State of Vermont

Agency of Human Services and Agency of Administration

Medicaid Pathway Overview
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I. Why a Medicaid Pathway?

This document is intended to provide high-level information about the Medicaid Pathway.

The Medicaid Pathway is a process that supports Medicaid payment and delivery system reforms. The Agency of Human Services and Agency of Administration have engaged in innovative Health Care Reform with the recognition that:

- Health care cost growth is not sustainable;
- Health care needs have evolved since the fee-for-service (FFS) system was established more than 50 years ago;
- More people are living today with multiple chronic conditions;
- The Center for Disease Control reports that treating chronic conditions accounts for 86% of our health care costs;
- FFS reimbursement is a barrier for providers trying to coordinate patient care and to promote health; and
- Care coordination and health promotion activities are not rewarded by FFS compensation structure.

One overarching goal of moving away from traditional FFS payment models is to allow for providers to have a greater focus on wellness and prevention, health promotion, early detection and intervention. The Medicaid Pathway focuses on Medicaid funded programs across the AHS such that the social determinants of health can be addressed on balance with the traditional health care system. Medicaid Pathway planning principles are defined below.

Medicaid Pathway Principles

- **Ensure Access to Care for Consumers with Special Health Needs**
  - Access to Care includes availability of high quality services as well as the sustainability of specialized providers
  - Ensure the State's most vulnerable populations have access to comprehensive care

- **Promote Person and/or Family Centered Care**
  - Person and/or Family Centered Care includes supporting a full continuum of traditional and non-traditional Medicaid services based on individual and/or family treatment needs and choices
  - Service delivery should be coordinated across all systems of care (Physical, Behavioral and Mental Health and Long Term Services and Supports)

- **Ensure Quality and Promote Positive Health Outcomes**
  - Quality Indicators should utilize broad measures that include structure, process and experience of care measures
  - Positive Health Outcomes includes measures of independence (e.g., employment and living situation) as well as traditional health scores (e.g., assessment of functioning and condition specific indicators)

- **Ensure the Appropriate Allocation of Resources and Manage Costs**
    - Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences resulting from decisions made in one area in isolation of other factors

- **Create a Structural Framework to Support Integration**
    - Any proposed change should be goal directed and promote meaningful improvement
    - Departmental structures must support accountability and efficiency of operations at both the State and provider level
    - Short and long term goals should align with current Health Care Reform efforts

State of Vermont Medicaid Pathway Goals

The State's high-level goal for all health reforms 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.

As delivery system and payment reforms mature under the All Payer and Accountable Care Organization Models, services that support home- and community-based service and address the social determinates of health must also be integrated into an organized and accountable system of care. Physical health care, LTSS, and Mental Health and Substance Use Disorder Treatment systems cannot work in isolation. Reform objectives include the development of an *organized delivery system* for serving individuals and promoting integration across services for:

- Mental Health
- Substance Use Disorder Treatment
- Long Term Services and Supports for individuals with developmental disability service needs
- Physical Health
- Long Term Services and Supports for individuals with physical disabilities and older Vermonters

Through the Medicaid Pathway, the State seeks to provide efficient, effective care to all Medicaid beneficiaries through an organized delivery system, 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 on the following page, to support this.

Care Delivery Goals

- Support primary and secondary prevention, including support of early intervention to reduce risk factors.
- 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.
- Foster integrated service delivery for Medicaid beneficiaries across the care continuum.

Payment Model and Quality Framework Goals

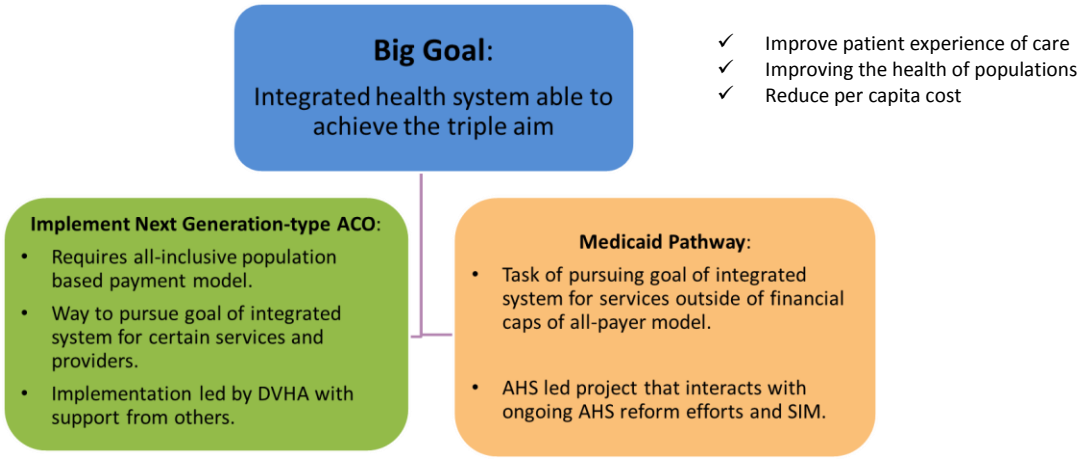
- Expressly move from FFS payments to population-based payments, increasing accountability and risk to impacted providers.
- Incentivize high quality, efficient services and reduce incentive for high service volume.
- Increase flexibility in payment to support more efficient delivery of services.
- Reduce payment silos and fragmentation across provider and service types.
- Connect payments with quality in service delivery and health of Medicaid beneficiaries.
- Align measurement and reporting with values, principles and goals.
- Provide data and feedback to providers delivering care 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 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.
- Standardize payment structure and quality measurement for similar services across AHS.
- Allow for seamless oversight and monitoring across AHS.
- Improve data collection to support future policymaking.
- Transition payments in a manner that is operationally feasible for both the State and providers.

II. What is the Medicaid Pathway?

The Medicaid Pathway is a planning process led by the AHS-Central Office in partnership with the Agency of Administration. These planning efforts are designed to systematically review payment models and delivery system expectations across the AHS Medicaid program to refine State and local operations to better support the integration of Physical Health, Long Term Services and Support, Mental Health, Substance Use Disorder Treatment and Children's Service providers.



Current planning efforts relative to All Payer Models (Medicare, Commercial and Medicaid) and Accountable Care Organization development offer the opportunity to more fully realize Vermont's Model of Care throughout the entire health care system including Long Term Services and Supports, Mental Health and Substance Use Disorder treatment services.

The Medicaid Pathway advances payment and delivery system reform for those services not subject to the additional caps and regulation that is expected under the State's All Payer Model. The goal of Medicaid's multi-year planning efforts is the alignment of payment and delivery system principles that support a more integrated system of care for all Medicaid supported services and enrollees. Table 1 on the following page offers an overview of how an Organized Delivery Model, such as an Accountable Care or similar organizational approach, could support Vermont's Model of Care.

Table 1: Delivery Reform Efforts and Opportunities to Support Vermont's Model of Care

Core Elements of Vermont's Model of Care	Delivery and Payment Reform Opportunities
Person Centered and Directed Process for Planning and Service Delivery	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services.
Access to Independent Options Counseling & Peer Support	Organized model could support multi-payer expansion of capacity of cost effective supports and services.
Actively Involved Primary Care Physician	Payment flexibility for care coordination services could support interaction with PCP; Organized model could enable single clinical record, physician supports and training.
Provider Network with Specialized Program Expertise	Organized model could support multi-payer expansion of capacity and planning across the full continuum of services.
Integration between Medical & Specialized Program Care	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services.
Lead Care Coordinator (Single Point of Contact for person with Specialized Needs across All Services)	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning and single point of contact across the full array of services; opportunity to develop training protocols/best practices across care management entities.
Standardized Assessment Tools	Tools could be modified to include all medical and functional needs.
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services (including Shared Care Plans)	Payment flexibility could expand range of services available to meet individual needs.
Care Coordination and Care Management (including across organizations)	Organization and flexibility could create opportunities for integrated care coordination.
Interdisciplinary Care Team & Care Conferences	Organization and flexibility could create opportunities for integrated teaming such as Blueprint for Health and other models.
Coordinated Support during Care Transitions	Organized model could enhance communications and training.
Use of Technology for Sharing Information	Organized model could facilitate integrated clinical record.

