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Vermont Medicaid All Payer Model Accountable Care Organization (ACO) Program Reimbursement

A. Overview

Payments under the Vermont Medicaid All Payer Model (APM) ACO Program will be made on a monthly basis for an All-Inclusive Population Based Payment (AIPBP). The AIPBP will be set based on the historic DVHA expenditures for actual attributed lives to the ACO using the attribution methodology described in Section C below. In addition to data based on attributed lives, the trend may also take into consideration the following elements: adjustments for policy related changes, differences across entitlement categories, geographic differences, truncation/capping of expenditures, and risk adjustment.

B. Attributed Populations

For the purposes of calculating monthly 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 the performance year.

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

C. Attribution Methodology

Beneficiaries will be attributed to ACOs in the Vermont Medicaid APM ACO Program through the following process:

1. Prospective attribution using a methodology in which claims for eligible beneficiaries are identified for the presence of qualifying Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes billed in the previous twenty four months by primary care providers enrolled with Medicaid.

2. For eligible beneficiaries not attributed through Step 1, assign the beneficiary to his/her non-primary care specialist provider through which the beneficiary has incurred claims for qualifying Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes in the last twenty-four months.

Attribution is done at the billing provider TIN level that is affiliated with an ACO participant. Any ACO participant that includes at least one ACO provider with attributed lives to him/her must have an exclusive participant relationship with only one ACO in this program. Those ACO participants who do not attribute lives can participate in multiple ACOs in this program.

D. Patient Freedom of Choice

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

E. Risk Score

Risk adjustment is done using the most recently released CMS community version of the Hierarchical Condition Classification software.

F. Covered Services

Participants in the APM ACO Program are responsible for administering a set of covered services for their attributed population of beneficiaries 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, mental health and substance abuse services funded exclusively by DVHA, durable medical equipment, prosthetics, orthotics, medical supplies, dialysis facility, and preventive services. Participating ACOs will receive a monthly AIPBP payment based on these services.

G. AIPBP Rate Calculation

Details to be added when they become available.

H. ACO Risk Arrangement

Participating ACOs will assume full financial risk for covered services for their attributed population.

I. 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. Each performance year, a portion of the monthly AIPBP payment to a participating ACO will be withheld. ACOs may be eligible to receive some or all of the withheld funds based on performance in a pay-for-performance component of the program, including both process and outcome quality measures. 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: *[hyperlink to be added when performance measures become available]*

J. Monitoring Processes

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