Appendix 6

A full version of the Vermont Medicaid Shared Savings Program Standards is included below. Also included at the end of the document is a description of the draft process for updating the quality and performance metrics.

Medicaid Shared Savings ACO Program Standards (VMSSP Standards)

I. Financial Stability
II. ACO Governance
III. Medicaid Patient Eligibility Requirements and Patient Attribution
IV. Calculation of ACO Financial Performance and Shared Savings
V. Performance Measurement and Shared Savings
VI. Care Management Standards
VII. Payment Alignment
VIII. Data Use Standards

I. Financial Stability

A. The program is designed to protect against the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the ACO can focus on management of performance risk (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition). To that end, the ACO will not be responsible financially if Actual Total Cost of Care (TCOC) exceeds Expected TCOC under this Agreement (i.e., no downside risk).

B. If requested by the State, the ACO will furnish financial reports regarding risk performance, with report formats defined by the State.

C. In order to continue to be eligible to participate in the Medicaid Shared Savings Program, the ACO shall maintain responsibility for a minimum number of 5,000 attributed lives.

D. A Risk Mitigation plan is not required**.**

II. ACO Governance

A. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction, holding the ACO's management accountable for its activities.

B. The ACO must identify its board members, define their roles and describe the responsibilities of the board in writing to the State.

D. The ACO's governing body must have a transparent governing process which includes the following:

1. Publishing the names and contact information for the governing body members, for example, on a website;
2. Devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of the ACO's activities;
3. Making meeting minutes available to the ACO's provider network upon request, and
4. Post summaries of ACO activities provided to the consumer advisory board on the ACO's website.

E. The ACO's governing body members shall have a fiduciary duty to the ACO and act consistently with that duty.

F. At least 75 percent voting membership of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

1. Has a signed Participant Agreement;
2. Has programs designed to improve quality, patient experience, and manage costs; and
3. Is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

A "participant" does not need to have lives attributed to the ACO to be considered a participant.

Of the 75% participant membership required on governing bodies:

a. At least one seat must be held by a participant representative of the mental health and substance abuse community of providers; and
b. At least one seat must be held by a participant representative of the post-acute care (such as home health or skilled nursing facilities) or long term care services and supports community of providers.
c. Institutional and home-based long-term care providers, sub-specialty providers, mental health providers and substance abuse treatment providers are strongly encouraged to participate on ACO clinical advisory boards. This shall not be construed to create a right to participate or to be represented.
d. It is also strongly encouraged that ACO participant membership serving all ages of Medicaid beneficiaries (pediatric and geriatric) be represented in governance and in clinical advisory roles. This shall not be construed to create a right to participate or to be represented.

G. The ACO's governing body must include at least one consumer member who is a Medicaid beneficiary. Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process for the consumer member. The ACO shall not be found to be in non-conformance with this provision if it has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

H. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the ACO's management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

III. Medicaid Patient Eligibility Requirements and Patient Attribution

A. Eligible Populations

The following population groups are eligible to be considered as attributed lives:

1. Aged, Blind or Disabled (ABD) Adult: Individuals who are 18 years of age or older who are aged, blind or disabled and who are not dually eligible for Medicare.
2. General Adult: Parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance; as well as adults with incomes below 133% of the Federal Poverty Level ("FPL") are assigned here. This could also include former VHAP, Catamount, ESIA, or previously uninsured individuals.
3. Blind or Disabled (BD) Child: Individuals who are under 21 years of age who are aged, blind or disabled and who are not dually eligible for Medicare.
4. General Child: Children under age 21 who are eligible for cash assistance; as well as children up to age 18 who were previously uninsured, living in families up to 300% FPL, and who are not otherwise classified under BD Child.

B. Excluded Populations

The following populations are excluded from being considered as attributed lives:

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.

C. Enrollment Requirements

Individuals must be enrolled at least ten non-consecutive months in the calendar year in any aid category across all four population groups. If an individual transitioned from one population group to another within the calendar year (e.g., from General Child to BD Child), then all of the member's months and expenditures are assigned to the population group where the member was enrolled last in the calendar year. Individuals may not be split across the four population groups within a year; however, an individual may appear in multiple population groups across the three baseline years.

D. Attribution Methodology

The State or its designee will conduct attribution monthly. The details of the attribution reports are described in the Data Use Standards section, section VIII of this document.

