VERMONT

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

A. Overview

Payments under the Vermont Medicaid Next Generation Model (VMNG) 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, members 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

For eligible members, a prospective attribution methodology will assign the member 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-year attribution period.

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. Covered Services

Participants in the VMNG 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, 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 AIPBP based on these services for their attributed beneficiaries.

F. AIPBP Rate Calculation

AIPBP (Column A): All Inclusive Population Based Payments – this is the financial obligation from DHVA to ACO for covered services. The AIPBP varies by MEG (Medicaid Eligibility Group) and includes all of the following components:

1. The risk corridor benchmark or expected total cost of care for members in each MEG (comprising the sum of amounts allocated for fixed prospective payments and fee for service payments to providers, Column B below);

2. Administrative funding of $6.50 per attributed member per month (Column C below);

3. Primary Care Case Management (PCCM) Fee of $2.50 per attributed member per month (Column D below) and4. The total AIPBP amount, which is the sum of amounts in 1-3 above (Column A below)

The AIPBP is comprised by multiplying the rate in Column A by the number of members in each MEG that are attributed to OneCare.

	A=B+C+D	B	C	D
MEG	AIPBP	Risk Corridor Benchmark or Expected TCOC	Administration	PCCM
ABD	$618.40	$609.40	$6.50	$2.50
Consolidated Adult	$362.93	$353.93	$6.50	$2.50
Consolidated Child	$121.38	$112.38	$6.50	$2.50

G. ACO Risk Arrangement

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

Expenditures over/under expected Total Cost of Caretarget	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. 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. See below for the current set of performance measures:

Measure	**Measure Use**	**Data Source**
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	Payment	Claims
30 Day Follow-Up after Discharge from the ED for Mental Health	Payment	Claims
Adolescent Well Care Visits	Payment	Claims

All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Payment	Claims
Developmental Screening in the First 3 Years of Life	Payment	Claims
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	Payment	Clinical
Hypertension: Controlling High Blood Pressure	Payment	Clinical
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	Payment	Claims
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Payment	Claims
Screening for Clinical Depression and Follow-Up Plan	Payment	Claims and Clinical
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	Reporting	Claims
Tobacco Use Assessment and Tobacco Cessation Intervention	Reporting	Claims
Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey Composite Measures collected by DVHA	Reporting	Survey

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.