

# DDS Payment Reform

Overview for DD Council  
2.19.19

# Payment Reform Goal:

Transparent, effective, accountable and administrable payment model that aligns with Agency of Human Services' broader payment reform and health care reform goals.

# Payment Model

## Assessment of Need

How are people's needs assessed?

## Resource Allocation

How do assessed needs translate into funding?

## Payment Model

How does state pay for services?

## Service Planning and Delivery

How is service plan developed, implemented and monitored?

## Accountability

How does state track what was provided and ensure people's needs are met?

# Why are we doing payment reform?

- State Auditor's report indicating need for enhancing the way state accounts for service delivery and payment
- Internal audits can not verify payments for services
- Concern that people are not receiving services they are assessed to need
- Agreement between providers and AHS Secretary to move forward with payment reform to address accountability

# Process Overview

Examine/Review the Current Process

Identify the issues to be addressed/improved  
in the redesigned model

Person applies at Designated Agency (DA)

DA screens for emergency | DA conducts initial intake



DA conducts assessment

Financial eligibility | Conducts needs assessment  
Clinical eligibility(verified by DDSD) | Determines if meets System of Care\*



DA submits proposal for unmet needs that meet SOCP funding priority

Local funding committee reviews; State Equity or public safety funding committee reviews and recommends service and funding amount to Division | Division authorizes funds based on agency rates, SOCP limits/rules, Level of Care general guide; sends notice to agency

Current Process:

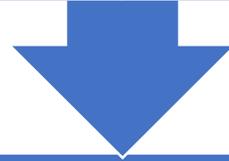
Application through Division approval

\*DA determines if situation meets DS System of Care (SOCP) funding priority to access HCBS and rules out other sources of funding

## Agency sends notification of decision with appeal rights to person

DA explains and offers provider/management options

Person selects provider/management option



## Chosen provider agency develops ISA with team

Provider agency provides services  
Provider agency bills for services

Provider agency reports services delivered in Monthly Service Report (MSR) reporting system



## Provider agency monitors service delivery

Agency adjusts services / budget as needs change

At least annually conducts periodic review

Current  
Process:

Notification  
through  
periodic  
review

Assessment and funding request process:

Not consistent with HCBS rules related to conflict-free case management

Needs assessment lacks standardization:

No standardization of process for conducting the assessment; done by many different staff at agencies

Needs Assessment  
Current challenges

Needs assessment tool: provides info about needs but does not translate into a specific amount of service to meet need;  
does not lend itself to analyzing data on needs of people in service

Assessment tool lacks training on administration:

Issues lead to inequitable distribution of services/funding across the state

Encounter data to track services delivered has significant gaps and is in multiple places, primarily in MSR and ARIS, but sometimes in neither

State cannot verify from available data that claims submitted reflect services delivered or follow allowable billing according to SOCP, CMS expectation to collect encounter data

**Claims and  
Encounter Data  
Current Challenges**

Lack of reliable encounter data hinders agencies in ability to monitor utilization and make real time adjustments to spreadsheets/budgets/plans

Lack of reliable encounter data interferes with State's ability to oversee payment and ensure that services are received based on authorization and assessed needs

No uniformity of service rates across agencies; rates listed on proposals and spreadsheet not necessarily consistent with costs\*

Case management rate is set by state; SOCP says when setting rates, agencies should submit costs to deliver the service or the state sets rate, whichever is lower

Rates  
Current Challenges

Agencies backing into rates based on total annual allocation for agency divided by the amounts of services needed or agreed upon in people's plans.

