State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

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

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 All-Inclusive Population Based Payments (AIPBPs) for a defined set of covered services for which they are responsible for administering to beneficiaries. 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.

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. Each performance year, a portion of the monthly AIPBP will be set aside by participating ACOs in a Quality Incentive Pool. A portion of the withhold, determined by performance on a set of measures, will be distributed to ACO network providers. Of the remainder of the withhold, 50% will be reinvested by participating ACOs in quality improvement initiatives, and the remaining 50% will be returned to DVHA. 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 website for the most up to date performance measures, found here: *http://dvha.vermont.gov/administration/1onecare-aco-32318-3-final-signed-with-exhbits.pdf*.

D. Attributed Populations

For the purposes of calculating monthly AIPBP payments to the ACO, beneficiaries will be considered prospectively attributed lives if they are enrolled in Medicaid at the beginning of a 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 do not have any paid Qualified Evaluation & Management service claims in the two years prior to the start of a performance year.

This exclusion is only for the purpose of calculating AIPBP 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 beneficiary 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 beneficiaries 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 beneficiaries are afforded free choice of providers participating in Medicaid, and in that the attribution methodology ensures that only patients who have a relationship with the participating providers are attributed to the ACO;

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 beneficiaries of their provider's participation in the VMNG ACO Program at the beginning of a performance year. Beneficiaries will then be provided the opportunity to opt-out of the sharing of their medical claims data.

    a. The ACO must ensure that each beneficiary 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 beneficiaries with written notification by mail and/or in person prior to, during or following the beneficiary's visit to a participating primary care practice. The ACO may also use electronic communication if a beneficiary 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 beneficiaries can opt-into having their substance abuse-related data shared with their ACO.