

Accountable Care Organization in DVHA's Next Generation Model

RFP #03410-175-16

Bidder Questions and DVHA Responses

QUESTION 1: DVHA indicates that it intends to follow the prospective attribution methodology set forth by the Centers for Medicare and Medicaid Services (CMS) Next Generation model; however, it also proposes to add in newborns who may be attributed throughout the year and perform a monthly exclusion process. Would DVHA be open to strictly following the CMS Next Generation attribution process and/or a counter proposal by the ACO?

- RFP Section: Chapter 3-Technical Proposal Attachment A- Scope of Work-, 1.1-1.2.2, p. 1-3

ANSWER: While the Next Generation attribution methodology was used as a starting point for developing the attribution methodology contained in the RFP, modifications were made that DVHA deems more appropriate for and inclusive of Vermont's Medicaid population. At this time, DVHA does not anticipate making changes to the proposed attribution methodology described in the RFP. DVHA would consider working with contracted ACOs in subsequent program years to explore modifications to the attribution methodology.

QUESTION 2: DVHA indicates that it intends to use the Next Generation full financial risk capitation model; however, it does not outline specifically the risk arrangements that will be available to the ACO. Can you verify that the risk arrangements will be identical to those offered under the Next Generation model, and if not identical, what variances are anticipated and/or are under discussion?

- RFP Section: Chapter 3- Technical Proposal Attachment A- Scope of Work-, 1.1, p. 1

ANSWER: At this time, DVHA anticipates contractors will assume 100% savings/losses. Bidders may propose alternative risk arrangements that are generally consistent with those offered under the Next Generation model.

QUESTION 3: For, quality improvement, network management, EPSDT, UM, DM), will the ACOs predefined risk some of the specifically delegated functions that the ACO assumes from DVHA (e.g., care management based capitated PMPM payment be adjusted and/or enhanced for taking on the administrative duties that would typically be performed by DVHA?

- RFP Section: Chapter 1- 3.3, p.16

ANSWER: At this time, DVHA anticipates that its actuary will take into account ACO administrative responsibilities when developing the capitated rates. The methodology that will be used to calculate actuarially sound rates for this population is under development. It is anticipated that DVHA's actuary will present the methodology used to compute the proposed capitation rates to the Apparently Successful Bidder(s) using the Bidder's projected attributed DVHA population as the basis for the analysis. In addition to the calculations using historical DVHA expenditures for these attributed members, the actuary will describe other analyses and/or information relevant for rate development. This includes, but is not limited to:

- adjustments for policy related changes,
- differences across entitlement categories,
- geographic differences,
- whether to employ truncation or capping of expenditures, and
- risk adjustment.

QUESTION 4: The quality measures that DVHA is proposing are not fully aligned with the current ACO SSP measures or Next Generation measures nor are the gates and ladders aligned. Would DVHA be open to aligning measures with those that currently exist (as to reduce provider and administrative burden) and would DVHA be open to following the CMS quality gates and ladders and/or the current gate and ladders that exist under current shared savings programs. If not can you please clarify your reasons for selecting measures and applying gates and ladders that do not align with current programs.

- RFP Section: Chapter 3- Technical Proposal Attachment D - Pay for Outcomes, #3, p. 2-4

ANSWER: At this time, DVHA does not anticipate making any changes to what was proposed in the RFP. The measures and associated performance targets included in Attachment D were selected because they were meaningful to the current Vermont Medicaid program's clinical priorities and to the population that Medicaid serves. DVHA is not employing a "Gate and Ladder" methodology in this program; the measures, targets, and benchmarks included in Attachment D of this RFP represent a significant evolution from the Vermont Medicaid Shared Savings Program.

QUESTION 5: DVHA is requiring that the ACO perform MTM services; yet the ACO is not responsible for pharmacy costs. Can you clarify if DVHA is requesting that the ACO offer MTM services Under 423.153(d) that traditionally a Part D sponsor must offer? Or is DVHA simply promoting medication management and reconciliation?

- RFP Section: Chapter 1 – Information for the Bidder- p. 14, question #21

ANSWER: In this requirement, DVHA is not requesting that the ACO offer MTM services Under 423.153(d) that traditionally a Part D sponsor must offer. DVHA is seeking to promote medication management and reconciliation as a part of broader care management activities.

