Value-Based Payment Measures – Calendar Year 2023
Specialized Service Agency
Pathways Vermont

A. Overview

In 2019, Vermont Medicaid implemented an alternative payment model for community mental health services as a part of a payment reform initiative. Mental Health Payment Reform represents a large operational and cultural shift towards focusing on how well Vermont is doing rather than simply how much it is doing. The shift gives communities more predictability, stability, and flexibility with funding to meet the needs of the children, youth, adults, and families they serve. By simplifying the baseline payment structures and adding value-based payments (VBPs) that reward outcomes and incentivize best practice, the State aims to make it easier for Medicaid providers to meet the goal of providing efficient and effective care for Vermonters with mental health needs. VBP programs tie healthcare reimbursement rates to quality care by offering providers incentive payments to meet specified quality measures during and after healthcare delivery.

B. Definitions and Methodology

VBP measures and methodologies are established collaboratively through the Scoring and Metrics subcommittee of the Payment Reform Advisory Group (PRAG). The measures found in this Appendix align with the calendar year and must be amended annually to include the new measures that the Centers for Medicare and Medicaid Services (CMS) approves for the subsequent calendar year. Please note that agency scoring is out of 27 points possible.

a. Monthly Service Report (MSR)

The MSR submission is a mechanism for SSAs to submit standardized service encounter data for services provided to clients in their respective catchment areas. The expectation is for the MSR submission to be both complete and on time.

i. Completeness

The MSR filing must include 80% or more of the data for the month of service being submitted in order to be considered complete. The expectations for filing completeness are for purposes of value-based payment only and do not change expectations for timely filing as set forth by the Department of Vermont Health Access (DVHA) in the Vermont Medicaid General Billing and Forms Manual.

ii. Timeliness

In order for reporting to be considered “on time” the report must be received by deadlines determined by the reporting period cadence. For monthly reporting, submissions are due on or before the last day of the subsequent month, which is

approximately 30 calendar days after the last reporting day. For quarterly, semi-annual, or annual reporting, submissions must be received within 90 calendar days after the last reporting day of that period.

b. MSR timely and complete scoring process includes the following:

i. The MSR file must be "accepted" in order to be submitted.
ii. The MSR file must be submitted on or before the last day of the following month.
iii. The system will auto-generate a message alerting that the file is "accepted" or that there is an error.
iv. The State will reply within 5-7 business days regarding the "error" for files that are not accepted.
v. The State will determine if the error is "simple" or "complex."
    a. "Simple" errors are those that either the State or the DA can fix themselves.
        i. Simple errors do not result in auto-passing; therefore, agencies should attempt to submit the file in a timely manner that allows for the correction of simple errors and for the file to be re-submitted before the last day of the month.
    b. "Complex" errors require third-party assistance, therefore result in an automatic passing scoring for timely.
vi. Completeness will be scored once the file is accepted based on the above referenced definition of 80%.
vii. Scoring is based on processed records.
viii. Final scores for each month will be issued quarterly starting June 2023.

The Specialized Service Agency (SSA) shall be responsible for the accuracy of its data. If a SSA discovers an error or omission after submission on a month that has already been scored, the Agency shall promptly make necessary revisions or corrections resulting from the errors or omissions. The requirement to submit corrections to ensure accuracy of reporting is not contingent on whether or not an appeal request for re-scoring will be granted, and therefore should not delay reporting.

Table 1: Value-Based Payment (VBP) Measures – Calendar Year 2023

Section 1: Monthly Service Report (MSR)-calculated Measures			
#	**Measure Description**	**Calculations**	**Reporting & Points**
1	Number of Medicaid-enrolled young adults (18-24 years old) served.	For any given year of service (January - December): • Pull MSR services • Match service records to MSR client services on agency-client number • Calculate age of client from the midpoint of the service year (June 30, XXXX) • Select clients who are aged 18-21	Submitted monthly to the MSR. **6 points total annually** (Measures 1-4) 0.25 points for each submission for timeliness (12 submissions annually)

		• Select clients who are reported as Medicaid enrolled (from client file) • Aggregate to agency-client level, with flag for total services during fiscal year • Select clients who have a least 1 unit (as defined in the Mental Health Provider Manual)	0.25 points for each submission for completeness (12 submissions annually) "On Time" defined as: report received on/before the last day of the following month (approx. 30 calendar days after last reporting day). Received in the format and standard as defined in the Provider Agreements.
2	Number of young adults (18-24 years old) served per 1,000 age-specific population.	For any given year of service (January-December): • Query MSR data for all services delivered • Calculate age of client from the midpoint of the service year (June 30th) • Select clients who are aged 18-21 years • Aggregate to clinic-specific level for total services during state fiscal year (July 1st -June 30th) • Select clients who have had a least 1 unit of service (as defined in the Mental Health Provider Manual) • Request most recent demographic data from Vermont Department of Health on a clinic catchment-level basis • Calculate per capita rate based on the following formula: $R = (\underline{1{,}000C})/\underline{\mathrm{P}}$ o where R is the rate of clients served per 1,000 population, C is the number of clients served, and P is the age-specific population of the geographic (catchment) area in question. o The rates of clients served per 1,000 population are presented as a comparable, standardized measure of the proportion of the residents of specified geographical regions who are served by specified programs.	

