ABA Value-Based Payment Proposal: Stakeholder Questions and Answers (June 2022)

Process Questions	Responses
Why is there no measure of percentage improvement (or something similar) for the client? To go along with this, some type of family satisfaction measure? What evidence was used to indicate that these performance measure lead to effective outcomes for this population?	Measures 1 and 2 are directly related to key goals of the initiative: • More children are served, those children receive more hours of service, and a higher percentage of hours are in the form of direct services. Other measures could be considered in the future. DVHA will monitor improvement and satisfaction. However, the relatively small number of clients served by each provider and the presence of confounding factors may make linkage of improvement and satisfaction measures to payment undesirable in this model.
How were the measures determined and by whom? What was the rationale for selecting the payment measures? Are they based on existing national models of VBP for ABA?	The ABA payment reform team at DVHA identified these measures as good candidates for value-based payment, and as previously noted, they are based on the goals of the initiative. Measure 3 is important because delays in claims submission have resulted in a lack of timely information and additional administrative burden for providers and DVHA, as well as delays in program monitoring and reconciliation (which can result in payment delays).
What was the process for stakeholder input so far?	Three stakeholder meetings were timed to allow for an additive payment for 2023 using enhanced federal funding (current guidance requires this federal funding to be spent in 2024). Stakeholders will also be able to provide feedback during the public comment period which occurs after DVHA reviews feedback from the stakeholder meetings and shares the final proposal.
Why is this rollout so rushed? Is there a reason at least this part of the timeline is so tight?	The funding that allows us to make this an additive payment must be spent in 2024, requiring the model to be in place for 2023. We have only recently received preliminary federal approval and state approval to use the funds for this program. This timeline is necessary to allow time for stakeholder meetings, as well as formal public posting and comment, in order to submit the model to the Centers for Medicare and Medicaid Services for federal approval by the October 1, 2022 deadline.
Have you viewed the proposed model through an equity lens?	The focus on access to care, regardless of region, is a broad view of equity. Other ideas for assessing equity are welcomed for consideration.
Has DVHA analyzed the data from the last few years of bundled payments for ABA to consider the financial impact of the proposed value-based payment model for providers?	In the first year, providers could receive up to 1% of earned payments in additional funds. In subsequent years, the model could result in a withhold (the current proposal is 1%).
Is the goal to move to a value-based payment model or is this an incentive/ladder to the case rate tier system that is currently in place? In the long-term, what percentage of the overall payment would be value-based? What is DVHA's	For 2023, we anticipate that it will be an additive payment. That will allow us to test the framework without the risk of a loss of funds in the first year. Unless additional funding is identified, we anticipate that we would move to a value-based payment in the form of a withhold for subsequent years. The proposal is for a very small percentage (1%) to be used to link value to payment. DVHA will continue to seek stakeholder input.

timeline for getting to that point? What is the stakeholder process for input?	
Measure Selection and Specification Questions	**Responses**
Will there be further supportive documentation including detailed measure definitions?	The document disseminated prior to the provider meetings outlines the measure definitions, including the person-months and direct service measures.
DVHA does onsite or virtual audits with each program each year, wouldn't it make sense for these audit results to be tied to an incentive payment for quality?	Audits are intended to be a collaborative quality assessment and improvement process involving the provider and DVHA. That approach has allowed us to work together to understand results, identify trends, and discuss improvement opportunities. DVHA is open to discussing additional future measures but also wants to ensure an effective and mutually beneficial audit process that supports continuous quality improvement.
For Measure #1, in reference to person months as a unit of measurement, does this mean that if they are not with us for a full month their time does not count? Or if they were served in a month regardless of the number of units billed, does that count as a person month?	For both the numerator, which reflects current year performance, and the denominator, which reflects baseline year performance, those people receiving at least 6 hours of service in a month (Tier 2 or higher) would be counted as person months. The person would not have to receive service throughout the month in order to be included in the person months calculation; they would just have to receive at least 6 hours of service total during the month.
In Measure #2, is the scoring calculated one time a year for the entire year or a monthly average or monthly discrete threshold?	Data is aggregated across all clients for the entire year.
In Measure #3, how was the discrete (all or nothing) target of 100% established? How does that fit into the "gate and ramp" CQI methodology you are proposing? What do the actual rates look like right now?	Medicaid requires that all claims be submitted within six months from the date of service, which is why 100% is proposed as the minimum threshold. As previously noted, delays in claims submission result in additional administrative burden for providers and DVHA, as well as delays in program monitoring and reconciliation. The project team considered establishing a target that exceeded the six-month requirement (e.g., three months), which would have been conducive to a ramp, but determined it was better to use the six-month requirement as the metric. Most providers submitted their claims on time in 2020.
What percentage of late claims submission is due to factors outside provider control, and should this be incorporated into the measure?	DVHA is typically unaware of why claims are submitted late unless a timely filing override request is made. Third party liability claims would not be included in the numerator or denominator because those claims are not part of the tiered ABA Program and because that may be outside the provider's control.
In Measure #3, will DVHA now allow us to submit claims within the same month the service is provided?	Claims can be submitted any time after the tier payment occurs. Tier payment typically occurs within 2 weeks of the request, allowing plenty of time for timely submission of claims.
Clinical Questions	**Responses**

