Review of Home and Community Based Services (HCBS) Payment Models
Comparison of Payment Model Options

Required Elements of Any Payment Model

1. Use of a standardized needs assessment tool	Individuals will be assessed using a standardized and reliable needs assessment tool. Assessment results can be linked to payments or funding levels. In payment models that are not fee-for-service, individuals should expect to be funded at the same level as other individuals with similar needs.
2. Use of a standard fee schedule	For each service, the assumed cost per unit will be the same across all providers. In a fee-for-service model, there would be a published fee schedule setting a single rate for each service type (a single service may have different rates based on staffing ratios, setting, or other factors, but the rate for each service type would be the same for all providers). For other payment models, the per-unit costs built into any payment model will be the same for all providers delivering the same service.
3. Use of a person-centered approach	Regardless of the payment model, service planning, approval, and delivery must always rely on a person-centered approach. Standardized needs assessment, a standard fee schedule, or fixed funding levels do *not* conflict with person-centered planning principles.
4. Submittal of claims or encounters	Regardless of the payment model, providers will be required to track and report the amount and type of services provided to each individual. Providers will have to submit claims if they are paid fee-for-service or encounters (the amount of services provided) in any other payment model. By showing how payments relate to the amount of services provided, this information ensures that providers are accountable for the funding that they receive and services provided to each individual can be monitored.

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Current Model	The provider assesses the individual and develops a service plan showing the type and amount of services for the individual. The provider sets the payment for each service in the plan and the yearly budget for the individual, which is subject to DAIL approval. The yearly budget is divided by 365 to establish the daily, all-inclusive payment to the provider for the individual's services.
Payment Model Options with Descriptions[1]	
1. Fee-for-Service Payment	Service planning is the same as in the current model, but rather than receiving a guaranteed daily rate based on the *planned* services, the provider would only be paid for the services *actually delivered.* There would be payment rates – standardized across providers – for each covered service, and providers would submit claims and be paid for each unit of service (e.g. hours or days) provided.
2. Tiered Matrix Bundled Payment	Individuals are assigned to funding levels using the following process: 1. Individuals are grouped based on their assessed needs as determined by a standard needs assessment tool and their living situation. 2. Service mixes are established for each group, reflecting the typical types and amounts of services that individuals in each group need. 3. Each group's service mix is priced suing a standard fee schedule (similar to the fee-for-service rates) to set the funding level for the individuals in the group. Providers are paid the daily or monthly funding level for the individual's group. These funding levels – which are the same across providers – are *not* intended to dictate an individual's service plan. The funding levels reflect the average cost of serving an individual in a group, but actual services will be determined based on a person-centered planning process. Some individuals in a group will use more services than the average and others will use less, but the payment to the provider will be the same regardless (there would likely be an exceptions process for individuals who use many more services than the average). There may be multiple payments for a group (e.g., one for residential services and another for day services and employment supports). Some services may be 'carved out' and paid fee-for-service (e.g., clinical services) or paid based on cost (e.g., home modifications).
3. 'Capitation-Like' Bundled Payment	This approach would mirror the tiered matrix approach except that instead of having different funding levels for different groups, each provider would get a fixed monthly (or daily) payment that is the same for all individuals that they serve. This amount would be based on group funding levels as described in the tiered matrix approach; the single payment for any given provider would be set based on a weighted average of the funding levels for all individuals served by the provider. The payment for each provider would differ based on the individuals receiving services from the provider (but the underlying funding levels for each group would be the same for all providers). The payment amount does *not* set an individual's service plan. The payment reflects the average cost of serving an individual, but actual services will be set based on a person-centered planning process. Some individuals will use more services than the average and others will use less, but the payment to the provider will be the same regardless (there would likely be an exceptions process for individuals who use many more services than the average). There may be multiple payments for a group (e.g., one for residential services and another for day services and employment supports). Some services may be 'carved out' and paid fee-for-service (e.g., clinical services) or paid based on cost (e.g., home modifications).

[1] This list is not intended to be exhaustive. The details of any option can be revised and elements from different options could be combined.