Implementing alternatives to FFS payment can also provide an opportunity for the State and providers to more fully support wellness and early intervention. Establishing alternative payment approaches may provide greater flexibility to support:

- Health Promotion
- Early Intervention and a Reduction of Client Risk Factors
- Provider Flexibility to Decide on Necessary Services
- Reduced Incentives for Volume
- Non-traditional (Home and Community Based) Services based on a Person's Unique Treatment and/or Support Plan Needs and Social Determinants of Health

Transformation Elements & Work Plan Steps

To address comprehensive planning, the Medicaid Pathway process has defined five planning domains. These domains include: organized delivery system expectations, including supporting changes in State contracting and oversight practices; defined value-based purchasing methodologies to support desired changes in delivery; payment model alignment and consistent approaches to rate development across programs; unified quality oversight and outcome monitoring across AHS Medicaid Programs. Lastly, the State will need to examine the resources needed for technical assistance and any staff, budget and business process changes to support and sustain necessary modifications in operation. Key areas of planning and sample design questions are summarized below.

1. Delivery System Transformation (Integrated Model of Care and Population Health Activities)

- What will providers do differently?
- What is the scope of the transformation?
- How will transformation support integration?

2. Payment Model Reform (Reimbursement Method, Rate Setting)

- What is the best reimbursement method to support the Model of Care (e.g. FFS, case rate, episode of care, capitated, global payment)?
- Rate setting to support the model of care, control State costs and support beneficiary access to care.
- Incentives to support the practice transformation.

3. Quality Framework (including Data Collection, Storage and Reporting)

- What quality measures will mitigate any risk inherent in a preferred reimbursement model (e.g. support accountability and program integrity) while allowing the State to assess provider transformation (e.g. structure and process) and assure beneficiaries' needs are met?

4. Outcomes

- Is anyone better off?

5. Readiness, Resources and Technical Assistance

- What resources are necessary to support the desired change and/or fund the delivery system?

Vermont's Model of Care

Vermont's Model of Care emerged over the course of several years and through many discussions with a broad set of stakeholders. Discussions began as part of the "Dual Eligible Project" work groups from 2011-2014 and continued to be refined by the Vermont Health Care Innovation Project (VHCIP) Disability and Long Term Supports and Services Work Group from 2013-2016.

The Integrated Model of Care has been agreed upon by stakeholders as foundational to reform efforts. It was adopted by the VHCIP Practice Transformation Work Group and utilized to inform The Integrated Communities Care Management Learning Collaborative activities and Core Competency Training curriculums. It is now foundational to ACO and Medicaid Pathway planning discussions. The Vermont Integrated Model of Care is based on the recognition that:

- Older people and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports.
    - In Vermont, approximately 25% of Medicaid beneficiaries are enrolled in Specialized Programs; however, they account for 72% of Medicaid Expenditures (55% in specialized programs and 17% in physical health care).
- Evidence suggests that the integration of care (Primary Care, Acute Care, Chronic Care, Mental Health, Substance Use Disorder Treatment services and Disability and Long Term Services and Supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care and lower costs.
- Community based supports help prevent the need for care in more expensive, acute care settings, thus improving well-being, quality and controlling costs.

- Research has shown that environmental and socio-economic factors are crucial to overall health.

- Integration, inclusive of peer supports, is a fundamental component of comprehensive, person/family directed care.

Many of the AHS Specialized Programs support model of care elements within specialty areas. However, discussion is ongoing regarding how the State's Health Care Reform efforts can preserve and enhance the ability to incorporate all elements across the full continuum of health care providers and services. Highlights of this model include:

1. **Person /Family Centered and/or Directed Services and Supports: Definition:** Care that is life-affirming, comprehensive, continuous and respectful in its focus on meeting an individual's goals and what is most important to them including health needs (medical, mental health, behavioral, long term care) as well as social needs (housing, employment), while promoting empowerment and shared decision-making through enduring relationships.

   "One size does not fit all" organizational/systemic capacity is needed to effectively respond to a range of preferences regarding services and coordination.

2. **Access to Independent Options Counseling & Peer Support**: Independent, easy-to-access information and assistance to assist individuals and families/caregivers to: understand insurance options, eligibility rules and benefits; choose services and providers; obtain information and make informed decisions about services, including Peer and Recovery Support.

3. **Involved Primary Care Physician (PCP)**: All people with specialized needs will have an identified PCP that is actively involved in their care and who has knowledge about specialized service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options.

4. **Access to Specialized Services**: To ensure that specialized service providers are available and address comprehensive care planning and care coordination for persons with special needs, including referrals to PCP whenever needed to address co-occurring and/or complex medical conditions for the individuals served.

5. **Lead Care Coordinator (Single Point of Contact)**: To ensure person centered care; coordination across all of the individual's physical, mental health, substance abuse, developmental, and long-term care service needs and care team members; relevant assessments are completed; develop and maintain both a comprehensive care plan and Shared Care Plan (that facilitates communication across an individual's care team); ensure support during transitions in care and settings.

6. **Medical Assessments and Disability and Long Term Services and Support Screening by PCPs, Medical Specialists:** PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits. If a person has mental health, substance abuse, functional or cognitive impairment, the PCP should be informed about specialized services, use a

brief screening tool (if necessary) and refer the person to specialized providers for more in depth assessments as necessary.

7. **Disability and Long Term Services and Support Specific Assessments:** The Individual's Lead Care Coordinator is responsible for assuring that all screening and assessment results (medical and specialized program related) as well as an individual's goals are included in, and inform, the individual's Comprehensive Care Plan and the Shared Care Plan used across the Individual's Care Team members and service organizations.

8. **Comprehensive Care Plan (including a Shared Care Plan)**: For individuals with specialized service needs that go beyond PCP care, the Lead Care Coordinator is responsible for developing and maintaining a single Comprehensive Care Plan that includes all identified needs, goals, preferences, services and supports (paid and unpaid). Shared Care Plans, (e.g., a written summary highlighting the individual's strengths, preferences, goals, priorities and short and long term needs), are also created in support of cross-organizational collaboration and communication).

9. **Individual Care Team (ICT) and Care Conferences:** For individuals with specialized needs that go beyond PCP care, the Lead Care Coordinator is responsible for ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Comprehensive and Shared Care Plans, including the individual's PCP. Care Conferences, with the individual and members of the care team, to facilitate communication, teaming, unified goal setting and monitoring of progress are an important tool for integrated care planning.

10. **Support During Care Transitions:** For individuals with specialized needs that go beyond PCP care, the Lead Care Coordinator is responsible for: initiating and maintaining contact at the beginning, during, and at the end of the care transition (including such things as identifying barriers to care and working with the individual, family and providers to overcome such barriers).

11. **Use of Technology for Information-Sharing:** Goal: A technological infrastructure that would:
    a. House a common care management database/system.
    b. Enable integration between the care management database and electronic medical records and between all providers of an Individual's ICT to electronically access and update the Shared Care Plan, report on quality measures, notify providers of transitions in care, and exchange relevant clinical information.
    c. Allow for communication and sharing of information within a secure, confidential environment, which allows for both low-tech and high-tech communication options.
    d. Adheres to Federal and State/AHS consumer information and privacy rules and standards, including informed consent.

Appendix 1 provides a summary overview of the model of care elements in comparison to other national frameworks.

