STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

SEALED BID
REQUEST FOR PROPOSAL FOR
Statewide Analytics Contractor Related to the State Innovation Model Grant

Expected RFP Schedule Summary:

DATE ISSUED	**January 17, 2014**
QUESTIONS DUE	**January 30, 2014**
BIDDERS' CONFERENCE CALL	**February 3, 2014 at 12:00pm**
WRITTEN RESPONSES TO QUESTIONS	**February 5, 2014**
PROPOSALS DUE	**February 14, 2014 at 3:00pm**
DATE AND TIME OF BID OPENING	**February 14, 2014 at 3:00pm**
LOCATION OF BID OPENING	**GMCB, 89 Main Street, Montpelier, VT 05602**
SELECTION NOTIFICATION	**February 28, 2014**
CONTRACT SELECTION ANNOUNCEMENT	**March 4, 2014**
WORK START DATE	**March 17, 2014**

PLEASE BE ADVISED THAT ALL NOTIFICATIONS, RELEASES, AND AMENDMENTS ASSOCIATED WITH THIS RFP WILL BE POSTED AT:

http://bgs.vermont.gov/purchasing/bids

CONTACT AGENT: **Janet Richard**
MAILING ADDRESS: **Green Mountain Care Board**
89 Main Street
Montpelier, VT 05620
TELEPHONE: **802-828-2901**
E-MAIL: **Janet.Richard@state.vt.us**

STATE OF VERMONT
Green Mountain Care Board
RFP: VHCIP Payment Models Analytics Contractor

SEALED BID INSTRUCTIONS

All bids must be sealed and must be addressed to the Green Mountain Care Board, 89 Main Street, Montpelier, Vermont 05620. BID ENVELOPES MUST BE CLEARLY MARKED 'SEALED BID' AND SHOW THE REQUISITION NUMBER AND/OR BID TITLE, OPENING DATE AND NAME OF BIDDER. **ALL BID SUBMISSIONS MUST CONTAIN AN ORIGINAL AND THREE (3) COMPLETE COPIES and one electronic copy, which may be submitted on a CD or to the following email address: Janet.Richard@state.vt.us**

All bidders are hereby notified that sealed bids must be in the office of the Green Mountain Care Board (GMCB) by the bid due date and time. Bidders are cautioned that it is their responsibility to originate the sending of bids in sufficient time to insure receipt by the GMCB on or before the bid due date. Hand-carried bids shall be delivered to a representative of the GMCB on or before the bid due date and stamped in by the GMCB representative to indicate the date and time of receipt. Bids not in possession of the GMCB by the due date and time will not be considered.

The GMCB may change the date and/or time of bid openings. If a change is made, the GMCB will make a reasonable effort to inform all bidders.

All bids will be opened publicly. Any interested party may attend bid openings. Bid results may be requested in writing and are available once an award has been made.

From the issue date of this RFP until a Contractor is selected and the selection is announced, bidders are prohibited from communicating with any GMCB staff regarding this procurement, except with Anna Bassford, Assistant to the Chair.

The GMCB shall reserve the right to reject the proposal if this provision is violated.

FAXED BIDS: **FAXED bids will NOT be accepted.**
ELECTRONIC BIDS: ELECTRONIC bids are required in addition to the hard copies.

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1. Overview and General Information

1.1 Overview

The Green Mountain Care Board (GMCB) is soliciting Proposals from qualified vendors to provide statewide analytic services to support Vermont's State Innovation Model (SIM) grant activities, with an initial focus on analyses to support the Accountable Care Organization (ACO) Shared Savings Program (SSP). The Grant Narrative and State Innovation Plan can be found here: http://gmcboard.vermont.gov/resources_reports.

1.2 RFP Background

On February 21, 2013, Vermont was notified of award of a $45 million SIM grant from the federal government. This grant will fund activities inside and outside of state government over the next four years to:

1. Increase both organizational coordination and financial alignment between Blueprint advanced primary care practices and specialty care;
2. Implement and evaluate the impact of value-based payment models;
3. Coordinate with those payment models a financing and delivery model for enhanced care management and new service options for dual-eligibles; and,
4. Accelerate development of a Learning Health System infrastructure designed to meet the needs of providers engaged in delivery system reform and the state's needs for ongoing evaluation of the impact of reforms.

Specifically, the grant will support:

- Rapid diffusion of three alternatives to fee-for-service payment:
  - Shared savings accountable care payments, under which a single network of providers takes responsibility for managing the costs and quality of care/services for a group of Vermonters;
  - Episodes of care, which provide a single reimbursement amount to a group of providers for treatment of a patient's acute or chronic care episode; and
  - Pay-for-performance models, which incorporate the total costs and quality of services in provider compensation
- Expansion of electronic health records (EHRs) to primary care, mental health and long term service providers;
- Accelerated development of interfaces between EHRs and the state's Health Information Exchange;
- Improved data transmission, integration and use across providers;

- Coordination and possibly expansion of the measurement of consumer experience;
- Improved capacity to measure and address provider workforce needs;
- Improved data analytics and predictive modeling to support monitoring system costs and quality; and
- Development of stronger links between the Blueprint for Health (Vermont's program to support development of advanced primary care practices) and specialty care, including mental health.

2. Schedule of Events

2.1 Questions and Answers

Any Vendor requiring clarification of any section of this RFP or wishing to comment or take exception to any requirements or other portion of this RFP must submit specific questions in writing no later than January 30, 2014. Questions may be e-mailed to or sent through the mail to: **Janet Richard, Green Mountain Care Board, 89 Main Street, Montpelier, VT 05620.** At the close of the question period a copy of all questions or comments and the State's responses will be posted on the State's web site http://bgs.vermont.gov/purchasing/bids. Every effort will be made to have these available as soon after the question period ends, contingent on the number and complexity of the questions.

There will be a **bidders' conference call on February 3, 2014 at 12:00pm**. The conference call number is: 1-877-273-4202 and the participant number is: 2252454

3. Scope of Work

3.1 General Overview

The Green Mountain Care Board, in coordination with the Department of Vermont Health Access (DVHA), seeks an independent, third-party contractor to assume responsibility for statewide analytics activities related to the implementation, monitoring, reporting, and evaluation of the Vermont Health Care Innovation Project (VHCIP) Accountable Care Organization Commercial and Medicaid Shared Savings pilot program. The pilot program commenced January 1, 2014 and will end December 31, 2016.

The participating payers are anticipated to be Blue Cross Blue Shield of Vermont, DVHA and MVP Health Care (collectively, "Participating Payers"). The participating ACOs are anticipated to be Community Health Accountable Care (CHAC), OneCare Vermont (OneCare) and Vermont Collaborative Physicians (VCP) (collectively, "Participating ACOs"). CHAC and OneCare are planning to enter into agreements to serve members of both of the commercial insurers and Medicaid

beneficiaries served by DVHA. VCP is planning to enter into a pilot agreement to participate with one of the two commercial insurers.

All Vermonters with commercial individual or small group coverage who are attributed to a pilot ACO that is contracted to a participating commercial insurer will be considered part of the pilot. All Medicaid beneficiaries who are attributed to a pilot ACO contracted with DVHA, with the exception of those dually eligible for Medicare and selected other smaller Medicaid populations, will be considered part of the pilot. GMCB anticipates that the pilot population during 2014 will number approximately 50,000 commercially-insured Vermonters and approximately 44,000 Medicaid beneficiaries.

While the GMCB does not anticipate a change in the composition of Participating Payers and ACOs over the term of the pilot, changes may possibly occur.

While the initial focus of the work resulting from this RFP will be the ACO SSP pilot, as VHCIP activities expand the GMCB may direct the Contractor to assume analytics responsibilities related to planning, implementing, and evaluating other payment models to be tested (e.g., Episodes of Care and Pay-for-Performance). Any additional programmatic work will be specified in an amendment to the agreement expected to result from this procurement and will reflect an expanded scope of work.

Work may be performed at the Contractor's office location. The Contractor shall be available to designated GMCB and DVHA staff during normal business hours to respond to questions or to provide needed information related to the services specified within this RFP. The Contractor shall participate in teleconference meetings and also in periodic on-site meetings at GMCB and DVHA offices during the contract period.

The contract will commence on March 17, 2014 and terminate on October 31, 2017. The contract may be extended for two additional 12-month periods at the discretion of the GMCB.

3.2 Mandatory Tasks

A. Calculation of ACO Financial Performance and Calculation of the Distribution of Earned Savings Payments

The Contractor shall be responsible for the calculation of interim and final determination of savings for the three ACO SSP pilot years (i.e., calendar years 2014, 2015 and 2016, respectively), and of the distribution formula of any savings for distribution to the ACOs. Savings calculations shall be performed using claim data submitted by the Participating Payers to the Contractor using the file format that payers use to submit data to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES).

Upon receipt of the claims files from the Participating Payers, the Contractor shall determine whether the pilot ACOs generated savings in accordance with the methodology defined within the

Vermont ACO Pilot Standards and found within Attachments F and G. Should questions arise in the course of interpreting Attachments F and G or any other specifications attached to this RFP, the Contractor shall seek guidance from the GMCB. Calculations shall be completed in full in accordance with the timelines specified within Attachment H and findings shall be reported in writing to the GMCB in a format reviewed with and approved in advance by the GMCB. Findings specific to DVHA shall also be reported directly to DVHA.

The methodologies for calculation of savings are subject to change. The GMCB will inform the Contractor in writing of any modifications.

B. Calculation of ACO Performance Measures

The Contractor shall calculate the quality measures comprising the Core Measure Set (Attachment I). The Core Measure Set consists of measures of ACO performance using three distinct data sources:

- Clinical data-based quality measures: These measures will be generated by the ACOs and reported as numerators and denominators to the Contractor.
- Claims-based quality measures: These measures will by generated by the Contractor using claim data provided by the Participating Payers.
- Survey-based quality measures: These measures will be generated by a third-party survey contractor and reported as numerators and denominators to the Contractor.

The Contractor shall also calculate or aggregate quality, cost and utilization measures comprising the Monitoring and Evaluation Measure Set. The Monitoring and Evaluation Measure Set consists of measures using four types of data sources:

- Claims-based utilization measures: These measures will be generated by the Participating Payers and reported as numerators and denominators to the Contractor.
- Claims-based cost measures: These measures will by generated by the Contractor using claim data provided by the Participating Payers.
- Claims-based quality measures: These measures will by generated *at the payer level* by the Participating Payers using claim data and reported as numerators and denominators to the Contractor.
- Other measures: These measures will be generated by other parties identified by the GMCB and reported as numerators and denominators to the Contractor.

The specifications for each of the Core Measure Set measures are provided in Attachment K and those for the Monitoring and Evaluation Measure Set measures are provided in Attachment L and the periodicity with which the measures shall be generated and reported is defined in Attachment M.

Participating Payers will transfer data for payer-generated measures to the Contractor using secure, web-based file transfer tools. The Contractor shall be responsible for obtaining all necessary data

use agreements (DUAs), including maintaining requirements of those DUAs throughout the contract period.

The GMCB has defined processes for annual and ad hoc measure set review. This review process may result in modification to the Core Measure Set and Monitoring and Evaluation Measure Set. The GMCB will inform the Contractor in writing of any modifications.

While the Centers for Medicare and Medicaid Services (CMS) is not a Participating Payer, Participating ACOs are contractually obligated to submit Medicare Shared Savings Program (MSSP) quality measures to the GMCB. The Contractor shall integrate MSSP performance measures provided to the Contractor into selected Section 3.2.B reports as directed by the GMCB.

C. Calculation of the Impact of ACO Quality Performance on the Distribution of Shared Savings

Should one or more ACOs be found to have generated savings after the conclusion of a pilot year, the Contractor shall annually utilize ACO-specific quality measures to determine what percentage of the savings should be distributed by one or more Participating Payers to one or more Participating ACOs. The Contractor shall utilize the methodologies contained within Appendices N and O for the purposes of performing the specified calculations, and shall report the results in writing to the GMCB upon task completion.

The GMCB has a defined process for review of the methodologies contained within Appendices M and N. This review process may result in modification of the calculations to be performed when determining the impact of quality performance on the distribution of savings. The GMCB will inform the Contractor in writing of any modifications.

D. Report Design and Generation

The Contractor shall propose to the GMCB report designs to present findings of all calculated and aggregated measures by ACO and by covered population (i.e., commercially–insured and Medicaid). Intended audiences include the GMCB, DVHA, Participating Payers and ACOs, policymakers, other interested stakeholders and consumers. The GMCB expects that the Contractor will propose varied report formats and content as appropriate to satisfy the needs of diverse audiences.

E. Other Activities

1. The Contractor shall conduct an assessment of the timeliness and completeness of the VHCURES database for informing the calculation of ACO financial performance as defined in Section 3.2.A, and for generating claims-based cost, quality and utilization measures as defined in Section 3.2.B. The Contractor shall submit the methodology for GMCB review and approval by December 1, 2014, and shall complete the assessment by October 1, 2015.

2. The Contractor shall conduct an annual assessment of the financial effect of changes in medical coding practices on ACO expenditures. The Contractor shall propose a methodology

for performing the analysis subject for GMCB review and approval by December 1, 2014. The methodology shall be informed by published and unpublished assessments of the effects of changes in coding to influence reimbursement. The Contractor shall complete the assessment of 2014 experience by October 1, 2015, and of 2015 experience by October 1, 2016.

3. The Contractor shall annually generate a sample of measure-eligible patients for whom medical records shall be reviewed by each ACO for each clinical data-based measure that the ACOs are required to report until such time that the GMCB informs the Contractor that it need not do so. The size of the sample shall be defined by the GMCB. The GMCB anticipates reducing and eventually eliminating this requirement as ACOs demonstrates anticipated future ability to report one more clinical data-based measures via electronic means.

4. The Contractor shall design and generate ad-hoc reports during the contract period as requested by the GMCB and DVHA.

5. The Contractor shall participate as requested in VHCIP work group, subgroup and other related meetings that pertain to the scope of work. Telephonic participation shall generally be considered acceptable, although the GMCB may require in-person participation on occasion. Bidders should assume in-person meetings on eight days per calendar year.

