem rate to episodic payment
Implementation Date:	January 1, 2019

APPLIED BEHAVIOR ANALYSIS PAYMENT REFORM

Project Overview:

“Applied behavior analysis” (ABA) consists of 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 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 the ABA payment model 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 assessment of needs. The monthly post-service delivery 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, and the program includes annual financial reconciliation.

Because most ABA services are provided in person, COVID-19 impacted services early in the PHE. However, the payment model allowed providers to rapidly adjust tiers and DVHA worked to identify services appropriate for coverage as telehealth services.

Progress to Date:

For this program, efforts in 2021 focused on refining the timing of tier submissions in response to feedback from providers, continuing to support and educate providers regarding the new model, and conducting the financial reconciliation for services provided from January 1, 2020 through December 31, 2020.

Reconciliation examined the difference between:

- Payments each ABA provider should have received for services delivered in 2020 (based on hours of services actually provided), and
- The amount each ABA provider was actually paid for those services (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.

An important goal of this program is to increase access to direct services for Medicaid beneficiaries 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 a higher proportion of services are in the form of direct services to members rather than assessments. Table 4 shows changes over time for several measures of ABA services.

Table 4: Change Over Time in Services Provided

Category	2017	2018	2019	2020	2021
Total Hours of Service	22,443	37,715	60,949	63,248	76,915
% of Hours as Direct Treatment Services	92.8%	91.1%	97.2%	96.7%	97.0%
Average Monthly Census	105	127	142	139	148
Average Service Hours Per Member Per Month	17.7	24.8	35.8	37.8	43.3

Total hours of service have increased year over year (even during the COVID-19 PHE). The percentage of hours as direct treatment hours has increased since implementation of the new payment model. The average monthly census declined slightly during 2020, the first year of the COVID-19 PHE, but that number rebounded in 2021. Average service hours per member per month have steadily increased.

In the next phase of work on the ABA payment model, DVHA will collaborate with providers and member recipients to continue to refine the model and reconciliation process if needed, 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 • Autism Spectrum Therapies • 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 (CY2021):	~242

Estimated Expenditures for New Payment Model (CY2021):	~$5,600,000
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 DELIVERY SYSTEM AND PAYMENT REFORM

Project Overview:

The Developmental Disabilities Services Division (DDSD) is part of the Department of Disabilities, Aging and Independent Living (DAIL). DDSD contracts with 15 non-profit developmental disability services providers throughout Vermont to assist individuals with developmental disabilities. The goal of this extremely complex delivery system and payment reform project is to create a transparent, effective, and operationally feasible payment model for developmental disabilities services (DDS) that meets individuals' needs and aligns with AHS' broader health care reform goals. Representatives from the state, provider network, individuals, family members, and advocates work together on this project.

Objectives of the project include:

- Provide flexibility in response to changes in individual needs and choices.
- Support a sustainable provider network.
- Provide equity and predictability, including the provision of similar budgets and services for individuals with similar needs, and consistent funding streams for providers.
- Align with and inform a potential 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 DDS, consistent with recommendations in the State Auditor's Report to improve the state's oversight of Designated Agencies.
- Ensure that providers submit data on all service encounters to the Medicaid claims system to support continued tracking of approved services.
- Improve the validity and reliability of needs assessments through use of a standardized assessment tool.

Project leaders from DAIL and DVHA have regularly communicated foundational project elements to stakeholders to help reinforce the need for timely and accurate tracking and an approach which ensures that services have been provided to address individuals' needs. Specific "must haves" were identified to communicate the key elements, additionally emphasizing the importance of the fair and equitable use of limited state resources across providers and people receiving services.

Table 5 below summarizes four "must have" elements of the overall project.

Table 5: “Must Have” Elements for Improving the System	
Person-centered planning	• Regardless of the payment model, service approval and delivery always reflect a person-centered approach
Submission of claims or encounter information	• Providers submit claims or encounter information so that there is a timely and accurate record of services provided.
Use of a standardized assessment	• A reliable assessment tool is used to assess needs. • Individual funding is at the same level as others with similar needs.
Use of a standard fee schedule	• Providers are paid the same amount for delivering the same service.

