
Table of Contents

State/Territory Name: Vermont

State Plan Amendment (SPA) #: 16-009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) HCFA 179 Form
- 3) Approved SPA Pages

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 17, 2016

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

Dear Secretary Cohen:

We are pleased to enclose an approved copy of Vermont's approved State plan amendment (SPA) No. 16-0009 with an effective date of January 1, 2016, as requested by your Agency.

This SPA amended your Title XIX State plan to update language related to the Vermont Shared Savings Program to refer to year 3 of the program, and to implement a program integrity audit at the end of year 3.

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.

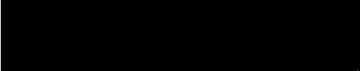

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Steven Costantino, Commissioner
Dylan Frazer, Health Programs Administrator, Policy Unit
Ashley Berliner, Director of Healthcare Policy and Planning

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 16-009	2. STATE: VERMONT
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (CHECK ONE): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)		4. PROPOSED EFFECTIVE DATE(S) JANUARY 1, 2016	
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §430.12(c)(1)(ii)	7. FEDERAL BUDGET IMPACT: a. FFY 2016 \$ 0.00 b. FFY 2017 \$ 0.00		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATT. 3.1-A PAGES 13A AND 13B ATT 4.19-B PAGES 14, 15, AND 16	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) ATT. 3.1-A PAGES 13A AND 13B ATT 4.19-B PAGES 14, 15, AND 16		
10. SUBJECT OF AMENDMENT: VT Medicaid Shared Savings Program Year 3			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED SIGNATURE OF SECRETARY OF ADMINISTRATION 	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: DYLAN FRAZER AGENCY OF HUMAN SERVICES CENTER BUILDING 280 STATE DRIVE WATERBURY, VT 05671-1000	
13. TYPED NAME: HAL COHEN		14. TITLE: SECRETARY, AGENCY OF HUMAN SERVICES	
15. DATE SUBMITTED: 3/29/16		17. DATE RECEIVED: 3/29/2016	
FOR REGIONAL OFFICE USE ONLY			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/01/2016		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Richard R. McGreal		22. TITLE Associate Regional Administrator	
23. REMARKS			

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 three 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:

TN# 16-009
Supersedes
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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.

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 three 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

TN# 16-009
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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 three, calendar year 2016 (CY 2016), the three historic benchmark years are CY 2012, 2013 and 2014. 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 year one. In year two, ACO contracts were amended to allow for a program integrity audit to be conducted upon the completion of the third year of the shared savings program. Should an audit (and any subsequent appeals process) find that a portion of ACO shared savings for the 2015 performance year was earned as a result of up-coding or inaccurate quality performance reporting, an amount equal to that portion of savings paid to the ACO in the Performance Year 2 reconciliation would be recouped as part of the financial transaction for the Performance Year 3 reconciliation. For the 2016 performance year, the DVHA Program Integrity unit reserves the right to conduct an audit of ACO providers within its normal business practices and would recover any overpayments accordingly.

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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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 three 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>.

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.