1. Attribution Step 1: Determine all Medicaid beneficiaries who were enrolled for at least 10 months in the study year across any of the four enrollment categories. Assign the beneficiary to the enrollment category where he/she appeared last in the study year.
2. Attribution Step 2: Claims for eligible members are identified by the presence of qualifying CPT Codes in the calendar year for primary care providers enrolled with Medicaid. The provider specialty must be internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, or naturopathic medicine. In addition to physicians, the primary care provider may be a nurse practitioner, physician assistant, or a provider in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
3. Attribution Step 3: For eligible beneficiaries not attributed in Step 2, assign the beneficiary to his/her primary care provider that he/she selected or was auto-assigned to in the study year. If the beneficiary changed primary care provider selection during the year, then the beneficiary is assigned to the primary care provider which he/she was assigned to last in the year.
4. Attribution is done at the rendering provider level; any ACO Participant that includes at least one ACO Provider/Supplier with Attributed Lives must have an exclusive Participant relationship with one ACO. ACO Participants, who do not have lives attributed, can participate in multiple ACOs.

E. Patient Freedom of Choice

Beneficiaries will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. Calculation of ACO Financial Performance and Shared Savings

A. Summary of Model Specifications

1. Program eligibility requires a minimum number of 5,000 attributed beneficiaries. The maximum savings rate is fifty percent (50%).

2. The ACO may elect to pursue an optional methodology that increases the maximum savings rate beginning on January 1, 2015. The standards shall remain as set forth in this document for ACOs electing to pursue the alternative methodology. The alternative methodology would increase the maximum sharing rate of 50% for the ACO by 10% to 60% if the ACO elects to be accountable for additional non-core service expenditures in the Total Cost of Care (TCOC) as defined by the State. The State will notify the ACO in writing of which non-core service expenditures will be required no later than October 1, 2014. The ACO would elect the optional track in writing no later than November 1, 2014.

3. The ACO will be required to be accountable for additional non-core service expenditures in the Total Cost of Care (TCOC) calculation as defined by the State in 2016. If the ACO elected to participate in the option described in the paragraph above, the ACO will continue to receive the additional 10% addition to the maximum sharing rate of 50% (or 60%). The State will notify the ACO in writing of which non-core service expenditures will be required no later than July 1, 2015.

B. Core Service Expenditures

Core Service expenditures include: inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.

C. Non-Core Service Expenditures

1. Non-Core Service expenditures include: personal care, pharmacy, dental, non-emergency transportation, services administered by the VT Department of Mental Health through Designated Agencies and Specialized Service Agencies, services administered by the VT Division of Alcohol and Drug Abuse Programs, services administered by the VT Department of Disabilities, Aging and Independent Living, services administered by the VT Department for Children and Families and services administered by the Vermont Department of Education.

2. Non-Core Service expenditures also include supplemental, lump sum disproportionate share payments and medical education payments as well as quality incentive payments made outside of the claims system.

D. Calculation of the Expected Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Expected TCOC. In July or August, the State or its designee will calculate the final

Actual TCOC for use in the calculation of savings. The State or its designee shall calculate the Expected TCOC using the following steps:

1. Attribute beneficiaries in each of three historic calendar years (the "benchmark years") using the attribution methodology described in section III of this document.
    a. For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years.
    b. For 2015, CYs 2011, 2012, 2013 will be benchmark years.
    c. For 2016, CYs 2012, 2013, 2014 will be benchmark years.

2. Identify expenditures using the allowed amount value on claims data for all Core Services for each attributed member within a calendar year.

3. Re-price core service expenditures to base year.
    a. Base Years
        i. For 2014, base year is 2013.
        ii. For 2015, base year is 2014.
        iii. For 2016, base year is 2015.
    b. Inpatient hospital, outpatient hospital and professional services are re-priced.
    c. FQHC and RHC encounter rates are re-priced. .
    d. If determined to be material, adjust for other changes in utilization. If additional changes in utilization are determined to meet the determination of materiality threshold defined in section III.D.4, adjustments will be applied accordingly.
    e. For all other services, the allowed amounts reported on the claims are used to sum expenditures.

4. Use the CMS-HCC (Hierarchical Condition Categories) prospective risk adjustment model to calculate member risk scores; apply a risk adjustment factor to account for changes in the health status of the population attributed in each of the benchmark years.

5. Determine a Cumulative Average Growth Rate (CAGR) is used for each of the four enrollment categories' to calculate total average per member per month (PMPM) value.

6. Trend the PMPM forward two full years to project a total average PMPM in the performance year (PY).

7. For PY1, the PMPM calculated in Step 6 (above) will be inflated to account for the November 1, 2013 rate increase which will be in effect in CY 2014 (PY1). PY2 and PY3 adjustments, if necessary, will be made to account for additional rate increases.

8. Calculate an annualized value for each beneficiary so that each beneficiary has a per member per year (PMPY) expenditure value for comparison purposes.