6. The Contractor shall review the results of its calculations performed as part of Section 3.2.A-C tasks with interested Participating ACOs and Payers, and shall work with such ACOs and Payers to reconcile any inconsistencies (such as conflicting Contractor and Participating Payer patient attribution counts) or other possible methodological or data quality concerns that Participating ACOs and Payers might identify, and shall do so as directed by the GMCB.

7. As requested by the GMCB, the Contractor shall provide feedback and advice to the GMCB and DVHA and to VHCIP-related work groups and committees concerning experience with the conduct of tasks defined within Sections 3.2.A-D and with respect to the implications of contemplated changes to existing measure sets.

8. The Contractor shall be prohibited from utilizing the data provided to it except as directed within this RFP and as directed by the GMCB and DVHA to address the stated objectives of the Vermont Health Care Innovation Project. Any unauthorized use of data obtained through the contract expected to result from this RFP shall be grounds for contract termination.

3.3 Deliverables

A. Defined Reports

The Contractor shall produce reports that provide the results of tasks undertaken to fulfill Section 3.2.A-D and Section 3.2.E.3, 3.2.E.5, 3.2.E.6 and 3.2.E.7 responsibilities.

B. Ad Hoc Reports

The Contractor shall prepare and submit to the GMCB ad hoc reports utilizing data reported to the Contractor to meet requirements Sections 3.2.A-D and as may be separately provided to the Contractor by DVHA. Attachment P contains examples of possible ad hoc report content and formats to be requested by the GMCB.

3.4 Contract Management

A. Contract Management Approach

The GMCB will designate an individual as the manager of the contract resulting from this RFP. That individual will serve as the point-of-contact for the Contractor. Performance instructions shall be communicated by the contract manager and all deliverables shall be sent to the contract manager.

The contract manager will establish a regular schedule of operational meetings with the Contractor to discuss contract tasks. In addition, the contract manager will establish a schedule of semi-annual meetings involving GMCB and DVHA staff and senior Contractor staff to define performance objectives for the year, review performance year-to-date relative to those objectives, and plan for upcoming contract activity. The GMCB may invite Participating Payers and ACOs to participate in these meetings from time to time.

B. Multi-agency Relationship

Because selected contract deliverables are to be utilized by DVHA, including but not limited to the ad hoc reports referenced in Section 3.2.E.3, the Contractor shall respond to queries and requests by DVHA-designated personnel and contractors, and shall deliver DVHA-identified reports directly to DVHA. In order to avoid Contractor confusion, the Contractor shall copy the GMCB-designated contract manager on all communications with DVHA unless indicated otherwise by the GMCB contract manager in specific circumstances. In order to maintain fiscal management of the Contract, no ad hoc analytic work for which the Contractor has not already received GMCB approval shall commence without written authorization from the GMCB contract manager.

C. Failure to Comply with Contractual Requirements

While the GMCB seeks a Contractor with which it can work in close collaboration and partnership, it shall take action should the Contractor fail to adhere to the terms of the agreement expected to result from this RFP. Specifically:

1. Should the Contractor submit reports that fail to address contractual requirements, the GMCB shall produce written direction regarding any necessary corrections and revisions.

2. For each late, incomplete or inaccurate report, the GMCB may notify the Contractor that liquidated damages of $1000 per day shall be assessed effective as of the report's assigned due date.

3. Should the Contractor submit a complete and accurate report(s) following such written notice and within five business days of the issuance of such notice, the Department will waive any liquidated damages.

4. Should the report still not be submitted in complete an accurate fashion 15 business days after the due date, the GMCB may notify the Contractor that liquidated damages of $3000 per day will be assessed effective as of 15 days after the report's assigned due date.

The Contractor shall not be held responsible for incomplete or tardy report submission should the Contractor have not received necessary information from Participating Payers or ACOs needed to complete the required report(s).

3.5 Confidentiality

The Contractor shall execute a Business Associate Agreement with the Green Mountain Care Board (see Appendix O) and with each of the Participating ACOs and Participating Payers.

4. METHOD OF AWARD

Awards will be made in the best interest of the State of Vermont. The State may award one or more contracts and reserves the right to make additional awards to other compliant Vendors at any time during the first year of the contract if such award is deemed to be in the best interest of the State.

Evaluation Criteria

Proposals that meet the specifications of this RFP, and that are received in this office by the appointed deadline, will be evaluated by a review committee composed of state staff and other stakeholders as designated by the Green Mountain Care Board.

Evaluation Factors

- Understanding of Work
- Approach and Methodology
- Proposed Staff Education, Experience and References
- Wage Requirements – fixed price and hourly labor cost
- Availability and Flexibility - Work schedule restrictions (e.g., part-time, full-time, maximum days per week, maximum hours per week months per year)
- Presentation: Proposed staff experience and references, communication and organizational skills and other pertinent topics.

Procedural Instructions:

If the procedural instructions are not followed, the proposal shall be considered non-responsive. Non-responsive proposals will be eliminated from further evaluation.

5. INSTRUCTIONS FOR BID PREPARATION

5.1 General Instructions

The bid is the GMCB's primary vehicle for obtaining essential information upon which contract award decisions are based. Instructions contained in the RFP must be met in order to qualify for consideration for award. Bids that do not meet or comply with all instructions may be considered non-responsive and may be discarded. **Mere reiterations of RFP-stated services are discouraged as they do not provide insight into the bidder's understanding of the required tasks and responsibilities, nor the uniqueness of the bidder's performance capabilities.**

5.2 Bid Submission Delivery Methods

- U.S. MAIL: Vendors are cautioned that it is their responsibility to originate the mailing of bids in sufficient time to ensure bids are received and time stamped by the Office of Purchasing and Contracting prior to the time of the bid opening.
- EXPRESS DELIVERY: If bids are being sent via an express delivery service, be certain that the RFP designation is clearly shown on the outside of the delivery envelope or box. Express delivery packages will not be considered received by the State until the express delivery package has been received and time stamped by the Office of Purchasing & Contracting.
- HAND DELIVERY: Hand-carried bids shall be delivered to a representative of the Office of Purchasing & Contracting prior to the bid opening.
- ELECTRONIC: Electronic bids will be accepted in addition to the hard copy bids.
- FAX BIDS: FAXED bids will not be accepted.

5.3 Specific RFP Response

Vendors must describe their experience for completing similar work as outlined in Section 3- Scope of Work as well as describe their qualifications for meeting the Professional Service Requirements in Section 4. Additionally, Vendors must provide information specific to the personnel (including any subcontractors) assigned to accomplish the work called for in this RFP. Vendors must provide a narrative description of the personnel who will actually work on the contract and provide their title and resume.

References: Provide the names, addresses, and phone numbers of at least three companies or State Agencies that the individual you are proposing has performed similar work within the last 3 years. You must include contact names who can talk knowledgeably about performance and

deliverables. The State reserves the right to contact any references provided by the Vendor. The State invites Vendors to provide letters of reference from previous clients.

Technical Bid: This section must describe the bidder's approach and plans for accomplishing the work outlined in the Scope of Work and Contractor Responsibilities section of this RFP. These plans and approaches must be described in sufficient detail to permit the GMCB to fully evaluate them. Further, the bidder must describe the effort and skills necessary to complete the project. The section must contain at least the following information:

A brief introduction outlining the bidder's overall technical approach to complete the requirements. The narrative must demonstrate to the GMCB an understanding of the process that is to be implemented, and persuade the GMCB that the bidder understands the nature of the required work, and the level of effort required.

A description of how the work will be accomplished. Simple statements that a task will be completed, or a reiteration of the RFP are not helpful. **Section 4** of this RFP (**Scope of Work)** shows the interface between the GMCB's responsibilities and the Contractor's responsibilities. Using Section 4 as a guide, the bidder must describe how it will fulfill these responsibilities.

A summary of the problems that the bidder might reasonably expect and its solution to those anticipated problems must be provided.

Enough information must be provided so that the GMCB is assured that the Contractor will be prepared to establish fully effective and efficient operations on the contract's effective start date.

The bidder must supply detailed information concerning any subcontractors proposed to be used during the performance of the responsibilities under the contract.

Organizational Experience: This section of the bid must contain pertinent information relating to the bidder's organization, personnel, and experience, including references together with a contact name and telephone number that will substantiate the bidder's qualifications and performance record. The bid must contain at least the following:

- the location of the bidder's headquarters and office(s);
- if applicable, the following information about the bidder and any parent corporation and all subsidiaries and affiliates: (1) an organizational chart by ownership of all affiliated entities; (2) the names and addresses of owners/partners/shareholders of each entity; and (3) the names and addresses of members of the governing board of each entity;
- a description of the bidder's background and experience in calculating savings and generating quality measures using data provided by multiple payers and providers. Documentation that clearly shows the bidder's experience in performing similar projects must be included. Bidders must include a list of references that reflect this experience;
- documentation as the bidder believes sufficient to show proof of the bidder's financial capacity to undertake the responsibilities required under this contract;
- confirmation that the bidder is free of actual or apparent conflict of interest, and
- evidence of professional liability insurance coverage for any and all services performed under the contract, with minimum coverage of $1,000,000 per occurrence.

Cost Bid: The bidder should offer a cost proposal, distinct from the technical proposal. The cost proposal shall be structured as follows:

1. Fixed price proposal for each year of CY 2014-17 for Section 3.2.A-D and 3.2.E.3, 3.2.E.5, 3.2.E.6, 3.2.E.7 tasks and the assigned staff class and corresponding hourly rates used to construct the fixed price proposal.
2. Fixed price proposal for each year of CY 2014-17 for Section 3.2E.1-2 tasks and the assigned staff class and corresponding hourly rates used to construct the fixed price proposal.
3. One hourly rate for each staff class for Section 3.2.E.4 tasks (i.e., ad hoc requests).

The aforementioned cost proposal shall be exclusive of travel-related costs. The bidder should budget visits to Montpelier or Burlington once per month per calendar year, with eight of those visits being a one-day visit and four visits being for two days. Any contract written as a result of this RFP will require receipts for all expenses other than vehicle mileage or will use per diem rates specified in the "General Service Administration (GSA) Per Diem 2000 study" for lodging, meals and incidentals. Vehicle mileage will be reimbursed at a rate determined at the time the contract is executed. The Contractor must bill the GMCB for work performed at least once a month.

For all work performed except for that relating to Section 3.2.E.4 tasks, the GMCB intends to pay the Contractor based on contracted hourly rates up to a maximum defined by the contracted fixed price proposals.

6. BID SUBMISSION

6.1 DUE DATE: The closing date for the receipt of bids is **February 14, 2013 at 3:00 p.m.**

The bid opening will be held at 89 Main Street, Montpelier, VT (3rd floor) at the date and time listed on page one and is open to the public.

All bids shall be submitted in a sealed package and must be clearly marked as follows:

"VHCIP Payment Models Analytics Contract"

6.2 Bid Confidentiality:

All submittals will be subject to the State's Access to Public Records Law, 1 VSA§ 315 et seq. Subsequent to award of this RFP, all or part of any submittal will be released to any person or firm who requests it. Vendors shall specify in their cover letter if they desire that any portion of their submittal be treated as proprietary and not releasable as public information. **A redacted copy should be included for portions of submittal that is not proprietary.**

6.3 Submission Checklist

- ✓ Hard *Copies* (3)
- ✓ Original Unbound *Master* (1)
- ✓ 1 CD or emailed electronic copy of the bid

- ✓ Cover Letter
- ✓ Experience & Qualifications
- ✓ References
- ✓ Cost Proposal
- ✓ Standard State Provisions for Contracts and Grants
- ✓ Offshore/outsource form
- ✓ Certificate of Compliance
- ✓ Workers' Compensation; State Contracts Compliance Requirement; Self Reporting
- ✓ Workers' Compensation; State Contracts Compliance Requirement; Subcontractor Reporting

6.4 Attachments

The following attachments are current as of the dates indicated on each document. Many of the attachments are still pending final approval and are subject to possible modification.

- Attachment A: Certificate of Compliance
- Attachment B: Offshore Outsourcing Questionnaire
- Attachment C: Standard State Provisions for Contracts and Grants (Nov 7, 2012)
  Workers' Compensation; State Contracts Compliance Requirement; Self Reporting
  Workers' Compensation; State Contracts Compliance Requirement; Subcontractor Reporting
- Attachment D: Sample Contract
- Attachment E: Other Contract Provisions
- Attachment F: Commercial ACO Standards
- Attachment G: Medicaid ACO Standards
- Attachment H: Timeline for Calculation of savings
- Attachment I: Core Measure Set
- Attachment J: Monitoring and Evaluation Measure Set
- Attachment K: Core Measure Set Narrative Specifications
  Attachment L: Monitoring and Evaluation Measure Set Narrative Specifications
  Attachment M: Timeline for Measure Generation and Reporting
- Attachment N: Methodology for Determining Distribution of Savings Based on Quality Performance - Commercial
- Attachment O: Methodology for Determining Distribution of Savings Based on Quality Performance - Medicaid
- Attachment P: Possible Ad Hoc Report Content and Formats
- Attachment Q: GMCB Business Associate Agreement
- Attachment R: Calculation of ACO Financial Performance and Distribution of Reconciliation Payments Model (Excel model is provided in a separate document)

7. General Terms and Conditions

7.1 Statement of Rights

The State of Vermont reserves the right to obtain clarification or additional information necessary to properly evaluate a proposal. Vendors may be asked to give a verbal presentation of their proposal after submission. Failure of Vendor to respond to a request for additional information or clarification could result in rejection of that Vendor's proposal. To secure a project that is deemed to be in the best interest of the State, the State reserves the right to accept or reject any and all bids, in whole or in part, with or without cause, and to waive technicalities in submissions. The State also reserves the right to make purchases outside of the awarded Contracts where it is deemed in the best interest of the State.

7.2 Non-Disclosure Agreement

Contractors will be required to sign a non-disclosure agreement in a form acceptable to the State if there is not already one on file.

7.3 Location of Work

As a general rule, project work will be done in Montpelier, VT. The Contractor will be required to work on-site in (such site or sites in Montpelier, VT as may be identified by the State) where space will be provided, however travel to other State facilities may be needed and the vendor will be responsible for such travel using its own mode of transportation. Occasional exceptions to this rule may be established by mutual agreement between the Contractor and the State.