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Criteria	Definition	Current Model	1. Fee-for-Service Rates	2. Tiered Payment	3. 'Capitation' Payment
Accountable[1]	Providers are paid for the services they actually deliver	**Low:** Payments are not consistently adjusted if providers do not deliver the services outlined in an individual's budget; without information on encounters, actual services are unknown.	**High:** Providers are only paid for services delivered.	**Medium:** In the short-run, there is no adjustment based on services delivered, but payment rates would likely be reviewed annually and could be adjusted.	**Medium:** In the short-run, there is no adjustment based on services delivered, but payment rates would likely be reviewed annually and could be adjusted.
Person-Centered[1]	Reflects the unique circumstances of each individual	**High:** Payments are tailored to a service plan designed to meet the needs of the individual.	**High:** Authorizations are tailored to a service plan designed to meet the needs of the individual.	**[Perception] – Low:** Payments are based on an average for individuals in a group, rather than tailored to the individual. **[Practice] High:** Payments are not intended to reflect a floor or ceiling. Providers should deliver what the individual needs, with some individuals receiving more than average and others receiving less.	**[Perception] – Low:** Payments are based on an average across all individuals served by a provider, rather than tailored to the individual. **[Practice] High:** Payments are not intended to reflect a floor or ceiling. Providers should deliver what the individual needs, with some individuals receiving more than average and others receiving less.
Transparent[1]	Stakeholders understand both *what* the payment is and *how* it was established	**Medium:** Payments are based on an estimated budget, which is transparent. The method for setting the amount of services in the budget and the payments for those services is complicated.	**High:** The rate established for each service and the method for setting the rate are published.	**High:** The payments established for each group (and the methods for setting the payments) are published. The criteria for setting the level of need for each group are also published.	**High:** The payments established for each provider (and the methods for setting the payments) are published. The criteria for setting the level of need for each group are also published.
Efficient[2]	Minimizes administrative burden for providers and the State	**Medium:** Billing is simple (with a single daily rate for each individual), but monthly authorization via spreadsheets is time-consuming and potentially inconsistent.	**Medium:** Requires authorization for every service and detailed tracking of services provided.	**High:** Group funding levels would be established on a statewide basis and limited in number.	**High:** Provider-specific payments would be based on statewide group funding levels and each provider would bill the same rate for everyone they serve.

[1] Vermont payment reform priorities.
[2] Required by the federal government; see 42 USC § 1396a(a)(30)(A).

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Economical[2]	Aligns with market costs so that payments are neither too high nor too low	**Low:** Payments are based on an estimated budget and do not reflect services actually delivered.	**High:** Rates are based on reasonable costs and providers are only paid for services delivered.	**Medium:** Payments vary by group, reflecting the estimated average funding level for each group, based on the level of need and living situation for individuals in the group.	**Medium:** The payment for each provider reflects estimated average funding level weighted by the number of individuals in each group receiving services from the provider.
Quality[2]	Supports and rewards the achievement of defined outcomes	**Neutral:** Need to define desired outcomes.	**Neutral:** Need to define desired outcomes.	**Neutral:** Need to define desired outcomes.	**Neutral:** Need to define desired outcomes.
Sufficient[2]	Supports a provider network that provides adequate access to services	**Neutral:** The model does not prevent or ensure sufficiency; it depends on actual funding.	**Neutral:** The model does not prevent or ensure sufficiency; it depends on actual funding.	**Neutral:** The model does not prevent or ensure sufficiency; it depends on actual funding.	**Neutral:** The model does not prevent or ensure sufficiency; it depends on actual funding.
Adaptable	Supports individuals with extraordinary needs and maintains designated agency responsibility when there is not another willing provider	**High:** Service plans are tailored to each individual, eliminating risk associated with outliers.	**High:** Individuals receive the services that they are determined to need. There is also an ability to establish higher rates for individuals with greater needs, if the basis for a higher rate can be defined (e.g., more intensive staffing, different staff qualifications, etc.).	**Dependent:** Based on the exceptions process that could be create to cover individuals who require much more support than assumed for their group.	**Dependent:** Based on the exceptions process that could be create to cover individuals who require much more support than assumed for their group.
Scalable	Supports providers of different sizes as well as changes in the number of individuals served	**High:** Service plans are tailored to each individual, eliminating risk associated with outliers. By setting their own rates, providers ensure that they cover their costs as they define them.	**Medium:** Fixed rates are based on independent data to reflect reasonable costs across providers, but do not account for economies of scale.	**Medium:** Fixed rates used to price service mixes are intended to reflect reasonable costs across providers, but do not account for economies of scale. This model should consider an exceptions process for those who require much more support than assumed for their group.	**Medium:** Fixed rates used to price service mixes are intended to reflect reasonable costs across providers, but do not account for economies of scale. This model should consider an exceptions process for those who require much more support than assumed for their group.
Choice	Supports an individual's choice of providers, choice in services, and delivery model (agency, self-management, shared)	**Medium:** Providers receive the total payment for an individual, making it difficult for individuals to receive services from multiple providers. With their budget, individuals can choose services and delivery models.	**High:** With rates for each services, individuals can choose the services they need (within any limits) from the provider or providers they wish.	**Medium:** Providers receive the total payment for an individual, making it difficult for individuals to receive services from multiple providers. With their budget, individuals can choose services and delivery models.	**Medium:** Providers receive the total payment for an individual, making it difficult for individuals to receive services from multiple providers. With their budget, individuals can choose services and delivery models.