Alternatives to Fee-for-Service Payment Models & Value-Based Purchasing

While there are many variations of provider payment models and reimbursement mechanisms, they all stem from three predominant payment methodologies: fee-for service, bundled payments and population-based payments. When developing payment models and reimbursement mechanisms, payers have a choice of creating the base payment model (i.e., the overall approach to paying for services) without value-based enhancements, incentives or other goal oriented performance tools, or a payment structure in concert with value-based purchasing elements. For mature payment models, already in operation, value-based purchasing elements can be added to it, or the program can be restructured to promote and reward service system change and quality.[1]

In Vermont's planning efforts, the following definition of Value-based Purchasing has been adopted:

> *Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.*

This definition was derived from two primary sources: The Centers for Medicare and Medicaid Services Roadmap for Implementing Value Driven healthcare[2] and comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP.[3]

One step in developing a Value-based Purchasing program is to understand the base payment model, its potential unintended consequences and effects on provider service delivery, and its relationship to the goals of the desired change. [4,5] Each payment model has its own type of financial risks that are assumed by the payer and /or provider. FFS payment can create financial incentives for volume. Bundled payments put slightly more risk on the provider since it is unknown at the beginning of the "episode" exactly what services may be needed. Population-based payments create incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner, but can also put providers at risk if they treat populations that are sicker than average.

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[1] Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf

[2] Ibid

[3] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

[4] Ibid

[5] Miller HD. (2007). *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund. Can be found at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2007/sep/creating-payment-systems-to-accelerate-value-driven-health-care--issues-and-options-for-policy-refor/miller_creatingpaymentsystemsvalue-drivenhltcare_1062-pdf.pdf

Examples of alternative payment models under review and their relationship to Medicaid Pathway and reform objectives can be found in Appendix 2.

III. Medicaid Pathway Efforts to Date

Current Planning Groups

The Medicaid Pathway includes the creation of work groups that are comprised of public and private sector stakeholders with expertise in the services under discussion. The work groups focus on all aspects of the proposed reforms including payment model, quality measures, delivery system reforms, and other necessary components.

Currently two work groups have been established. One group is focused on Mental Health, Substance Use Disorder Treatment and Developmental Disability programs and encompasses Designated and Specialized Service Agencies and Alcohol and Drug Abuse Preferred Providers and Children's Service providers involved in the Integrating Family Services Initiative. The Mental Health (MH), Substance Use Disorder Treatment (SUDT)and Developmental Disability Services (DDS) group began meeting in December of 2015. This group is an extension of planning that began earlier in the year related to certified community behavioral health clinics (CCBHC) design opportunities under section 223 of the Protecting Access to Medicare Act. The second work group is focused on Long Term Services and Supports offered through the DAIL Adult Service Division including Choices for Care and other Medicaid funded supports. This work group began meeting in June of 2016. Descriptions of each group and their membership can be found in Appendix 3.

Delivery System Design and Transformation

In asking "What will providers be doing differently?" the MH, DDS, SUDT planning group created the long-term vision for delivery design efforts depicted on Table 2 below.

Table 2: Long Term Vision for Delivery Reform Efforts

Delivery System Transformation	
What will providers be doing differently?	**How will Change Support Integration?**
Adopting the Vermont Model of Care	Through Consumer Experience of Integrated Care such as: • Person/Family directed planning • Bi-directionality of referrals between PCP and Community Service Providers • Standardized and comprehensive assessments • Interdisciplinary team inclusive of PCP • Single/Lead Care Coordinator • Interdisciplinary Teaming • Use of IT to support information sharing & outcomes
Creating a provider-led process to support, at a minimum: • Achievement of the Model of Care including enhancing efforts to address social determinants of health • Assessment of community needs and gaps • Monitoring of community and quality data to make decisions about community services, gaps, assets • Consensus regarding community investments that will support population health and social well-being and better integration of services	Through integration of service delivery and shared: • Governance of community goals & progress • Assessments of community assets & gaps • Decision-making regarding resources and community priorities • Accountability • Quality monitoring and improvement goals and outcomes at the community level

Delivery System Transformation	
What will providers be doing differently?	**How will Change Support Integration?**
Promoting Population Health (Population-Based Health, Adoption of Best Practices; Address Social Determinates of Health and Early Intervention)	Through coordination and accountability at the community level to promote innovation and monitor quality and outcome measures that "everyone can get behind" (i.e., all providers can impact)
Ensuring Efficient Operations and Oversight, (including non-duplication of services and supports and streamlined reporting)	Through consolidation of functions at the provider and state level such as care coordination, data reporting and IT platforms across AHS programs

Emerging Definitions of Integration

In defining options for a seamless and organized delivery system across specialized programs, the MH, DDS, SUDT work group discussed conceptual models and explored emerging national models. Along these lines, Vermont's All Payer Model is designed to support an Accountable Care Organization (ACO) as its foundation to foster enhanced integration of care and promote quality throughout the State's health care system. The All Payer Model is designed to move away from a volume-driven FFS payment to a value-based, pre-paid model for ACOs. It will require alignment across public and private payers and anticipates full integration and coordination of care for all medical, mental health, substance use disorder treatment and long term services and supports.

In discussing levels of integration for AHS specialized Medicaid programs, stakeholders discussed the meaning of the term "integration'. It is anticipated that, as providers work to define their respective roles and relationships in an organized system of care, the level of provider integration will range from coordinated to fully integrated partnership agreements. Definitions of integration as a key delivery system design component are outlined below.

Full Integration: Separate entities develop a formal and/or unified governance structure that oversees a defined set of services and providers for a region or statewide. Structure is developed through contract agreements, corporate relationships (e.g., LLC, ACO partnerships, merger) or other legally recognized arrangements whereby providers share administrative services, data collection and/or tracking, responsibility for outcomes, responsibility for budget monitoring, budget decisions and investments in direct care. Providers have an in depth understanding of each other's roles and responsibilities. *Provider staff view work together as one of a single team and the principle of treating the whole person is applied to total population, not just identified target groups.*

- Shared administrative functions may involve designation of one existing entity as "lead", the creation of a new statewide or regional entity, or a combination of methods.
- Expectations and standards for quality framework, integrated model of care and outcomes are defined by State and shared across providers
- Target Group: Whole or subset of population
- Funding: Flows to single entity or consortium and partners make decisions regarding resource allocation at the local level

Partial Integration – Targeted Services: Separate entities create shared planning and decision-making structure for certain aspects of service delivery, target populations or specific goals, while maintaining

legally separate organizations. Written agreements between providers may include: direct referral arrangements (e.g., dedicated staff or slots for partner agencies, ACO network agreements); co-location of services or staff; purchase of service agreements for activities such as specialized care, staff supervision, training or administrative services (e.g., claims processing, human resources, IT support). *Provider staff from multiple agencies view their work as part of interdisciplinary teams for specific target groups. Providers have an in depth understanding of each other's roles and responsibilities as it relates to target group and scope of shared governance.*

- Shared administrative functions are determined through local planning and may involve: proactive assignment roles and responsibilities through an agreed upon decision-making process; ad hoc assignment of functions as needs are identified to achieve shared goals.
- Expectations and standards for quality framework, integrated model of care and outcomes are defined by State and shared across providers
- Target Group: Whole or Subset of Population
- Funding: Could flow to locally entity for defined administrative functions and quality incentive payments. Payments for direct care remains provider specific.

Coordination: Separate entities may share information regarding other organizations in the area with clients and/or make referral calls on the client's behalf; entities may have information sharing protocols and/or other agreements regarding how they coordinate services for shared clients*. Provider agencies may serve in consultant roles to each other regarding specific types of client profiles or conditions.*

- Administrative functions are not shared
- Expectations and standards for quality framework, integrated model of care and outcomes are defined by State and shared across providers
- Target Group: Specific to provider type and/or individual contract agreement
- Funding: No shared funding

Definitions and delivery models are expected to be more fully defined, through provider led reform, while State and provider staff explore how to create or modify State policies and incentives to assist providers to achieve more integrated approaches to care and support the adoption of the Vermont Model of Care. A summary of delivery system models that support each level of integration are described on Table 3 on the following page.