Where applicable, the State will provide a project facility with desks, telephone, LAN connections, and printers. If specific laptop computers or other mobile peripheral devices are required by the Contractor then the Contractor must provide its own equipment and will be given the appropriate support by the State. Contractors will be provided support by the State in setting up any accounts or connections required (i.e. State email system, network connectivity, network printing etc.) and vendors will have access to State phones for use in project related business calls. The State will not pay Contractors' cell phone bills.

7.4 Contract Terms

The selected bidder(s) will sign a contract with the GMCB to provide the services named in the bid, at the price listed. A copy of the standard State contract is attached. PLEASE NOTE THAT THE STATE WILL NOT ACCEPT THE VENDOR'S TERMS AND CONDITIONS IN LIEU OF THE STANDARD STATE CONTRACT PROVISIONS.

Acknowledgment of Terms

A statement from the Vendor and its legal counsel acknowledging all Customary State Contract Provisions and Purchasing and Contract Administration Terms and Conditions with any exceptions or additional provisions noted. (These will be considered when making an award).

The GMCB may cancel upon discovery that a bidder is in violation of any portion of the agreement, including an inability by the bidder to provide the services, and/or support offered in their bid. Contracts may be amended by mutual agreement of the parties. The contract may be cancelled by the GMCB by giving written notice at least 30 days in advance. The Contractor may cancel the contract by giving 120 days written notice in advance. If, during the term of the contract, the Contractor cannot provide the required services using the personnel identified in the bid, the Contractor will notify the GMCB and provide assurances that the substitute personnel will in no way diminish the capacity of the Contractor to perform.

7.5 Work Product

All Work Product shall belong exclusively to the State, with the State having the sole and exclusive right to apply for, obtain, register, hold and renew, in its own name and/or for its own benefit, all patents and copyrights, and all applications and registrations, renewals and continuations thereof and/or any and all other appropriate protection. To the extent exclusive title and/or complete and exclusive ownership rights in and to any Work Product may not originally vest in the State by operation of Laws or otherwise as contemplated hereunder, Contractor shall immediately upon request, unconditionally and irrevocably assign, transfer and convey to the State all right, title and interest therein.

"Work Product" means any tangible or intangible work product, creation, material, item or deliverable, documentation, information and/or other items created by Contractor, either solely or jointly with others, including by Contractor staffing that are specifically commissioned by the State under a Contract or other written agreement, and which are developed, conceived of, prepared, procured, generated or produced by Contractor. Work Product specifically excludes any tangible or intangible work product, creation, material, item or deliverable, documentation, information, deliverables and/or other items which were proprietary to the Contractor prior to the date of contracting with the State. Work Product may include ideas, inventions, improvements, discoveries, methodologies or processes, or writings, designs, models, drawings, photographs, reports, formulas, algorithms, patterns, devices, compilations, databases, computer programs, specifications, operating instructions, procedures manuals, or other documentation, whether or not protectable under Title 17 of the U.S. Code and whether or not patentable or otherwise protectable under Title 35 of the U.S. Code, that are developed, conceived of, prepared, arise, procured, generated or produced in connection with a Contract with the State, whether as individual items or a combination of components and whether or not the Services or the intended Work Product itself are or is completed or the same are or is reduced to practice during the Term.

7.6 Confidentiality of State Information

Contractor agrees to keep confidential all information received and collected by Contractor, or to which the Contractor may have access to or come in contact with in connection with a project. The Contractor agrees not to publish, reproduce, or otherwise divulge any such State information in whole or in part, in any manner or form or authorize or permit others to do so. Contractor will take reasonable measures as are necessary to restrict access to State Information in the Contractor's possession to those employees on his/her staff who must have the information on a "need to know" basis. The Contractor shall promptly notify the State of any request or demand by any court, governmental agency or other person asserting a demand or request for State information to which the Contractor or any third party hosting service of the Contractor may have access, so that the State may seek an appropriate protective order. In the Contract, the Contractor shall represent and warrant that it has implemented and it shall maintain during the term of any agreement the highest industry standard administrative, technical, and physical safeguards and controls consistent with NIST *Special Publication 800-53* and *Federal Information Processing Standards Publication* 200 and designed to (i) ensure the security and confidentiality of State Information; (ii) protect against any anticipated security threats or hazards to the security or integrity of the State Information; and (iii) protect against unauthorized access to or use of State Information. Such measures include at a minimum, as applicable: (1) access controls on information systems, including controls to authenticate and permit access to State Information only to authorized individuals and controls to prevent the Contractor employees from providing State Information to unauthorized individuals who may seek to obtain this information (whether through fraudulent means or otherwise); (2) industry-standard firewall protection; (3) encryption of electronic State Information while in transit from the Contractor networks to external networks; (4) measures to store in a secure fashion all State Information which shall include multiple levels of authentication; (5) dual control procedures, segregation of duties, and pre-employment criminal background checks for employees with responsibilities for or access to State Information; (6) measures to ensure that the State Information shall not be altered or corrupted without the prior written consent of the State; (7) measures to protect against destruction, loss or damage of State Information due to potential environmental hazards, such as fire and water damage; (8) staff training to implement the information security measures; and (9) monitoring of the security of any portions of the Contractor systems that are used in the provision of the services against intrusion on a twenty-four (24) hour a day basis.

7.7 Performance Measures

In accordance with current State of Vermont policy and procedures, the Contract may include Contractor performance measures. The specific performance measures will be determined during the Contract negotiation process.

7.8 Taxes

Most State purchases are not subject to federal or state sales or excise taxes and must be invoiced tax free. An exemption certificate will be furnished upon request covering taxable items. The

Contractor agrees to pay all Vermont taxes which may be due as a result of this order. If taxes are to be applied to the purchase it will be so noted in the response.

7.9 Amendments

No changes, modifications, or amendments in the terms and conditions of a Contract shall be effective unless reduced to writing, numbered, and signed by the duly authorized representative of the State and Contractor.

7.10 Non-Collusion

The State of Vermont is conscious of and concerned about collusion. It should therefore be understood by all that in signing bid and contract documents they agree that the prices quoted have been arrived at without collusion and that no prior information concerning these prices has been received from or given to a competitive company. If there is sufficient evidence to warrant investigation of the bid/contract process by the Office of the Attorney General, all Vendors should understand that this paragraph might be used as a basis for litigation.

7.11 Insurance

In addition to the insurance coverage's required in Attachment C, ***Standard State Provisions for Contracts and Grants,*** the Contractor shall carry Professional Liability insurance and data breach insurance in minimum coverage amounts of $1,000,000 per occurrence.

7.12 Business Registration

To be awarded a contract by the State of Vermont a Vendor must be (except an individual doing business in his/her own name) registered with the Vermont Secretary of State's office www.sec.state.vt.us/tutor/dobiz/forms/fcregist.htm and must obtain a Contractor's Business Account Number issued by the Vermont Department of Taxes www.state.vt.us/tax/pdf.word.excel/forms/business/s-1&instr.pdf

7.13 Contract Negotiation

Upon completion of the evaluation process, the State may select one or more Vendors with which to negotiate a contract, based on the evaluation findings and other criteria deemed relevant for ensuring that the decision made is in the best interest of the State of Vermont. In the event the State is successful in negotiating with the Vendor, the State will issue a notice of award. In the event State is not successful in negotiating a contract with a selected Vendor, the State reserves the option of negotiating with another Vendor.

7.14 Worker's Compensation; State Contracts Compliance Requirement

The Department of Buildings and General Services in accordance with Act 54, Section 32 of the Acts of 2009 and for total projects costs exceeding $250,000.00, requires Vendors comply with the following provisions and requirements.

- (a) (1) Vendor is required to self-report detailed information including information relating to past violations, convictions, suspensions, and any other information related to past performance and likely compliance with proper coding and classification of employees requested by the applicable agency.
- The Vendor is required to report information on any violations that occurred in the previous 12 months.
- (a) (2) Vendor is required to provide a list of subcontractors on the job along with lists of subcontractor's subcontractors and by whom those subcontractors are insured for workers' compensation purposes. Include additional pages if necessary. This is not a requirement for subcontractor's providing supplies only and no labor to the overall contract or project.

In order for a Vendor's response to be considered valid, Vendors must complete and submit the following two (2) forms at time of bid:

Workers' Compensation; State Contracts Compliance Requirement; Self Reporting

Workers' Compensation; State Contracts Compliance Requirement; Subcontractor Reporting

7.15 Certificate of Compliance

This form must be completed and submitted as part of the response for the proposal to be considered valid.

7.16 Offshore Outsourcing Questionnaire

This form must be completed and submitted as part of the proposal to be considered valid.

7.17 Price Guarantee

Contractor is required to maintain its price for a fixed period of time. Provide an hourly rate for future work should an extension of the Contractor's services be requested.

7.18 Terms and Conditions for Technology Contracts

The State will reserve the right to terminate a Contract upon discovery that a Contractor is in violation of any portion of the Contract.

Vendors planning to submit a bid are advised of the following:

1. All contracts are subject to review and approval by the Chief Information Officer, the Office of the Attorney General and the Secretary of Administration.

2. The Vendor should guarantee that its rate offerings, over the term of the Contract, are comparable to other customers of similar size and requirements. If offerings are rendered to a comparable customer which improve the pricing agreed to in the Contract, the Vendor agrees to apply those same discounts and offerings to the State of Vermont.
3. The State of Vermont has no legal authority to indemnify a Vendor, nor limit the liability of the Vendor from third party claims against the Vendor. These 2 conditions are not negotiable. Vendors who are not able to legally enter into a Contract under those conditions should not submit a bid.

Required Project Policies, Guidelines and Methodologies

The Contractor shall be required to comply with all applicable laws, regulations, policies, standards, fingerprint supported background checks, and guidelines affecting State of Vermont IT projects, which may be created or changed periodically. It is the responsibility of the Contractor to insure adherence and to remain abreast of new or revised Laws, regulations, policies, standards and guidelines affecting project execution. These may include, but are not limited to:

- Health Insurance Portability and Accountability Act (HIPAA)
- The State's Enterprise Architecture Program
- The State Information Technology Security Policy and Standards
- The State Digital Imaging Guidelines
- The State File Formats Policy and Guidelines
- The State's Record Management Best Practice

The above policies and/or guidelines can all be found here: http://dii.vermont.gov/Policy_Central

Attachment A: Certificate of Compliance

This form must be completed in its entirety and submitted as part of the response for the proposal to be considered valid.

TAXES: Pursuant to 32 V.S.A. § 3113, Vendor hereby certifies, under the pains and penalties of perjury, that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due to the State of Vermont as of the date this statement is made. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes.

INSURANCE: Vendor certifies that the company/individual is in compliance with, or is prepared to comply with, the insurance requirements as detailed in Section 7 of Attachment C: Standard State Contract Provisions. Certificates of insurance must be provided prior to issuance of a contract and/or purchase order. If the certificate(s) of insurance is/are not received by the Office of Purchasing & Contracting within five (5) days of notification of award, the State of Vermont reserves the right to select another vendor. Please reference the RFP when submitting the certificate of insurance.

CONTRACT TERMS: The undersigned hereby acknowledges and agrees to Attachment C: Standard State Contract Provisions.

TERMS OF SALE: The undersigned agrees to furnish the products or services listed at the prices quoted. The Terms of Sales are Net 30 days from receipt of service or invoice, whichever is later. Percentage discounts may be offered for prompt payments of invoices; however such discounts must be in effect for a period of 30 days or more in order to be considered in making awards.

Form of Payment: Would you accept the Visa Purchasing Card as a form of payment? __ Yes __ No

Insurance Certificate(s): Attached _____will provide upon notification of award _____

Delivery Offered: _____ days after notice of award Terms of Sale: _____
(If Discount)

Quotation Valid for: _____ days Date: _____

Name of Company: _____ Contact Name: _____

Address: _____ Fax Number: _____

_____ E-mail: _____

By: _____ Name: _____
Signature (Bid Not Valid Unless Signed) (Type or Print)

Worker's Compensation; State Contracts Compliance Requirement

RFP/PROJECT:
DATE:

WORKERS' COMPENSATION; STATE CONTRACTS COMPLIANCE REQUIREMENT
Self-Reporting
Form 1 of 2

This form must be completed in its entirety and submitted as part of the response for the proposal to be considered valid.

The Department of Buildings and General Services in accordance with Act 54, Section 32 of the Acts of 2009 and for total projects costs exceeding $250,000.00, requires Vendors comply with the following provisions and requirements.

Vendor is required to self-report the following information relating to past violations, convictions, suspensions, and any other information related to past performance relative to coding and classification for worker's compensation. The state is requiring information on any violations that occurred in the previous 12 months.

Summary of Detailed Information	Date of Notification	Outcome

WORKERS' COMPENSATION STATE CONTRACTS COMPLIANCE REQUIREMENT: Vendor hereby certifies that the company/individual is in compliance with the requirements as detailed in Act 54, Section 32 of the Acts of 2009.

Date: _____

Name of Company: _____ Contact Name: _____

Address: _____ Title: _____

_____ Phone Number: _____

E-mail: _____ Fax Number: _____

By: _____ Name: _____

Signature (Bid Not Valid Unless Signed)* (Type or Print)

*Form must be signed by individual authorized to sign on the Vendor's behalf.

RFP/PROJECT:

WORKERS' COMPENSATION; STATE CONTRACTS COMPLIANCE REQUIREMENT

Subcontractor Reporting
Form 2 of 2

This form must be completed in its entirety and submitted as part of the response for the proposal to be considered valid.

The Department of Buildings and General Services in accordance with Act 54, Section 32 of the Acts of 2009 and for total projects costs exceeding $250,000.00 requires bidders to comply with the following provisions and requirements.

Bidder is required to provide a list of subcontractors on the job along with lists of subcontractor's subcontractors and by whom those subcontractors are insured for workers' compensation purposes. Include additional pages if necessary. This is not a requirement for subcontractor's providing supplies only and no labor to the overall contract or project.

