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State/Territory Name: Vermont

State Plan Amendment (SPA) #: 15-0011

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

September 2, 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 Vermont's approved State plan amendment (SPA) No. 15-0011 with an effective date of July 9, 2015, as requested by your Agency.

This SPA amended your Title XIX State plan to update various provisions of Vermont Medicaid's Shared Savings Program for performance year 2.

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

- Attachment 3.1-A, pages 13A and 13B
- Attachment 4.19-B, pages 14, 15 and 16

If there are questions, please contact Tom Schenck at (617) 565-1325, or tom.schenck@cms.hhs.gov .

Sincerely,

[redacted]

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: 15 - 011

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)
JULY 9, 2015

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)(1)(ii)

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $ 0
b. FFY 2016 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 3.1-A PG. 13A, 13B
ATT. 4.19-B PG. 14, 15, 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
ATT. 3.1-A PG. 13A, 13B
ATT. 4.19-B PG. 14, 15, 16

10. SUBJECT OF AMENDMENT:
[redacted] 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:
HAL COHEN

14. TITLE:
SECRETARY, AGENCY OF HUMAN SERVICES

15. DATE SUBMITTED: August 4, 2015

16. RETURN TO:
LINDSAY PARKER
AGENCY OF HUMAN SERVICES
208 HURRICANE LANE
WILLISTON, VT 05495

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 4, 2015

18. DATE APPROVED: September 2, 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 9, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator

23. REMARKS Pen and Ink change to box 10

FORM CMS-179 (07-92)

Instructions on Back

State: VERMONT

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 two 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 year 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/totalcostofcare.pdf

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

State: VERMONT

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.

A. 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 two of the program contains ten 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 the

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

A. 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 and billing provider TIN 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 two 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 two, calendar year 2015 (CY 2015), the three historic benchmark years are CY 2011, 2012 and 2013. 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. 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 follows:

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

Gate -- The ACO must earn a minimum number 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 two of the VMSSP pilot, the ACO's performance on the payment measures will be compared to performance targets. The targets are based either on national Medicaid HEDIS benchmarks or ACO-specific prior year performance. 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 prior year performance, 2 points for no statistically significant change over prior year performance, and 3 points for a statistically significant improvement over prior year performance.

In addition to earning points for attainment of quality relative to national benchmarks, ACOs can earn 1 additional point for every payment measure that is compared to a national benchmark for which they achieved statistically significant improvement relative to the prior program year. Improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks.

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.

I. 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.