The COVID-19 PHE had a significant impact on this project. Work was paused for approximately six months in 2020; work resumed in late 2020 and continued into 2021. Timing for some of the work has been impacted by provider workforce challenges.

Progress to Date:

Actions to support achievement of the goals and objectives of the project include improving collection of encounter data on services provided, identifying and implementing a standardized assessment tool to ensure consistent determinations of individuals’ needs, and designing and transitioning to a new payment model. Progress in each of those areas is outlined below.

- *Collection of Encounter Data on Services Provided*: DAIL and DVHA have worked with providers to support them in reporting all service encounters to the Medicaid claims system. Significant progress occurred in 2021, including the following:
  - The updated encounter data reporting structure went live on 3/1/2021.
  - Work continued with the state’s claims processing vendor to implement requirements.
  - The final encounter data submission guidance was posted to DAIL’s website.
  - Frequently Asked Questions and answers were developed and posted.
  - Training was held for providers.
  - The 7/1/2021 deadline for full submission of encounter claims was met by most providers.

- *Standardized Assessments to Ensure Consistent Determination of Needs*: This effort is focused on the administration of a uniform, valid, and reliable standardized assessment tool for determining what services and supports an individual needs. The following progress was made in 2021:
  - A standardized assessment tool, the Supports Intensity Scale®(SIS-A), was selected.
  - A contract was executed with an independent contractor to conduct the assessments.
  - Supplemental questions were developed and vetted for use with the assessment.
  - The initial implementation of the SIS-A occurred on time (7/1/2021).
    - Significant challenges and stakeholder concerns have affected the early stages of the standardized assessment roll-out. DAIL has worked to increase accessibility, improve communication, and plan for gradual and steady implementation of this important component of the overall project. A key milestone for 2022 was the completion of initial assessments.

    - Gathering stakeholder feedback on the assessment process and methods for translating the results of the SIS-A into service needs and funding levels will be discussed and developed with stakeholder input during 2022.

- *Design and Transition to New Payment Model:* This work involves the development of a transparent, effective, and operationally feasible payment model for DDS that meets individuals' needs and aligns with AHS' broader health care reform goals. Payment model discussions that occurred in 2021 included the following:
    - How best to design the structure of individual budgets for services.
    - How best to translate service needs into individual budgets.
    - How best to put payments into practice.
    - How best to reconcile payments made with services provided.
    - How best to evaluate whether the payment model is achieving desired outcomes.

  This work is continuing but will be impacted by provider workforce challenges.

Above all, this project is intended to reflect a person-centered approach for the individuals who rely on DDS and ensure accountability. Provider network representatives, individuals, family members, the state, and other stakeholders have been working together diligently and collaboratively since 2018 within a structure that includes an advisory committee and focused work groups to design a system that achieves the desired goals. Continued collaboration on design, implementation, and evaluation will be critical to the project's success.

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 Expenditures for New Payment Model (State Fiscal Year 2021):	$226,506,925
Type of Payment Reform:	TBD
Implementation Date:	Encounter data collection was launched first quarter of CY2021; standardized assessment implementation launched third quarter of CY2021; payment model implementation estimate is CY2024.

CHILDREN'S INTEGRATED SERVICES PAYMENT REFORM

Project Overview:

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 for 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. The contract total for each fiscal agent is calculated by multiplying the estimated caseload by the monthly case rate. The statewide appropriation for CIS services covered by these contracts was $10,294,464 (annualized for calendar year 2021).

Progress to Date:

During 2019 and 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 DVHA 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. Previously, rates were historically based and had varied by region.

As in most payment reform efforts, another key element of this initiative is the collection of accurate encounter data through claims submissions from providers. That data is used to inform caseload assumptions, assess utilization of services, support contract monitoring, and conduct ongoing program analysis. DCF and DVHA engaged in extensive technical work with providers and Medicaid's claims processing contractor (Gainwell Technologies) to implement encounter data collection. Provider training occurred in October of 2020, and providers began submitting claims to the MMIS in November 2020. Refinements in data collection specifications were made during 2021, and ongoing technical support is available to providers as needed. Providers have worked diligently to submit their claims data, and as a result DCF and DVHA are now able to generate reliable reports from the MMIS.