Subcontractor	Insured By		Subcontractor's Sub	Insured By

Date: _____

Name of Company: _____ Contact Name: _____

Address: _____ Title: _____

_____ Phone Number: _____

E-mail: _____ Fax Number: _____

By: _____ Name: _____
Signature (Bid Not Valid Unless Signed)* (Type or Print)

*Form must be signed by individual authorized to sign on the bidder's behalf.

Attachment B: Offshore Outsourcing Questionnaire

Vendors must indicate whether or not any services are or will be outsourced under the terms of any agreement with the State of Vermont. Indicate N/A if not applicable. This is required by the State of Vermont but cannot be used as an evaluation criterion under Federal Law.

Services:

Proposed Service to be Outsourced	Bid Total or Contract Estimate	Represents what % of total Contract Dollars	Outsourced Dollars	Outsourced Work Location (Country)	Subcontractor

If any or all of the services are or will be outsourced offshore, Vendors are required to provide a cost estimate of what the cost would be to provide the same services onshore and/or in Vermont.

Proposed Service to be Outsourced	Bid Total or Contract Estimate if provided Onshore	Bid Total or Contract Estimate if provided in Vermont	Cost Impact	Onshore Work Location	Subcontractor

Name of Bidder: _____ Signature of Bidder: _____ Date: _____

ATTACHMENT C: STANDARD STATE PROVISIONS
FOR CONTRACTS AND GRANTS

1. Entire Agreement: This Agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

2. Applicable Law: This Agreement will be governed by the laws of the State of Vermont.

3. Definitions: For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Sub-recipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement.

4. Appropriations: If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority. In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, and in the event federal funds become unavailable or reduced, the State may suspend or cancel this Grant immediately, and the State shall have no obligation to pay Sub-recipient from State revenues.

5. No Employee Benefits For Party: The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. Independence, Liability: The Party will act in an independent capacity and not as officers or employees of the State.

The Party shall defend the State and its officers and employees against all claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit.

After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party.

The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party.

7. Insurance: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverage's are in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the state through the term of the Agreement. No warranty is made that the coverage's and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.
General Liability and Property Damage: With respect to all operations performed under the contract, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

- Premises - Operations
- Products and Completed Operations
- Personal Injury Liability
- Contractual Liability
- The policy shall be on an occurrence form and limits shall not be less than:
- $1,000,000 Per Occurrence
- $1,000,000 General Aggregate
- $1,000,000 Products/Completed Operations Aggregate
- $ 50,000 Fire/Legal/Liability

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than: $1,000,000 combined single limit.
Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

8. Reliance by the State on Representations: All payments by the State under this Agreement will be made in reliance upon the accuracy of all prior representations by the Party, including but not limited to bills, invoices, progress reports and other proofs of work.

9. Requirement to Have a Single Audit: In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Sub-recipient will complete the Sub-recipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a single audit is required for the prior fiscal year. If a single audit is required, the Sub-recipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Sub-recipient Annual Report is required.

A single audit is required if the Sub-recipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. The Sub-recipient Annual Report is required to be submitted within 45 days, whether or not a single audit is required.

10. Records Available for Audit: The Party will maintain all books, documents, payroll papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the Agreement and for three years thereafter for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this Agreement.

11. Fair Employment Practices and Americans with Disabilities Act: Party agrees to comply with the requirement of Title 21V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement. Party further agrees to include this provision in all subcontracts.

12. Set Off: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

13. Taxes Due to the State**: a. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

b. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

c. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

d. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

14. Child Support: (Applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she: a. is not under any obligation to pay child support; or
b. is under such an obligation and is in good standing with respect to that obligation; or
c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.
Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

15. Sub-Agreements: Party shall not assign, subcontract or sub-grant the performance of his Agreement or any portion thereof to any other Party without the prior written approval of

the State. Party also agrees to include in all subcontract or sub-grant agreements a tax certification in accordance with paragraph 13 above.

16. No Gifts or Gratuities: Party shall not give title or possession of anything of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

17. Copies: All written reports prepared under this Agreement will be printed using both sides of the paper.

18. Certification Regarding Debarment: Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing/debarment

19. Certification Regarding Use of State Funds: In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

(End of Standard Provisions)

ATTACHMENT D
Sample Contract

STATE OF VERMONT Contract #:
STANDARD CONTRACT FOR SERVICES

1.**Parties.** This is a contract for services between the **State of Vermont, Green Mountain Care Board** (hereafter called **"State"**), and _____, (hereafter called **"Contractor")** with principal place of business at _____ . Contractor's form of business organization is ____. It is the Contractor's responsibility to contact the Vermont Department of Taxes to determine if, by law, the Contractor is required to have a Vermont Department of Taxes Business Account number.

2. **Subject Matter.** The subject matter of this contract is development of a data analytic plan. Detailed services to be provided by the Contractor are described in Attachment A.

3. **Maximum Amount**. In consideration of the services to be performed by Contractor, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed **$ _____.** The State does not guarantee the assignment of any minimum number of hours or any other work under the contract.

4. **Contract Term.** The period of Contractor's performance shall begin on _____ and end on _____.

5. **Prior Approvals.** If approval by the Attorney General's Office, Secretary of Administration or the CIO/Commissioner DII is required (under current law, bulletins, and interpretations), neither this contract nor any amendment to it is binding until it has been approved by any or all such persons.

- Approval by the Attorney General's Office is required.
- Approval by the Secretary of Administration is not required.
- Approval by the CIO/Commissioner DII is not required.

6. **Amendment.** No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and Contractor.

7. **Cancellation.** This contract may be canceled by the State by giving written notice at least 30 days in advance. The Contractor may cancel this contract by giving 120 days written notice in advance.

8. **Attachments**. This contract consists of _____ pages including the following attachments which are incorporated herein:
Attachment A - Specifications of Work to be Performed
Attachment B - Payment Provisions
Attachment C – Standard State Contract Provisions
Attachment D - Other Provisions.

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

By the State of Vermont:
Date: _____

Signature: _____

Name:

By the Contractor:
Date: _____

Signature: _____

Name:
Company:

PAYMENT PROVISIONS

1. The maximum amount payable under this contract for service and expenses shall not exceed $ _____. The State does not guarantee the assignment of any minimum number of hours or other work under this contract. The hourly rates for assigned staff are as follows:

2. Payments for subcontractors will only be made upon approval (See Attachment C, #15).

3. The State shall reimburse Contractor for travel expenses utilizing the most current General Services Administration Per Diem Study for lodging, meals and incidentals. Expenses will not be reimbursed without prior written approval from the State.

4. Contractor will submit an invoice on a monthly basis to the State for services provided and expenses incurred during the previous month. Invoice must include unique invoice number, dates of service, itemized hours being invoiced, a list of allowable expenses incurred and the address for remittance of payment. A billing for mileage shall include the points of origin and destination and the number of miles traveled. Only actual charges will be paid.

8. Invoices shall be submitted to:

Janet Richard
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

ATTACHMENT E
OTHER CONTRACT PROVISIONS

1. Confidentiality

Contractor agrees to keep information related to the State and all agencies and companies related to this contract confidential and agrees not to use any information obtained in relation to the services performed under this contract for any purpose other than as authorized by the State. Contractor agrees not to publish, reproduce, or otherwise divulge such information in whole or in part, in any manner or form or authorize or permit others to do so. Contractor will take reasonable measures as are necessary to restrict access to confidential information in the Contractor's possession to those employees who must have the information to perform their job. Contractor agrees to immediately notify, in writing, the State's authorized representative in the event Contractor determines or has reason to suspect a breach of this requirement.

2. Obligations Regarding Protected Information

Contractor shall assure compliance by the State and Contractor of any and all obligations the State or Contractor may have under HIPAA and any other applicable state or federal law regarding protected health, personal, or otherwise confidential information.

3. Security

Contractor shall maintain security and confidentiality policies and procedures consistent with industry standards with regard to the information obtained from regulated entities. Contractor shall have recovery procedures in place to handle replacement of data in the event of a disaster.

4. Conflicts of Interest

If the State determines that a conflict of interest, as defined by the State, exists between a regulated entity and a member or members of the Contractor's staff, the Contractor shall substitute similarly qualified individuals for the conflicted members. If the State determines that a conflict of interest, as determined by the State, exists between Contractor and a regulated entity, the State may immediately remove that assignment from the Contractor, or may invoke its right to terminate this contract pursuant to paragraph 7 on page 1 of this contract. The State reserves the right to make the ultimate determination as to whether a conflict of interest exists.

5. Protection of Personal Information

Contractor agrees to establish and maintain policies and procedures designed to ensure compliance with 9 V.S.A. Chapter 62 (Protection of Personal Information) with respect to data collected in connection with Contractor's activities pursuant to the Contract.

ATTACHMENT F
COMMERCIAL ACO STANDARDS

Vermont Commercial ACO Pilot
Compilation of Pilot Standards

Revised to include technical corrections approved by the ACO Standards Work Group on November 26, 2013
Revised for Technical Corrections on December 16, 2013

This document contains ACO commercial pilot standards reviewed and approved by the Green Mountain Care Board and the Vermont Health Care Improvement Project Steering Committee during November 2013.

ACO pilot standards are organized in the following categories:

- Standards related to the ACO's structure:
  - Financial Stability
  - Risk Mitigation
  - Patient Freedom of Choice
  - ACO Governance

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
  - Care Management
  - Payment Alignment
  - Data Use Standards

The objectives and details of each draft standard follow.

I. Financial Stability

Objective: Protect ACOs from 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).

A. Standards related to the effects of provider coding patterns on medical spending and risk scores

1. Payers will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.

B. Standards related to downside risk limitation

1. The Board has established that for the purposes of the pilot program, the ACO will assume the following downside risk in each pilot program year:
    - Year 1: no downside risk
    - Year 2: no downside risk
    - Year 3: downside risk not less than 3% and up to 5%

2. ACOs are required to submit a Risk Mitigation Plan to the state that demonstrates that the ACO has the ability to assume not less than 3% and up to 5% downside risk in Year Three and receive state approval. Such a plan may, but need not include, the following elements: recoupment from payments to participating providers, stop loss protection, reinsurance, a provider payment withhold provision, and reserves (e.g., irrevocable letter of credit, escrow account, surety bond).

3. The Risk Mitigation Plan must include a downside risk distribution model that does not disproportionately punish any particular organization within the ACO and maintains network adequacy in the event of a contract year in which the ACO has experienced poor financial performance.

C. Standards related to financial oversight.

1. The ACO will furnish financial reports regarding risk performance to the VHCIP Payment Models Work Group or its successor[1] and to the GMCB on a semi-annual basis by June 30th and December 31st in accordance with report formats defined by the GMCB.

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. ACOs are required to demonstrate that actual or projected enrollment meets or exceeds a minimum of 60,000 annually attributed member months in aggregate.

2. Participating insurers must not participate with a given ACO should projected or actual attributed member months with that ACO fall below 36,000 annually.

E. The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.

[1] All future references to the VHCIP Payment Models Work Group should be understand to mean that work group or its successor.

II. Risk Mitigation

The ACOs must provide the GMCB with a detailed plan to mitigate the impact of the maximum potential loss on the ACO and its provider network in Year 3 of the commercial ACO pilot. Such a plan must establish a method for repaying losses to the insurers participating in the pilot. The method may include recoupment from payments to its participating providers, stop loss reinsurance, surety bonds, escrow accounts, a line of credit, or some other payment mechanism such as a withhold of a portion of any previous shared savings achieved. The ACO must provide documentation, of its ability to repay such losses 90 days prior to the start of Year 3.

Any requirements for risk mitigation, as noted above, will be the responsibility of the ACO itself, and not of the participating providers. The burden of holding participating providers financially accountable shall rest with the ACO, and the ACO should be able to exhibit their ability to manage the risk as noted above.

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

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

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. 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 ACO activities;
    c. making meeting minutes available to the ACO's provider network upon request, and
    d. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control 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:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

b. 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. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

   The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of 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 ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution

An ACO must have at least 60,000 member months attributed annually in the commercial Exchange pilot to the participating insurers in the aggregate and at least 36,000 member months attributed annually to each insurer in the commercial Exchange in order to participate in the pilot with that insurer.

Patients will be attributed to an ACO as follows:
1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
    - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
    - The insurer is the primary payer.

3. For products that require members to select a primary care provider, attribute those members to that provider.

4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[2] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409

[2] Should the Blueprint for Health change the qualifying CPT codes to be other than those listed in this table, the VHCIP Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
• New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least monthly.

9. The VHCIP Payment Models Work Group will reconsider whether OB/Gyns should be added to the attributing clinician list during Year 1.

VI. Calculation of ACO Financial Performance and Distribution of Reconciliation Payments

(See Attachment R for model calculations)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.
Years 1 and 2: The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services

(see below), high-cost outliers[3], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2.
The ACO-responsible services used to define expected spending shall include all covered services except for:

1. services that are carved out of the contract by self-insured employer customers
    - prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion, and
2. dental benefits [4].

Year 3: The Year 3 expected spending shall be calculated using an alternative methodology to be developed through the Payment Models Work Group and recommended to the GMCB Board for approval. The employed trend rate will be made available to the insurers prior to the deadline for GMCB rate submission in order to facilitate the calculation of premium rates for the Exchange. It is the shared intent of the pilot participants and the GMCB that the methodology shall not reduce expected spending based on any savings achieved by the pilot ACO(s) in the first two years.

The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.
Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

As noted above, the Year 3 targeted spending shall be calculated using an alternative methodology to be developed by the VHCIP Payment Models Work Group and approved by the GMCB.

[3] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.
[4] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

Actions Initiated After the Performance Year Ends

Step 3: Determine actual spending and whether the ACO has generated savings.
No later than eight months (i.e., two months following the six-month claim lag period) following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using a common methodology across commercial insurers;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000, and
- conversion from allowed to paid claims value.

For Years 1 and 2, insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold. The GMCB and participating pilot insurers and ACOs will reassess this practice during Years 1 and 2 for Year 3.

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

In Years 1 and 2 of the pilot:

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

In Year 3 of the pilot:
The formula for distribution of insurer-specific savings will be the same as in Years 1 and 2, except that the ACO will be responsible for a percentage % of the insurer-specific excess spending up to a cap equal to an amount no less than 3% and up to 5% of the ACO's insurer-specific expected spending.

