Vermont Commercial ACO Pilot
Data Use Standards
July 15, 2015

I. Reports from the Payers to each ACO:

a. **Patient attribution report – enrollment:** This report is provided on a monthly basis on the 15th of the month for the commercial shared savings program (XSSP) and the last date of the month for the Medicaid shared savings program (VMSSP). This report lists the patients who are attributed to a particular ACO, with identification of PCP. For this report, payers use an adapted Blueprint format recommended by MVP Health Care.

b. **Patient attribution report - claims extract:** This report is provided on the last day of the month for both the XSSP and the VMSSP. Payers provide each ACO with a file containing claims paid in the past month for enrollees previously attributed and reported to the ACO for the prior month, and claims paid in the past 12 months for newly attributed enrollees. The payers use the VHCURES file format.

c. **Stratification of patients by risk score with supplemental information**: This report is provided on a quarterly basis to each ACO. The report provides a ranked listing of attributed patients with risk scores in the top 20% of the ACO's attributed population using a Bailit Health-developed format. Payers use predictive modeling software of their own choosing.

d. **Patient gaps in care:** This report is provided in accordance with the existing payer schedules for the XSSP and on an ad hoc schedule for the VMSSP using the existing payer formats subject to possible modification for alignment purposes at a future date.

II. Reports from the Payers to the GMCB Analytics Contractor:

a. **Exchange premium and enrollment by product**: This report was provided on a one-time basis by commercial insurers only on June 30, 2014. The report provided exchange premium and enrollment by product.

b. **Six-month claims file submission for calculation of claims-based quality measures and M&E measures:** Payers were first required to send the claims files for the claims-based quality measures required for Year One and Monitoring and Evaluation measures for the time period covering January 1, 2014 through June

30, 2014 to the GMCB analytics contractor by October 7, 2014 (to account for a 90-day claims lag and one week to process the data). This requirement repeats annually.

c. **Nine-month claims file submission for calculation of claims-based quality measures and M&E measures:** Payers were first required to send the claims files for the claims-based quality measures and Monitoring and Evaluation measures required for Year One for the time period covering January 1, 2014 through September 30, 2014 on January 7, 2015 (to account for a 90-day claims lag and one week to process the data). This requirement repeats annually.

d. **Annual year-end claims file submission for calculation of claims-based quality measures and M&E measures:** Payers are required to send the claims files for the claims-based quality measures and Monitoring and Evaluation measures required for Year One for the time period covering January 1, 2014 through December 31, 2014 on July 15, 2015 (to account for a 180-day claims lag and two weeks to process the data). This requirement repeats annually.

III. Reports from the ACOs to each Payer:

a. **Initial provider report:** ACOs first reported a list of participating providers to the payers in April 2014. For this report, the ACOs used a modified version of the GMCB oncology pilot format entitled, "ACO Provider Roster for Patient Attribution and Payment."

b. **Monthly provider changes within PCP practices for attribution:** This report is provided on a monthly basis. This report describes provider additions and terminations by site, including site-specific information of providers practicing at multiple sites. For this report, the ACOs use a modified version of the GMCB oncology pilot format entitled, "ACO Provider Roster for Patient Attribution and Payment."

c. **ACO provider roster**: ACOs provided to each payer an ACO provider roster on March 1, 2015 and will continue to do so on an annual basis moving forward.

d. **Additional reports will only be adopted should there be consensus to do so among the GMCB, payers, and ACOs.**

IV. Reports from the ACOs to the Analytics Contractor:

a. **Clinical data-based quality measures required for Year One using sample method:** If ACOs choose to use the sample methodology for collection of quality measures, they are required to send to the GMCB's Analytics Contractor the numerators and denominators for the clinical data-based quality reporting measures (core measures #14-20) for the time period covering January 1, 2014 through December 31, 2014 by July 15, 2015. The ACO will receive the sample from either the payers or the GMCB's analytics contractor by January 31, 2015. The ACO will report to the GMCB's analytics contractor using the Bailit Health-developed report template entitled "Clinical Data-based Measures Report."

b. **Clinical data-based quality measures required for Year One using EHR method:** If ACOs choose to use the EHR methodology for collection of quality measures, they are required to send to the GMCB's Analytics Contractor the numerators and denominators for the clinical data-based quality reporting measures (core measures #14-20) for the time period covering January 1, 2014 through December 31, 2014 by July 15, 2015. The ACO will generate numerators and denominators for all practices with EHR capability to report one or more rates, and report the percentage of attributed lives represented by the practices reporting each measure to the GMCB's analytics contractor using the Bailit Health-developed report template entitled "Clinical Data-based Measures Report."