APPENDIX I
Value-Based Payment Measures – Calendar Year 2022

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 the Centers for Medicare and Medicaid Services (CMS) approves for the subsequent calendar year.

a. Monthly Service Report (MSR)

The MSR submission is a mechanism for DAs 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 2022.

The DA shall be responsible for the accuracy of its data. If a DA 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 2022

Section 1: Monthly Service Report (MSR)			
#	**Measure Description**	**Calculations**	**Reporting & Points**
1	Number of children/youth (0-17) served.	For any given year of service (Jan - Dec): • Pull MSR services • Calculate age of client from the midpoint of the service year (June 30, XXXX) • Select clients who are aged 0-17 • Aggregate to clinic client level, with flag for total services during fiscal year • Select clients who have a least 1 unit (as defined in the Provider Manual)	Submitted monthly to the MSR. **8 points total annual** (Measures 1-9) 0.33 points for each submission for timeliness 0.33 points for each submission for completeness

2	Number of Medicaid-eligible children/youth (0-17) served.	For any given year of service (Jan - Dec): • Pull MSR services • Match service records to MSR client services on clinic-client no. • Calculate age of client from the midpoint of the service year (June 30, XXXX) • Select clients who are aged 0-17 • Select clients who are reported as Medicaid enrolled (from client file) • Aggregate to clinic client level, with flag for total services during fiscal year • Select clients who have a least 1 unit (as defined in the Provider Manual)	"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.
3	Number of eligible children/youth (0-17) served per 1,000 age-specific population.	For any given year of service (Jan - Dec): • Follow steps for measure 1 (Number of children/youth (0-17) served). • Request most recent demographic data from VDH on a catchment level basis • Calculate per capita rate based on formula below 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. This utilization rate is computed according to the formula: $R = \frac{1{,}000\ C}{P}$ 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 area in question.	
4	Number of young adults (18-21) served.	Same as Measure 1, except: • Select clients who are aged 18-21	

5	Number of Medicaid-eligible young adults (18-21) served.	Same as Measure 2, except: • Select clients who are aged 18-21		
6	Number of eligible children/youth (18-21) served per 1,000 age-specific population.	Same as Measure 3, except: • Select clients who are aged 18-21		
7	Number of adults (18+) served.	Same as Measure 1, except: • Select clients who are aged 18 or older		
8	Number of Medicaid-enrolled adults served	Same as Measure 2, except: • Select clients who are aged 18 or older		
9	Number of adults (18+) served per 1,000 age-specific population	Same as Measure 3, except: • Select clients who are aged 18 or older		
Section 2: Client Survey Reporting				
#	**Measure Description**	**Calculations**	**Target**	**Reporting and Points**
10	Percentage of clients 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 youth and adult in the following VCP survey program categories: • Children, Youth, and Family Programs (NOT Success Beyond Six), • Community Rehabilitation and Treatment • Crisis bed • Emergency Services • JOBS • Mental Health – Adult	82%	Submitted Annually to VCP. **6 points total annual** 1.5 points for each survey question for target met

11	Percentage of clients indicate they received the services they “needed”	• Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey) • Denominator = Total # of responses Client defined as youth and adult in the following VCP survey program categories: • Children, Youth, and Family Programs (NOT Success Beyond Six), • Community Rehabilitation and Treatment • Crisis bed • Emergency Services • JOBS • Mental Health – Adult	82%	
12	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 youth and adult in the following VCP survey program categories: • Children, Youth, and Family Programs (NOT Success Beyond Six), • Community Rehabilitation and Treatment • Crisis bed • Emergency Services • JOBS • Mental Health – Adult	87%	
13	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	75%	

		Client defined as youth and adult in the following VCP survey program categories: • Children, Youth, and Family Programs (NOT Success Beyond Six), • Community Rehabilitation and Treatment • Crisis bed • Emergency Services • JOBS • Mental Health – Adult		

Section 3: Access, Screening, and Assessment Measure Reporting					
#	**Measure Description**	**Calculations**	**Reporting & Points**	**Target**	**90th Percentile**
14	Percentage of clients offered a face-to-face contact within **5 calendar days** of initial request	• Numerator = # of inactive clients offered a face to face (or telehealth) appointment within five calendar days • Denominator = Total # inactive clients calling saying they need help Client defined as youth and adult.	Submitted quarterly to DMH using VBP reporting template (excel). **6 points total annual**, potential for 3 bonus points 0.75 points for each measure for target met 0.375 points for meaningful improvement	48%	93%
15	Percentage of clients seen for treatment within 14 calendar days of assessment	• Numerator = # seen face to face (or telehealth) for any clinically indicated service within 14 days after the intake assessment (psychosocial assessment) is completed • Denominator = Total # of previously inactive clients seen within the calendar year (January 1 to December 31) with a completed intake assessment Client defined as youth and adult.		49%	77%
16	Percent of adult clients with an assessment who have been screened for **depression**	• Numerator = Total # of clients with new episode of care screened for depression using the PHQ-9 or PHQ-2 • Denominator = Total # of clients with a new episode of care in the time frame with an initial assessment	Submitted quarterly to DMH using VBP reporting template (excel).	50%	95%

		Client defined as 18+ years old.			
17	Percent of adult clients with an assessment who have been screened for **trauma**	• Numerator = Total # of clients with a new episode of care screened for psychological trauma history using the PC-PTSD-5 • Denominator = Total # of clients with a new episode of care in the time frame with an initial assessment Client defined as 18+ years old.	**6 points total annual**, potential for 3 bonus points 0.5 points for each measure for target met 0.25 points for meaningful improvement	48%	96%
18	Percent of adult clients with an assessment who have been screened for **substance use**	• Numerator = Total # of clients with a new episode of care screened for substance use using the CAGE-AID • Denominator = Total # of clients with a new episode of care in the time frame with an initial assessment Client defined as 18+ years old.		52%	98%
19	Percent of child/youth clients with a **CANS** assessment within the last 6 months	• Numerator = # of children and youth who have had a CANS administered or re-administered on them within the past 6 months of programming • Denominator = All youth enrolled in CYFS programming* who have received a clinical (not emergency) assessment and have passed the threshold of at least 75 days since their original care inquiry call to that agency Client defined as 0-22 years old.	Submitted biannually to DMH using VBP reporting template (excel). **4 points total annual**, potential for 2 bonus points 2 points for each measure for target met 1 point for meaningful improvement	58%	96%
20	Percent of adult clients with an **ANSA** assessment within the last 12 months	• Numerator = Number 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	Submitted annually to DMH using VBP reporting template (excel).	n/a	n/a

		• Denominator = All adults enrolled in MH Case Rate programming who have received a clinical (not emergency) 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. Agencies may use clinical skill to determine if a transition age client should be receiving a CANS or an ANSA and utilize the tool that best fits.	**2 points total annual**. 2 points for reporting only.		
Meaningful Improvement definition for measures 14-19: Points awarded to items that: • did not meet the target but did show 5% improvement over their previous (CY2020 & 2021) average, OR • achieve the highest achievable benchmark (90th percentile)					