No standardized rate setting methodology; agencies, not state, set most rates

\*Agencies have told State that rates are not based on costs; Agencies say rates too low to cover costs

Local/State Equity/PS process is time/labor intensive

Difficulty finding and retaining workers results in challenges in providing all services authorized

Process  
Current  
Challenges

Managing spreadsheets is labor intensive for both providers and State\*

Level of Care document is a guide; document not current

\*Managing spreadsheets with real-time, up-to-date information according to rules in SOCP and spreadsheet manual is especially labor intensive at the beginning of FY for annual update (“respreads”)

# What have we done so far?

- Started meeting in January, 2018
- Conducted a Provider Rate Study
- Formed four workgroups:
  - Statewide Advisory Committee
  - Needs Assessment workgroup
  - Payment Model workgroup
  - Encounter Data workgroup

# Rate Study Status and Planning

- Consultants, Burns and Associates, sent survey to all agencies to gather information regarding costs to provide categories of service
- They are analyzing the data and will use that to make recommendations to the state about payment rates for services
- A report with recommended rates will be sent out for public comment, probably April or May
- Rates will be used is designing payment model

The Standardized Assessment Work Group is focusing on the adoption of a uniform, standardized assessment tool for determining what services individuals need

Assessment tool options are being reviewed as well as the process for transitioning to a new tool. The workgroup will provide direction and input for implementation.

#### Work Group Goals, planning stage

- Gather facts and comparisons to other tools
- Develop a preference for a standardized approach
- Address internal process requirements and changes needed for existing procedures
- State intends to move forward with standardized assessment tool
- Taking steps to prepare for adopting tool as there are questions to be answered and steps to implementation

# Standardized Needs Assessment: Update

- Workgroup arrived at consensus that the Supports Intensity Scale appears to be the most viable option for a standardized assessment tool, with the following caveats and concerns. State is working to address these issues.
  - what supplemental questions would be needed to be added to adequately determine funding levels
  - State has gathered questions from other states to consider. Will need to customize for VT needs.
  - how funding exceptions or 'outliers' would be addressed
  - State agrees that an exceptions or outlier process needs to be part of the model. This will be included in design.
  - how the SIS assessment would (or would not) be used for a person-centered plan
  - TBD in payment model design
  - how the SIS would (or would not) be used in determining staffing including staff skill and training
  - TBD
  - protocols for reassessments
    - how minor changes in needs, funding or service plans would be addressed in a workflow
    - how major changes in needs, funding or service plans would be addressed in a workflow
    - TBD
  - How the workflow would be designed which could potentially impact the zero-reject premise of the current system
  - TBD

Note: the workgroup recommends that should the cost of implementing the SIS be found prohibitive, DAIL/DDSD consider revamping and expanding the current Vermont needs assessment, with an improved training process, such that the current needs assessment's equity/consistency/reliability could be improved.

# Standardized Needs Assessment update, cont.

- how much a transition to the SIS would cost
  - State is evaluating costs to transition to use of SIS
  - Possibility of 90/10 match from CMS for start up costs
  - Doing some cost estimates, state will cover new costs
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- Who would perform the assessment
  - State exploring ideas about who should do the assessments, part of exploration of addressing conflict free case management
  - Want to get your input on the criteria to be used to evaluate who should conduct the assessments, see handout
  - Seek input from others. Send suggested criteria by 2.15
    - Suggestions for the best ways to score
- 
- At a later date, we will:
    - Gather the scored charts
    - Review the data with the advisory committee

The Encounter Data Work Group is focused on the process provider agencies use to report to the state the services delivered to participants

- **What?**

- A single source of Truth about payments and services for Medicaid members across programs

- **How?**

- The Medicaid Management Information System (MMIS) (the State will always have such a system)

- **Why?**

- Accountability: Medicaid payment models cannot be transparent or accountable (to recipients of services, Vermont taxpayers, or CMS) if encounter data is unavailable, incomplete, or inaccurate.
- Compliance: The State cannot be compliant with Program Integrity requirements if encounter data exists outside the MMIS.
- Measurement: The State cannot effectively monitor programs or establish new payment models if encounter data exists in multiple (and disconnected) databases and formats
- Fiscal Responsibility: Medicaid cannot bill other payers (where applicable) without accurate encounter detail to maximize public payer resources

# The Encounter Data Work Group is focused on the process provider agencies use to report to the state the services delivered to participants

Providers will be reporting services through the Medicaid Management Information System (MMIS). The workgroup will provide input into implementation of this new process.