All participating ACOs shall assume the same level of downside risk in Year 3, as approved by the VHCIP Payment Models Work Group and the GMCB.

The calculation of the ACO's liability will be as follows:

- If the ACO's total actual spending is greater than the total expected spending (called "excess spending"), then the ACO will assume responsibility for insurer-specific actual medical expense spending that exceeds the insurer-specific expected spending in a way that is reciprocal to the approach to distribution of savings.
- If the insurer-specific excess spending is less than the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 25% of the insurer-specific excess spending.
- If the ACO's excess spending exceeds the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 60% of the insurer-specific excess spending over the difference, up to a cap equal to an amount no greater than 5% of the ACO's insurer-specific expected spending.

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap. [5]

[5] A reciprocal approach shall apply to ACO excess spending in Year3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.

Step 4: Assess ACO quality performance to inform savings distribution.
The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

Methodology for distribution of shared savings: For year one of the commercial pilot, compare the ACO's performance on the payment measures (see Table 1 below) to the PPO HEDIS national percentile benchmark[6] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

Table 1. Core Measures for Payment in Year One of the Commercial Pilot

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 Nat. 50th: .78 Nat. 25th: .83 *Please note, in interpreting this measure, a lower rate is better.
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 89.74 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
Core - 5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	Claims	Nat. 90th: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09

[6] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

	NQF #0004, NCQA HEDIS IET CMMI		
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The 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 shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

Table 2. Distribution of Shared Savings in Year One of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months

of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month claim lag period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

VII. Care Management Standards (*still under development but not expected to have any material relevance to the work of the Analytics Contractor.)*

Objective: Effective care management programs close to, if not at the site of care, for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. Any standards will be developed by the VHCIP Care Models Work Group. For Year 1 of the pilot emphasis will be placed upon member communication and care transitions.

VIII. Payment Alignment

Objective: Improve 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.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
    a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
    b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO Data Use Standards (*still under development but not expected to have any material relevance to the work of the Analytics Contractor beyond that already referenced in this RFP.)*

X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs

VHCIP Quality and Performance Measures Work Group
Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs
January 13, 2014 Work Group Recommendation (Subject to GMCB Review and Approval)

Standard:

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set at the beginning of the third 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 at the beginning of the third quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth 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** during the third 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.

ATTACHMENT G
MEDICAID ACO STANDARDS
As of December 27, 2013

Note: "Contractor" in this Attachment G refers to an ACO that has contracted with DVHA.

I. Calculation of Contractor Financial Performance and Shared Savings

A. Summary of Model Specifications

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

The Contractors 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 Contractors electing to pursue the alternative methodology. The alternative methodology would increase the maximum sharing rate of 50% for the Contractor by 10% to 60% if the Contractor 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 Contractor in writing of which non-core service expenditures will be required no later than October 1, 2014. The Contractor would elect the optional track in writing no later than November 1, 2014.

The Contractors 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 Contractor elected to participate in the option described in the paragraph above, the Contractor will continue to receive the additional 10% addition to the maximum sharing rate of 50% (or 60%). The State will notify the Contractor 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

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.

Non-Core Service expenditures also includes 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 June-July, 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 a methodology communicated by DVHA to the Contractor**.**
    i. For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years.
    ii. For 2015, CYs 2011, 2012, 2013 will be benchmark years.
    iii. 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 using a methodology communicated by DVHA to the Contractor**.**

d. If required, adjust utilization of inpatient hospital, emergency room, ambulatory and specialty services for attributed members participating in the Care Alliance for Opiod Addiction using a methodology communicated by DVHA to the Contractor**.** e. For all other services, the allowed amounts reported on the claims were 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. Trend the expenditures within each of the four enrollment categories using a Cumulative Average Growth Rate (CAGR) at the category of service level. Because the benchmark years are lagged, expenditures for each category of service will be trended forward two full years to project expenditures in the performance year (PY)

6. Sum the trended expenditures within each of the four enrollment categories to derive total trended expenditures in the PY.

7. For PY1, the expenditures 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 account for any changes or additional rate increases.

8. For beneficiaries enrolled less than 12 months, calculate a per member per month (PMPM) expenditure per person based on the number of months enrolled in the CY. Then 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 June-July, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The TCOC will be calculated for each of the four enrollment categories for the beneficiaries attributed to the Contractor using Medicaid claims data and enrollment files. TCOC shall be defined to include all paid claims for the Contractor-responsible core services using a methodology communicated by DVHA to the Contractor.)

Actual TCOC will be calculated using by:

1. Running the attribution algorithm using a methodology communicated by DVHA to the Contractor 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 will be communicated by DVHA to the Contractor**.**
   i. Re-price the FQHC/RHC encounter rates using a methodology communicated by DVHA to the Contractor**.**

3. 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.

4. Expenditures are truncated at the 99th percentile for each enrollment category using a methodology communicated by DVHA to the Contractor**.**

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

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

7. The same weighting of annualized member months in the performance year is applied to the four enrollment category Expected PMPM TCOCs using a methodology communicated by DVHA to the Contractor to derive a single weighted Expected PMPM TCOC.

8. 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 using a methodology communicated by DVHA to the Contractor, by TMM, using a methodology communicated by DVHA to the Contractor**.**
2) Multiplying the Expected PMPM, using a methodology communicated by DVHA to the Contractor, by TMM, using a methodology communicated by DVHA to the Contractor
3) Subtracting #2 from #1 above.

G. Total Eligible Savings Amount

Based on the calculation using a methodology communicated by DVHA to the Contractor 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.

1. 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 Contractor in that performance year. The MSR shall serve as the threshold necessary to share in savings.

   The State or its designee will calculate the MSR based on the table and formula below:

Minimum Savings Rate by Number of Assigned Beneficiaries (One-Sided Model)

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%

MSRs which are in between the stated endpoints are calculated using the equation specified below, 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)

If total savings are greater than or equal to the MSR, then the Contractor would be eligible to share in the savings. If not, the Contractor would not be eligible to share in savings.

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

3. The final shared amount is subject to a cap equal to 10% of total actual expenditures in the performance year calculated using a methodology communicated by DVHA to the Contractor.

4. The final sharing rate is equal to the product of the Contractor's quality score and the maximum sharing rate. Computation of the quality score uses a methodology communicated by DVHA to the Contractor.

ATTACHMENT H
TIMELINE FOR CALCULATION OF SAVINGS

Timeline and Process for Calculation of ACO Financial Performance and Payment Distribution
As of December 15, 2013

Date	Action	Responsible Party	Details
January 31, 2014[7]	Determine the expected PMPM medical expense for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending" for Year 1	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "insurer-specific expected spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of expected spending.
January 31, 2014	Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO for Year 1	GMCB analytics contractor	Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population.
January 31, 2014	The GMCB approves the target rate for Year 1	GMCB	The GMCB will review the targeted spending calculations and notify the relevant payers and providers of the approved rate.

[7] January and February 2014 dates subject to revision based on timeline for Analytics Contractor RFP release and contract award and start dates.

Date	Action	Responsible Party	Details
February 28, 2014	Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO for Year 1	GMCB analytics contractor	The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[8], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2. 1. The ACO-responsible services used to define expected spending shall include all covered services except for: 3. services that are carved out of the contract by self-insured employer customers 4. prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following SIM Payment Models Work Group discussion, and 5. dental benefits [9].
November 30, 2014	Determine the expected PMPM medical expense for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending" for Year 2	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "insurer-specific expected spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of expected spending.

[8] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.
[9] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

Date	Action	Responsible Party	Details
November 30, 2014	Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO for Year 2	GMCB analytics contractor	Years 1 and 2: The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[10], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2. 1. The ACO-responsible services used to define expected spending shall include all covered services except for: a. services that are carved out of the contract by self-insured employer customers b. prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following SIM Payment Models Work Group discussion, and c. dental benefits[11].
November 30, 2014	Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO for Year 2	GMCB analytics contractor	Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population.
November 30, 2014	The GMCB approves the target rate for Year 2	GMCB	The GMCB will review the targeted spending calculations and notify the relevant payers and providers of the approved rate.

[10] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.
[11] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

Date	Action	Responsible Party	Details
April 30, 2015	Calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending	GMCB analytics contractor	The GMCB's analytics contractor will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad and inform the insurers and ACOs of the results, providing supporting documentation when doing so.
May 15, 2015	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.	Insurer	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible. The insurers must notify the GMCB that they have offered the ACOs this opportunity.
August 31, 2015	Determine actual spending and whether the ACO has generated savings for Year 1.	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "actual medical expense spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of actual medical expense spending.

Date	Action	Responsible Party	Details
August 31, 2015	Compare the actual spending for each ACO to its expected spending.	GMCB analytics contractor	The GMCB's analytics contractor will a conduct the aggregate assessment: a. If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer. b. If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers. c. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer. Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level. Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step In Years 1 and 2 of the pilot: a. If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings. b. If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending). c. An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

Date	Action	Responsible Party	Details
August 31, 2015	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2015	Notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of this aggregate and insurer specific assessments after the completion of the GMCB's analytics contractor's analysis.
September 15, 2015	Savings distributed to contracted ACOs for Year 1	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.
November 30, 2015	Determine the expected PMPM medical expense for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending" for Year 3	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "insurer-specific expected spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of expected spending.

Date	Action	Responsible Party	Details
November 30, 2015	Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO for Year 3	GMCB analytics contractor	The Year 3 expected spending shall be calculated using an alternative methodology to be developed through the Payment Models Work Group and recommended to the GMCB Board for approval
November 30, 2015	Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO for Year 3	GMCB analytics contractor	Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population.
November 30, 2015	The GMCB approves the target rate for Year 3	GMCB	The GMCB will review the targeted spending calculations and notify the relevant payers and providers of the approved rate.
April 30, 2016	Calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending	GMCB analytics contractor	The GMCB's analytics contractor will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad and inform the insurers and ACOs of the results, providing supporting documentation when doing so.

Date	Action	Responsible Party	Details
May 15, 2016	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.	Insurer	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible. The insurers must notify the GMCB that they have offered the ACOs this opportunity.
August 31, 2016	Determine actual spending and whether the ACO has generated savings for Year 2	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "actual medical expense spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of actual medical expense spending.

Date	Action	Responsible Party	Details
August 31, 2016	Compare the actual spending for each ACO to its expected spending for Year 2.	GMCB analytics contractor	The GMCB's analytics contractor will a conduct the aggregate assessment: a. If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer. b. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers. c. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer. Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis ("insurer-specific actual spending"). The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level. The ACO's share of savings will be determined in two phases: the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending and ACO performance on quality measures. In Years 1 and 2 of the pilot: a. If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings. b. If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending). c. An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

Date	Action	Responsible Party	Details
August 31, 2016	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2016	Notify each ACO and insurer dyad of results of this aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments after the completion of the GMCB's analytics contractor's analysis.
September 15, 2016	Savings distributed to contracted ACOs for Year 2	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.
April 30, 2017	Calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending.	GMCB analytics contractor	The GMCB's analytics contractor will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad and inform the insurers and ACOs of the results, providing supporting documentation when doing so.
May 15, 2017	The insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.	Insurer	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible. The insurers must notify the GMCB that they have offered the ACOs this opportunity.

Date	Action	Responsible Party	Details
August 31, 2016	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2016	Notify each ACO and insurer dyad of results of this aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments after the completion of the GMCB's analytics contractor's analysis.
September 15, 2016	Savings distributed to contracted ACOs for Year 2	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.
August 31, 2017	Determine actual spending and whether the ACO has generated savings for Year 3	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "actual medical expense spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of actual medical expense spending.

Date	Action	Responsible Party	Details
August 31, 2017	Compare the actual spending for each ACO to its expected spending.	GMCB analytics contractor	The GMCB's analytics contractor will a conduct the aggregate assessment: a. If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer. b. If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers. c. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.
August 31, 2017	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2017	Notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of this aggregate assessment after the completion of the GMCB's analytics contractor's analysis.
September 15, 2017	Savings distributed to contracted ACOs for Year 3	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

ATTACHMENT I
CORE MEASURE SET
Current as of January 16, 2014

I. VERMONT ACO CORE MEASURE SET

The Core Measure set consists of those measures for which the ACO has accountability for either reporting or payment purposes. The measures designated for monitoring and evaluation are not considered Core Measures. **(32 measures for Year 1 payment and reporting; 23 Year 1 pending measures)**

1. **Commercial and Medicaid Quality Measures for Payment (8 measures):** *ACO performance on measures designated for "payment" will be considered when calculating shared savings. The payers will be responsible for submitting all of the relevant claims files for these measures to the state Analytics Contractor. The Analytics Contractor will be responsible for calculating performance on the measures for the Medicaid population, for the individual commercial payer populations, and for the combined commercial populations for each ACO. All payment measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Year Two and/or Three as a result of these annual reviews.*

   a. **Claims-based Measures for Payment in Year One (8 measures):**
      1. (Core-1) All-Cause Readmission
      2. (Core-2) Adolescent Well-Care Visit
      3. (Core-3a) Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)[12]
      4. (Core-4) Follow-up After Hospitalization for Mental Illness, 7 day
      5. (Core-5) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
      6. (Core-6) Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis
      7. (Core-7) Chlamydia Screening in Women
      8. (Core-8) *Developmental Screening in the First Three Years of Life (Medicaid only)*
      ~~9.~~ *[(Core-9) Depression Screening by 18 years of age was removed from the measure set prior to finalization and was not presented to or approved by the GMCB.]*

2. **Commercial and Medicaid Quality Measures for Reporting (24 measures):** *ACOs will be required to provide information to the state Analytics Contractor on the clinical data-based Reporting measures*

[12] Core-3a is the claims-based HEDIS measure "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) and will be used for payment until Core 3b, the clinical data-based "IVD: Complete Lipid Panel and LDL Control" measure which is currently pending, is ready to be used for payment, at which point it will replace Core 3a.

either through electronic means or as a result of chart reviews. If payers are collecting data on the clinical data-based measures in a way that allows them to determine ACO-level performance, the payers may provide information to the Analytics Contractor on behalf of the ACO. Performance on these measures will not be considered when calculating shared savings. All reporting measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Year Two and/or Three as a result of these annual reviews.

