DS Statewide Advisory Committee Meeting

FEBRUARY 1, 2019

Welcome and Introductions

DS Statewide Advisory Committee Meeting:
February 1, 2019

MEETING OBJECTIVES

1. Reinforce values and goals of DS payment reform project
2. Develop understanding of the challenges in current process
3. Review reports from work groups

MEETING AGENDA

Welcome

Feedback from prior advisory committee meeting

Review recent feedback from stakeholders

Rate study status and planning

Process overview

- **Current process path: from initial steps (application) to end (periodic review)**
- **Challenges in current process**

Work group updates

- **Standardized Assessment**
- **Encounter Data**
- **Payment Model**

Planning for next meeting and public comment

The purpose of the DS payment reform project is to create a transparent, effective, and administrable payment model for DS services that aligns with the Agency's broader payment reform and health care reform goals.

HELPFUL TO DIFFERENTIATE BETWEEN MODEL/DESIGN OPTIONS

- Address provider financial risk
- Administrable
- Easy to understand
- Predictable and sustainable financing
- Accommodate outliers
- Avoids cherry-picking

NECESSARY TO BUILD INTO ANY MODEL

- Revenue neutral
- Based on service level and financial data that is consistent, reliable, verifiable, and accurate
- Contemplate quality measurement development and reporting
- Transparent regarding the services paid for, accountable to all
- Avoids unnecessary administrative burden
- Scalable to accommodate providers of different sizes and increases or decreases in number served
- Maintains at least the status quo regarding access to services for consumers and families
- Support zero-reject system
- Person Centered
- Equitable across individuals and providers
- Objective

Prior Meeting Update

The December 18 Advisory Committee meeting focused on work group discussion – a few highlights…….

Standardized assessment tool

- Concerns that costs would be prohibitive for SIS adoption; thoughts regarding a more consistent version of existing tool
  - Reaffirmed State's intention to implement a validated, standardized assessment
  - Any additional costs will be covered by the State
- Discussion about needing a significant training component for new tool
  - Will be a limited number of assessors
  - The State will invest in appropriate training to ensure that tool will optimize the validity of the results

Encounter data

- Perspectives on the significant change for providers
  - Agencies will need to change processes for collecting and reporting information
  - Additional staffing and software updates may be needed
  - Encounter data is required

Payment model

- Thoughts shared regarding influence of type of residence on individual budget
  - Choice may be limited to other services when residential is already decided
  - Will ensure that model works with other components of our overall system

Review of Recent Feedback and Response

Recent Feedback

1. Concern regarding maintaining values
   a) Flexibility
   b) Choice
   c) Individualized
   d) Fostering inclusion
2. Enhance participation of all stakeholders in the design of the new payment model

Plan to address:

1. Will add values noted in VCP letter to criteria for evaluating model

2. Commissioner reaching out to SPSC members regarding how to make process more inclusive

- Strive to get materials out ahead of time and make them accessible, will send advisory meeting materials at least a week

- We will continue to have meetings with stakeholders to get input after initial meeting with Burns and HSRI

Recent feedback

1. Ensure that providers have an opportunity for reviewing and correcting data for rate study
2. Reference points for comparing wages and benefits
3. VCP request to meet to discuss concerns
4. Don’t forget people who self/family manage in the payment redesign

Plan to address:

1. Burns has reached out to providers for more information; a session will be offered to answer questions and provide comments before finalizing report
2. Additional information is welcomed
3. Commissioner has invited members of VCP to meet later in February for discussion
4. Maintaining option for self/family-management will be key; will add that to criteria for evaluation of model

Rate Study Status and Planning

Burns and Associates presented preliminary analysis in December

PROVIDER SURVEY: PRELIMINARY ANALYSIS

Burns & Associates sent emails to providers seeking clarification on submitted information

Survey analysis will be updated to incorporate clarifications

A RATE MODEL IS JUST ONE COMPONENT OF OUR PAYMENT METHODOLOGY

Based on information from provider survey and other information

Intended to reflect the cost for providing a unit (e.g., day or hour) of service

Other elements will be determined*

DRAFT RATE MODELS: WILL BE RELEASED FOR PUBLIC COMMENT IN Q2

Recommendations will be presented to providers; a month allocated for written feedback