3	Number of Medicaid-enrolled adults (18+ years old) served.	Same as Measure 1, except: • Select clients who are aged 18 or older		
4	Number of adults (18+ years old) served per 1,000 age-specific population.	Same as Measure 2, except: • Select clients who are aged 18 or older		
Section 2: Client Satisfaction Survey Measures				
#	**Measure Description**	**Calculations**	**Reporting and Points**	**Target**
5	Percentage of clients who indicate services were "right" for them	• Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey) • Denominator = Total # of responses Client defined as adult in the following survey program categories: • Community Rehabilitation and Treatment	Submitted annually to DMH **4 points total annuall**y 1.33 points for each survey question for target met for each scoring period	XX%
6	Percentage of clients indicate they were treated with respect	• Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey) • Denominator = Total # of responses Client defined as adult in the following survey program categories: • Community Rehabilitation and Treatment		XX%
7	Percentage of clients indicate services made a difference.	• Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey) • Denominator = Total # of responses Client defined as adult in the following survey program categories: • Community Rehabilitation and Treatment		XX%
Section 3: Clinical Service Delivery Measures				
#	**Measure Description**	**Calculations**	**Reporting & Points**	**Target**

8	Percentage of adult clients offered a face-to-face contact within **five (5) calendar days** of initial request	• Numerator = # of inactive adult clients offered a face-to-face (or telehealth) appointment within five (5) calendar days • Denominator = Total # inactive adult clients requesting to enroll in services Adult client defined as 18+ years old.	Submitted quarterly to DMH using VBP reporting template **6 points total annually** 0.75 points for each measure for target met	52%
9	Percentage of adult clients seen for treatment within **fourteen (14) calendar days** of assessment	• Numerator = # of adult clients seen face-to-face (or telehealth) for any clinically indicated service within 14 days after the intake clinical evaluation/assessment is completed • Denominator = Total # of previously inactive adult clients seen within the calendar year (January 1st to December 31st) with a completed intake clinical evaluation/assessment Adult client defined as 18+ years old.		46%
10	Percentage of adult clients with an assessment who have been screened for **depression**	• Numerator = # of adult with new episode of care screened for depression using the PHQ-9 or PHQ-2 • Denominator = Total # of adult clients with a new episode of care in the time frame with an initial clinical evaluation/assessment Adult client defined as 18+ years old.	Submitted quarterly to DMH using VBP reporting template **6 points total annually** 0.25 points for each adult screening measure for target met	59%
11	Percentage of adult clients with an assessment who have been screened for **trauma**	• Numerator = # of adults with a new episode of care screened for psychological trauma history using the PC-PTSD-5 • Denominator = Total # of adult clients with a new episode of care in the time frame with a completed initial clinical evaluation/assessment Adult client defined as 18+ years old.		55%
12	Percentage of adult clients with an assessment who have been screened for **substance use**	• Numerator = # of adults with a new episode of care screened for substance use using the CAGE-AID • Denominator = Total # of adult clients with a new episode of care in the time frame with a completed initial clinical evaluation/assessment		60%

		Adult client defined as 18+ years old.		
13	Percentage of clients with an **ANSA** assessment within the last 12 months	• Numerator = # of adults in mental health case rate programs who have had an ANSA administered or re-administered on them within the past 13 months of programming • Denominator = Total # of adults enrolled in MH Case Rate programming who have received a clinical (not emergency) evaluation/assessment and have passed the threshold of at least 75 days since their original care inquiry call to that agency Adult defined as 18+ years old.	Submitted annually to DMH using VBP reporting template **3 points total annually**	35%
14	Percentage of adults with a follow-up visit after hospitalization for mental illness with a mental health provider within 7 days	• Numerator = # of clients with a qualifying service from their agency within seven days of discharge from inpatient stay, not including visits on the date of discharge • Denominator = All clients who were discharged connected to that agency	Submitted through administrative Medicaid claims data and clinical service encounter data via MSR submissions. Scored on annual basis **2 points total annually**	N/A