Value-Based Payment Measures – Calendar Year 2023

Specialized Service Agency

Northeastern Family Institute, Vermont (NFI VT)

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 with NFI VT. 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.

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

Provider Performance Measures				
#	**Measure Description**	**Calculations**	**Reporting**	**Target**
1	Percentage of Medicaid enrollees receiving a CANS assessment in the past 6 months	• Numerator = # of clients administered CANS in the past 6 months • Denominator = Total # clients served during report period	January 1st & July 1st and discussed during January and July Utilization Review (UR) meetings	90%
2	Minimum caseload for Medicaid enrollees is 91; Target	1. Count actual # of referrals 2. Count of clients served since beginning of the fiscal year	Submitted bi-annually (July 1st & December 31st) to DMH	> 100

	Caseload is 100 or above for incentive payments			
3	Percentage of Medicaid enrollees declined after the completed referral	• Numerator = # of referrals that are declined • Denominator = Total # of completed referrals during reporting period	Submitted quarterly to DMH	<10%
4	Number of Medicaid enrollees where NFI staff had contact with primary caregivers for 2 hours or more (aggregated) per month.	Number of cases where NFI staff had contact with primary caregivers for 2 hours or more (aggregated) per month. 3.a. Baseline year to gather data and will set target % of cases that meet goal at end of year. Incentive paid for reporting data for this contract year.	Submitted quarterly to DMH Final numbers reported within 45 days of the end of the fiscal year	N/A (Pay for reporting)