Rate models will be revised based on comments as appropriate

*e.g., basis for determining amount of support for an individual, method of payment, timing of implementation

Process Overview

EXAMINE/REVIEW THE CURRENT PROCESS

IDENTIFY THE ISSUES TO BE ADDRESSED/IMPROVED IN THE REDESIGNED MODEL

Current Process:

Application through Division approval

Person applies at Designated Agency (DA)

- DA screens for emergency
- DA conducts initial intake

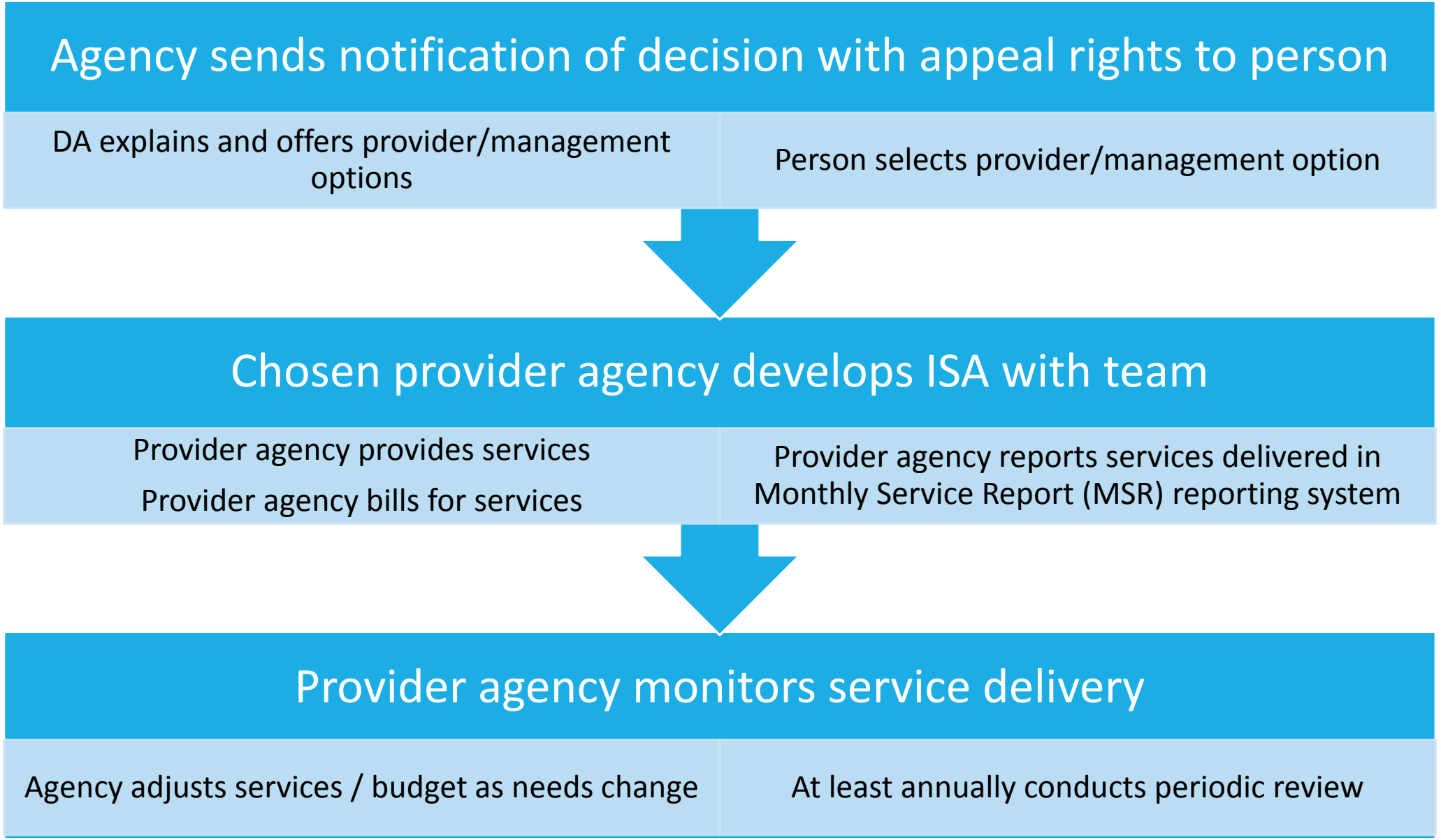