Table 3: Continuum of Integrated Delivery System Models

Continuum of Integrated Delivery System Models					
Level of Provider-defined Delivery System Integration	Characteristics	Support for Reform Objectives	Local Partnership Governance Agreements	Shared Functions	Flow of Funds
1. Coordinated Model	○ Provider specific work and populations, standards defined by State contracts.	○ Provider Specific (incentives could be created for adoption of some aspects of reform)	None	None	Provider Specific
2. Specialized Delivery System Integration: (Minimum Service Array - CCBHC-like model) (Partial Integration)	○ Provider Led ○ Consumer/Peer directed ○ State standards and oversight ○ Integrated care for target population	○ Allows for adoption of model of care within targeted program ○ Limited early intervention options ○ Limited to no impact on population health and prevention	○ Optional based on scope of services and local provider-led decisions regarding shared functions	○ Optional based on provider-led decisions; could include: IT; data analysis and reporting; quality and outcome monitoring; assessment of community assets and gaps; claims processing; etc.	○ Provider specific payment agreements ○ At discretion of local provider-led partnerships some funds could flow to defined local entity for shared administrative and quality incentive payments ○ Could include incentives for enhanced care coordination
3. Integrated Community Delivery System: (Minimum Service Array plus additional health care partners based on local decision) (Partial or Full Integration)	○ All of the Above + ○ Integrated care for whole or subset of population ○ Streamlining of Medicaid fund sources to each provider ○ Shared investments	○ Same as above with added flexibility for early intervention, population health and prevention based on partners	○ Required if shared investments are part of local agreements	○ Same as above	○ Same as above ○ Shared investments could be part of local agreements
4. ACO Affiliated or Similar Model (statewide or regional) (Full Integration)	○ All of the Above + ○ Streamlining of all Medicaid fund sources	○ Supports all objectives	○ Required for resource decisions, priority setting and shared quality and outcome tracking	○ All of the above + ○ Budget monitoring, priority setting and resource planning	○ Single Entity with shared investments

Emerging Definitions of Governance

Medicaid Pathway planning included discussions on various models and elements important to governance in provider-led efforts. Specifically, how a region or other provider partnership could address: strategic planning and local accountability for population health; integration of health and human service systems; person-centered and directed care; and integrated planning contemplated in the Vermont Model of Care. In designing a more integrated system of care, it is expected that a provider-led reform will include shared goals, decision-making and accountability for integrated care delivery models and beneficiary outcomes. This includes:

- Addressing social determinants of health;
- Assessing community needs and gaps;
- Using community profiles and other quality data to make decisions about local services, gaps and assets; and
- Creating consensus regarding community investments to support population health and the adoption of the Model of Care.

Providers may choose to create formal or informal structures to address collaboration and outcome monitoring. It is expected that providers review existing community frameworks such as the Blueprint Community Collaboratives, Integrating Family Services or other Local Interagency Team structures to determine if shared oversight functions can be supported through existing frameworks and to identify any components that may require additional enhancements.

Table four below outlines community oversight functions or local governance roles that AHS and stakeholders have determined are critical to support desired delivery and payment reforms.

Table 4: Shared Oversight

Expected Regional Oversight/Governance Functions	
Function	**Description**
1. Strategic Oversight and Goal Setting	Local entities should have shared goals, community vision and clearly defined roles (based on final State standards and contract expectations)
2. Accountability for Management of Partnership Agreements	Any formal local agreements regarding decision making and roles need unified, agreed on point of responsibility (e.g., how each provider relates to local governance structure and decision-making)
3. Designation of an Administrative Lead Agency for Shared Services (if utilized)	Shared services and administrative structures are discretionary based on local provider decisions and agreements, if regions decide to share functions then roles and responsibilities across providers should be clearly defined
4. Consumer Voice and Involvement in Governance	Local entities should include consumers and family members in decision-making structure
5. Community Needs Assessment and Asset Building	State should develop standards to bring separate requirements across government together across services, providers and populations; Local entities would be responsible for unified needs assessment across domains and submitting cohesive plan for addressing gaps in a collaborative fashion.
6. Monitoring of Quality Data and Community Indicators of Health (Including Consumer Experience of Care and compliance with State standards)	Local entities would share responsibility for monitoring quality and outcome data, including how well the system is complying with state and/or federal standards as outlined in contract agreements
7. Monitoring of Service Utilization and Waiting List	Local entities should monitor service use and waiting list to inform both quality improvement and resource allocation/investment decisions
8. Direct Priorities for Local Quality Improvement (QI) Efforts	Local entities should make Quality Improvement decisions based on data from items above and local discussion

Payment Models

Payment models that are being explored to support delivery system integration include:

- *Community, Population Based or Global Budget*: Development of a total budget by community and requiring providers to collaborate to manage to a total community budget. Another approach may involve developing a global budget by provider, while measuring integration and outcomes across the local system and individual provider performance.

- *Capitated or Sub-Capitated*: A capitation amount based on number of eligible members in region, regardless of need could be developed for a region, provider or group of providers. Provider specific sub-capitation amounts could also be developed based on services that are the responsibility of each provider.

- *Case Rates:* There are several methodologies to developing a case rate or bundled payment approach. Monthly rates per enrollee (e.g. per member per month or PMPM) could vary based on program expectations or population type.

- *Care Coordination Case Rates/Enhanced Care Coordination Payments*: Develop payment model for care coordination that is fully compliant with Model of Care.

In July of 2016, the MH, DDS, SUDT planning group began its review of proposed payment models to support the delivery system designs outlined above. Through implementation of an alternative payment model, AHS seeks to support efficient, effective care to all Medicaid beneficiaries and to ensure that care is consumer/family-directed and meets the criteria described in the Vermont Model of Care.

In early September of 2016, AHS and AOA proposed a payment modeling methodology beginning with the services provided through the DA/SSA provider network. The proposed alternative payment model for these providers consists of two components:

1) Global budget target (including a process to monitor and adjustment rates in each year); and
2) Monthly, prospectively-set, case-mix adjusted bundled payment inclusive of all services.

Global budgets are expenditure targets for health care spending. The purpose of setting an expenditure target is to constrain both the level and rate of growth of spending. The advantage of this approach is that it provides a clear incentive to operate efficiently. The downside however, is that these constraints can lead to access problems due to rationing by waiting. On-going monitoring and adjustment of the global budget process is required to both enforce targets and make informed decisions about shifting resources across AHS programs, particularly in response to caseload demand and access issues.

The bundled payment mechanism is supported by the global budget and allows AHS to compare regional activities and results as well as to include additional services and supports in the bundle as future phases of the project progress. Compared to FFS, the advantage of a bundled payment model is that it incents efficiency of resources within the bundle, within a given month. However, the weakness of the monthly bundled payment approach is that on its own, it does not provide a direct incentive to manage how many monthly bundles are provided overall throughout the year. When paired with the global budget approach however, the model will allow for providers to respond and accrue revenue for

increased utilization through the bundled payment which can be adjusted if needed when monitored against the global budget target.

To support State and provider discussions, a sample bundled payment rate model was developed that compiled financial and claims data for a historic period. Survey data, audited financial data, claims data, and data from the DMH Monthly Service Report (MSR) database were compiled into a comprehensive data set of historic service, financial and utilization information. The data set contains information from calendar years 2013, 2014, and 2015. The State used a fiscal impact model based on State Fiscal Year 2015 data to display the impact of various bundled payment models against actual baseline or adjusted baseline cost and payments.