QUESTION 6: The RFP contains many delegated services and requirements that do not appear optional because they do not begin with the phrase “If the bidder chooses”. If the ACO does not believe that such “non-optional” services or requirements are part of the ACOs business and/or clinical model, can the ACO make a case in its proposal for why such services should not be delegated to the ACO and anticipate flexibility in assessing responsiveness to the question and RFP?

- RFP Section: Chapter 1 – Information for the Bidder- 2 and 2.1 p. 10-11

ANSWER: Please refer to Addendum 1 pertaining to questions beginning with the phrase “If the bidder chooses.” If there are additional areas that the bidder feels should be optional as part of its business and/or clinical model, the bidder may provide an explanation in the narrative portion of the technical proposal. However, bidders must provide a written response to all questions in the technical response as described in Addendum 1.

QUESTION 7: The RFP is requesting that pay for outcomes provisions start in 2017. Would DVHA be willing to defer the start date to 2018 to align with CMS Next Generation Model?

- RFP Section: Chapter 3-Technical Proposal Attachment D- Pay for outcomes Program-.2, p. 1

ANSWER: At this time, DVHA anticipates that these provisions will go into effect for the 2017 performance year as described in the RFP.

QUESTION 8: We are seeking further clarification with regard to the incentive payments from funds withheld. Is Performance Withhold paid out if outcome measures are achieved in whole or in part, AND if expenditures come in below the AIPBP target? Or is Performance Withhold paid out if outcome measures are achieved in whole or in part but expenditures come in above the AIPBP target. In other words, does the ACO have to meet both quality AND financial targets to be eligible for all or part of the Performance Withhold payment or are these two gates independent of each other.

- RFP Section: Technical Proposal Attachment D - Pay for Outcomes Program, #3. Calendar Year 2017 Outcome Measures and Incentive Payment Structure, p. 2

ANSWER: It is envisioned that an ACO meeting quality targets as outlined in Attachment D will be eligible to earn back some or all of the withhold. Total expenditures are not a factor in determining quality incentive payments.

QUESTION 9: Can DVHA define and/or provide specifics for the following. “Contractor will be eligible for incentive payments if Contractor outcomes on individual measures for a certain year decline from the previous year’s outcomes by a de minimus amount defined by DVHA for each measure”.

- RFP Section: Technical Proposal Attachment D - Pay for Outcomes Program, #3. Calendar Year 2017 Outcome Measures and Incentive Payment Structure, p. 2, 3rd paragraph

ANSWER: As the Pay for Outcomes Program develops over time, DVHA is amenable to reviewing historical ACO performance in addition to the performance year results when determining incentive payments. Additional details will be finalized prior to contract execution.

QUESTION 10:

- What will DVHA’s actuary use for risk adjustment?
- How will DVHA’s actuary factor the natural decline of functional status of Aged, Blind, or Disabled members into forecasted future cost/utilization trends?
- Would DVHA consider excluding from attribution members whose costs fall above the 99th percentile of national Medicare spending and truncates a patient’s total claims at \$100,000?
 - Reference: Section A.1.2.1 Page 1

ANSWER: The methodology that will be used to calculate actuarially sound rates for this population is under development. It is anticipated that DVHA’s actuary will present the methodology used to compute the proposed capitation rates to the Apparently Successful Bidder(s) using the Bidder’s projected attributed DVHA population as the basis for the analysis. In addition to the calculations using historical DVHA expenditures for these attributed members, the actuary will describe other analyses and/or information relevant for rate development. This includes, but is not limited to:

- adjustments for policy related changes,
- differences across entitlement categories,
- geographic differences,
- whether to employ truncation or capping of expenditures, and
- risk adjustment.

QUESTION 11:

- Per Section A.10.4.2, DVHA and HPE will provide the list of attributed members to ACOs. Given that the capitation payments would be recouped for the DVHA members who became ineligible, are the ACOs allowed to recoup dollars associated with claims paid

for services rendered prior to being informed by DVHA/HPE of the member's ineligibility?

ANSWER: ACOs will be able to make payments to and recoup payments from their contracted network providers according to the provisions of those contracts.

- Can DVHA consider capping the number of months that the capitation can be retrospectively adjusted for prior periods due to the criteria stated in 1.2.2?
 - Reference: Section A.1.2.3 Page 3

ANSWER: DVHA would consider capping the number of months that the capitation can be retrospectively adjusted for prior periods.