DA conducts assessment

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

DA submits proposal for unmet needs that meet SOCP funding priority

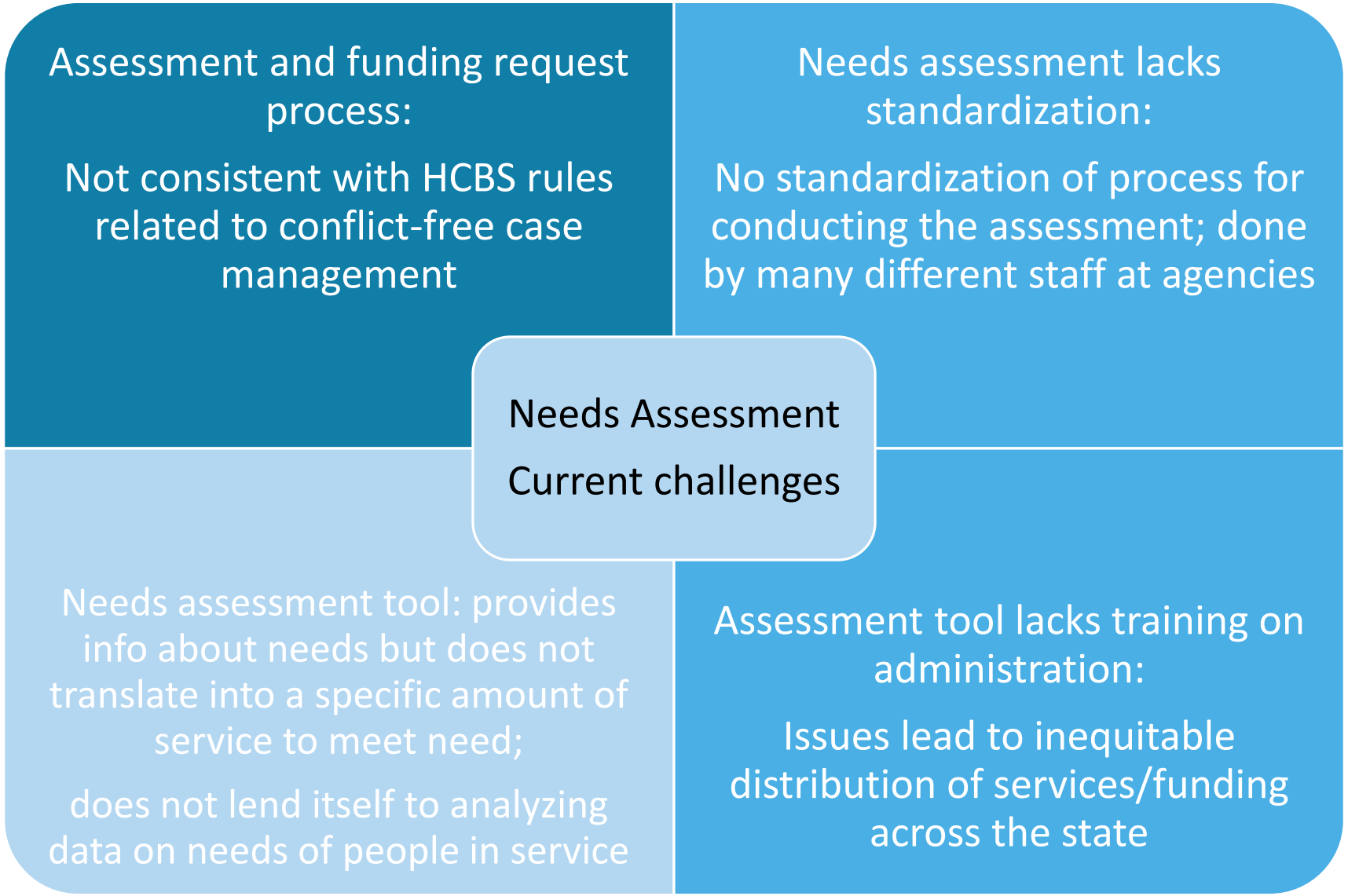
- Local funding committee reviews; State Equity or public safety funding committee reviews and recommends service and funding amount to Division
- Division authorizes funds based on agency rates, SOCP limits/rules, Level of Care general guide; sends notice to agency