The State then conducted extensive financial analysis on the compiled data to assess the sample size, variability in spending, outliers and the best approach to case-mix and/or risk adjustment. The data was validated using external sources where possible. Next, the State calculated the historic cost of providing services included in the bundle. Upon reviewing the findings of the financial and costing analysis, the proposed bundles and options for outlier and case-mix adjustment were developed.

The State considered case-mix adjusting within each bundle such that actual services that actual services received in any given month could trigger a higher bundled rate. This approach would provide additional resources when a beneficiary experienced a higher than historically recorded use of services; however, the approach has a strong incentive for providing more services to trigger an enhanced payment, referred to as up-coding in risk adjustment or in the diagnostic resource group (DRG) system. Because of this, the State is not currently proposing to case-mix adjust within each bundle. AHS has proposed using historic, provider-specific historic case-mix to set the prospective bundled rates. Updates to the case-mix would be reflected as future re-basing of the bundled rates occurred. Historic provider-level case-mix will be determined by using weighted bundled costs to construct a relative weight across the five bundles proportionate to their resource use and utilization for that provider in the historic data. To convert the relative weights to rates which, in the aggregate, will equal a total percent of cost, a provider-specific conversion factor will be set.

To ensure that the predicted spending in the prospective rate is as accurate as possible, adjustments to historic utilization are proposed for known changes in trends. For example, autism coverage is a relatively new service being offered; if necessary, risk corridors will be set up so that the new methodology does not create significant increases or decreases in spending compared to baseline or adjusted baselines. Moreover, an outlier policy based on monthly costs in excess of two standard deviations of the mean, approximately equivalent to a total withhold in spending of approximately 2.5% across all DAs and SSAs, is proposed.

In summary, under the proposed bundled model, the total monthly payment for a beneficiary would be the sum of the provider-specific rates for those bundles triggered net of any applicable outlier payments and/or adjustments, if applicable, e.g., discounting for efficiencies when multiple bundles are provided in the same month. Bundles would be triggered based on some unique combination of services and modifiers recorded on professional services claims forms (CMS1500). The rates would reflect historic provider-specific case-mix and be set equal to a specified percent of cost target.

As proposed the AHS would exclude certain DA/SSA provided services from the bundled payment in the firsts phase of implementation. Unless already part of the IFS pilot, these exclusions include: Self or Surrogate Managed Developmental Disability Services; Intermediate Care Facilities (ICF); Success Beyond Six (SBS); Traumatic Brain Injury (TBI); private non-medical institution (PNMI); Choices for Care (CFC); and services provided by the DA/SSAs under contract with the Department of Child and Families, Department of Education and the non-ADAP divisions of the Department of Health.

AHS and AOA are currently working with the DA/SSA representatives, State staff and consultants to review the model and assess the following questions:

1. Does the proposed payment model support the Medicaid Pathway goals and level of integration contemplated in the Model of Care?
2. Are there revisions or alternatives to the payment model that would further support meeting the goals and level of integration?
3. What additional information or data reports would be helpful to assess the model's feasibility?
4. Is the model feasible for implementation in the DA/SSA provider system and expandable to other services and provider networks in future project phases?

Quality and Outcome Measurement

A key component of the Medicaid Pathway work to support delivery system and payment reform is the quality and outcomes framework. The overall quality and outcome framework is related to, but broader than, quality metrics that may be used to determine incentive payments. The impact of quality measures on the payment model will be only upside risk, meaning providers can increase revenue through the achievement of higher quality. This is meant to transition these providers from the current, non-risk based payment model into one where there is increased accountability. Through the quality framework, AHS will seek to achieve the following:

- Align measurement and reporting with values, principles and goals
- Create a foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning:
    - Accountability: Confirm that contracted services were delivered. Did the State get what it paid for?
    - Appropriateness: Were the services delivered based on best practice and State standards (e.g., process and clinical, Model of Care, Home and Community Based, Trauma, Recovery, Reliance, etc.)?
    - Outcomes: Did the services delivered produce the expected results?

Key elements of quality and outcome measurement involve quality indicators that utilize a broad measure set including structure, process and experience of care measures, examples of measures that may be considered in each area, include but are not limited to:

- Access, Structure and Process
    - Efficiency and timely access o Primary Care involvement in comprehensive treatment and care planning
    - Communication between the medical and specialized systems of care

- Adherence to State standards and best practice

- Beneficiary Experience
  - Involvement in decision-making
  - Satisfaction regarding care coordination and access
  - Support during care transitions
  - Increased overall satisfaction with services and supports
  - Decreased out-of-pocket costs (e.g., fewer co-pays for ER, other services)
  - Increased early intervention options for children, adults and families

- Positive Health Outcomes that include measures of independence as well as traditional health scores

- Person and Service Related Outcomes
  - Decreased emergency room utilization
  - Decreased avoidable hospital admissions/re-admissions
  - Decreased nursing home utilization
  - Health assessment and/or condition specific scores (asthma, diabetes, overall assessment of functioning)
  - Decreased use of residential care for children, youth and adults
  - Stable community living situation
  - Stable employment
  - Attainment of person-centered goals and objectives

Examples of potential systemic outcomes include:

- Decreased Provider Cost-shifting across Payers (due to more service oversight and coordination across all of the individual's medical and specialized needs via a single point of contact, comprehensive care plan, and integrated care team)
- Decreased Overall Costs for Health Care System

AHS has sponsored a Medicaid Pathway outcomes subgroup. The group is comprised of representatives from all AHS Departments (except for DOC) and includes representatives from Integrating Family Services, Green Mountain Care Board, DAs, SSAs, Preferred Providers, and Vermont Care Partners. The group is chaired by AHS and supported by Vermont Health Care Innovation Project consultants. The group is tasked with recommending DDS, MH, and SUDT Medicaid Pathway measures for the following purposes:

- Payment: to inform incentive payment and/or withhold return
- Monitoring: to inform contract compliance activity or track measures not suitable for payment
- Evaluation: to track cost and utilization

A kickoff meeting was held in August of 2016 and the group has been reviewing measures already in use in Vermont. Information on the following topics has been provided: overview of the MH, DDS, SUDT Medicaid Pathway; overview of Value-based Purchasing; the role of measures in Value-based Purchasing; measure set organization - including the use of domains, review of service categories,

measure selection criteria; and individual adult mental health measures. Measures for Adult Mental Health are anticipated for initial selection followed by measures for Children's Mental Health and Emergency/Crisis Services.

The group has agreed upon the format of a measures library, generated a list of potential Adult Mental Health measures, adopted a set of measure review criteria, and initiated the review of Adult Mental Health measures. While the group is engaged in the measure selection process, the following issues have been identified as key decisions needed to move forward: description of the final payment model; selection of incentive payment type (e.g., quality bonus, shared savings, withhold), and the relationship between the measures selected and the measures currently in use for separate, yet related, DDS, MH, and SUDT projects.

Readiness, Resources and Technical Assistance

Throughout the planning process, DA/SSA and other stakeholders have noted challenges in the current system related to work force development and staff turnover and its profound impact on service delivery. Often the senior staff who have the knowledge and ability to lead internal agency reforms are also responsible for staff recruitment, training and supervision and may also carry a direct service caseload. High turnover rates not only inhibit quality and continuity of direct care for the consumer, but also impacts the organizations' ability to engage in internal innovation and delivery transformation. Modern Information Technology and data analytics have also been identified as priority. Additionally, Planning groups have also noted a gap in disability awareness within hospital and physician systems. Support for continued training in DLTSS core competencies and home and community based provider systems and supports has been suggested.

The following areas have been identified, to date, by stakeholder planning groups, as resource needs:

Information Technology and Data Analytics

- Data collection and reporting systems that allows for consistent and streamlined measurement of quality and outcome standards;
- Data Analytics staff at the State and local level; and
- Shared care planning and care management systems.