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:	~4,000 to ~5,000 unique beneficiaries per year
Estimated Expenditures for New Payment Model (Annualized for Calendar Year 2021):	~$10,294,464
Type of Payment Reform:	Bundled Rate (updated monthly case rate)
Implementation Date:	Payment model implemented on October 1, 2020

HIGH-TECHNOLOGY NURSING SERVICES PAYMENT REFORM

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 individual participants with complex medical needs in support of their choice to remain in their homes and communities.

The primary goal of the HTN project is to improve access to high-technology nursing services. Payment reform strategies are intended to be one component of a multi-faceted approach to help participants receive increased access to authorized services. This project includes representatives from VDH, DAIL, DVHA and AHS.

Objectives of the project include:

- Supporting improved access to services.
- Developing and implementing a payment model in collaboration with stakeholders.
- Basing the model on accurate, verifiable, and reliable data.
- Including relevant monitoring and performance measures.

Vermont's home health agencies and visiting nurse associations are the HTN providers at the focus of this payment reform project. Vermont Family Network and Vermont Legal Aid have represented participant perspectives. Regular stakeholder engagement has supported communication with external partners to refine, reinforce and improve project components.

The project will potentially impact both program participants and providers. As noted above, the intended impact for participants is to increase access to authorized services. The potential impact for providers is to provide a greater level of stability and flexibility by implementing a “hybrid” payment model.

The payment model consists of two components:

- A monthly payment to provide home health agencies with enough stability to assign and maintain staff to provide authorized hours of service. The agency gets to keep this payment if a minimum service threshold is met.
- A fee-for-service payment to support increased hours of service beyond the minimum threshold.

Progress to Date:

Payment model design has been completed and project implementation is in early stages. Stakeholder engagement resulted in improvements to the payment model and increased understanding of the payment model. Implementation planning has resulted in creation of a payment model reconciliation process and work with Gainwell Technologies, the Medicaid claims processing contractor, to specify needed information system changes.

HTN services are critical supports for the participants and families who need them to remain in their communities. The HTN project team will continue to work to support access to these important services.

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:	~24
Estimated Expenditures for New Payment Model (State Fiscal Year 2021):	Historically program expenditures are ~$2,300,000. The payment reform is projected to add ~$230,000 to that expenditure.
Type of Payment Reform:	Hybrid model with fee-for-service and monthly payment components
Implementation Date:	Estimated implementation: Calendar Year 2022

SUMMARY: MEDICAID PAYMENT AND DELIVERY SYSTEM REFORM INITIATIVES

It is clear that the COVID-19 PHE will continue to have significant impacts on AHS priorities and operations, including payment reform activities, well into 2022. Despite the pandemic, and perhaps in part in response to it, there continues to be interest in initiating new delivery system and payment reform projects. For example, exploratory discussions have occurred with DMH and the Agency of Education regarding the Success Beyond Six program that provides mental health services to students in Vermont's schools, with the Office of Alcohol and Drug Abuse Programs at VDH on system of care transformation for substance use disorder treatment, and with DAIL on Adult Day Services.

SECTION 4: INTEGRATION OF REFORM INITIATIVES AND CONCLUSIONS

This section of the report summarizes 2021 progress on integration and alignment between payment and delivery system reform initiatives. It specifically addresses:

- Development of a menu of common models, a standardized process, and common approaches and tools.
- Efforts to integrate affected providers into the APM and with other payment and delivery system reform initiatives.
- Changes to quality measure collection and alignment.
- The interrelationship of results-based accountability initiatives with quality measurement.
- A summary dashboard of initiatives that were active in 2021.

The Appendix to this report provides a detailed description of the Payment Reform Process that has been developed by DVHA and AHS, as well as the menu of common models, approaches, and tools that are used across projects. With each new project, the Payment Reform Unit continues to gain valuable experience and improve upon the process described in the Appendix, fostering consistent and effective approaches to planning, payment model design, implementation, performance measurement and monitoring, and evaluation.