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Objective	Uses impartial criteria to assign payments	**Medium:** Service plans reflect individual needs, but there is not a standardized assessment tool to determine needs.	**Medium:** Service plans reflect individual needs, but there is not a standardized assessment tool to determine needs.	**High:** Individuals in the same group based on need and living situation (using a standardized assessment tool) receive the same funding level.	**High:** The payment for each provider would be based on standard group funding levels that reflect individuals' needs and living situations (using a standardized assessment tool).
Comprehensible	Easily explained and understandable	**Medium:** The service plan and conversion of services to a daily payment is understandable, but monthly authorization via spreadsheets is complicated.	**High:** Set payments for each unit of service is understandable.	**(5) Medium:** Use of a standardized assessment tool and group payments based on need requires some explanation.	**High:** A single rate that reflects the average cost of service is understandable.
Equitable	Offers equivalent budgets/ services to individuals with similar needs	**Medium:** Service plans reflect individual needs, but there are no guidelines to ensure that individuals with similar needs receive similar plans.	**Medium:** Service plans reflect individual needs, but there are no guidelines to ensure that individuals with similar needs receive similar plans.	**High:** Providers receive the same funding level for all individuals within a group, based on level of need and living situation. Funding levels are higher for groups with higher needs.	**High:** Each provider receives the same payment for all individuals they serve. The average funding level is different for different providers, and is based on the needs and the living situations of the individuals receiving services from the provider.
Flexible	Responds to changes in individual needs and choices	**High:** With a fixed daily rate that is paid regardless of service delivered, providers can easily redirect funding to meet individual needs.	**Medium:** Providers are paid for services delivered so an update to an individual's service plan resulting from changes in their needs would require changes to their authorizations.	**High:** With fixed payments that are paid regardless of service delivered, providers are able to easily redirect funding to meet changes in individuals' needs.	**High:** With a single fixed payment that is paid regardless of service delivered, providers are able to easily redirect funding to meet changes in individuals' needs.
Predictable	Funding streams are consistent, allowing providers to effectively plan and manage their funding	**High:** Once an individual's budget is approved, the provider is assured of that revenue, unless the budget needs to be revised.	**Medium:** Providers are only paid for services delivered, which can vary from week to week. Over time, service needs are likely to be stable.	**High:** With fixed payments that are paid regardless of services delivered, providers have predictable funding. Funding levels may be adjusted each year.	**High:** With a single fixed payment that is paid regardless of services delivered, providers have predictable funding. Funding levels may be adjusted each year.