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Agency of Human Services

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

Effective January 1, ~~2022~~2023 – Global Commitment Register (GCR) # ~~21-06322-131~~

A. Providers

Accountable Care Organizations (ACOs) are organizations of healthcare and social service providers. ACOs must include primary care providers who provide primary care case management services under authority of §1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A) - (B) of the Act, an ACO must be, employ, or contract with a physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services. The ACO provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, and naturopathic medicine.

B. Service Descriptions

ACOs are under contract to receive risk-based Value-Based Care Payments for a defined set of covered services for which they are responsible for administering to members. These categories of service 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.

Prior authorization requirements will be waived for all providers for certain services in the above defined set of Medicaid services provided to attributed members for which the ACO is accountable, ~~except for a subset of. Certain~~ services ~~for which will continue to require~~ prior authorization and clinical review ~~will still be required~~ for patient safety reasons, regardless of ACO-attribution status of the member. Additionally, DVHA is working to align its prior authorization requirements for ACO-attributed and non-ACO attributed members, and will reinstate prior authorization requirements for ACO-attributed members beginning on January 1, 2023 for certain categories of service, including therapies, chiropractic care, and out-of-network services.



ACOs must be under contract with the State and have demonstrated through the procurement process that:

1. The full scope of primary care services, including locating, coordinating, and monitoring primary care and lab services, are provided by their ACO participants;
2. They will coordinate innovative approaches to sharing data and information, strengthening coordination at a local level, creating new partnerships, and disseminating evidence-based practices or clinical pathways;
3. They will establish partnerships with community-based organizations and public health resources;
4. They will establish a process to engage patients and their families meaningfully in the care they receive;
5. They will have the capacity to receive data from the State via secure electronic processes;
6. They will use data provided by the State to identify opportunities for recipient engagement and to stratify its population to determine the care model strategies needed to improve outcomes;
7. They will enhance coordination of care with other medical providers, which may include ACO participants or other independent or state entities, who are responsible for pertinent aspects of care;
8. They will participate in quality measurement activities as required by the State; and
9. They will have the ability to pay providers in arrangements that are alternatives to traditional fee-for-service reimbursement.

C. Outcomes

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 will be administered by DVHA based on participating providers' performance on a set of pre-defined quality measures. \$500,000 of this funding 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, ~~found here: [hyperlink will be included here once the final contract is executed]~~.

D. Attributed Populations

For the purposes of calculating monthly Value-Based Care 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 a performance year with a primary care provider that is not participating in the VMNG ACO program.

This exclusion is only for the purpose of calculating Value-Based Care Payments and will not impact the receipt of services in any way.

E. Limitations

The following limitations apply to the Vermont Medicaid Next Generation Model (VMNG) ACO Program:

1. The provision of services under the VMNG ACO program does not duplicate the locating, coordinating and monitoring of health care services provided under the Vermont Chronic Care Initiative;
2. The VMNG ACO Program does not restrict members' free choice of provider as described in 42 CFR 431.51;
3. Qualified ACOs are those that have submitted successful responses to the Department's request for proposals and are under contract with the State to participate in this demonstration.

F. Assurances

The following member protections in § 1905(t) apply to the VMNG ACO Program:

1. §1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because members are afforded free choice of providers participating in Medicaid;
2. §1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner, is met in that members are afforded free choice of providers participating in Medicaid;
3. §1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because qualified ACOs will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.

In addition, the following apply to the VMNG ACO Program:

1. ACOs will notify members of their provider's participation in the VMNG ACO Program at the beginning of a performance year. Members will then be provided the opportunity to opt-out of the sharing of their medical claims data.
 - a. The ACO must ensure that each member receives one notice during the course of his/her attribution to the ACO, including a description of provider payment incentives, and the use of personal information. The ACO must provide the members with written notification by mail and/or in person prior to, during or following the member's visit to a participating primary care practice. The ACO may also use electronic communication if a member agrees to this form of communication.
2. §1903(d)(1), which provides for protections against fraud and abuse, is met in that all providers participating in an ACO are enrolled as providers with DVHA and are bound by the rules of the Medicaid program.
3. The prohibitions set forth in 42 CFR Part 2 are strictly adhered to in all activities of the program. In order to ensure strict compliance with 42 CFR Part 2, a Vermont Medicaid VMNG ACO Substance Abuse Data Confidentiality Policy was created and disseminated to appropriate parties.

Included in that Policy are specific instructions, taken from the text of 42 CFR Part 2, as to how members can opt-into having their substance abuse-related data shared with their ACO.