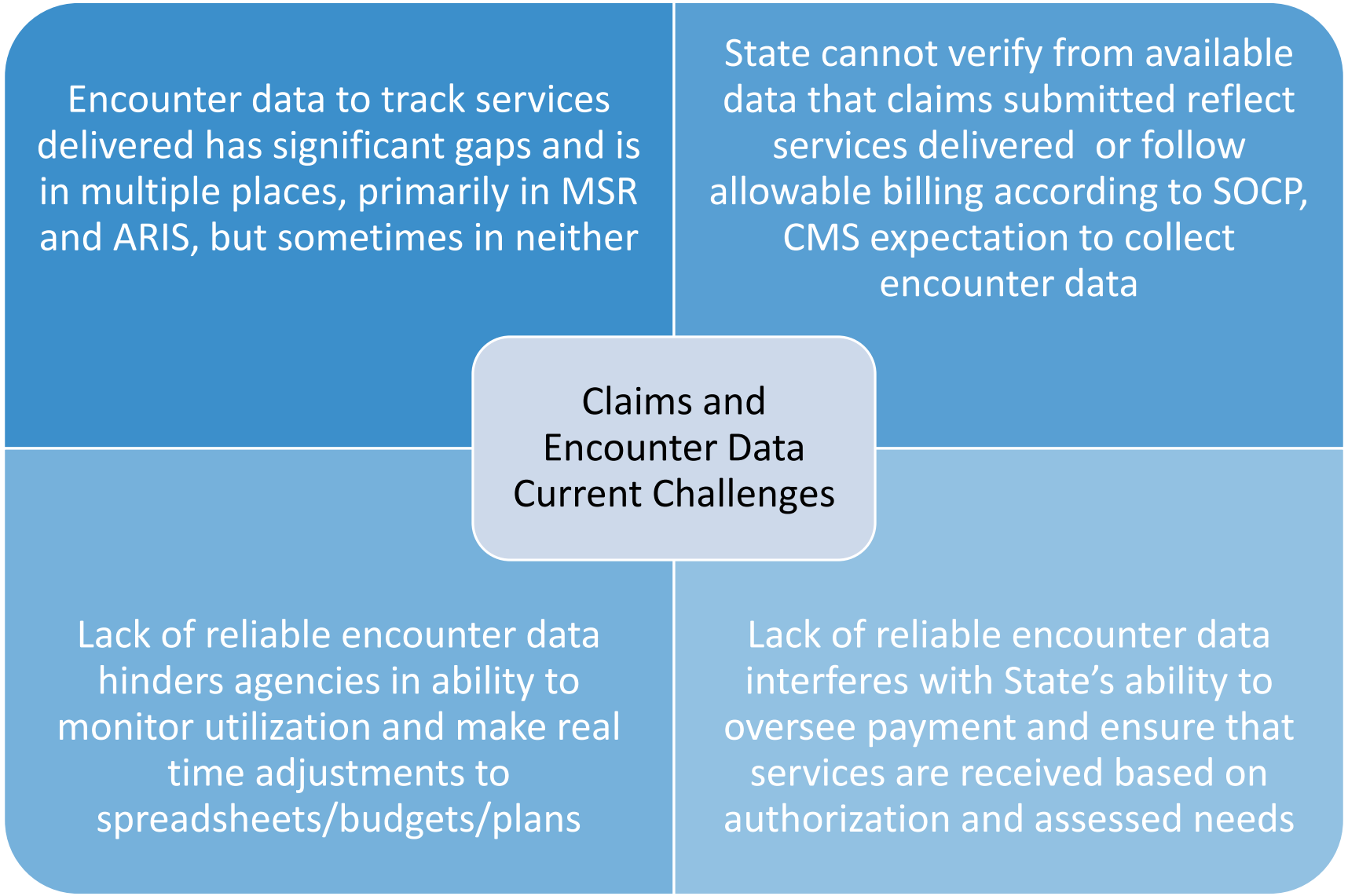
**DA determines if situation meets DS System of Care (SOCP) funding priority to access HCBS and rules out other sources of funding*