QUESTION 12:

- Similar to "50 Nurse Practitioner" in Attachment B, table 2, can DVHA consider adding "97 Physician Assistant"? Same consideration for Section A.3.2, page 26 and A.5.2.2, page 42, given the goal outlined in A.5.2.5.
 - Section A.1.2.4 Page 3

ANSWER: Physician Assistants are considered among the non-physician practitioners (NPPs) referenced in "Primary care practitioners" (Attachment A, Section 1.2.5). DVHA is not making any changes regarding Physician Assistants to Attachment B, Table 2, or Attachment A, Sections 3.2 or 5.2.2 at this time.

QUESTION 13:

- We understand that existing DVHA members will be attributed to existing providers based on QEM services.
- As the Medicaid population grows, ACOs will add new providers to increase access. Will those new providers see members on a FFS basis or help treat other providers' attributed members within the ACO until they get their own members attributed to them?
- For members who just became eligible for Medicaid and have not used services, how will they be attributed to providers? Or would they be assigned only after they use a QEM service?
 - Reference: Section A.1.3, Page 6

ANSWER: Per the attribution methodology, a provider will need historical claims experience with attributable members in order to attribute beneficiaries to an ACO. In the first year, any providers without such historical relationships with Medicaid members will not attribute lives to an ACO; however, experience in the first year will

be taken into consideration when prospective attribution occurs in subsequent years. Although attribution occurs as a result of the relationship between a member and a primary care provider or specialist, there is no requirement that members only receive care from the provider that attributes them to an ACO, nor that ACO providers only provide services to their own attributed members. All Vermont Medicaid members (whether attributed to an ACO or not) retain full freedom of choice of provider.

Newly eligible Medicaid beneficiaries will not be considered eligible for prospective attribution to an ACO until they use a QEM. Prospective attribution will occur annually prior to the start of each new performance year.

QUESTION 14:

- Can DVHA provide more details on how the MLR will be calculated? Can investments that address the Triple Aim be included (e.g., disease management, care management, analytics to determine gaps in care and risk stratification, utilization management, program integrity, member incentives, provider pay-for-outcome incentives, health or wellness promotion programs, preventive care)?
 - Reference: Section A.2.7.4, Page 19

ANSWER: DVHA will consult its actuary in finalizing the definition of the Medical Loss Ratio.

QUESTION 15:

- Given that the ACO will have accountability for inpatient hospital services, will it take over the concurrent review process for its attributed members?
- How will DVHA pass timely inpatient notifications to the Contractor?
 - Reference: Section A3.2, Page 26

ANSWER: It is envisioned that the ACO has the opportunity to conduct concurrent review processes for its attributed members receiving inpatient hospital services. DVHA will not assume responsibility for passing any inpatient notifications for ACO attributed members to the contractor; the contractor would have to develop strategies for securing that information from the hospitals providing inpatient services.

QUESTION 16:

- With regards to “nursing facility care”, can DVHA confirm that both short-term skilled nursing stays and long-term nursing home are excluded from ACO capitation?

- Reference Section A.3.6, Page 28

ANSWER: DVHA can confirm that both short-term skilled nursing stays and long-term nursing home stays are currently excluded from the capitated rate.

QUESTION 17:

- “If an ACO attributed member leaves the ACO during an inpatient stay, the Contractor will remain financially responsible for the hospital payment until the member is discharged from the hospital or the member’s eligibility in Medicaid terminates.”
- Does the ACO continue to receive capitation until member is discharged from the inpatient stay?
 - Reference: Section A.3.7, Page 29

ANSWER: At this time, DVHA does not anticipate continuing to pay capitated payments to an ACO for members who are no longer attributed.

QUESTION 18: We understand that members can “change their PCP selection at any time”. Would DVHA confirm that attribution will change no more than once a month?

- Reference: Section A.4.2.1, Page 30

ANSWER: Using the prospective attribution methodology an eligible member will be considered attributed to an ACO for the full program year, regardless of changes to member PCP selection during the program year. While Medicaid beneficiaries retain full freedom of choice of provider, the ACO to whom a beneficiary is attributed at the beginning of the program year will remain accountable for the cost and quality of care for that beneficiary for the full program year (unless the beneficiary becomes otherwise ineligible for attribution during the course of the program year).

QUESTION 19: Can DVHA confirm that Contractor will receive a full (100%) month’s capitation payment for any ACO attributed member who dies after the 15th calendar day of the month?

- Reference: Section A.4.2.3, Page 32

ANSWER: The ACO will receive a full monthly capitation payment for any attributed member who dies after the 15th calendar day of the month. Capitation payments for that member will cease after that time.

