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State/Territory Name: Vermont

State Plan Amendment (SPA) #: 14-017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

June 5, 2015

Hal Cohen, Secretary
Vermont Agency of Human Services
208 Hurricane Lane, Suite 103
Williston, Vermont 05495

Dear Secretary Cohen:

We are pleased to enclose a copy of approved State plan amendment (SPA) No. 14-017 with an effective date of February 1, 2014, as requested by your Agency.

This SPA transmitted a proposed amendment to your approved Title XIX State plan to create an integrated care model known as the Vermont Medicaid Shared Savings Program.

Enclosed are the following pages to be incorporated within your State plan:

- Attachment 4.19-B, pages 12-17

If there are questions, please contact Lynn Wolfsfeld at (401) 999-4004, or Tom Schenck at (617) 565-1325.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Steven Costantino, Commissioner
Lindsay Parker, Health Programs Administrator, Policy Unit
Ashley Berliner, Medicaid Policy and Planning Chief, Policy Unit

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14 -- 017

2. STATE: VERMONT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
~~JANUARY 1, 2014~~ February 1, 2014

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §430.12(c)(ii)

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ 0
b. FFY 2015 $ ~~0~~ ($3,930,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~ATT. 3.1-A PG. 13 AND 14~~ Att. 3.1-A, pages 13-13E
~~ATT. 4.19-B PG. 12, 13, 14 and 15~~ ATT.4.19-B pg. 12-16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT:
ACO SHARED SAVINGS PROGRAM

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
SIGNATURE OF SECRETARY OF ADMINISTRATION
[redacted]

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
DOUGLAS A. RACINE

14. TITLE:
SECRETARY, AGENCY FOR HUMAN SERVICES

15. DATE SUBMITTED: March 19, 2014

16. RETURN TO:

ASHLEY BERLINER

DEPARTMENT OF VERMONT HEALTH ACCESS
312 HURRICANE LANE, SUITE 201
WILLISTON, VT 05495

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 19, 2014

18. DATE APPROVED: June 5, 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
February 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Richard R. McGreal

22. TITLE Associate Regional Administrator

23. REMARKS

Pen and Ink changes to boxes 4, 7 and 8 (TS)

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. Integrated Care Models

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. Integrated Care Models

Vermont Medicaid Shared Savings Program (VMSSP)

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 share savings gained on the total cost of care (TCOC) for defined services. Services included in the TCOC for year one include: inpatient hospital, outpatient hospital, physician (primary care and specialty), nurse practitioner, physical and occupational therapy, mental health facility and clinic, ambulatory surgery center, federally qualified health center, rural health center, chiropractor, podiatrist, psychologist, optometrist, optician, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.

Performance years two and three may include an expanded TCOC. A full list of services will be posted on the Department of Vermont Health Access (DVHA) website in advance of the beginning of the performance year, and can be found at: http://dvha.vermont.gov/administration/total-cost-of-care.pdf

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

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. Integrated Care Models (Continued)

1. They maintain 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; and,

8. They will participate in quality measurement activities as required by the State.

C. Outcomes

The overall goal of the program is to improve quality of care and contain the growth of healthcare costs. The payment of savings is contingent upon meeting quality of care thresholds. The measure set being used to assess quality for year one of the program contains eight payment measures and twenty reporting measures. This measure set includes process and outcome measures based on a combination of claims, clinical and survey data. The measures currently span ten domains. The measure set will be reviewed and updated annually. Changes in the measure set will be derived from recommendations generated as part of the Vermont Health Care Innovation Project. Please refer to

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. Integrated Care Models (Continued)

DVHA website for the most up to date performance measures, found here: http://dvha.vermont.gov/administration/performance-measures-and-shared-savings.pdf.

D. Attributed Populations

For the purposes of calculating shared savings, beneficiaries will be considered attributed lives if they are enrolled in Medicaid for at least ten non-consecutive months in 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; and
4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

This exclusion is for the purpose of shared savings calculation only, and will not impact the receipt of services in any way.

E. Limitations

The following limitations apply to the VMSSP:

1. The provision of services under the VMSSP does not duplicate the locating, coordinating and monitoring of health care services provided under the Vermont Chronic Care Initiative;
2. The VMSSP does not restrict members' free choice of provider as described in 42 CFR 431.51;

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. Integrated Care Models (Continued)

3. Qualified ACO provider organizations 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, ending in three years on December 31, 2016.