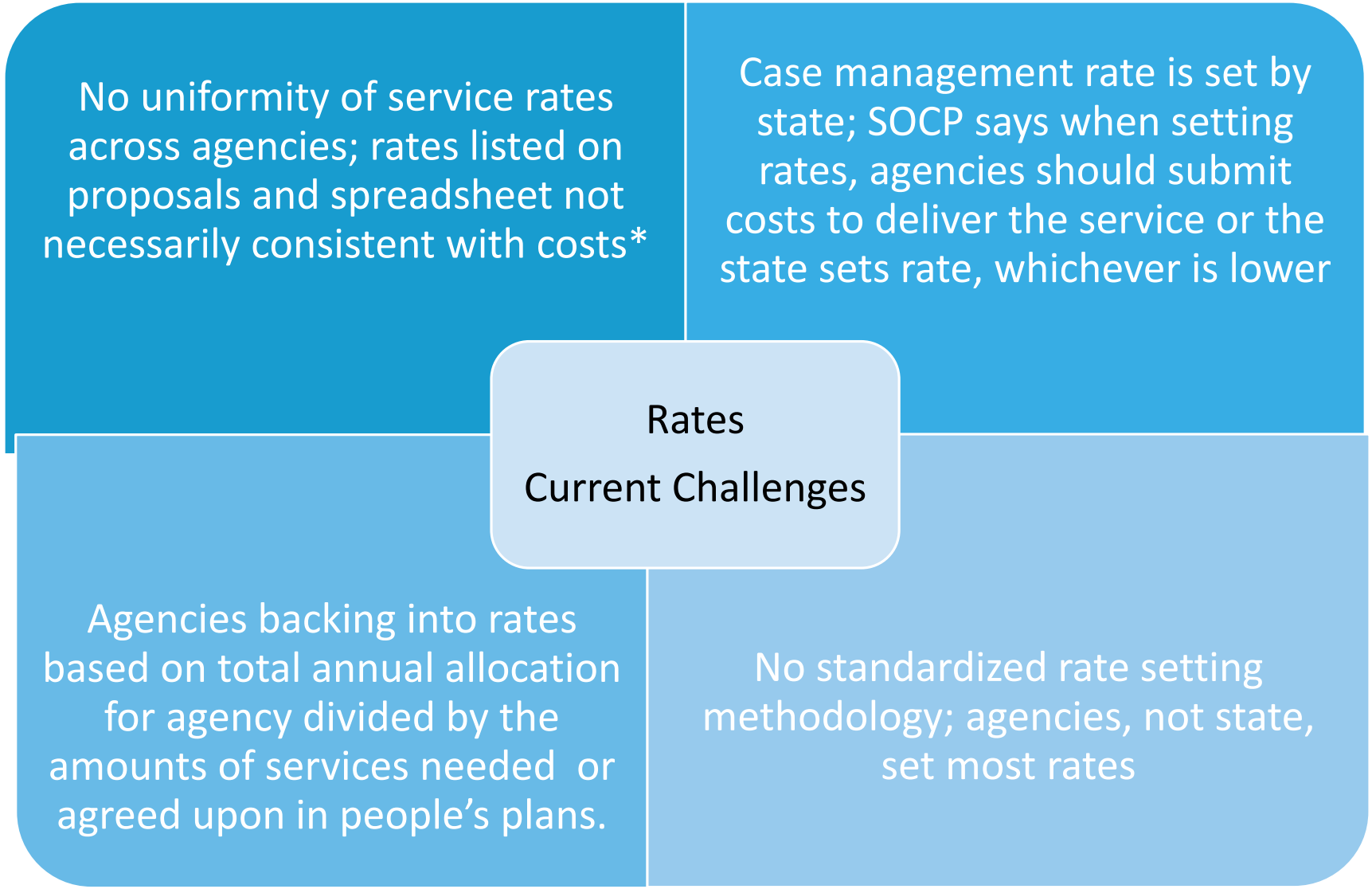


Current Process:

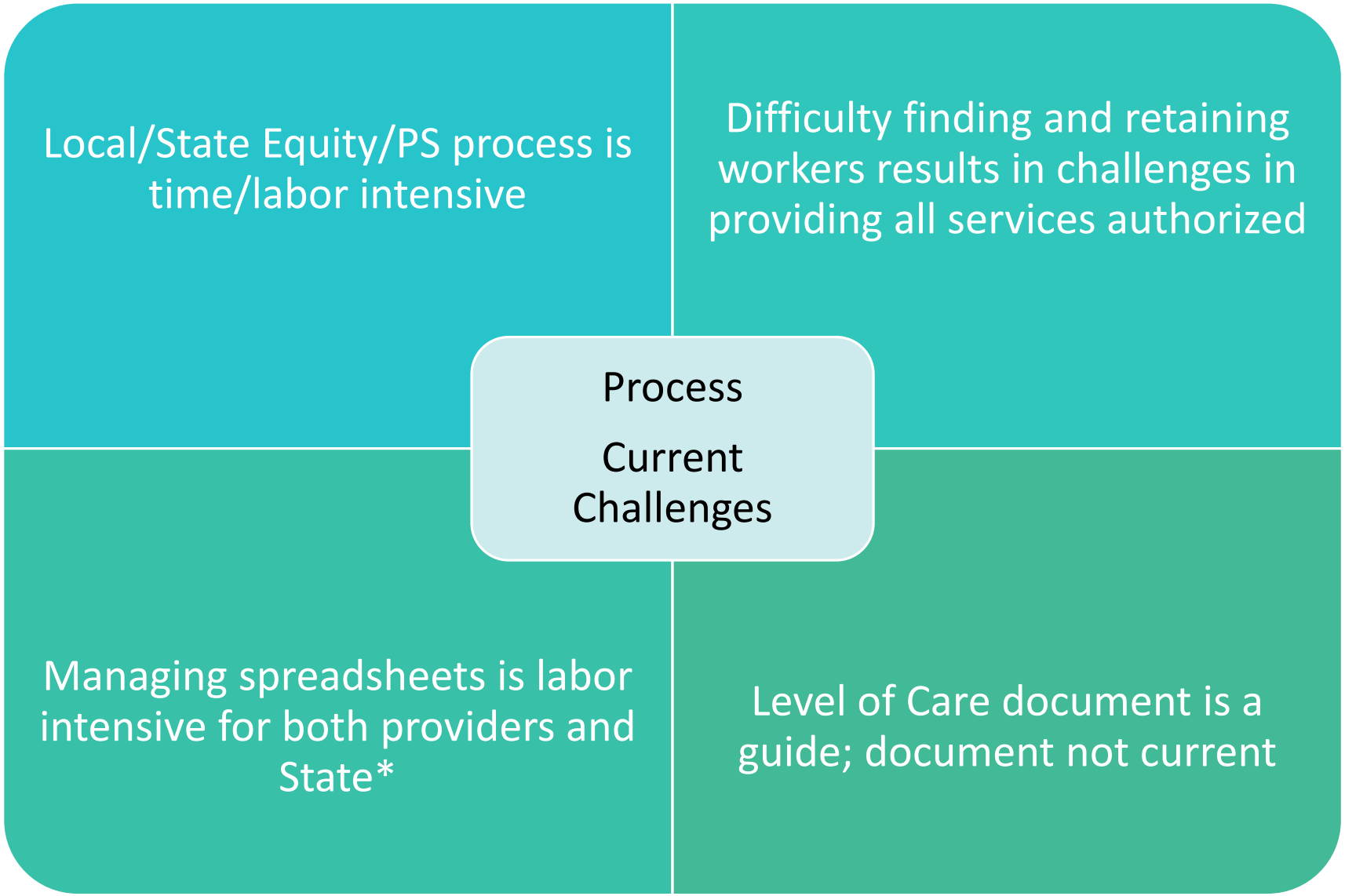
Notification through periodic review


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



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



*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”)

Work Group Updates

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

- 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
• Identify appropriate billing codes for use in determining what services were delivered to individuals.	• 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. • 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.
• Understand MMIS systems changes needed to accept identified billing codes and ensure MMIS systems readiness.	• 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.
• Ensure provider readiness to submit encounter claims using appropriate billing codes.	• Working to identify perceived challenges and barriers to be addressed in future meetings.