a. **Claims-based Measures for Reporting in Year One (4 measures):**
   1. (Core-10/ MSSP-9) Ambulatory Care-Sensitive Conditions Admissions: COPD[13]
   2. (Core-11/ MSSP-20) Mammography /Breast Cancer Screening
   3. (Core-12) Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
   4. (Core-13) Appropriate Testing for Children with Pharyngitis

b. **Clinical Data-based Measures for Reporting in Year One (11 measures):**
   1. (Core-14) Childhood Immunization Status (Combo 10)
   2. (Core-15) Pediatric Weight Assessment and Counseling
   3. (Core-16a/ MSSP 22) Diabetes Composite (D5) (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)
   4. (Core-16b/ MSSP 23) Diabetes Composite (D5) (All or Nothing Scoring): Low Density Lipoprotein (<100)
   5. (Core-16c/ MSSP 24) Diabetes Composite (D5) (All or Nothing Scoring): Blood Pressure <140/90
   6. (Core-16d/ MSSP 25) Diabetes Composite (D5) (All or Nothing Scoring): Tobacco Non-Use
   7. (Core-16e/ MSSP 26) Diabetes Composite (D5) (All or Nothing Scoring): Aspirin Use
   8. (Core-17/ MSSP-27) Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)
   9. (Core-18/ MSSP-19) Colorectal Cancer Screening
   10. (Core-19/ MSSP-18) Depression Screening and Follow-up
   11. (Core-20/ MSSP-16) Adult Weight (BMI) Screening and Follow-up

c. **Patient Experience Measures for Reporting in Year One (9 measures):**
   1. (Core-21) Access to Care Composite
   2. (Core-22) Communication Composite
   3. (Core-23) Shared Decision-Making Composite
   4. (Core-24) Self-Management Support Composite
   5. (Core-25) Comprehensiveness Composite
   6. (Core-26) Office Staff Composite
   7. (Core-27) Information Composite

[13] Any ACO participating in the MSSP is required to submit MSSP measure results for the Medicare population (with the exclusion of the patient experience measures) to the GMCB for review.

8. (Core-28) Coordination of Care Composite
9. (Core-29) Specialist Composite

3. <u>Commercial and Medicaid Quality Measures Pending in Year One (23 measures):</u> *Measures designated as "pending" are included in the core measure set, but are not required for reporting in Year One. Pending measures are considered to be of importance to the ACO pilot, but are not required for initial reporting for one of the following reasons: the target population is not presently included in the pilot, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely-accepted specifications, or the measure is presently overly burdensome to collect. All pending measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Year Two and/or Three as a result of these annual reviews.*

a. Pending claims-based measures (1 measure):

1. (Core-49) *Use of High Risk Medications in the Elderly (Medicaid only, duals-specific measure)*

b. Pending clinical data-based measures (20 measures):

1. (Core- 3b/ MSSP-29) Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)[14]
2. (Core-30) Cervical Cancer Screening
3. (Core-31/ MSSP-30) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
4. (Core-32) Proportion not admitted to hospice (cancer patients)
5. (Core-33) Elective delivery before 39 weeks
6. (Core-34) Prenatal and Postpartum Care
7. (Core-35/ MSSP-14) Influenza Immunization
8. (Core-36/ MSSP-17) Tobacco Use Assessment and Tobacco Cessation Intervention
9. (Core-37) Care Transition-Transition Record Transmittal to Health Care Professional
10. (Core-38a/ MSSP-32) Coronary Artery Disease (CAD) Composite: Lipid Control
11. (Core-38b/ MSSP-33) Coronary Artery Disease (CAD) Composite: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy-Diabetes of Left Ventricular Systolic Dysfunction (LVEF <40%)
12. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure
13. (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented
14. (Core-43) *Frequency of Ongoing Prenatal Care (Medicaid only)*
15. (Core-44) *Percentage of Patients with Self-Management Plans (Medicaid only)*
16. (Core-45) *Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*

[14] Core-3a is the claims-based HEDIS measure "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) and will be used for payment until Core 3b, the clinical data-based "IVD: Complete Lipid Panel and LDL Control" measure which is currently pending, is ready to be used for payment, at which point it will replace Core 3a.

17. (Core-46) *Trauma Screen Measure (Medicaid only)*
18. (Core-47/ MSSP-13) *Falls: Screening for Future Fall Risk (Medicaid only, duals-specific measure)*
19. (Core-48/ MSSP-15) *Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only, duals-specific measure)*
20. (Core-50) *Persistent Indicators of Dementia without a Diagnosis (Medicaid only, duals-specific measure)*

c. Pending survey-based measures (2 measures):

1. (Core-41) How's Your Health?
2. (Core-42) Patient Activation Measure

ATTACHMENT J
MONITORING AND EVALUATION MEASURE SET
Current as of January 16, 2014

II. VERMONT ACO MONITORING & EVALUATION MEASURE SET

The Monitoring and Evaluation Measure Set consists of measures with one of three characteristics. First, it includes Monitoring measures that were not prioritized for Core Measure Set inclusion because baseline insurer-level performance suggests that there is not currently a sufficiently high opportunity for improvement to warrant such inclusion. Second, it includes Monitoring measures for which ACO level measurement is not presently feasible. Third, it includes a comprehensive set of service utilization and cost Evaluation measures.

Monitoring and Evaluation measures are distinctive from Core Measure Set Reporting and Payment measures in that they will have no bearing on shared savings and will not be collected at the ACO level; nonetheless, they are important to collect to inform programmatic evaluation and selection of measures for future inclusion in the Core Measure Set. These measures will be reported at the insurer, the state level, or both to the state Analytics Contractor. Data for these measures will be obtained from sources other than the ACO (e.g., health insurers, VHCURES, Department of Education). Performance on the Monitoring measures will be reviewed at the insurer or state level on an annual basis. The measures will remain Monitoring measures unless the Quality and Performance Measures Work Group, determines that there is an opportunity for improvement. The Work Group, with input from the Payment Models Work Group, may recommend at the measure should be moved to the Core Measure Set and performance assessed at the ACO level and used for either payment or reporting. **(23 measures in total)**

1. **Commercial and Medicaid Measures for Monitoring (9 measures):** *These are measures that all pilot participants would benefit from tracking and reporting. They are distinctive from Reporting and Payment in that they will have no bearing on shared savings; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the insurer level, the state level, or both, and will come from sources other than the ACO. All measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Years Two and/or Three as a result of these annual reviews.*

    a. **Claims-based Monitoring measures (6 measures):** *These measures will be reported by each payer and will be reported at the payer level rather than at the ACO level.*
        1. (M&E-1) Appropriate Medications for People with Asthma
        2. (M&E-2) Comprehensive Diabetes Care: Eye Exams for Diabetics
        3. (M&E-3) Comprehensive Diabetes Care: Medical Attention for Nephropathy
        4. (M&E-4) Use of Spirometry Testing in the Assessment and Diagnosis of COPD
        5. (M&E-5) Follow-up Care for Children Prescribed ADHD Medication
        6. (M&E-6) Antidepressant Medication Management

b. Survey-based Monitoring measures (1 measure):

7. (M&E-7) Family Evaluation of Hospice Care Survey

c. Monitoring measures derived from other non-ACO sources (2 measures):

8. (M&E-8) School Completion Rate
9. (M&E-9) Unemployment

2. <u>Commercial and Medicaid Measures for Evaluation (14 measures):</u>

These measures reflect utilization and cost metrics to be monitored on a quarterly basis for each ACO, and will be reported by each payer. Commercial information will be reported by individual commercial payer and for the combined commercial populations for each ACO. All measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Years Two and/or Three as a result of these annual reviews.

a. Claims-based Evaluation measures (14 measures):

1. (M&E-10) Health Partners TCOC: Total Cost Index (TCI)
2. (M&E-11) Health Partners TCOC: Resource Use Index (RUI)
3. (M&E-12) Ambulatory surgery/1000
4. (M&E-13) Average # of prescriptions PMPM
5. (M&E-14) Avoidable ED visits-NYU algorithm
6. (M&E-15) Ambulatory Care (ED rate only)
7. (M&E-16) ED Utilization for Ambulatory Care-Sensitive Conditions
8. (M&E-17) Generic dispensing rate
9. (M&E-18) High-end imaging/1000
10. (M&E-19) Inpatient Utilization - General Hospital/Acute Care
11. (M&E-20) Primary care visits/1000
12. (M&E-21) SNF Days/1000
13. (M&E-22) Specialty visits/1000
14. (M&E-23) *Annual Dental Visit (Medicaid only)*

b. Clinical data-based Evaluation measures (no measures)

- none

ATTACHMENT K
CORE MEASURE SET NARRATIVE SPECIFICATIONS
As of January 10, 2014

The draft specifications for the Core measures used for Payment or Reporting are below. The specifications for the pending measures will be determined by the VHCIP Quality and Performance Measures Work Group or its successor entity at the time when the measures are ready to be used for Payment or Reporting. The VHCIP Quality and Performance Measures Work Group or its successor entity will publish revised specifications in advance of each pilot year that details the specifications for any new measures and any changes from the previous year.

Core-1 (NCQA HEDIS; NQF # 1768): ACO All-Cause Readmission

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
For attributed individuals 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator)
2. Count of 30-Day Readmissions (numerator)
3. Average Adjusted Probability of Readmission
4. Observed Readmission (Numerator/Denominator)
5. Total Variance

DENOMINATOR:
Individuals attributed to the ACO ages 18-64 as of the Index Discharge Date.

NUMERATOR:
At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

EXCLUSIONS:
Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date and any inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Rather than applying this measure at the plan level, this measure will be applied to the ACO, therefore the title of the measure has been changed from "Plan All-Cause Readmission" to "ACO All- Cause Readmission."
3. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-2 (NCQA HEDIS): Adolescent Well-Care Visit

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:

The percentage of attributed individuals 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

DENOMINATOR:
The eligible population.

NUMERATOR:

At least one comprehensive well-care visit (Well-Care Value Set) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the attributed individual.

EXCLUSIONS: None

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-3 (NCQA HEDIS): Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:

The percentage of attributed individuals 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:

- LDL-C screening.

DENOMINATOR:
The eligible population.

NUMERATOR:
An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. The organization may use a calculated or direct LDL for LDL-C screening and control indicators

EXCLUSIONS: None

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

NOTE: Please note that Core-3 is counted in both the "payment" and "pending" categories since the claims-based LDL-screening will be used for payment until the clinical data-based NQF#0075/ MSSP-29 "Complete Lipid Panel and LDL Control" are ready to be used for payment, at which point, it will replace LDL screening.

Core-4 (NCQA HEDIS; NQF #0576): Follow-up After Hospitalization for Mental Illness, 7 day

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:

The percentage of discharges for attributed individuals 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. One rate is reported:

- The percentage of discharges for which the attributed individual received follow-up within 7 days of discharge.

DENOMINATOR:
The eligible population.

NUMERATOR:

An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set ***and*** FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set ***and*** FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner.

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).

EXCLUSIONS: None

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-5 (NCQA HEDIS; NQF #0004): Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:

The percentage of adolescent and adult attributed individuals with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment.* The percentage of attributed individuals who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of attributed individuals who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

DENOMINATOR:
The eligible population.

NUMERATOR:

***Initiation of AOD Treatment*:** Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the attributed individual is compliant.

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the attributed individual must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a diagnosis of AOD, within 14 days of the IESD (inclusive). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set.

- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.

If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).

Do not count Index Episodes that include inpatient detoxification or detoxification codes (Detoxification Value Set) as initiation of treatment. Exclude attributed individuals from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Engagement of AOD Treatment Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.

For attributed individuals who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).
Do not count engagement encounters that include inpatient detoxification or detoxification codes (Detoxification Value Set).

EXCLUSIONS: None

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-6 (NCQA HEDIS; NQF #0058): Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

DENOMINATOR:
The eligible population.

NUMERATOR:
Dispensed prescription for antibiotic medication (Table AAB-D) on or three days after the IESD.

EXCLUSIONS: None

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-7 (NCQA HEDIS; NQF #0033): Chlamydia Screening in Women

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

DENOMINATOR:
The eligible population.

NUMERATOR:
At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

EXCLUSIONS: None

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-8 (NCQA; NQF #1448): Developmental Screening in the First Three Years of Life

Programs Requiring Use of the Measure for 2014:

Commercial: _____ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: __X__ Reporting: ____

Name and date of specifications used: The Center for Medicare and Medicaid Services. Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resources Manual for Federal Fiscal Year 2012 Reporting. Updated November 2012.

URL of Specifications: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf

DESCRIPTION:
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

DENOMINATOR:
Indicator 1: Attributed individuals who turn 12 months of age between January 1 of the measurement year and December 31 of the measurement year
Indicator 2: Attributed individuals who turn 24 months of age between January 1 of the measurement year and December 31 of the measurement year
Indicator 3: Attributed individuals who turn 36 months of age between January 1 of the measurement year and December 31 of the measurement year

Claims data: CPT codes 96110 (Developmental testing, with interpretation and report)

NUMERATOR:
The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening over the first three years. The measure is based on three, age-specific indicators.

Indicator 1: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 12 months of age
Indicator 2: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 24 months of age

Indicator 3: Children who screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 36 months of age

EXCLUSIONS: None

MEASURE DETAILS:
See page 53 of The Center for Medicare and Medicaid Services. Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resources Manual for Federal Fiscal Year 2012 Reporting. Updated November 2012.

Current recommended tools:
- Ages and Stages Questionnaire (ASQ) - 2 months to 5 years
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to 2 years
- Brigance Screens-II – Birth to 90 months
- Child Development Inventory (CDI) - 18 months to 6 years
- Infant Development Inventory – Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

NOTE: Important Note About Appropriate Use of Claims Data: This measure is anchored to standardized tools that meet four criterion specified above. States who have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

MODIFICATIONS TO MEASURE SPECIFICATIONS:
Claims NOT Included in This Measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Future efforts should be made to develop complimentary measures focused specifically on autism screening (for which national recommendations exist) and a measure on social-emotional screening (for which a large number of ABCD states have been focused, are implementing and for which growing evidence supports).