One area in which DVHA's Payment Reform Unit has made particular progress is 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 ensures accountability by supporting effective monitoring and evaluation.

As noted in Section 2, 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 also shares those characteristics.

Section 3 outlines the variety of initiatives underway to develop alternative payment models for affected providers, allowing for potential integration of reform initiatives. In terms of the APM, Vermont has proposed that CMS consider a one-year extension of the current agreement to allow for full testing of the current model and strong stakeholder engagement (both of which have been significantly impacted by the ongoing COVID-19 PHE). As part of that proposal, Vermont has requested that CMS "eliminate the report in the current agreement related to Medicaid Behavioral Health and Long-Term Services and Supports and replace it with a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with all-payer financial target services in a subsequent agreement, to be submitted as a component of any proposal for a subsequent agreement by December 31, 2022. This will allow alignment of stakeholder engagement in the development of a proposal for a subsequent agreement that both defines the all-payer financial target services within that agreement and additional strategies to further achieve integration across the health care delivery system."[6]

As the statutory language for this report suggests, alignment is important in the selection of monitoring, performance, and quality measures. Alignment helps focus resources and provider efforts in areas that have been prioritized for quality improvement. In payment and delivery system reform, intentional efforts

[6] From December 17, 2021 letter from GMCB Chair Kevin Mullin and AHS Secretary Michael K. Smith to Dr. Katherine J. Sapra, Director of Division of All-Payer Models, CMS Center for Medicare and Medicaid Innovation.

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. Both frameworks 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.

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 continued during 2021, the program's fifth year, and will also continue into 2022.

A graphic providing a visual overview of AHS' eight current payment reform projects is found in Figure C.

FIGURE C: Payment and Delivery System Reform Project Summary (as of December 31, 2021)

	PLANNING	DESIGN	IMPLEMENTATION	EVALUATION	Current & Next Steps
Vermont Medicaid Next Generation ACO Program (DVHA)				★	• Program launch in 2017 • 2020 results finalized • 2020 evaluation • 2021 implementation • Contracting for 2022
Mental Health Payment Reform (DMH)			★		• Program launch in 2019 • 2020 results finalized • 2020 evaluation • 2021 implementation
Residential SUD Program Payment Reform (ADAP)			★		• Program launch in 2019 • 2020 results finalized • 2020 evaluation • 2021 implementation and rate refinement
Applied Behavior Analysis Payment Reform (DVHA)			★		• Program launch in 2019 • 2020 results finalized • 2020 reconciliation and evaluation • 2021 implementation and model refinement
Developmental Disability Services Payment Reform (DAIL)		★			• Interim payment methodology implemented • Encounter data submission initiated • Standardized assessment underway
Children's Integrated Services Payment Reform (DCF)			★		• Program launch in 2020 • Encounter data submission underway • 2021 implementation
High-Technology Nursing (VDH and DAIL)			★		• Payment model design completed, with stakeholder engagement • Implementation underway
Brattleboro Retreat (AHSCO and DMH)			★		• Finalized details of payment model and rate with input from provider • MMIS design completed • Payment initiated in March 2021