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

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 proposal on the table, will hold forums for input

Input on criteria for evaluating payment model

- Incorporates items from charter and stakeholder input
- Feedback appreciated
- Input now and send additional by 2/10, if possible

Key criteria serve as a basis for comparing payment methodologies

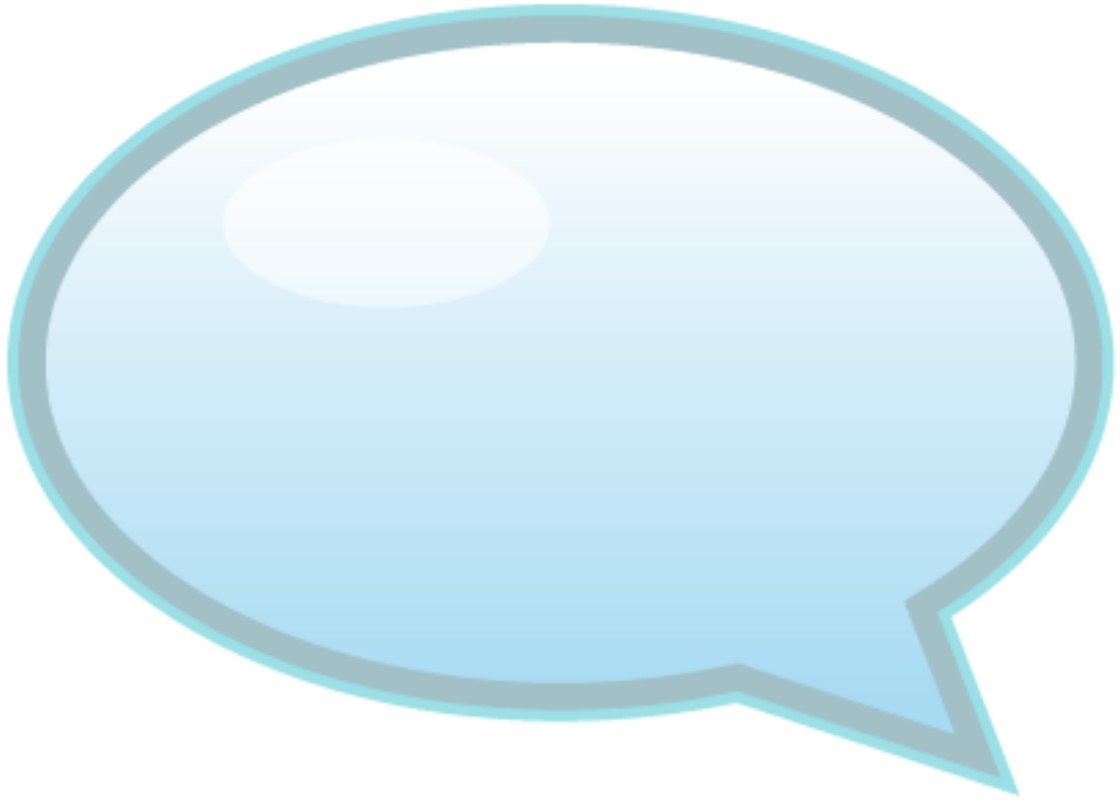
Criteria	Definition
Efficient	Minimizes administrative complexity/burden
Economic	Aligns with provider costs, and are neither too high nor too low
Quality	Supports and incentivizes the achievement of defined outcomes
Sufficient	Supports a provider network that provides access to services comparable to 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 *what* the payment /rate is and *how* 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

Milestones

DS Payment Reform Timeline & Milestones

Milestones	Status
Enhanced federal funding for standardized assessments	Content determination started Jan 15, 2019. Submission to CMS 5/1/19
MMIS taxonomy design	Billing code determination / identification targeted for 2/1/19 – 3/1/19; next step will be DXC code "loading" / programming of system to accept codes
Payment model design structure	Workshop sessions guided by Burns and HSRI. Continued input from payment model workgroup and stakeholder groups, 2/13/19- 7/31/19
HCBS conflict free case management rule plan developed	Solicit stakeholder input regarding how to address conflict free case management requirement. 2/1/19-5/1/19 Create plan for compliance 5/1/19 – 6/1/19
Roll out zero paid claims	Start of encounter data collection process to all providers 4/1/19 – 7/1/19, pending system readiness



Public Comment?

Next steps

1. Gather feedback from stakeholders you represent in order to report back to the State and Statewide Advisory Committee
   - Criteria for determining who should conduct assessment by February 15
   - Criteria for evaluating payment model by February 10
   - Send to Jennifer.perkins@vermont.gov
2. Next Statewide Advisory Committee meeting will be March 15
3. Draft Rate Models targeted to be released for public comment in Q2 (April / May timeframe anticipated)