Core-9 was not approved by the GMCB and has been removed from the Core measure set

Core-10 (NQF #0275; AHRQ PQI #05; MSSP-9): Ambulatory Care-Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013

URL of Specifications: www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2005%20COPD%20or%20Asthma%20in%20Older%20Adults%20Admission%20Rate.pdf

DESCRIPTION:
Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.

DENOMINATOR:
Population ages 40 years and older attributed to the ACO.

NUMERATOR:
Discharges, for patients ages 40 years and older with either:

- A principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis)
- A principal ICD-9-CM diagnosis code for asthma; or
- A principal ICD-9-CM diagnosis code for acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD (excluding acute bronchitis)
-

EXCLUSIONS: Exclude cases:

- With any listed ICD-9_CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system
- Transfer from a hospital (different facility)
- Transfer from a Skilled Nursing facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender, age, quarter, year, principal diagnosis, or county

MEASURE DETAILS:
Please see AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013 for technical specifications.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a metropolitan area or county.

Core-11 (NCQA HEDIS; NQF #0031; MSSP-20):
Preventive Care and Screening: Breast Cancer Screening

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

DENOMINATOR:
The eligible population.

NUMERATOR:
One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

EXCLUSIONS: (optional exclusions)
Bilateral mastectomy any time during the attributed individual's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral mastectomies (Unilateral Mastectomy Value Set) on different dates of service.
- Both of the following (on the same or a different date of service):
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same date of service).
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same date of service).

NOTE:

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds or MRIs because they are not appropriate methods for primary breast cancer screening.

MEASURE DETAILS:

See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-12 (PQI #92): Prevention Quality Chronic Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013

URL of Specifications: www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2092%20Prevention%20Quality%20Chronic%20Composite.pdf

DESCRIPTION:
Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population ages 18 and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower- extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.

DENOMINATOR:
Population ages 18 years and older attributed to the ACO.

NUMERATOR:
Discharges, for patients 18 years and older that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #1 Diabetes with short-term complications admission rate
- PQI #3 Diabetes with long-term complications admission rate
- PQI# 5 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate
- PQI # 7 Hypertension admission rate
- PQI #8 Heart failure admission rate
- PQI #13 Angina without a cardiac procedure admission rate
- PQI #14 Uncontrolled diabetes admission rate
- PQI #15 Asthma in younger adults admission rate
- PQI #16 Lower- extremity amputation among patients with diabetes

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

EXCLUSIONS: none

MEASURE DETAILS:
AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a metropolitan area or county.

Core-13 (NCQA HEDIS; NQF #0002): Appropriate Testing for Children with Pharyngitis

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

DENOMINATOR:
The eligible population.

NUMERATOR:
A Group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the IESD through three days after the IESD.

EXCLUSIONS: none

MEASURE DETAILS:
See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-14 (NCQA HEDIS; NQF #0038): Childhood Immunization Status (Combo 10)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Report Combination 10 only.

DENOMINATOR:
The eligible population.

NUMERATOR:

For MMR, hepatitis B, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result for each antigen.

For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count *only*:

- Evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.

DTaP	At least four DTaP vaccinations (DTaP Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
IPV	At least three IPV vaccinations (IPV Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
MMR	Any of the following with a date of service on or before the child's second birthday meet criteria:

- At least one MMR vaccination (MMR Value Set).
- At least one measles and rubella vaccination (Measles/Rubella Value Set) ***and*** at least one mumps vaccination (Mumps Value Set) on the same date of service or on different dates of service.
- At least one measles vaccination (Measles Value Set) ***and*** at least one mumps vaccination (Mumps Value Set) ***and*** at least one rubella vaccination (Rubella Value Set) on the same date of service or on different dates of service.

HiB At least three HiB vaccinations (HiB Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis B Either of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Value Set), with different dates of service.
- History of hepatitis (Hepatitis B Diagnosis Value Set).

VZV At least one VZV vaccination (VZV Value Set), with a date of service on or before the child's second birthday.

Pneumococcal conjugate At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A At least one hepatitis A vaccination (Hepatitis A Value Set), with a date of service on or before the child's second birthday.

Rotavirus Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.

- At least two doses of the two-dose rotavirus vaccine (Rotavirus Two-Dose Schedule Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus Three-Dose Schedule Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (Rotavirus Two-Dose Schedule Value Set) ***and*** at least two doses of the three-dose rotavirus vaccine (Rotavirus Three-Dose Schedule Value Set), all on different dates of service.

Influenza At least two influenza vaccinations (Influenza Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	Hep A	RV	Influenza
Combination	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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Medical record

For immunization evidence obtained from the medical record, organizations may count attributed individuals where there is evidence that the antigen was rendered from one of the following:

- A note indicating the name of the specific antigen and the date of the immunization.
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the attributed individual's second birthday.

Notes in the medical record indicating that the attributed individual received the immunization
"at delivery" or "in the hospital" may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "attributed individual is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

EXCLUSIONS: (optional)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the attributed individual's second birthday meet optional exclusion criteria:

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set).
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set), with a date of service prior to

October 1, 2011.

DTaP	• Encephalopathy (Encephalopathy Due To Vaccination Value Set) ***with*** a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).
MMR, VZV and influenza	• Immunodeficiency (Immunodeficiency Value Set). • HIV (HIV Value Set). • Lymphoreticular cancer (Lymphoreticular Cancer Value Set). • Multiple myeloma (Multiple Myeloma Value Set). • Leukemia (Leukemia Value Set). • Anaphylactic reaction to neomycin.
IPV	• Anaphylactic reaction to streptomycin, polymyxin B or neomycin.
Hepatitis B	• Anaphylactic reaction to common baker's yeast.

NOTE: Report Combination 10 only.

MEASURE DETAILS:
See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-15 (NCQA HEDIS; NQF #0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*.
- Counseling for nutrition.
- Counseling for physical activity.

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

DENOMINATOR:
The eligible population.

NUMERATOR:

BMI Percentile	BMI percentile (BMI Percentile Value Set) during the measurement year.
Counseling for Nutrition	Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.
Counseling for Physical Activity	Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.
Medical record	Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile.
- BMI percentile plotted on age-growth chart.

For attributed individuals who are younger than 16 years of age on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.

For adolescents 16–17 years on the date of service, documentation of a BMI value expressed as kg/m^2 is acceptable.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile or value, if applicable, is required for numerator compliance.

Counseling for Nutrition Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Attributed individual received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.

- Attributed individual received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance for physical activity.
- Weight or obesity counseling.

EXCLUSIONS: (optional)
Attributed individuals who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these attributed individuals must do so for all rates.

- **NOTE:** *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI or BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to an acute or chronic condition do not count toward the Counseling for nutrition and Counseling for physical activity indicators.*

MEASURE DETAILS:
See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-16 (MN Community Measurement; NQF #0024; MSSP 22-26): Optimal Diabetes Care (Diabetes Composite (D5))

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: MN Community Measurement, revised 9/19/2012

URL of Specifications: www.health.state.mn.us/healthreform/measurement/adoptedrule/msr12fnl01odc.pdf

DESCRIPTION:
The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes.

Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.

DENOMINATOR:
Patients ages 18 to 75 with diabetes who have at least two visits for this diagnosis in the last two years (established patient) with at least one visit in the last 12 months.

NUMERATOR:
Patients ages 18 to 75 with diabetes who meet all of the following targets from the most recent visit during the measurement year:
A1c less than 8.0, LDL less than 100, Blood Pressure less than 140/90, Tobacco non-user and Daily aspirin for patients with diagnosis of ischemic vascular disease use unless contraindicated.

EXCLUSIONS: Valid exclusions include patients who only had one visit to the clinic with diabetes codes during the last two years, patients who were pregnant, died or were in hospice or a permanent resident of a nursing home during the measurement year.

NOTE: Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This

is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.

MEASURE DETAILS:
See Minnesota Community Measurement, revised 9/19/2012.

Core-17 (NCQA HEDIS; NQF #0059; MSSP-27):
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of attributed individuals 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- HbA1c poor control (>9.0%).

DENOMINATOR:
The eligible population.

NUMERATOR:

HbA1c Poor Control >9% Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The attributed individual is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The attributed individual is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the attributed individual is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

HbA1c Poor Control >9%	The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review. At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The attributed individual is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The attributed individual is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%. *Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.*

EXCLUSIONS: (optional)

Identify attributed individuals who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the attributed individual's history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes (Gestational or Steroid-Induced Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude attributed individuals from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator.

NOTE: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

MEASURE DETAILS:
See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-18 (NCQA HEDIS; NQF #0034; MSSP-19): Colorectal Cancer Screening

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:
The percentage of attributed individuals 50–75 years of age who had appropriate screening for colorectal cancer.

DENOMINATOR:
The eligible population.

NUMERATOR:

One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Value Set) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

Medical record Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this
is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The attributed individual meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the attributed individual meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the attributed individual does not meet the screening criteria for inclusion.
- iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the attributed individual meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.

– *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The attributed individual meets the screening criteria for inclusion in the numerator.

– *If the medical record indicates that three or more samples were returned,* the attributed individual meets the screening criteria for inclusion in the numerator.

– *If the medical record indicates that fewer than three samples were returned,* the attributed individual does not meet the screening criteria.

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

EXCLUSIONS: (optional)
Either of the following any time during the attributed individual's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set)

MEASURE DETAILS:
See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-19 (CMS; NQF #0418; MSSP-18): Screening for Clinical Depression and Follow-up Plan

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012.

URL of Specifications: www.acr.org/~/media/ACR/Documents/P4P/Resources/2013/2013_PQRS_MeasureSpecManual.pdf

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression during the measurement period using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period.

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION: (Exclusions only applied if patient did not receive screening for clinical depression using an age appropriate standardized tool)

- Documentation of medical reason(s) for not having screening for clinical depression performed during the measurement period (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools [For example: certain court appointed cases or cases of delirium], or patient has an active diagnosis of depression or bipolar disorder)
- Documentation of patient reason(s) for not having screening for clinical depression performed during the measurement period (e.g., patient refuses to participate)

NUMERATOR:
Patients screened for clinical depression during the measurement period using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Clinical Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population where it is being utilized. Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years)

Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ 2

Adult Screening Tools (18 years and older)

Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI- II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression. Scale (GDS), Cornell Scale Screening and PRIME MD-PHQ 2

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening *must* include one or more of the following:

- Additional evaluation
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

MEASURE DETAILS:

See Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012 for details.

Core-20 (CMS; NQF #0421; MSSP-16): Body Mass Index (BMI) Screening and Follow-up

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

Claims: ____ Clinical data: __X__ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012.

URL of Specifications: www.acr.org/~/media/ACR/Documents/P4P/Resources/2013/2013_PQRS_MeasureSpecManual.pdf

DESCRIPTION:
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is **outside of normal parameters**, a follow-up plan is documented within the past six months or during the current visit.

Normal Parameters: Age 65 years and older BMI $\geq$ 23 and $<$ 30
Age 18 – 64 years BMI $\geq$ 18.5 and $<$ 25

DENOMINATOR:
All patients aged 18 years and older at the beginning of the measurement period.

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:
(Exclusion only applied if a calculated BMI was not documented as normal OR was outside parameters with a follow-up not performed during the measurement period)

- Documentation of medical reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient is receiving palliative care, patient is pregnant or patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status)
- Documentation of patient reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient refuses BMI measurement or if there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate)

NUMERATOR:
Patients with BMI calculated within the past six months or during the current visit and a follow-

up plan is documented within the last six months or during the current visit if the BMI is outside of normal parameters.

Definitions:
BMI – Body mass index (BMI) is expressed as weight/height (BMI; kg/m^2) and is commonly used to classify weight categories.
Calculated BMI – Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.
Follow-up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. Such follow-up may include but is not limited to: documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional or surgeon), pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.
Not Eligible/Not Appropriate for BMI Measurement or Follow-Up Plan – A patient is **not** eligible if one or more of the following reasons exists:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

NOTE: *Calculated BMI or follow-up plan for BMI outside of normal parameters that is documented in the medical record may be reported if done in the provider's office/facility or if obtained by the provider from outside medical records within the past six months.*

The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters"

MEASURE DETAILS:
See Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012 for details.

Core-21 (NQCA HEDIS CAHPS PCMH Survey): Access to Care Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
2. In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?
3. In the last 12 months, how often were you able to get the care you needed from this provider's office during evenings, weekends, or holidays?
4. In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?
5. In the last 12 months, when you phoned this provider's office during after office hours, how often did you get an answer to your medical question as soon as you needed?
6. Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-22 (NQCA HEDIS CAHPS PCMH Survey): Communications Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1.	In the last 12 months, how often did this provider explain things in a way that was easy to understand?
2.	In the last 12 months, how often did this provider listen carefully to you?
3.	In the last 12 months, how often did this provider give you easy to understand information about your health questions or concerns?
4.	In the last 12 months, how often did this provider seem to know the important information about your medical history?
5.	In the last 12 months, how often did this provider show respect for that you had to say?
6.	In the last 12 months, how often did this provider spend enough time with you?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-23 (NQCA HEDIS CAHPS PCMH Survey): Shared Decision-making Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might want to take a medicine?
2. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might not want to take a medicine?
3. When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-24 (NQCA HEDIS CAHPS PCMH Survey): Self-Management Support Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health?
2. In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-25 (NQCA HEDIS CAHPS PCMH Survey): Comprehensiveness Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, did anyone in this provider's office ask you if there was a period of time when you felt sad, empty, or depressed?
2. In the last 12 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?
3. In the last 12 months, did you and anyone in this provider's office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-26 (NQCA HEDIS CAHPS PCMH Survey): Office Staff Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?
2. In the last 12 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-27 (NQCA HEDIS CAHPS PCMH Survey): Information Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?
2. Some offices remind patients between visits about tests, treatment or appointments. In the last 12 months, did you get any reminders from this provider's office between visits?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-28 (NQCA HEDIS CAHPS PCMH Survey): Coordination of Care Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2012

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
2. In the last 12 months, how often did the provider seem informed and up-to-date about the care you got from specialists?
3. In the last 12 months, did you and anyone in this provider's office talk at each visit about all the prescription medicines you were taking?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

Core-29 (Adapted from CMS' National Implementation Survey): Specialist Care Composite

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: These questions are adapted from CMS' National Implementation Survey (time frame changed from 6 months to 12 months).

