
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.

$$PYSS\$_{TOTAL(ACOi+PAYER)} = (\text{Expected TCOC } \$_{ACOi} - \text{Actual TCOC } \$_{ACOi}) \text{ risk adjusted, truncated}$$

subject to cap of 10% of the "Actual \$_{ACoi}"

$$\text{Payout of } PYSS\$_{ACOi+} = (\text{MAXSR}_{ACOi} * (PYSS\$_{TOTAL(ACOi+PAYER)})) * QS$$

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.

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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.

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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 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 ~~one-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

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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~~two, calendar year ~~2014~~2015 (CY ~~2014~~2015), the three historic benchmark years are CY ~~2010~~2011, ~~2011~~2012 and ~~2012~~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, ~~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 follows:

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Gate -- The ACO must earn a minimum percentage-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 one-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 historie Vermont Medicaid benchmarks 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 baseline prior year performance, 2 points for no statistically significant change over baseline prior year performance, and 3 points for a statistically significant improvement over baseline-prior year 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.