F. Assurances

The following beneficiary protections in § 1905(t) apply to the VMSSP:

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 VMSSP:

1. Any ACO which meets the qualifications established by the state will be allowed to participate in the VMSSP;

2. ACOs will notify beneficiaries of their provider's participation in the VMSSP. Beneficiaries will then be provided the opportunity to opt-out of the sharing of their medical claims data.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

29. Integrated Care Models (Continued)

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. Initial notices will be sent to beneficiaries at the start of the program, and notices to newly attributed beneficiaries will be sent quarterly. 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.

3. §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.

4. The prohibitions set forth in 42 CFR Part 2 are strictly adhered to in all activities of the VMSSP. In order to ensure strict compliance with 42 CFR Part 2, a VMSSP Substance Abuse Data Confidentiality Policy was created and disseminated to appropriate parties.

a. 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 or ACOs.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE
(Continued)

30. Integrated Care Models
Vermont Medicaid Shared Savings Program (VMSSP)

A. Overview

Payments under the VMSSP are made following the end of a performance year to qualifying ACOs that have agreed to participate for the purpose of improving clinical quality and patient experience, and achieving efficiencies across the total cost of care. Once data is collected and analyzed at the end of a performance year, a lump sum shared savings payment will be made to qualifying ACOs no later than the last day of August following the end of that performance year. The ACO distributes payments to member providers according to their participation agreements. The program will only pay shared savings (up-side risk) if eligible, and will not require recoupment (down-side risk) in the event there is an increase in actual expenditures in any of the first three performance years.
As represented by the formulas below, the total amount of shared savings in a given performance year is equal to the difference between the truncated, risk-adjusted, expected total cost of care (TCOC) and the truncated, risk-adjusted actual total cost of care for the attributed population of each ACO. The ACO portion of shared savings payment is equal to the product of the maximum savings rate and the total amount of shared savings for that ACO, adjusted by the ACO-specific quality score.

$$PYSS\$_{TOTAL\ (ACOi+PAYER)} = (\text{Expected TCOC } \$_{ACOi} - \text{Actual TCOC } \$_{ACOi})$$ *risk adjusted, truncated*
subject to cap of 10% of the "Actual $\$_{ACOi}$"

$$\text{Payout of } PYSS\$_{ACOi+} = (\ MAXSR_{ACOi} * (\ PYSS\$_{TOTAL\ (ACOi+PAYER)}\ ))\ *\ QS$$
subject to MSR, savings rate tiers, and adequate population size

Where:

PAYER=DVHA (State Share and FMAP)

PYSS$ = Performance Year Shared Savings Dollars

TCOC = Total Cost of Care

MAXSR= Maximum Savings Rate (50%)

QS= Quality Score

MSR=Minimum Savings Rate

ACOi = a specific ACO contracted with the VMSSP

The calculations are done retrospectively for each ACO using the claims data for services identified in the TCOC rendered in a performance year with allowance for six months run-out. To be eligible for savings, a minimum population size of 5,000 and minimum savings rate of at least 2% must be demonstrated. Once the minimum savings rate is reached, the state will calculate a tiered savings rate based on total savings. If program savings are between 2-5% (Tier 1), the ACO will qualify for 25% of total shared savings. If program savings is above 5% (Tier 2), the ACO will qualify for 50% of total shared savings up to a cap. The cap is set at 10% of actual total cost of care in a given performance year for that ACO.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE
(Continued)

B. Attributed Populations

For the purposes of calculating shared savings, beneficiaries will be considered attributed lives if they are enrolled in Medicaid for at least ten non-consecutive months in 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; and

4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

This exclusion is for the purpose of shared savings calculation only, and will not impact the receipt of services in any way.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE
(Continued)

C. Attribution Methodology

Beneficiaries will be attributed to ACOs in the VMSSP through the following process:

1. Retrospective claims 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 twelve months by primary care providers enrolled with Medicaid.

2. For eligible beneficiaries not attributed by retrospective claims attribution, assign the beneficiary to his/her primary care provider that he/she selected or was auto-assigned upon enrollment.