Why is there a minimum threshold of service hours provided for a child even to count towards person months?	A small percentage of person months are currently below 6 hours. Our data from 2021 indicates 8% of members being served are in Tier 1 or less, which is less than 6 hours per month. When creating the tier system, the purpose of Tier 1 was to support members transitioning in and out of ABA services. Additionally, Tier 1 is to support providers during member absences or times of illness/vacation. Setting a minimum of Tier 2 (6 hours or more per month) for counting person months captures those children who are engaged in more comprehensive treatment.
Clinical Questions (cont'd)	**Responses**
For clients [for which] we do an assessment, with the limit from DVHA of 4 hours, we could never get to 6 hours for the minimum hours for them to count. We often do not have a new client start the same month we assess them because there is so much writing...and...back and forth communication with caregivers and waiting on staffing...	For both the numerator, which reflects current year performance, and the denominator, which reflects baseline year performance, those people receiving at least 6 hours of service in a month (Tier 2 or higher) would be counted as person months. The purpose of Tier 1 is to support members transitioning in and out of ABA services. Setting a minimum of Tier 2 for counting person months captures those children who are engaged in more comprehensive treatment.
When a BCBA provides direct service should we bill 97155 or 97153 per the definition of the code?	Both codes count as direct service. If a BCBA is the only clinician providing direct service, the correct billable code is 97153 as the service is not supervision. Please refer to the CPT code definitions.
Is it DVHA's intention to incentivize intensity of serve volume by dropping Tier 1? Is this the end of the tiered system?	We are not proposing to drop Tier 1 for payment or end the tiered system; Tier 1 will remain as a Tier for payment purposes. As previously stated, the purpose of Tier 1 was to support members transitioning in and out of ABA services and to support providers during member absences or times of illness/vacation.
How do you account for significant potential variables outside of provider control for Measure #1 (impacts of client illnesses, absences or missed appointments, staff illnesses, and staff retention)?	The variables cited are always present. The payment model is intended to provide predictability in payment and flexibility in how services are provided, which may help providers in responding to those variables. Data shown in the Power Point from the May 19th meeting indicates that we are seeing more services statewide, which is encouraging.
For Measure #2, DVHA is proposing that direct service excludes assessment when the parent or child is not present. Is it DVHA's intention to disincentivize these activities?	It is not DVHA's intent to disincentivize needed assessments. A key goal of the project is to maximize direct services that include support for the child, the family, or both. Per the Vermont Medicaid ABA Benefit, providers are allowed a combined total of 8 hours of assessment every 6 months. The assessment is used to inform the treatment plan which contains goals for direct service.
In Measure #2, please explain the rationale in disincentivizing team care conferencing when the rest of our system of care is reinforcing care coordination.	The measure does not disincentivize care conferencing. In fact, care conferencing with the family present (CPT code 99366) is considered direct service when calculating results for Measure 2. The goal is to encourage direct service, parent education, and team care conferencing that involves the child and/or the family.