9. Truncate annualized expenditures at the 99th percentile within each of the four enrollment categories. In other words, if a particular beneficiary incurred expenditures above the 99th percentile value within the enrollment category, this beneficiary's expenditures are truncated so that their total expenditures in the calculation will equal the value set at the 99th percentile.

10. Divide the trended, rate change-adjusted, annualized, and truncated expenditures by annualized member months to compute the Expected PMPM TCOC for each of the four enrollment categories.

E. Retrospective Calculation of the Actual Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Actual TCOC. In July-August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The TCOC will be calculated using Medicaid claims data and enrollment files. TCOC shall be defined to include all paid claims for the ACO-responsible core services as defined in section IV(B) of this document. Actual TCOC will be calculated by:

1. Running the attribution algorithm as described in section III(A)–(D) of this document using the claims and enrollment data for the performance year (PY).

2. Calculate per member per year expenditures for each attributed beneficiary, imputing an annualized value for those beneficiaries enrolled only 10 or 11 months and not 12 months. The formula for annualizing is the same as that described in section IV(D)(8) of this document.

3. Re-price the FQHC/RHC encounter rates..

4. Use the CMS-HCC prospective risk adjustment model to calculate risk scores for each of the four enrollment categories. If the risk scores within an enrollment category differ between the performance year and the benchmark years, then a risk adjustment factor will be applied to the performance year expenditures to align them with the risk scores in the benchmark years.

5. Expenditures are truncated at the 99th percentile for each enrollment category in the same manner as described in section IV(D)(9) of this document.

6. The truncated expenditures are then divided by annualized member months to compute the Actual PMPM TCOC for each of the four enrollment categories.

7. A single weighted Actual PMPM TCOC is computed by weighting each of the four enrollment category Actual PMPM TCOCs by the annualized member months.

8. The same weighting of annualized member months in the performance year is applied to the four enrollment category Expected PMPM TCOCs from section IV(D)(1)-(10) of this document to derive a single weighted Expected PMPM TCOC.

9. Calculate Total Member Months (TMM). TMM is the sum of the actual, non-annualized number of member months for final attributed beneficiaries during the PY.

F. Aggregate Difference in Expected and Actual Expenditures (Savings Calculation)
Total savings will be calculated by:

1. Multiplying the Actual PMPM calculated in section IV(E)(7) of this document by TMM from section IV(E)(9) of this document.

2. Multiplying the Expected PMPM calculated in section IV(E)(8) by TMM from section IV(E)(9)) of this document.

3. Subtracting #1 from #2 above.

G. Total Eligible Savings Amount

1. Based on the calculation in section IV(F) of this document, the State or its designee will determine if the Actual Cost of Care is less than the Expected Cost of Care for the Performance Year.

2. The State will then determine whether or not the savings are greater than or equal to the minimum savings rate (MSR) based on the number of beneficiaries attributed to the ACO in that performance year. The MSR shall serve as the threshold necessary to share in savings.

a. The State or its designee will calculate the MSR based on the following table and formula:

Minimum Savings Rate by Number of Assigned Beneficiaries

Number of Beneficiaries	MSR Low End	MSR High End
5,000 – 5,999	3.9%	3.6%
6,000 – 6,999	3.6%	3.4%
7,000 – 7,999	3.45	3.2%
8,000 – 8,999	3.2%	3.1%
9,000 – 9,999	3.1%	3.0%
10,000 – 14,999	3.0%	2.7%
15,000 – 19,999	2.7%	2.5%

20,000 – 49,999	2.5%	2.2%
50,000 – 59,999	2.2%	2.0%
60,000 +	2.0%	2.0%

b. MSRs which are in between the stated endpoints are calculated using the following equation, which is a weighted average of the stated endpoints: MSR High End % x (Number of Beneficiaries High End – Number of Attributed Beneficiaries) / (Number of Beneficiaries High End – Number of Beneficiaries Low End) + MSR Low End % x (Number of Attributed Beneficiaries – Number of Beneficiaries Low End) / (Number of Beneficiaries High End – Number of Beneficiaries Low End)

3. If total savings are greater than or equal to the MSR, then the ACO will be eligible to share in the savings. If not, the ACO will not be eligible to share in savings.

4. If MSR is met, the total eligible amount of shared savings will be calculated by multiplying the total savings by the maximum savings rate.

5. The final shared amount is subject to a cap equal to 10% of total actual expenditures in the performance year calculated in section IV(F)(1) of this document.

6. The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate. Computation of the quality score is described in section V of this document.