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

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. Total Cost of Care

Participants in the VMSSP are responsible for the Total Cost of Care (TCOC) of their attributed population of beneficiaries in each performance year. The TCOC is comprised of a defined set of core services. Core services included in the TCOC for year one include: inpatient hospital, outpatient hospital, physician (primary care and specialty), nurse practitioner, physical and occupational therapy, mental health facility and clinic, ambulatory surgery center, federally qualified health center, rural health center, chiropractor, podiatrist, psychologist, optometrist, optician, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility. The TCOC is the sum of payments made for core services rendered in the given performance year. Expenditures for attributed beneficiaries are capped at the value of the 99th percentile of expenditures for the attributed lives within enrollment categories.

Core services are determined by the State annually. DVHA determines the core service applicable in each performance year prior to the start of the program year. Services not in the TCOC calculations are called

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE
(Continued)

non-core services. DVHA maintains the list of core and non-core services applicable to each performance year, which can be found at: http://dvha.vermont.gov/administration/totalcostofcare.pdf

G. Expected Total Cost of Care (TCOC)

The expected total cost of care calculation uses three historic benchmark years of claims data. In performance year one, calendar year 2014 (CY 2014), the three historic benchmark years are CY 2010, 2011 and 2012. The benchmark years will be updated on a rolling basis annually—that is, the oldest year of data used in the calculations of the benchmark in the previous performance year will be dropped and a more current year will be added to the benchmark reflecting data closer to the performance year.

The risk adjustment process described in section E and the truncation calculation described in section F are performed and a total ACO eligible population compound annual growth rate (CAGR) is calculated from re-priced data in the three benchmark years.

The expected TCOC is computed for each enrollment category separately.

The formula applied is:

(Truncated, risk adjusted PMPM from last year in the benchmark period) * (1+CAGR) * (1+CAGR)

In some years, an additional adjustment may be made to the expected TCOC to account for rate changes made by DVHA between the benchmark years and the performance year that would not be reflected in the CAGR.

H. Actual Total Cost of Care

The actual TCOC calculation will be derived from claims for actual attributed population of each ACO during a performance year. Risk-adjustment and truncation are also performed as described in sections E and F.

I. Gain and Loss-Sharing

The maximum savings rate in the VMSSP is fifty percent, unless the ACO chooses to expand the TCOC in performance year two, in which case the savings rate would increase to sixty percent. There are no loss-sharing and/or recoupment requirements under the program for the first three years.

J. Quality and Patient Experience Measures Requirements for Reporting Measures

The VMSSP uses the Gate and Ladder methodology to calculate a Quality Score (QS) that is then used in the calculation of the payment of shared savings as described in section A. The Gate and Ladder are defined as follow:

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE
(Continued)

Gate -- The ACO must earn a minimum percentage of the eligible points as stated in its contract in order to receive a share of any generated savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings.

Ladder -- In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There are six steps on the ladder, which reflect increased levels of performance.

For year one of the VMSSP pilot, the ACO's performance on the payment measures will be compared performance targets. The targets are based either on national Medicaid HEDIS benchmarks or historic Vermont Medicaid benchmarks. When the targets are based on national Medicaid HEDIS benchmarks, 1, 2 or 3 points will be assigned based on whether the ACO performed at the national 25th, 50th or 75th percentile for the measure. When no national benchmarks are available, the ACO will receive 0 points for a statistically significant decline over baseline, 2 points for no statistically significant change over baseline, and 3 points for a statistically significant improvement over baseline performance.

The core measure set and Gate and Ladder threshold and scores are subject to change prior to the beginning of each performance year. Current measure sets, thresholds and scores can be found at the following web address: http://dvha.vermont.gov/administration/performance-measures-and-shared-savings.pdf.

K. Monitoring and Reporting

The VMSSP includes a series of internal monitoring and reporting measures that are scheduled to be calculated and analyzed quarterly or at minimum, semi-annually.

As a condition of continuance beyond December 31, 2016, Vermont will evaluate the program to demonstrate improvement against past performance using cost and quality data to determine whether the payment methodology has achieved or needs revisions to achieve the goals of improving health, increasing quality and lowering the growth of health care costs. With regard to methodological changes and moving towards a more robust metric framework that is tied to payment, Vermont will reflect in its annual updates any changes to the measures being used to assess program performance and/or determine payment eligibility and distribution.

Vermont will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the program against the goals of improving health, increasing quality and lowering the growth of health care costs;
2. Provide CMS, at least annually, with updates, as conducted, to the state's metrics;
3. Review and renew the payment methodology as part of the evaluation; and,
4. Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment updates.