Does Measure #2 include supervision/ observation time where the supervisor is present with the staff and client during services?	Yes, supervision is included. The clinical description for CPT code 97155 is: "The physician or other qualified health care provider conducts a face-to-face behavior therapy session to a single patient with destructive behavioral concerns, such as harming oneself, damaging property, and aggression or behaviors resulting from recurring actions or issues related to communication or social interactions. During the encounter, the provider solves at least one problem with the protocol and may, at the same time, coach a technician or assistant behavior analyst, guardian, and/or caregiver in how to oversee the treatment procedures (modified protocol). The patient must be present during the session, including instructions provided to the technician and/or caregiver…"
Data, Calculation, and Scoring Questions	**Responses**
What is the reporting and scoring timeline? (i.e., is it once a year for all 10 points? Or quarterly?)	Scoring will occur annually after the end of the performance year, allowing for a six-month claims runout.
Will the payment model allow a process for agencies to recoup lost points?	As with past reconciliations, providers would have an opportunity to review results prior to final reconciliation.
When "provider" is referenced, does that mean the group including all credentialed providers or each individual provider as rendering through billing?	Provider means the organization, not individual providers.
The document contains the following sentence: "In subsequent years, make full tier payments with performance reductions (if any) occurring at reconciliation." Does this mean that we would have money recouped in the amount of full tier payments?	Full tier payments would not be recouped as a result of performance, if the model evolves into a value-based payment withhold. The most that would ever be deducted from year-end reconciliation calculations would be the percentage of earned payments allocated to the withhold. The current proposal is 1%. The entire 1% would be deducted only if the "gate" (minimum performance level required to earn any points) was not met for any of the three measures.
In Measure #1, please explain what point totals are allocated at which percentages (do you get one point for hitting 90%, two for hitting 95%, etc.).	Please refer to the scoring tables for Measures 1 and 2 in the Power Point from the May 19th meeting.
In Measure #1, how are the percentage targets of clients served established? Are they based on each individual agency's previous year performance?	For the first year, the proposal is to base the targets on each provider's person months of service during calendar year 2021 and compare 2023 person months to that 2021 baseline.
How will you account for clients who are not open to the agency for the full calendar year? Example scenario: a staff serves two clients per week for 10 hours each. That would be 24 person months for	Each client that receives 6 hours of service in a month would result in one person month. If a client doesn't receive service during a month, they would not result in a person month (either for the baseline year or the performance year). The example provided illustrates that client needs can vary. It is also

the year. In 2022 that staff serves 1 client per week for 20 hours. That would be 12 person months for the year, a 50% reduction. This would be the same hours, same care, but would have a very different impact on the measure.	possible that a staff member could serve one client in the baseline year and two clients in the performance year.
Could Measure #1, as specified, negatively impact agencies that have new referrals for high-needs children or lead to serving more children with fewer hours of service?	A key design element of the ABA Tiered Payment Model is that it increases levels of support for children with higher levels of need, which is intended to encourage providers to implement appropriate levels of service for all children. For example, a provider would get $13,667 providing 170 hours to one child (in Tier 14) and $11,878 providing 85 hours to two children (in Tier 8). The project team has concluded that it would be beneficial to also link a small amount of funding (proposed at 0.4% of earned payments) to Measure #1, which encourages expanding the number of children served.
Data, Calculation, and Scoring Questions (cont'd)	**Responses**
Measure #1 proposes that providers have to exceed the baseline year's person months by at least 10% to get full points. Will the baseline increase year over year, making it impossible to attain the 110% required to receive maximum points?	There has been no decision to increase the baseline year over year. The data from the first performance year and input from providers will be reviewed before making a decision on whether the baseline will remain the same or change.
Looking at Measure #2, a question is where these percentages [96% minimum and 99% maximum] came from? Are these indicative of the billing metrics since the current reimbursement system was put in place? Do these rates vary by region across the state?	A goal of the program was to encourage more direct service. The targets were based on analysis of recent data and reflect the current reality. Data shows improvement over time with little variation across providers. The average across all providers has been the same in all three years of ABA payment reform. All providers already met the minimum threshold in CY 2021, and most (9 of 17) met the target for maximum points.
What goes into the denominator for Measure #2?	Total hours billed.
In Measure #3, is the scoring based on closed claims? Or just submitted claims?	Any claim actively submitted before the 6 months would count regardless of when it reaches a paid and final claims processing status. Batch resubmission of claims would not count if they introduced new claims after 6 months. Measure #3 is important because delays in claims submission have resulted in a lack of timely information and additional administrative burden for providers and DVHA, as well as delays in program monitoring and reconciliation (which can result in payment delays).
What codes would be used in the numerator for Measure #2 (direct services for the client and/or family)?	The numerator for Measure #2 would include the following codes: 97153, 97154, 97155, 97156, 97157, 97158, 0373T, 99366
How would providers have done if the proposed model had been in place in previous years?	For Measure #1, 10 providers would have gotten maximum points, 3 providers would have gotten some points, and 5 would have gotten no points if the model had been in place in 2021. For Measure #2, all

providers would have received some points if the proposed model had been in place in 2021, and 9 of the 17 providers would have received the maximum points. For the Measure #3 (timely claims submission), it appears that 6 providers in 2020 and 4 providers in 2019 would not have received points.

Measure 1: Percent Growth of Total Person Months (Tier 2 or more)

CY 2021* over CY 2020 Result	# of Providers
4 Points (110% or more)	10
Some Points (90-110%)	3
0 Points (90% or less)	5
	18

***Not all billing is in for 2021**

Measure 2: Historical Levels of Direct Therapeutic Services by # of Providers

	CY 2020	CY 2021
99% or over	8	9
96 to 99%	8	8
Under 96%	1	0
Total	17	17