State of Vermont Goals:
Medicaid Pathway – Designated and Specialized Service Agencies and Preferred Providers

Background

There is a growing national recognition that fee-for-service (FFS) payment to providers has been responsible for the development and maintenance of a delivery system which does not adequately address the needs of the most complex Medicaid beneficiaries. The elderly, persons with disabilities, those with severe mental illness, and children with complex medical needs all constitute some of the most vulnerable and costly Medicaid members. Many of them are still served by fragmented delivery systems which are driven by historically siloed funding streams and a lack of financial incentives to coordinate or improve care.[1] Vermont recognized this with Act 48 of the Acts of 2011, which supports a transition away from fragmented care towards an integrated delivery system supporting the whole person.

In 2014, Vermont began exploring the possibility of an All Payer Model based on Medicare's Next Generation Accountable Care Organization (ACO) model with federal partners at the Centers for Medicare & Medicaid Innovation. An All-Payer Model would include an agreement between the State and the federal government to target a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers, and would build on past programs like Vermont's Medicaid and commercial Shared Savings Programs. If implemented, this model will focus on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services); it would also include strict quality and performance measurement.

As ACO-focused delivery reforms mature under the All Payer Model, they must begin to integrate with providers that support Home and Community-Based Service in Vermont and address the social determinates of health in order to realize a fully organized and accountable system of care. The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model, including disability and long-term services and supports (DLTSS), mental health, and substance abuse treatment.

The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care for all Vermonters – including integrated physical health, long-term services and supports, mental health, substance abuse treatment, developmental disabilities services, and children's service providers – that can achieve the Triple Aim. The payment model reforms start with Designated and Specialized Service Agencies (DAs and SSAs). The proposed payment model is designed to provide DAs and SSAs with a predictable, responsible, and flexible revenue

[1] National Association of Medicaid Directors, "Value-Based Purchasing in Medicare and Medicaid: Areas of Intersection and Opportunities for Future Alignment" (June 2016). Available at: http://medicaiddirectors.org/wp-content/uploads/2016/06/FINAL-ISSUE-BRIEF_Medicaid-VBP-and-MultiPayer-Alignment.pdf.

stream with appropriate quality measurement to support accountability to the State and individuals served.

State of Vermont Medicaid Pathway Goals – Designated and Specialized Service Agencies

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

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

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

Care Delivery Goals

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

Payment Model and Quality Framework Goals

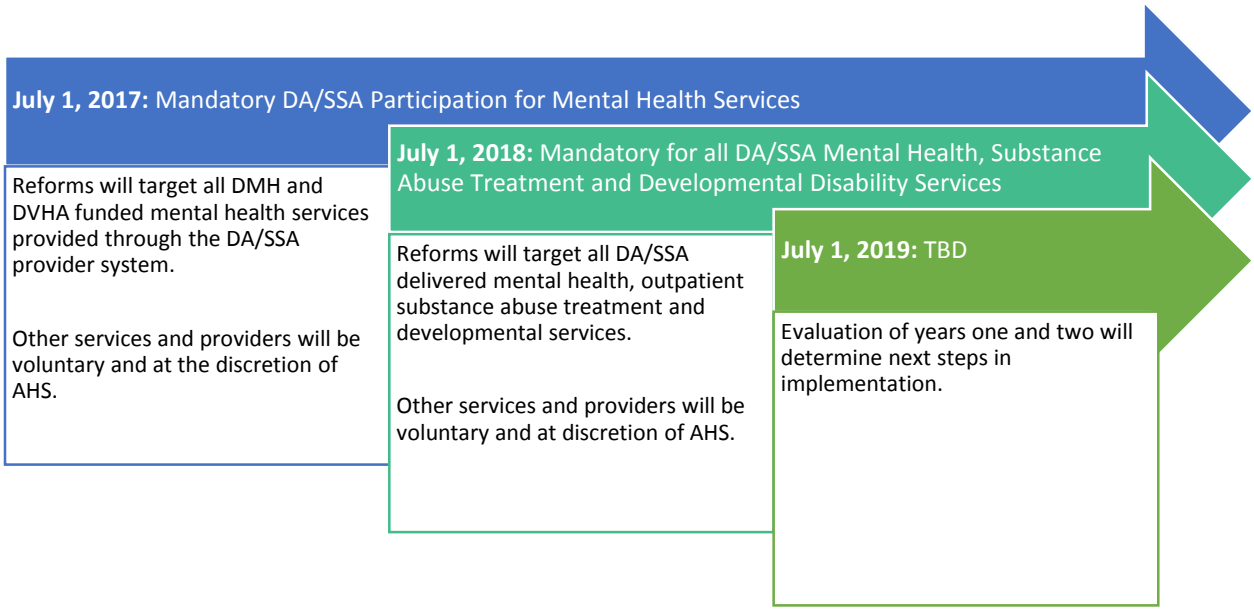
1. *Expressly move from fee-for-service payments to population-based payments, increasing accountability and risk to impacted providers.*
2. *Incentivize high quality, efficient services and reduce incentive for high service volume.*
3. *Increase flexibility in payment to support more efficient delivery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

Administrative Goals

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

Phasing of Reforms

In order to meet these goals, the State has developed a plan for payment and delivery system reforms in Medicaid. This plan recognizes the iterative nature of this work and the need to ensure payer and provider readiness. The graphic below describes the proposed phasing of reforms.