Workforce Training, Education and Awareness

- Vermont Model of Care;
- DLTSS core competencies;
- Consumer education, engagement and involvement in reform process;
- Learning Collaboratives for best practice support in the field; and
- Cross training opportunities between community based providers and physical health system (i.e. DA or Preferred Provider training led training for other providers on trauma, community based care and social wellbeing, peer support models of care, motivational interviewing, addictions and recovery principles, etc.).

Potential Budget Items

- Support for workforce salaries, predictable cost of living allocations to stabilize the workforce and minimize turnover;
- Stable funding for Independent Options Counseling;
- Quality incentive bonuses to support value-based purchasing models;
- Support for increased availability of wellness prevention support and treatment options;
- Support for enhanced care coordination and integration of services, including Choices for Care Model of Care improvements and new assessment tools;
- Efforts to address regionally designed population health outcomes;
- Independent evaluation of effectiveness of delivery system and outcomes;
- Independent review of provider budgets and anticipated costs prior to rate setting; and
- Development of IT and data analytic platforms and staff at the State and local level to conduct analysis and create reports for data-driven performance management.

Long Term Services and Supports/Choices for Care

The Long Term Services and Supports (LTSS) planning group met approximately every three weeks June 8th through December 19, 2016. The group began by reviewing DAIL services and defined its focus to include those services and supports provided through the Choices for Care program.

Following the decision to focus initial Medicaid Pathway work on the Choices for Care (CFC) program, the LTSS/CFC Stakeholder group reviewed a variety of performance and outcome information currently collected through DAIL and/or other AHS initiatives. Through an informal voting process, the group identified the "Top Ten" indicators that DAIL should consider to guide project work. These indicators provide the foundation for quality oversight and serve as a pool of potential areas to consider should the State seek to create a value-based incentive payment in the CFC program. The top ten indicators are provided below:

1. Participant involvement in plan of care development and decision-making;
2. Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need;
3. Participant's medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed;
4. A reduction in avoidable hospital admissions/re-admissions for program participants;
5. A reduction in emergency room visits for program participants;
6. Proportion of people who have transportation to get to medical appointments when needed;
7. Participants report that their quality of life improves;
8. Participants have stable community living situation and/or a reduction in homelessness;
9. Participants report satisfaction regarding care coordination and access;
10. Participants receive support during care transitions.

Consumer feedback from several past focus groups, interview and survey projects was also reviewed and summarized in support of the LTSS/CFC Medicaid Pathway planning. Sources of information included:

- *Vermont Dual Eligible Focus Group Project Summary* (Feb 2012): A report detailing the results of focus groups held with Vermonters dually eligible for Medicaid and Medicare (prepared by Lisa Horn, Finch Network LLC);
- *The Adequacy of Choices for Care Provider System* (Oct 2015): Department of Disabilities, Aging and Independent Living Report to the Vermont Legislature in accordance with 2013 Acts and Resolves No. 50 (prepared by Megan Tierney-Ward);
- *What Matters to At-risk Seniors: An Interview Study and Supporting Literature Review* (June 2016): Frail Elders Project (prepared by Brian Costello, Vermont Medical Society Education and Research Foundation)

Many of the identified consumer feedback themes related to the desire for improved care coordination and adoption of increased interdisciplinary teaming, comprehensive planning, prevention and early intervention to support persons with disabilities and seniors in aging in place at home. The feedback reviewed showed strong alignment with Medicaid Pathway goals and the core elements of the VT Model of Care. Because of this alignment, DAIL solicited additional feedback from work group members related to how the Choices for Care program could improve performance related to the key elements of the VT Model of Care. From this analysis, four priority areas for delivery and payment reform were identified:

1. ***Improve Early Options Counseling and Assessment****:* Support early Aging and Disability Resource Connections (ADRC) Options Counseling, holistic screening, and assessment for specialized needs in all settings (e.g., PCP, hospital admission, Nursing Facilities, Blueprint screening, referral and/or co-location agreements for ADRC and other CFC staff in non-CFC settings). (Model of Care Elements 1, 2, 7, 11);

2. ***Enhance Service Delivery Flexibility****:* Increase program flexibility for providers to match service and staffing to the person-centered plan, including regional funding allocations for moderate needs group services through the approval of overall budget or package of services for homemaker, respite, companion, PCA (e.g., eliminate hourly service limits) and other enrollee services and supports. (Model of Care Elements 1, 4, 5, 8, 11);

3. ***Create Interdisciplinary Teams****:* Implement interdisciplinary teaming and improve coordination of in-home care (e.g., PCA, respite staff), ancillary support needs (e.g., heat, food, housing, transportation) and increase support during care transitions. (Model of Care Elements 1, 3, 5, 7, 8, 9, 10, 11, 12); and

4. ***Improve Integration****:* Improve more formal linkage and seamless services between CFC case management agencies and mental health, substance abuse and other disability service providers to address specialized health needs. (Model of Care Elements 1, 4, 5, 6, 8, 9, 10, 11, 12).

Delivery and payment reform recommendations began to emerge during LTSS/CFC group discussions. There was a strong group sense that any final reforms should:

- Preserve and strengthen the successes of the Choices for Care program. Choices for Care has been nationally recognized for its innovation in LTSS. Participant access to benefits under the Choices for Care (CFC) program is based on: (1) financial eligibility; (2) clinical criteria; and (3) full

consumer choice in when, where and from whom to receive services. Unlike traditional LTSS programs, the Choices for Care program allows enrollees to move seamlessly between nursing facility, residential care, acute rehabilitation facilities, home care, adult day care, and adult family care in any given eligibility period. The seamless nature of services and strong support for participant directed care and service delivery must be preserved;

- Involve continued consumer and stakeholder dialogue and foster meaningful input into the reform process;
- Ensure informed consent, privacy, confidentiality, and appropriate release forms regarding information sharing and especially among interdisciplinary team members;
- Support the alignment of Model of Care and Choices for Care through the creation of common Model of Care contract standards, program and policy guidance and/or rule across all health care systems.

In addition, recommendations emerged related to specific aspects of the Choices for Care program. These ideas reflect informal group discussion but do not represent formal group consensus. Emerging ideas to date include:

A. Independent Options Counseling, Screening and Assessment

1. Link increased access to Options Counseling to provider incentives and/or payment rules:
   - Create incentives for ADRC and other consumer support agencies to develop co-location agreements with primary care practices, hospitals, nursing facilities and other non-CFC or disability specific settings;
   - Create standards within Medicaid and ACO regulations and/or provider contract language that requires participating physicians and hospitals to support Options Counseling such as:
     - Having up-to-date information on Options Counseling and ADRC-resources available for consumers,
     - Implementation of formal referral agreements with ADRC and/or other agencies, and
     - Co-locating independent options counseling staff in their service settings on a regular basis;
   - Link potential savings under the All Payer Model to increased support for Options Counseling and Peer Support;

2. Develop infrastructure/resources within the health care system to support Options Counseling for all Vermonters regardless of payer, including how capacity and/or population based payments could support long term development;

3. Develop business processes within the Medicaid program to identify beneficiaries that may benefit from Options Counseling who are not currently enrolled in Choices for Care or other Disability and Long Term Services and Supports programs;

4. Determine what resources (FTE funding and staff training) are needed to support the desired level of Options Counseling within the CFC program and/or the general Medicaid Program;

5. Determine if and where Options Counseling resources should be added and in what amount (e.g., Blueprint Community Health Teams, ADRC teams, other DLTSS providers, Peer Support organizations, VCCI, ACO, etc.);

6. Link person centered goals and information gathered during Options Counseling and pre-screening process to CFC assessment and care planning process (e.g., technology supports and/or provider delivery expectations);