QUESTION 20: Can DVHA clarify what it means by “some cases” in the following sentence; “...In some cases, DVHA members attributed to the Contractor may receive covered services outside of the Contractor’s provider network...”?

- Reference: Section A.5.1, Page 41

ANSWER: Historically, members attributed to ACOs under the Vermont Medicaid Shared Savings Program have sought and received care (for both ACO covered and non-covered services) outside the network of providers in the ACO to which they are attributed. We would expect such patterns to be observed in this new model as well. The ACO to which the beneficiary is attributed shall be responsible for the costs of all covered services (as described in Attachment A, Section 3.2) whether the beneficiary receives care for those services within or outside the ACO’s provider network.

QUESTION 21:

- DVHA is expanding the availability of telehealth. Will the Contractor be able to leverage DVHA’s telehealth efforts?
- Can services provided via telehealth providers (e.g., dermatologists, mental health providers) or mobile clinics help meet the network requirements in rural areas?
 - Reference: Section A.5.2.3 and A.5.2.4 pages 43 and 44

ANSWER: DVHA encourages bidders to describe their approach for leveraging DVHA’s telemedicine efforts in their response. Services provided via telemedicine providers can help meet network requirements in rural areas, as long as they are consistent with DVHAs current telemedicine policies. More information about telemedicine under Vermont Medicaid can be found in Section 10.3.52 of the Vermont Medicaid Provider Manual (see Bidders’ Library for full document).

QUESTION 22: “DVHA will continue to run its own utilization management program for services delivered to DVHA members attributed to the ACO that are not covered in the capitation payment to the Contractor.” How will DVHA and Contractor coordinate approvals and care (e.g., nursing facility care)?

- Reference: Section A.6.1, Page 53

ANSWER: DVHA encourages bidders to propose solutions for how they would work to coordinate care with DVHA for services not covered in the ACO contract.

QUESTION 23: At what time will DVHA provide the list of complex cases, and how will complex cases be incorporated into the experience for setting rates?

- Reference: Section A.7.0, Page 60

ANSWER: DVHA will provide the contractor(s) with lists of complex cases at the time that the prospective attribution is completed. DVHA anticipates this will occur in the month prior to the start of each performance year.

The methodology that will be used to calculate actuarially sound rates for this population is under development. It is anticipated that DVHA's actuary will present the methodology used to compute the proposed capitation rates to the Apparently Successful Bidder(s) using the Bidder's projected attributed DVHA population as the basis for the analysis. In addition to the calculations using historical DVHA expenditures for these attributed members, the actuary will describe other analyses and/or information relevant for rate development. This includes, but is not limited to:

- adjustments for policy related changes,
- differences across entitlement categories,
- geographic differences,
- whether to employ truncation or capping of expenditures, and
- risk adjustment.

QUESTION 23: Will DVHA provide data at the start of the contract period to enable the ACO to identify those members who have not been seen by a PCP within the previous 12 months?

- Reference: Section A.7.1.1, Page 60

ANSWER: Historical claims data for attributed members will be provided at the beginning of the contract period to allow the contracting ACO(s) to perform such an analysis.

QUESTION 24: "The Contractor's initial screening tool(s) should be evidence-based, should align with other State screening tools, and will be subject to DVHA's review prior to use." What screening tool is currently being utilized by DVHA?

- Reference: Section A.7.1.1, Page 61

ANSWER: DVHA is not presently using a screening tool for the Medicaid population. However, other Departments and programs within the Agency of Human Services are utilizing a variety of screening tools; where possible, screening tools utilized by the contractor(s) should align with other evidence-based tools being used by the State.

QUESTION 25: The Contractor is required to coordinate the care and services for the very high risk members, including "high and complex pharmacy utilization", which is not in the ACO capitation. How will the pharmacy utilization data be provided to the Contractor and how often?

- Reference: Section A.7.2.4, Page 64

ANSWER: Pharmacy data for attributed members will be provided as a claims extract on a monthly basis (see Attachment A, Section 10.4.7, Page 83).