Work Group Goals	Status Update
<ul style="list-style-type: none"><li>Identify appropriate billing codes for use in determining what services were delivered to individuals.</li></ul>	<ul style="list-style-type: none"><li>The work group is currently reviewing a broad list of potential codes identified by State and provider work group participants. Primary goals include 1) identifying codes that best represent DS services, and 2) aligning with codes already in use wherever possible.</li><li>The work group expects to finalize a recommended code list at its next meeting (2/1), and will also discuss a plan for disseminating and gathering feedback on this recommendation.</li></ul>
<ul style="list-style-type: none"><li>Understand MMIS systems changes needed to accept identified billing codes and ensure MMIS systems readiness.</li></ul>	<ul style="list-style-type: none"><li>State team has begun to meet with team from DXC Technology to discuss MMIS systems operations and needed changes. MMIS changes will not occur until finalized code list is available.</li></ul>
<ul style="list-style-type: none"><li>Ensure provider readiness to submit encounter claims using appropriate billing codes.</li></ul>	<ul style="list-style-type: none"><li>Working to identify perceived challenges and barriers to be addressed in future meetings.</li></ul>

The Payment Model Work Group is determining model preference and path for new model “roll out”

A review of a straw payment model, model options and examples from other states resulted in detailed exploration of payment tiers. The rate model survey will inform the process.

**Work Group Goals, project planning phase**

**Status Update**

- Provider rate survey to be finalized

- Revisions to be made based on provider responses to questions from Burns and Associates. Final report from Burns likely Q2 to be informed by further state collaboration

- Review straw payment model and select model preference

- Examination of alternative / transitional payment methodologies underway. Next steps: explore and document comparison of options
- Work will continue with Burns & Associates

- Develop preliminary view of services to be included in bundles

- Human Services Research Institute (HSRI) and Burns and Associates will facilitate further exploration. Next steps: February workshop to develop increased foundational planning

# One Possible Payment Model

Assessment  
of Need

Standardized  
Assessment  
tool, (SIS?)

Resource  
Allocation

Score on  
tool leads to  
assignment  
to tier

Payment  
Model

Tiered  
payment,  
based on  
living  
situation

Service  
Planning &  
Delivery

Options  
counseling,  
develop &  
monitor  
plan

Accountability

Providers report  
services delivered  
through MMIS, data  
can be used by state  
and others to  
ensure people  
receive what they  
need

# Key criteria serve as a basis for comparing payment methodologies

Criteria	Definition
Efficient	Minimizes administrative complexity/burden
Economic	Aligns with provider costs, and are neither too high nor too low
Quality	Supports and incentivizes the achievement of defined outcomes
Sufficient	Supports a provider network that provides access to services comparable to the current level of access
Person-Centered	Reflects the unique circumstances of each individual
Objective	Uses impartial criteria to assign payments
Equitable	Offers equivalent services to similarly situated individuals
Comprehensible	Easily explainable and understandable
Transparent	Service recipients and external stakeholders understand both <i>what</i> the payment /rate is and <i>how</i> it was established
Flexible	Responds to changes in individual needs
Accountable	Answerable for actions taken

Criteria	Definition
Supports self/family management	Maintains the option to self/family-manage
Predictable and sustainable financing	Allows providers to reasonably predict revenues and funding is adequate to sustain provider network
Avoids cherry-picking	Ensures that system does not leave out those whose services might include financial risk
Accommodates outliers	Provides a method of funding extraordinary costs
Revenue neutral	Maintain overall DDS budget
Based on service level and financial data that is consistent, reliable, verifiable, and accurate	Use good data in constructing new model
Scalable	Accommodate providers of different sizes and increases or decreases in number served
Support zero-reject system	Maintains DAs as responsible entity for eligible individuals when no other available or willing provider
Maintains choice	Maintains choice of providers/management options/ service options/ability to direct one's life
Fosters inclusion	Supports inclusion in community and fosters relationships

# Plan for involving stakeholders

- After initial meeting with Burns and HSRI, we will bring ideas to and seek input from payment model workgroup and advisory committee
- Multiple ideas to consider, questions to be answered and decisions to be made.
- We will bring information out to stakeholder groups such as SPSC, providers, GMSA, VFN, etc.
- When there is a draft of a proposed options on the table, will hold forums for input