7. Develop 'Plain English' information and tools that employ accessible formats and layouts (e.g., graphics and easy to understand steps) that:
   - Explain long-term care options and support consumer decision-making, and
   - Ensure that peer support, discharge planners and other support organization have access to information and tools to support persons in understanding their options and in supporting those who request more formal Options Counseling in gaining access to the service;

8. Incorporate Options Counseling information gathering and screening tools into web-based health care tools and web-based information and referral tools to support:
   - Individuals who may want to explore and assess their options on their own (e.g., software development that replicates the Options Counseling information gathering and pre-screening process)
   - Individuals, caretakers/family members and other health care professionals have access to up-to-date information and referral resources (e.g., 211-Information and Referral resources);

9. Link assessment information across DLTSS programs and providers and ensure CFC and other assessment tools do not duplicate information already collected; support a reduction in administrative burden for the consumer as well as provider;

10. Create screening and formal linkages between primary care and DLTSS providers and comprehensive identification of needs;

11. Consider an assessment process that leads to the identification of goals and needs regardless of specific program rules; facilitate access to a scope of services that is person-centered rather than program-based. For example, if someone in the CFC program is interested in employment, the CFC assessment process could identify employment as a goal area even though employment support is not a CFC covered benefit; build from the VHCIP learning collaborative work on shared care planning.

A. Bundled Payments, Provider Flexibility, Interdisciplinary Teaming

1. Use of an alternative to fee-for-service payment model for CFC or increased flexibility in service packages at the provider level, should be accompanied by: strong beneficiary choice and protection regulations; and include a mechanism for annual provider inflationary adjustments to support quality service delivery and staffing;

2. Adoption of the Model of Care could be supported with financial incentives for quality that are funded through balancing priorities between HCBS and hospital-based care, re-investing Medicaid savings and/or requiring all payer (commercial and Medicare) participation in financing the Model of Care across providers;

3. Adoption of the Model of Care could be supported with enhanced care coordination payments that are funded through re-balancing Medicaid budget priorities, re-investing Medicaid savings and/or requiring all payer (commercial and Medicare) participation in financing the Model of Care across providers.

From these discussions and emerging recommendations, DAIL staff have identified several priorities to explore for improving program operations and enhancing VT Model of Care and Choices for Care alignment. Areas for further discussion with the DAIL staff, providers and Advisory Boards include, but are not limited to:

- Exploring stable funding and ACO/APM alignment with ADRC services, including opportunities to bridge gaps between acute/primary care and long-term services and supports. (Emerging Stakeholder Recommendations A1-5; Model of Care Opportunity #1, 4)

- Creating a new LTSS person-centered assessment/care plan tool for use by all LTSS programs, that can be used in SAMS and preferably linkable to the ACO platform. (Emerging Stakeholder Recommendation A8-11; Model of Care Opportunity #1, 4)

- Exploring integration of LTSS information into health care records, including ACO records and information sharing protocols with LTSS providers. (Emerging Stakeholder Recommendation A6, A8-10; Model of Care Opportunity #1, 4))

- Analyzing the viability of developing a per member per month case management payment paid directly to the case management provider for all CFC participants (i.e., moderate, high, highest). (Emerging Stakeholder Recommendation B1-3; Model of Care Opportunity #3-4)

- Analyzing the viability of developing a per member per month personal care/respite/companion payment, for agency directed services, to the provider chosen by the CFC participant. (Emerging Stakeholder Recommendation B1-3; Model of Care Opportunity #3-4)

- Determining if there are existing regional healthcare teams that can be charged with monitoring/contributing to the personal's LTSS person-centered plan. (Emerging Stakeholder Recommendation A5, A9-10; Model of Care Opportunity #3-4)

Information Gathering, Implementation Planning and Next Steps

In September of 2016 the AHS and AOA launched a one-month written information gathering process to solicit feedback and ideas for delivery reform from consumers, providers and other stakeholders who were not part of the on-going planning group meeting process. Interested parties, providers and Designated and Specialized Service Agencies were asked to respond to key questions regarding: the VT Model of Care; governance; quality and outcome planning; global budget and bundled payment models; rate setting methods; and the proposed multi-year phasing of alternatives to FFS and value-based payment reform models. The results of this process have been incorporated into planning and in subsequent discussions with DA/SSA representatives.

In addition, the State has identified planning areas and departmental activities that will need to be addressed to successfully support delivery and payment system change across the AHS specialized programs. These implementation areas include:

- *Project Integration and Management* (e.g., overseeing implementation planning across departments and supporting internal integration as appropriate across AHS);

- *Policy, Program Standards & Provider Contracting* (e.g., creating unified provider standards to support reform models, reviewing and revising program guidance as needed, determining if legislative or CMS approvals are needed to support the change, revising provider contract expectations);

- *Finance & Reimbursement* (e.g., defining the base payment model, defining any proposed value-based performance incentives, revising provider billing and claiming, fiscal monitoring and reporting as needed, modifying AHS program monitoring and financial operations as needed, addressing any budget development needs);

- *Quality, Data Collection, IT, Reporting and Outcomes* (e.g., defining quality and outcome metrics for the reform model, including data collection, information technology tools, data analytic resources, quality monitoring and designation review protocols);

- *Stakeholder Engagement* (e.g., implementing on-going outreach, education, status reporting and methods for gathering stakeholder input into reform models and refinements in future phases); and

- *Long Term Planning and Alignment* (e.g., developing timelines and priorities for future reform phases and assuring ACO/APM Alignment).

In October of 2016, federal terms and conditions were finalized for Vermont's All Payer Model agreement and the five-year renewal of Global Commitment to Health Section 1115 Medicaid Demonstration, both effective January 1, 2017. Along these lines, a final Medicaid ACO contract agreement for Medicare Part A and Part B-like services is also expected with an effective date of January 1, 2017. The State is undertaking a review of emerging Medicaid Pathway proposals and feedback received against the final terms and conditions of these overarching reforms. To that end, AHS and AOA staff are developing recommendations for implementation to align reform efforts and address the following questions:

- What model options are most viable over short term and long term?
- What model promotes alignment with the All Payer Model and Accountable Care Organization design? decision-making
- What changes are necessary for year one?

- What is the budget and operational impact of the proposed changes?

Final recommendation for reform models and project phasing will be reviewed with executive branch and legislative leadership, the Green Mountain Care Board, stakeholders and providers in early 2017.

Appendix 1: Vermont's Model of Care and National Frameworks

COMPARISON OF NATIONAL EVIDENCED-BASED MODELS				
Core Elements of Vermont's Model of Care*	Commission on Long-Term Care, September 2013 Report to Congress	CCBHC Model	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	(peer)		✓
Actively Involved Primary Care Physician		(coordinated)	✓	
Provider Network with Specialized Program Expertise	✓	✓	✓	✓
Integration between Medical & Specialized Program Care	✓	✓	✓	✓
Lead Care Coordinator (Single Point of Contact for person with Specialized Needs across All Services)	✓		✓	
Standardized Assessment Tools	✓			✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services (including shared care plans)			✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team & Care Conferences		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓
*** Elements Fully Align with CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care**				
CCBHC – Certified Community Behavioral Health Center Sec. 233 Demonstration				