V. Performance Measurement and Shared Savings

To be eligible for savings, the ACO must first meet the quality performance threshold. If the threshold is met, a quality score will be calculated. The State or its designee will calculate the threshold and quality score and in so doing will sample only Beneficiaries who have been continuously enrolled for twelve (12) or more months.

The calculations are described below.

A. Assignment of Scores to Core Payment Measures

1. Table 1 below summarizes the core payment measures and benchmarks used in the calculation. Points are assigned using the following methodology:

   a. One point is assigned to the national Medicaid HEDIS 25th percentile for each measure.
   b. Two points are assigned to the national Medicaid HEDIS 50th percentile for each measure.

c. Three points are assigned to the national Medicaid HEDIS 75th percentile for each measure.

2. For measures where national Medicaid HEDIS benchmarks do not exist (Core-1 and Core-8 in Table 1), points are assigned using the following methodology: The State will calculate a Vermont Medicaid 2012 benchmark and assign 0, 2, or 3 points based on statistically significant decline, no statistically significant change, or statistically significant improvement, respectively. The benchmarks will be completed no later than April 30, 2014.

B. Requirements for Reporting Measures

Table 2 below summarizes the core reporting measures. These measures will not be used in the calculation but submission of these measures by the ACO to the State is required, however, failure to report will not jeopardize Shared Savings or funding. The State also requires the reports to include an analysis of barriers, costs incurred related to reporting and a plan to mitigate those barriers where possible. Guidelines for the content and format of this analysis and plan will be provided by the State.

Table 1. Core Measures for Payment

#	Measure	Data Source	2012 Benchmark
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA (Average Adjusted Probability of Readmission)	Claims	National benchmark not available Vermont Medicaid Benchmark to be calculated
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 65.45 Nat. 75th: 57.07 Nat. 50th: 47.24 Nat. 25th: 41.72
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 88.84 Nat. 75th: 85.20 Nat. 50th: 82.36 Nat. 25th: 78.44
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 68.79 Nat. 75th: 54.64 Nat. 50th: 43.95 Nat. 25th: 30.91
Core -5	Initiation & Engagement of Alcohol and Other	Claims	Nat. 90th: 34.04 Nat. 75th: 29.64

	Drug Dependence Treatment a) Initiation, b) Engagement NQF #0004, NCQA HEDIS IET CMMI		Nat. 50th: 24.75 Nat. 25th: 20.59
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 35.45 Nat. 75th: 28.07 Nat. 50th: 22.14 Nat. 25th: 17.93
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 68.81 Nat. 75th: 63.72 Nat. 50th: 57.15 Nat. 25th: 50.97
Core-8	Developmental Screening in First 3 Years of Life NQF#1448	Claims	National benchmark not available Vermont Medicaid Benchmark to be calculated
Core-9	Depression Screening by 18 Years of Age NQF#1515		MEASURE NOT TO BE USED IN YEAR 1

Table 2. Core Measures for Reporting

#	**Measure**	**Data Source**
Core-10	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	Claims
Core-11	Breast Cancer Screening	Claims
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Claims
Core-13	Appropriate Testing for Children with Pharyngitis	Claims
Core-20	Adult BMI Screening and Follow-Up	Clinical
Core-19	Screening for Clinical Depression and Follow-Up Plan	Clinical
Core-18	Colorectal Cancer Screening	Clinical
Core-16	Diabetes Composite (D5) (All-or-Nothing	Clinical

	Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	
Core-17	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	Clinical
Core-14	Childhood Immunization Status	Clinical
Core-15	Pediatric Weight Assessment and Counseling	Clinical
Core-21	Access to Care Composite	Survey
Core-22	Communication Composite	Survey
Core-23	Shared Decision-Making Composite	Survey
Core-24	Self-Management Support Composite	Survey
Core-25	Comprehensiveness Composite	Survey
Core-26	Office Staff Composite	Survey
Core-27	Information Composite	Survey
Core-28	Coordination of Care Composite	Survey
Core-29	Specialist Care Composite	Survey

C. Calculation of Performance

The State or its designee will calculate the performance by the ACO for the measures and assign points as described in section V(A) of this Agreement. The State or its designee will also calculate the total number of points possible for the measures described in section V(A) of this Agreement**.**

D. Threshold Calculation

The ACO must earn 35% of eligible points in order to meet the minimum threshold for performance ("the gate"). If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings.

E. Calculation of the Quality Score

If the ACO meets the performance threshold ("the gate"), it may retain at least 75% of the savings for which it is eligible. The amount of eligible savings will vary based on the ACO's quality score. The quality score will be equal to the ACO's actual performance as determined in Table 3 based on calculations described in section V of this Agreement**.**

Table 3. Quality Score

Percentage of available points	Quality Score
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

F. Final Calculation of Shared Savings Payments
The total eligible savings amount calculated in section IV(G)(5) will be multiplied by quality score determined in section V(E) of this document**.** This represents the ACO's share in the savings.