Phase 1 (SFY17-SFY19[2])

Phase 1 of the reforms transitions the majority of services provided by DAs and SSAs from the current, fragmented funding and program streams into one episode-based population payment. This reform will support flexibility at the DA/SSA level to deliver services based on the individuals' unique needs while providing predictability and accountability and minimizing administrative burden. A key aspects of the reform is standardized data collection through the MMIS claims processing system to allow for ease of data sharing among AHS departments; this will also reduce the number of times the providers have to submit information to the state for monitoring and oversight. This phase lasts three years and in the last half of the reform, the State and providers will review progress to date and determine if the payment can transition to a full capitated payment and when/if/how the payments can fall within the all-payer model financial targets. Phase 1 requires annual review and rebasing of the model design and payments.

Phase 2: (SFY18-SFY20)

Phase 2 of the reforms begins a transition for Preferred Providers from the current fee structure to a new structure that supports standardization. The first year of this phase is voluntary for Preferred Providers; the second year is mandatory. Evaluation of potential transition for Long-Term Services and Supports for future reforms.

[2] Note that the graphic above shows calendar dates and the phases are listed with state fiscal years.

Crosswalk – Medicaid Pathway Goals and Proposed Payment Model Elements

Goal	Proposed Payment Model Element
Care Delivery Goals	
Support primary and secondary prevention, including early intervention to reduce risk factors.	Providers have greater flexibility within bundles to deliver services based on the needs of individuals served, including services that were previously not reimbursable.
Support flexibility to allow individuals and providers to decide on necessary services based on a person's unique treatment and/or support plan needs and social determinants of health, including use of home-and community-based services.	Providers have greater flexibility within bundles to deliver services based on the needs of individuals served, potentially including services that were previously not reimbursable.
Foster integrated service delivery for Medicaid beneficiaries across the care continuum.	Bundled payment models can include payment for services that coordinate care across organizations/care settings.
Payment Model and Quality Framework Goals	
Expressly move from fee-for-service type payments to population-based payments, increasing accountability and risk to impacted providers.	Payment model (global budget + bundled payments) supports comparisons across regions, as well as future integrated payment models beyond Phase I of the Medicaid Pathway.
Incentivize high quality, efficient services and reduce incentive for high service volume.	Payment model (global budget + bundled payments) incentivizes efficient resource use within bundles and is responsive to increases in patient volume without encouraging unchecked growth in the total number of bundles. Historical provider-specific case-mix adjustment of bundled payments with periodic rebasing reduces provider incentive to cherry-pick.
Increase flexibility in payment to support more efficient delivery of services.	Providers have greater flexibility within bundles to deliver services based on the needs of individuals served, including services/service delivery models that may not have been previously reimbursable.
Reduce payment silos and fragmentation across provider and service types.	Payment model creates a consistent and rational payment model across provider organizations that reduces current funding source fragmentation and associated reporting burden.
Connect payments with quality in service delivery and health of Medicaid beneficiaries.	Quality framework will utilize broad measure set including structure, process, and experience of care measures.
Align measurement and reporting with values, principles and goals.	Quality framework will utilize broad measure set including structure, process, and experience of care measures.
Provide data and feedback to providers delivering care to support accountability for quality and cost.	Quality framework will include a process for feedback to providers to support accountability for quality and cost.
Administrative Goals	
Create a foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning that assesses	Program oversight and monitoring will be structured to support provider-led reform.

accountability for delivering contracted services; appropriateness of care based on best practice and State standards; and outcomes.	
Reduce administrative burden to providers and the AHS.	Payment model and quality framework aligned with overall program goals (vs. many siloed funding streams) support administrative simplification and reduced reporting burden.
Standardize payment structure and quality measurement for similar services across AHS.	Global budget sets expenditure target for AHS portion of DA/SSA total budget. Quality framework will be aligned program-wide.
Allow for seamless oversight and monitoring across AHS.	Proposed bundles build on current monitoring and reporting structure and systems. Standardized data collection will allow for ease on information transfer.
Improve data collection to support future policymaking.	Aligned quality framework and simplified reporting requirements will support improved reporting on measures of greatest interest for providers and policymakers.
Transition payments in a manner that is operationally feasible for both the State and providers.	Outlier policy protects against drastic changes in DA/SSA revenue. Global budget targets are set at the DA/SSA level in order to achieve aggregate cost coverage for a defined set of services at the provider level.