Appendix 2: Payment Model Overview

Summary Overview of Payment Models and VT Reform Opportunities	
Payment Option	**VT Reform Opportunities**
Community, Population Based or Global Budget: Develop total budget by community and require providers to collaborate in order to manage to budget.	• Maximizes flexibility to develop service options that meet individual needs. • Could promote early intervention/prevention. • Payments could be tied to performance. • Creates more predictable funding level.
Capitated or Sub-Capitated: Capitation amount based on number of eligible members in region, regardless of need. Sub-capitation amount based on services that are responsibility of each provider.	• Maximizes flexibility to develop service options that meet individual needs. • Could promote early intervention/prevention. • Payments could be tied to performance. • Creates more predictable funding level that varies as eligible population changes
Case Rates: Develop daily/weekly/monthly rates per enrollee (e.g. per member per month or PMPM). Rate could vary based on program or need.	• Provides additional flexibility to develop individualized service packages. • Payments could be linked to performance rather than volume.
Care Coordination Case Rates/Enhanced Care Coordination Payments: Develop payment model for care coordination that is fully compliant with Model of Care.	• Provides additional flexibility at the community level to coordinate care and adhere to Model of Care requirements. • Requires new funding or reinvested savings

Comparison of Payment Models Relative to Early Intervention, Prevention and Provider Risk						
Payment Type	**Payment Model Overview**		**Support for Key Objectives of Vermont Reform**			**Provider Risk**
	Reimbursement Method	**Enrollee Participation**	**Integration**	**Early Intervention**	**Prevention**	
Cost Based	Pre-determined definitions of allowable costs and service	N/A	Varies based on specifications in contract agreement	Varies based on specifications in contract agreement	Varies based on specifications in contract agreement	None, unless limits
Fee for Service	Defined Unit (e.g., minutes, hours, session, encounter, day) and procedure based	Client must actively seek services	Referral and/or Coordination Agreements	Potentially if diagnosed in early stages of condition	Only for pre-defined preventive services (e.g. well child, annual physical, screening test, etc.)	None, unless limits
Person-Centered Budget	Based on allowable services and individual plan	Client must actively seek services	Referral and/or Coordination Agreements	Typically for complex conditions	To prevent or slow further deterioration	None, unless limits
Episodes of Care	Episode or condition; time window (e.g. 30, 60, 90 days)	Client must actively seek services	Referral and/or Coordination Agreements	If diagnosed in early stages of condition	Typically 'condition' based payments	Moderate
Case Rate	Individual or multiple services; time window	Client must actively seek services	Information sharing; co-location	Depends on what is included in case rate and contract		Moderate
Sub-Capitated	Target group and/or target services	Attribution to target group regardless of client utilization	Information sharing; integration; co-location; merge	Provider has flexibility to deliver preventive, curative and/or palliative services based on person centered approach to care		High
Capitated/Global Payment (Population based)	All services and/or enrollees	All persons in a given region regardless of client utilization	Information sharing; integration; co-location; merge	Provider has flexibility to deliver preventive, curative and/or palliative services based on person centered approach to care		High

Appendix 3: Work Group Descriptions & Membership

Mental Health, Substance Use Disorder Treatment, Developmental Disability Services

The AHS has engaged representatives of the Designated and Specialized Service Agency System, the Substance Use Disorder Treatment Preferred Provider Network, consumers and other stakeholders to guide discussions on payment and delivery system reforms in partnership with the VHCIP demonstration and in preparation for participation in the All-Payer Model. Invited stakeholders include:

- Bill Claessens (Counseling Service of Addison County)
- Bob Bick (Howard Center)
- Catie Iacuzzi (Maple Leaf)
- Elizabeth Sightler (Champlain Community Services)
- Jason Goguen (BARRT)
- Mary Moulton (Washington County Mental Health)
- Simone Rueschemeyer (Vermont Care Partners)
- Sandy McGuire (Howard Center)
- Ed Giroux (Howard Center)
- Ted Mable (Northwest Counseling and Support Services)
- Julie Tessler (Vermont Care Partners)
- Cathy Dubois (BARRT)
- Peter Mallory (People Education Advocacy and Recovery)
- Heidi Hall (Washington County Mental Health)
- DW Bouchard (Northeast Kingdom Human Services)
- Nancy Breiden (Disability Law Project, VT Legal Aid)
- Kathy Holsopple (Vermont Federation of Families for Children's Mental Health)
- Sarah Launderville (Vermont Center for Independent Living)
- Ed Paquin (Disability Rights Vermont)
- Deborah Lisi-Baker (VHCIP, Disability and Long Term Services and Supports Work Group Chair)
- Steve Rauh – Upper Valley Services and Family Representative
- Josh Smith – Green Mountain Services and Supports

Long Term Services and Supports/Choices for Care

The AHS has engaged representatives of the Home Health, Area Agencies on Aging, Nursing Facility, Residential Care, Traumatic Brain Injury and other service agencies, consumers and other stakeholders to guide discussions on payment and delivery system reforms in partnership with the VHCIP demonstration and in preparation for participation in the All-Payer Model. Invited stakeholders include:

- Patrick Flood (Citizen representative)
- Mike Hall (Area Agencies on Aging)
- Sarah Launderville (Vermont Center for Independent Living)
- Jackie Majoros (Long Term Care Ombudsmen)
- Joanne Bohen (Adult Day)
- Ed Paquin (Disability Rights Vermont)

- Deborah Lisi-Baker (VHCIP, Disability and Long Term Services and Supports Work Group Chair)
- Kim Lague (Central Vermont Home Health)
- Treny Burgess (Caledonia Home Health)
- Rita Laferriere (Vermont New Hampshire Home Health),
- Laura Pelosi (Vermont Health Care Association)
- Molly Dugan (Support and Services at Home)
- Lynn Lawson (Consumer)
- Trevor Squirrell (Brain Injury Association)
- Virginia Milkey (Community of Vermont Elders)
- Kirsten Murphy (Developmental Disabilities Council)
- John Pierce (Advocate/Consumer)
- Jeanne Hutchins (University of Vermont)
- Rosemary Mayhew (Bel-Aire Center)
- Joyce Touchette (Converse Home)
- Josh Smith (Green Mountain Support Services)
- Susan Shane (OneCare Vermont)
- Floyd Nease/Victoria Loner (OneCare Vermont)
- Julie Tessler (Vermont Care Partners)

Work Group Discussion Topics

Discussion topics and questions for work groups include, but are not limited to:

- Overview of the current system (providers, expenditures, types of services)
- VT Integrated Model of Care
    - Care Delivery: are providers ready to implement an integrated approach to care?
    - What are the current program requirements?
- Scope for long term and short term planning related to both delivery reform and payment reform
- Opportunities for Performance Improvement in the Choices for Care Program
    - Identification of opportunities for improvement related to the VT Integrated Model of Care
    - Stakeholder rating of the “Top Ten” performance and outcome indicators for Choices for Care program
    - Emerging recommendations to support integration and adoption of Model of Care for LTSS/Choices for Care
- Delivery Model Design Options
    - Organized Delivery System Models
    - Levels of Delivery Integration (formal and informal)
- Overview of Payment Models and how they support delivery model and reform goals
    - Level of accountability: (i.e., what VBP model do we employ?)
    - What level of risk can the providers take on?
- Consortium Governance
    - Should the governance structure be statewide or regional?
    - What are the necessary governance elements to achieve reform objectives?
- Quality and Outcomes

    - What quality measures should we use?
    - Are they aligned with the existing measures?
    - Is the health data infrastructure able to collect and report necessary quality and oversight data?
    - What data does the State stop collecting?
- Base Payment Model 'Straw Man' for Designated and Specialized Service Agencies
    - Examples of how a case-mix adjustment payment and global budget approach may apply in Vermont's specialized service system
    - Global Budget and bundled payment model refinements and alternative options
- Vermont Care Partners Self-Assessment of Provider Readiness for Alternative Payment Models and Delivery Integration
- Formal Written Information Gathering Process
    - Development of a formal process for statewide information gathering and written stakeholder feedback on potential Medicaid Pathway delivery and payment models
    - Development of stakeholder questions for statewide feedback
- Implementation and operational considerations
    - Should the transformation process be mandatory or voluntary?
    - Are there enough lives/money/services for this to work?
    - Impact on non-Medicaid populations, services and funding
    - What is feasible in first year?