

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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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 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 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>~~ <http://dvha.vermont.gov/administration/totalcostofcare.pdf>

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

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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~~ two of the program contains ~~eight~~ 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

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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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- 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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- 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.

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