QUESTION 26:

- Medicaid Member Attribution File will be generated and provided to the Contractor by DVHA/HPE including member contact information. In the case that the member can't be located based on the member information provided in the Medicaid Member Attribution File (e.g., phone, address), who will be responsible for locating the member?
- Do the requirements related to timeline for initial screening and comprehensive health assessment (Sections 7.1.1 and 7.1.2) still apply to those members?
 - Reference: Section A.10.4.2, Page 80

ANSWER: Participating ACOs will be responsible for locating attributed Medicaid members; however, DVHA encourages bidders to propose strategies for partnering with DVHA to locate members to support the delivery, coordination, and experience of care for attributed members. Timelines related to initial screenings and comprehensive health assessments will apply to all members.

QUESTION 27: How much are the optional services that support the Triple Aim (e.g., utilization management, provider pay-for-outcomes program, member incentive program) weighted in the technical scoring?

- Reference: RFP Page 13

ANSWER: Please refer to Addendum 1.

QUESTION 28: Would DVHA provide a listing of all DVHA Medicaid participating providers to include name, address, phone number, email address, specialty, provider type, total dollar value and number of claims paid in 2014 and 2015?

- Reference: General

ANSWER: A directory of Medicaid providers is publicly available at the following link; however, it does not include detail on the dollar value or number of claims paid in past years: <http://www.vtmedicaid.com/secure/providerLookUp.do>

QUESTION 29: What is the withhold anticipated for primary care providers, specifically for FQHCs, RHCs, and CAHs?

ANSWER: At this time, DVHA does not anticipate incorporating withholds that are specific to provider types. A portion of an ACO's overall capitated payment will be withheld for the Pay for Outcomes component of the program (see Attachment D). An additional percentage will be withheld to account for fee-for-service expenditure for attributed lives for covered services received outside of an ACO's contracted provider network.

QUESTION 30: Do you anticipate any changes to calculation of the PMPM from what is stated in the RFP?

ANSWER: The methodology that will be used to calculate actuarially sound rates for this population is under development. It is anticipated that DVHA's actuary will present the methodology used to compute the proposed capitation rates to the Apparently Successful Bidder(s) using the Bidder's projected attributed DVHA population as the basis for the analysis. In addition to the calculations using historical DVHA expenditures for these attributed members, the actuary will describe other analyses and/or information relevant for rate development. This includes, but is not limited to:

- adjustments for policy related changes,
- differences across entitlement categories,
- geographic differences,
- whether to employ truncation or capping of expenditures, and
- risk adjustment.

QUESTION 31: The RFP includes reference to pay for performance payments that could be interpreted as additional and above the capitation payments. Please clarify the application of the pay for performance to the PMPM

ANSWER: A portion of an ACO's total capitated rate will be withheld throughout the performance year; this portion can be earned back in part or in total by the ACO based on quality performance during the year. The payments available for quality performance are a portion of the total capitation payment, not an addition to the total capitation payment.

QUESTION 32: Will DVHA review an application by entities other than the two Vermont ACOs?

ANSWER: DVHA will review proposals by any qualified bidders; bidders need not have participated in the Vermont Medicaid Shared Savings Program.

QUESTION 33: How would the bidder wishing to not perform pre-authorization or other traditional forms of UM be scored given the stated RFP scoring?

ANSWER: Please refer to Addendum 1.

QUESTION 34: If a bidder wishes to note it will not offer what is asked and instead conduct business in another manner, should that be addressed in the section with questions about UM/CM?

ANSWER: Please refer to Addendum 1.

QUESTION 35: If providers are not part of an ACO network chosen for a contract as a result of this RFP, we assume that those providers continue in the current Medicaid reimbursement mode. Please confirm.

ANSWER: Any providers not part of a participating ACO network in 2017 (and onward) will continue to be reimbursed by Medicaid under DVHA's standard reimbursement methodologies.

QUESTION 36: What are the criteria if any for evaluating non-risk proposals or upside sharing proposals?

ANSWER: At present, DVHA is only contemplating offering a full-risk, capitated payment model to participating ACOs. Bidders may propose alternative risk arrangements that are generally consistent with those offered under the Next Generation model.

QUESTION 37: At the bidders' conference, DVHA invited proposals that display creativity and innovation. Such proposals will not track entirely with the RFP, or may be inconsistent with the RFP. Please confirm that DVHA will accept proposals that are not 100% on track with the RFP. If there are parameters around DVHA's flexibility in accepting alternative, innovative proposals, please disclose those parameters.

ANSWER: Please refer to Addendum 1.

Deferred Questions from the April 15, 2016 Bidders' Conference:

QUESTION 38: For the technical component, there are optional sections around Utilization Management/Program Integrity – how would answering these sections count towards the overall grading if a bidder chooses to supply creative answers to reduce cost in the Triple Aim?