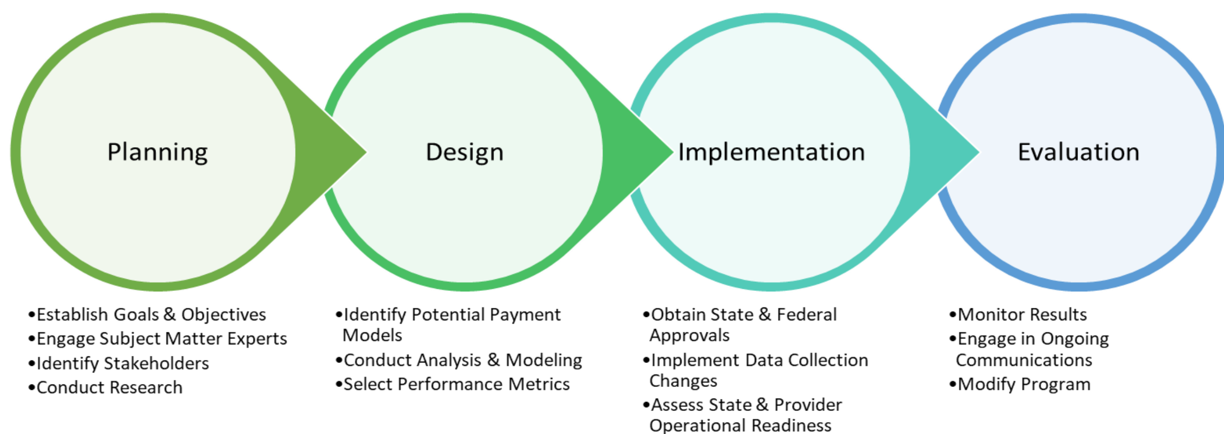
The broad cross-section of programs, providers, and state agencies participating in these projects is indicative of an ambitious and conscious strategy to integrate providers into Vermont's delivery system and payment reform efforts. AHS anticipates that steady progress will continue on these projects, and that requests for new projects will continue to arise. 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 COVID-19 PHE, 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.

APPENDIX - PAYMENT REFORM PROCESS

INTRODUCTION

This Appendix contains a description of DVHA and AHS' payment reform process. The high-level phases of the payment reform process are shown in Figure D.

FIGURE D: Payment Reform Process



PLANNING

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

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

DESIGN

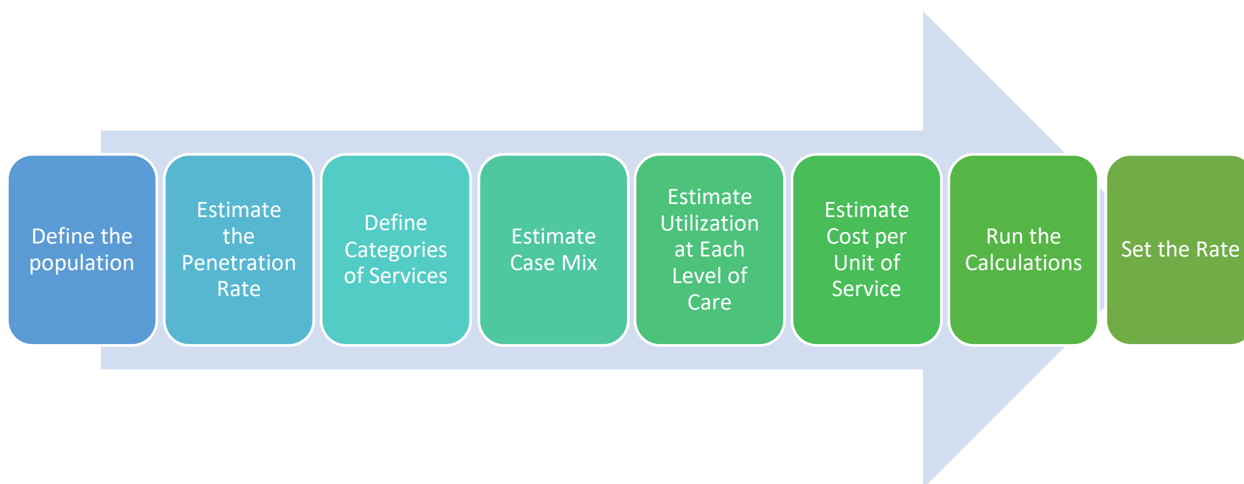
There are several existing payment model options, and the first step in the design phase is to identify which of the available options may further the goals and objectives of a particular project. These options, described in Table 6 below, generally focus on whether payments will be made fee-for-service, in a bundled payment, or in a population-based (or capitated) payment. They can, and frequently are, customized and combined.

Table 6: 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 E demonstrates the series of steps typical for most rate development processes.

FIGURE E: 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.

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.

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
- 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.