VERMONT

Annotated

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Vermont Medicaid Next Generation Model Accountable Care Organization (ACO) Program Reimbursement

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A. Overview

Payments under the Vermont Medicaid Next Generation Model (VMNG) ACO Program will be made on a monthly basis for a Value-Based Care Payment. The Value-Based Care Payment will be set based on past ACO performance year claims. In addition to data based on past performance, trend factors may also take into consideration the following elements: adjustments for policy related changes, differences across aid categories of the members who will be attributed in the performance year through the methodology described in Section C below, geographic differences, truncation/capping of expenditures, and risk adjustment.

B. Attributed Populations

For the purposes of calculating monthly payments to the ACO, members will be considered prospectively attributed lives if they are enrolled in Medicaid as of November 1 prior to the beginning of the performance year, except for the following excluded populations:

1. Individuals who are dually eligible for Medicare and Medicaid;
2. Individuals who have third party liability coverage;
3. Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers;
4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package; and
5. Individuals who have paid Qualified Evaluation & Management service claims in the two and three-quarter years prior to the start of the performance year with a primary care provider that is not participating in the VMNG ACO program.

These exclusions are only for the purpose of calculating payments, and will not impact the receipt of services in any way.

C. Attribution Methodology

For eligible members, a prospective attribution methodology will assign the member into one of two attribution cohorts. The traditional attribution cohort is based on the payments on QEM services provided by primary care specialists (physicians and practitioners with a primary care specialty who are designated as providers eligible to attribute by OneCare in the annual submission of the participating provider roster) during the two-and-three-quarter-year attribution period (AYs). This methodology conducts attribution at the billing provider NPI level that is affiliated with an ACO participant. The expanded attribution cohort allows attribution for members not attributed to the traditional cohort who have a full Medicaid benefits package and who do not have (1) paid claims for QEM services during the two-and-a-half year attribution period (AYs) provided by primary care specialists who are not participating in the VMNG ACO program; and (2) evidence of other insurance coverage (see excluded population criteria above). Both attribution cohorts will remain closed and static for the performance year.

D. Patient Freedom of Choice

Members will have freedom of choice with regard to their providers consistent with their benefit as described in 42 CFR 431.51.

E. Covered Services

Participants in the VMNG ACO Program are responsible for administering a set of covered services for their attributed population of members in each performance year. Covered services include: inpatient hospital, outpatient hospital, physician (primary care and specialty), nurse practitioner, ambulatory surgical center, federal qualified health center and rural health clinic, home health, hospice, physical, occupational and speech therapists, chiropractor, audiologist, podiatrist, optometrist and optician, independent laboratory, ambulance transport (emergent and non-emergent), physician-administered drugs, mental health and substance abuse services funded exclusively by DVHA (with some exceptions), durable medical equipment, prosthetics, orthotics, medical supplies, dialysis facility, and preventive services. Participating ACOs will receive a monthly Value-Based Care Payment based on these services for their attributed members.

F. AIPBP Rate Calculation

ETCOC (Column A): Expected Total Cost of Care – this is the financial obligation from DHVA to ACO for covered services. The ETCOC varies by MEG (Medicaid Eligibility Group) and includes all of the following components:

a. Provider Reform Support Payments of $4.75 per attributed member per month for both the traditional and expanded attribution cohorts, which is pass-through funding to the ACO's provider network to fund care coordination and population health management activities.

b. A monthly payment in an amount designated by OneCare as reimbursement for services provided to attributed members by participating hospitals and select

independent physician practices designated by OneCare. This payment shall be referred to as a Fixed Prospective Payment (FPP); and

c. Fee for service payments made for services to attributed members of OneCare.

The ETCOC is comprised by multiplying the rate in Column A by the number of members in each MEG that are attributed to OneCare. The Monthly Value-Based Care Payment (Column E) is paid prospectively on a monthly basis from DVHA.

Table 1. Combined Traditional and Expanded Attribution Cohort Rates:

	~~A=B+C~~	~~B~~	~~C~~	~~D~~	~~E = C + D~~
~~MEG~~	~~ETCOC~~	~~Allocation for FFS~~	~~Allocation for FPP~~	~~Provider Reform Support Payment~~	~~Monthly Value-Based Care Payment to Contractor~~
~~ABD~~	~~$656.92~~	~~$289.26~~	~~$367.66~~	~~$4.75~~	~~$372.41~~
~~New Adult~~	~~$286.99~~	~~$115.50~~	~~$171.49~~	~~$4.75~~	~~$176.24~~
~~Non-ABD Adult~~	~~$362.06~~	~~$129.69~~	~~$232.37~~	~~$4.75~~	~~$237.12~~
~~Consolidated Child~~	~~$128.78~~	~~$63.36~~	~~$65.42~~	~~$4.75~~	~~$70.17~~
~~SCHIP Child~~	~~$120.65~~	~~$54.76~~	~~$65.89~~	~~$4.75~~	~~$70.64~~

	A=B+C	B	C	D	E = C + D
MEG	ETCOC	Allocation for FFS	Allocation for FPP	Provider Reform Support Payment	Monthly Value-Based Care Payment to Contractor
ABD	$713.65	$335.33	$378.32	$4.75	$383.07
New Adult	$330.63	$132.22	$198.41	$4.75	$203.16
Non-ABD Adult	$436.08	$148.39	$287.69	$4.75	$292.44
Consolidated Child	$141.77	$80.08	$61.69	$4.75	$66.44
SCHIP Child	$121.27	$70.78	$50.49	$4.75	$55.24

G. ACO Risk Arrangement

The risk arrangement between DVHA and participating ACOs is outlined in the tables below:

Table 2. Combined Traditional and Expanded Attribution Cohort Risk Arrangement:

Expenditures over/under expected Total Cost of Care target	ACO share	DVHA share
-3% to 3%	100%	0%
<-3% or >3%	0	100%

H. Quality and Pay for Performance Measures

The overall goal of the program is to improve quality of care and contain the growth of healthcare costs. To incentivize the provision of higher-quality care, each performance year a ~~$2 million~~ Value Based Incentive Fund (VBIF) will be administered by each contracted ACO based on participating providers' performance on a set of pre-defined quality measures. The Value-Based Incentive Fund for performance year 2025 totals $2.12 million. Of that $2.12 million, $500,000 must be used to provide shared interest payments to Designated Agencies based on Health Service Area (HAS)-level performance for 3 mental health/substance use disorder (MHSUD) -related quality measures related to follow-up care. A Year-End Quality Adjustment will also be applied to the ACOs' Expected Total Cost of Care during the reconciliation period based on the ACOs' quality performance. The measures included and the associated performance targets will be reviewed and updated as needed throughout the multi-year contract period to ensure that participating ACOs have incentives for continued quality improvement. Please refer to the DVHA grants and contracts website for the most up to date performance measures.

I. Monitoring Processes

The Vermont Medicaid VMNG ACO Program includes a series of internal monitoring and reporting processes that are scheduled to be evaluated and analyzed quarterly, semi-annually, or annually.