ANSWER: Please refer to Addendum 1. While DVHA will continue its current function in Program Integrity, the sections in the RFP relating to Program Integrity are not optional. Please review sections 11.1, 11.1.1, 11.1.2, and 11.1.3 of Attachment A.

QUESTION 39: When we submit the bids, can we propose specific counties/population types?

ANSWER: Although bidders are discouraged from limiting their proposals to specific member population types, bidders are not required to have a statewide provider network. As a part of responses to the Bidder's Capacity to Perform section, bidders will be required to submit a preliminary list of network providers.

QUESTION 40: How do you decide whether you would consider a model that was not a Next Generation model in terms of the risk and something that looked more like the current Shared Savings Program?

ANSWER: At present, DVHA is only contemplating offering a full-risk, capitated payment model to participating ACOs. Bidders may propose alternative risk arrangements that are generally consistent with those offered under the Next Generation model.

April 15, 2016 Bidder's Conference Question and Answer:

QUESTION: For the technical component, there are optional sections around Utilization Management/Program Integrity – how would answering these sections count towards the overall grading if a bidder chooses to supply creative answers to reduce cost in the Triple Aim?

ANSWER: To be clear, there are some questions that we will not be able to answer today, and will be providing answers in writing to potential bidders. *See Question 38 above*

QUESTION: Will you remind us that the answers to the questions will come back in May?

ANSWER: Yes, responses will be posted to the website on May 4th.

QUESTION: When we submit the bids, can we propose specific counties/population types?

ANSWER: We will address this in writing as well. *See question 39 above*

QUESTION: Could you review the process of payments? It's prospective, capitated, and there's a withhold, correct? What is the payback based on?

ANSWER: We are contemplating in the RFP a withhold of 3% for the quality component, so we would anticipate withholding 3% from capitated payments throughout the year. The ACOs will have the opportunity to earn back that portion based on quality performance for that performance year (this 3% is the Pay-for-Outcomes program). Other elements will be added to the year-end reconciliation and are consistent with the Next Generation model – we are taking into account any out of network expenditure for beneficiaries during the program year.

QUESTION: Do you have an anticipation of what the total population will be?

ANSWER: The total eligible population that we are anticipating based on preliminary calculations is approximately 80-90,000 Medicaid beneficiaries. If there are further questions, we are happy to supply answers in written responses. This number is impacted by the number of providers in the ACO network, given that methodology relies on the relationship between beneficiaries and their primary care providers, and would also depend on eligibility in the actual performance year, which we will examine when we're closer to that date.

QUESTION: If there's a specific question and we want to provide a creative answer and not respond to the exact question being asked, is it expected that we'd provide that response in that section under that question, but tailoring our response and note that it's being creative, not necessarily addressing that question directly?

ANSWER: Yes.

QUESTION: You have existing ACOs – do you anticipate how this RFP and program would change them or impact the ACO network?

ANSWER: We have current ACOs that have been operational in the state for several years, DVHA has partnered with two of them in the VMSSP, this model is an evolution of that model, which is not to say that other organizations would not be eligible to participate in this new model. We will need to see what ACO landscape looks like in

the coming months, but welcome any new applicants that meet the criteria of the RFP.

QUESTION: How do you decide whether you would consider a model that was not a Next Generation model in terms of the risk and something that looked more like the current Shared Savings Program?

ANSWER: We will provide that answer in writing. See Question 40 above

QUESTION: In the attribution methodology, it does talk about utilizing the Next Generation methodology, however there are some variations, like addition of newborns. Would you be willing to consider a “true” Next Generation model in our proposal, is there flexibility in the attribution methodology in the RFP?

ANSWER: We would need to consider written responses before considering modifying the attribution methodology outlined in the RFP. We’ve tried to modify the Next Generation model to be appropriate for our Medicaid population.

QUESTION: To the degree that there are providers servicing Medicaid beneficiaries in Vermont, if current providers of care aren’t part of the network, do we assume that the Medicaid system continues under traditional fee-for-service with these organizations?

ANSWER: For any providers who have not been participating in ACO networks, would they continue to operate Medicaid FFS? Yes, that is the assumption. We would anticipate that maybe there would be some changes to current ACO networks, and whatever networks are in place from bidding organizations are set, but any providers electing in 2017 not to be participants in ACOs would continue to receive fee-for-service payments.