VI. Care Management Standards

A. The ACO will maintain regular contact with Vermont Chronic Care Initiative (VCCI) to ensure that efforts around care management are well coordinated through regular and ad-hoc in-person and telephonic meetings; at minimum, the ACO agrees to a meeting monthly but as frequently as both parties agree is needed.

B. The ACO will maintain as needed contact with other Vermont Agency of Human Services (AHS) departments engaged in care management or care coordination activities particularly as it relates to federal mandates (e.g., Early Periodic Screening, Diagnosis, and Treatment) and vulnerable populations (e.g., Disabilities, Traumatic Brain Injury, Integrated Family Services). Examples of this contact will include but not be limited to: meetings (in-person and telephonic), educational outreach, partnering, launching or rolling out new or existing initiatives, and direct care coordination.

C. If requested, the ACO will, no more frequently than annually and no sooner than 60 days from the request, participate with the State to create a written plan describing detailed approach to care management activities described above. Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS programs or procedures, AHS employees and contractors shall cooperate with and implement the Clinical Model or Care Model of the ACO for a mutually agreeable time frame. DVHA and AHS acknowledge that this cooperation is critical to ACO in order to meet the quality, patient experience and financial performance thresholds under this Agreement. In the event of a dispute

regarding the Clinical Model or Care Model, the parties may invoke the Dispute Resolution process set forth in section V of this document.

VII. Payment Alignment

The parties share the objective of improving the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

A. The performance incentives that are incorporated into the payment arrangements between the State and the ACO should be appropriately reflected in those that the ACO utilizes with participating providers. Annually, no later than the third quarter of each program year, the ACO will share with the State their written plans for:

1. Aligning provider payment and compensation with ACO performance incentives for cost and quality; and

2. Distributing any earned shared savings.

3. Specific to affiliated providers or incentive pool forms of compensation, the ACO will provide detailed and specific plans for funding and distribution under these programs.

B. The State will support the ACO by collaborating to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

VIII. Data Use

A. Program Reporting Requirements- ACO to the State
The following tables summarize reporting requirements:

Report	***Details***	***Start Date***	***Frequency***	***Responsible Party***	***Receiving Party***	***Format***
Monthly provider changes within PCP practices for attribution. Other additions to participant, provider/supplier lists.	Additions and terminations by site, including site-specific information of providers practicing at multiple sites	As mutually agreeable to the parties	Monthly	ACO	DVHA	Specified by State
Clinical data- based measures required for Year One	Sample method: ACOs, the State or its designee will generate sample.	Sample method: The State or its designee	Annual	ACO	ACO and the State	VHCIP Specified Format

ACO may elect between the Sample method and the Electronic data method	The ACO will generate numerators and denominators and report to the State or its designee using report template. OR Electronic data method: The ACO generates numerators and denominators for all practices with EHR capability to report one or more rates, and reports percentage of attributed lives represented by the practices reporting each measure.	provide sample to the ACO by January 2015. Sample and electronic data methods: The ACO report to the State or its designee by April 2015.				

B. Reports from the State to the ACO
The following tables summarize reporting requirements.

Report	***Details***	***Start Date***	***Frequency***	***Responsible Party***	***Receiving Party***	***Format***
Patient attribution report - enrollment	Data file with list of patients that are attributed to a particular ACO, with identification of Primary Care Physician	January 2014	monthly	The State or its designee	ACO	State specified, includes HCC Scores
Patient attribution report - claims extract	Initial file to contain 12 months of incurred claims, including pharmacy, for attributed enrollees. Every month thereafter a file contained claims paid in the past month for currently attributed enrollees, and for the past 12 months for new enrollees	March 2014	monthly	The State or its designee	ACO	VHCURES Format
If requested, Stratification of patients by risk score with supplemental information	The State's software	April 2014	quarterly	The State or its designee	ACO	Format used by the State
If requested, Patient gaps in care	The State's gaps in care reports	Existing payer schedules	Existing payer schedules	The State or its designee	ACO	Format used by the State

Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs
(February 10, 2014 Work Group Recommendation)

1. The VHCIP Quality and Performance Measures Work Group will review all Payment and Reporting measures included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all targets and benchmarks for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national x^{th} percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all measures designated as Pending in the Core Measure Set and consider any new measures for

addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review state or insurer performance on the Monitoring and Evaluation measures beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the final measure specifications for the next pilot year by no later than October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.