URL of Specifications: N/A

DESCRIPTION:

1.	In the last 12 months, did you try to make any appointments with specialists?
2.	In the last 12 months, how often was it easy to get appointments with specialists?
3.	In the last 12 months, how often did the specialist you saw most seem to know the important information about your medical history?

DENOMINATOR: TBD

NUMERATOR: TBD

MEASURE DETAILS:

CORE MEASURES THAT ARE PENDING AS OF 12-26-13:

The specifications for the following Pending measures will be determined by the ACO Measures Work Group or its successor entity at the time when the measures are ready to be used for Payment or Reporting.

a. **Pending claims-based measures (1 measure):**
   - (Core-49) *Use of High Risk Medications in the Elderly (Medicaid only, duals-specific measure)*

b. **Pending clinical data-based measures (19 measures):**
   0. (Core- 3/ MSSP-29) Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)[15]
   1. (Core-30) Cervical Cancer Screening
   2. (Core-31/ MSSP-30) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
   3. (Core-32) Proportion not admitted to hospice (cancer patients)
   4. (Core-33) Elective delivery before 39 weeks
   5. (Core-34) Prenatal and Postpartum Care
   6. (Core-35/ MSSP-14) Influenza Immunization
   7. (Core-36/ MSSP-17) Tobacco Use Assessment and Tobacco Cessation Intervention
   8. (Core-37) Care Transition-Transition Record Transmittal to Health Care Professional
   9. (Core-38/ MSSP-32-33) Coronary Artery Disease (CAD) Composite
   10. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure
   11. (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented
   12. (Core-43) *Frequency of Ongoing Prenatal Care (Medicaid only)*
   13. (Core-44) *Percentage of Patients with Self-Management Plans (Medicaid only)*
   14. (Core-45) *Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*
   15. (Core-46) *Trauma Screen Measure (Medicaid only)*
   16. (Core-47/ MSSP-13) *Falls: Screening for Future Fall Risk (Medicaid only, duals-specific measure)*
   17. (Core-48/ MSSP-15) *Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only, duals-specific measure)*
   18. (Core-50) *Persistent Indicators of Dementia without a Diagnosis (Medicaid only, duals-specific measure)*

[15] Core-3 is counted in both the "payment" and "pending" categories since the claims-based LDL-screening will be used for payment until the clinical data-based Complete Lipid Panel and LDL Control are ready to be used for payment, at which point, it will replace LDL screening.

c. Pending survey-based measures (2 measures):

- (Core-41) How's Your Health?
- (Core-42) Patient Activation Measure

ATTACHMENT L
MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Draft as of January 10, 2014

M&E-1 (NCQA HEDIS; NQF# 0036): Appropriate Medications for People with Asthma

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The measure assesses the percentage of members 5-64 years of age during the measurement year who were identified as having moderate to severe persistent asthma and who were appropriately prescribed medication during the measurement year.

DENOMINATOR:
All health plan members 5–64 years of age during the measurement year who were identified as having moderate to severe persistent asthma.

NUMERATOR:
The number of members who were dispensed at least one prescription for a preferred therapy during the measurement year.

EXCLUSIONS:
Exclude any members who had at least one encounter, in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis, or acute respiratory failure (Table ASM-E) any time on or prior to December 31 of the measurement year.

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-2 (NCQA HEDIS; NQF# 0055): Comprehensive Diabetes Care: Eye Exams for Diabetics

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year.

DENOMINATOR:
Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

NUMERATOR:
Members who received an eye screening for diabetic retinal disease. This includes diabetics who had the following:
- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist)

in the measurement year
OR
- A negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

For exams performed in the year prior to the measurement year, a result must be available.

EXCLUSIONS:
Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year.

Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-3 (NCQA HEDIS; NQF# 0062): Comprehensive Diabetes Care: Medical Attention for Nephropathy

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.

DENOMINATOR:
Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

NUMERATOR:
Members who received a nephropathy screening test or had evidence of nephropathy during the measurement year.

EXCLUSIONS:
Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face

encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year.

Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-4 (NCQA HEDIS; NQF# 0577): Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: This measure assesses the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

DENOMINATOR:
Any health plan member 42 years or older as of December 31 of the measurement year, who had a diagnosis of COPD during the Intake Period.

NUMERATOR:
The measure looks at the number of health plan members whose initial diagnosis of COPD is being confirmed using spirometry.

EXCLUSIONS:
Members are excluded from the denominator if they had a claim/encounter with a COPD diagnosis during the 730 days (2 years) prior to the index episode start date

(IESD).

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-5 (NCQA HEDIS; NQF# 0108): Follow-up Care for Children Prescribed ADHD Medication

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.
• Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
• Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

DENOMINATOR:
Initiation Phase: 6-12 years of age (6 as of March 1 of the year prior to the measurement

year; 12 years as of February 28 of the measurement year), AND
Medical and pharmacy benefit, AND
Dispensed an ADHD medication during the 12-month Intake Period.

Continuation and Management Phase: Eligible Population (see details)
6-12 years of age (6 as of March 1 of the year prior to the measurement year; 12 years as of February 28 of the measurement year), AND
Medical and pharmacy benefit, AND
Had continuous treatment for at least 210 days out of the 300-day period

NUMERATOR:
Initiation Phase: One face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD.
Note: Do not count a visit on the IPSD as the Initiation Phase visit.

C&M Phase: Identify all members who meet the following criteria.
An Initiation Phase Visit in the first 30 days, and
At least two follow-up visits from 31–300 days (10 months) after the IPSD
One of the two visits (during days 31–300) may be a telephone visit with practitioner.

EXCLUSIONS:
Initiation Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse during the 30 days after the IPSD.

Continuation and Management Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis of mental health substance abuse during the 300 days after the IPSD.

Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-6 (NCQA HEDIS; NQF# 0105): Antidepressant Medication Management

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.
a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

DENOMINATOR:
Diagnosed with a new episode of major depression and treated with antidepressant medication.

NUMERATOR:
a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment

gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

EXCLUSIONS:

Exclude members who have antidepressant prescriptions filled during the Negative Medication History period 90 days (3 months) prior to the IPSD.

Exclude members who had a claim/encounter for any diagnosis of major depression or prior episodes of depression during the Negative Diagnosis History period during the 120 days (4 months) prior to the IPSD.

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

VT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-7: Family Evaluation of Hospice Care Survey

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: ____ State Level: __X__

Name and date of specifications used: 2011 Family Evaluation of Hospice Care (FEHC) Survey

URL of Specifications: www.nhpco.org/fehc-survey-materials

DESCRIPTION: The Family Evaluation of Hospice Care (FEHC) is a post-death survey designed to yield actionable information that reflects the quality of hospice care delivery from the perspective of family caregivers. The GMCB's Analytics Contractor will collect this measure information from the Vermont Assembly of Home Health & Hospice Agencies.

DENOMINATOR: as defined by the Vermont Assembly of Home Health & Hospice Agencies.

NUMERATOR: as defined by the Vermont Assembly of Home Health & Hospice Agencies.

EXCLUSIONS: as defined by the Vermont Assembly of Home Health & Hospice Agencies.

MEASURE DETAILS: See the National Hospice and Palliative Care Organization (NHPCO) website for more information: www.nhpco.org/performance-measures/family-evaluation-hospice-care-fehc

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-8: School Completion Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: ____ Other (specify): __X__

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: ____ State Level: __X__

Name and date of specifications used: Four Year-cohort graduation rate as defined by the Vermont Agency of Education

URL of Specifications: http://education.vermont.gov/documents/EDU-Data_2010_2011_Dropout_and_High_School_Completion.pdf

DESCRIPTION: The Vermont Agency of Education will collect the data, calculate and report the school completion rate results at the state level. The GMCB's Analytics Contractor will collect this measure information from the Vermont Agency of Education.

DENOMINATOR: as defined by the Vermont Agency of Education

NUMERATOR: as defined by the Vermont Agency of Education

EXCLUSIONS: as defined by the Vermont Agency of Education

MEASURE DETAILS: See the Vermont Agency of Education website for more information: http://education.vermont.gov/data/dropout-and-high-school-completion

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-9: Unemployment Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: ____ Other (specify): __X__

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: ____ State Level: __X__

Name and date of specifications used: Annual average statewide unemployment rate calculated by the Local Area Unemployment Statistics (LAUS) program through the Vermont Department of Labor.

URL of Specifications: www.vtlmi.info/unemp.cfm

DESCRIPTION: The Vermont Department of Labor will collect the data, calculate and report the Annual average unemployment rate at the state level. The GMCB's Analytics Contractor will collect this measure information from the Vermont Department of Labor.

DENOMINATOR: as defined by the Vermont Department of Labor.

NUMERATOR: as defined by the Vermont Department of Labor.

EXCLUSIONS: as defined by the Vermont Department of Labor.

MEASURE DETAILS: See the Vermont Department of Labor website for more information: www.vtlmi.info/unemp.cfm

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-10: Health Partners TCOC: Total Cost Index (TCI)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: HealthPartners technical guidelines updated 10/3/2013.

URL of Specifications: www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057425.pdf

DESCRIPTION: Health Partners Total Cost of Care Calculation: Total Cost Index. Total Cost of Care (TCOC) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. The TCOC includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary, and behavioral health services. Both the TCOC and Resource Use measures are based on a risk adjusted PMPM relative to a specified peer group or benchmark. The TCOC is the risk adjusted total paid amount divided by the sum of the member months attributed to the provider.
HealthPartners offers two licensing agreements free of charge to external users implementing Total Cost of Care and Resource Use in their organizations. TCOC measures can be used by SAS users and non-SAS users.

DENOMINATOR: Peer Group Risk-Adjusted PMPM

NUMERATOR: Risk adjusted PMPM = (Total PMPM/Risk Score)

EXCLUSIONS: N/A

MEASURE DETAILS: See the Health Partners website for more information: www.healthpartners.com/public/tcoc/toolkit/

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-11: Health Partners TCOC: Resource Use Index (RUI)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: HealthPartners technical guidelines updated 10/3/2013.

URL of Specifications: www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057425.pdf

DESCRIPTION: Health Partners Total Cost of Care Calculation: Resource Use Index. The Resource Use Index is a risk adjusted measure of the frequency and intensity of services utilized to manage a provider's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. Both the TCOC and Resource Use measures are based on a risk adjusted PMPM relative to a specified peer group or benchmark. The resource use measure is the risk adjusted total resources divided by the sum of the member months attributed to the provider. The total resources are the sum of the Total Care Relative Resource Values, which are a standardized price value that acts in the same fashion as a dollar (as described in the TCRRV™ Methodology). HealthPartners offers two licensing agreements free of charge to external users implementing Total Cost of Care and Resource Use in their organizations. TCOC measures can be used by SAS users and non-SAS users.

DENOMINATOR: Peer Group Risk-Adjusted Resource Use PMPM

NUMERATOR: Risk-Adjusted Resource Use PMPM = (Total Resource PMPM/Risk Score)

EXCLUSIONS: N/A

MEASURE DETAILS: See the Health Partners website for more information: www.healthpartners.com/public/tcoc/toolkit/

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-12: Ambulatory surgery/1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on: Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: N/A

DESCRIPTION: The rate of outpatient ambulatory surgeries. (unique cases / member months) * 12000

DENOMINATOR: member months

NUMERATOR: unique cases of outpatient ambulatory surgeries

EXCLUSIONS: Rolled up to a hierarchy that makes an entire claim one type of OP Claim. Second behind Outpatient Emergency Department (ED) visits.

MEASURE DETAILS:
CPT Codes:
between 10021 and 36410
between 36420 and 55920
between 56405 and 58301

between 58340 and 58960
between 59100 and 62365
between 63001 and 69020
between 69100 and 69990
between 92920 and 92944
between 92973 and 92974
between 93451 and 93462
between 93501 and 93533
between 93580 and 93581
between 99141 and 99150
between G0104 and G0105
between G0168 and G0173
between G0289 and G0291
between G0297 and G0305
between G0338 and G0343
between G0392 and G0393
between G0413 and G0419
between G0440 and G0441
between S2053 and S2118
between S2135 and S2152
between S2205 and S2900
59899, G0127, G0251, G0259, G0267, G0269, G0364, G0455, M0301, S0199, S0400, S0601, S9034

Revenue Codes:

between 360 and 369
481
between 490 and 499
between 750 and 759
between 790 and 799

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-13: Average Number of Prescriptions PMPM

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: N/A

DESCRIPTION: The rate of prescriptions per member per month.
DENOMINATOR: member months

NUMERATOR: total prescriptions (in any setting)

EXCLUSIONS: N/A

MEASURE DETAILS: N/A

VT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-14: Avoidable ED visits-NYU algorithm

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on: Version 21 of the NYU ED Algorithm. Code Sets source: Milliman HCG Grouper, 2013 version 3

URL of Specifications: http://wagner.nyu.edu/faculty/billings/nyued-download

DESCRIPTION: With support from the Commonwealth Fund, the Robert Wood Johnson Foundation, and the United Hospital Fund of New York, the NYU Center for Health and Public Service Research has developed an algorithm to help classify ED utilization. The algorithm was developed with the advice of a panel of ED and primary care physicians, and it is based on an examination of a sample of almost 6,000 full ED records. Data abstracted from these records included the initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used in the ED.
The NYU Center for Health and Public Service Research has developed software for applying the algorithm using three different software applications: SAS, SPSS, and ACCESS. Detailed instructions on how to use the algorithm are included in Download section of their website. All three applications produce an output data set that adds a new set of variables to your original data set.

DENOMINATOR: N/A

NUMERATOR: N/A

EXCLUSIONS:

MEASURE DETAILS:

Data abstracted from these records included:

- Initial complaint
- Presenting symptoms
- Vital signs
- Medical history
- Age & Gender
- Diagnoses
- Procedures performed & resources used in the ED

Each case is classified into one of the following categories:

- Non-emergent - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;
- Emergent/Primary Care Treatable - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests)
- Emergent - ED Care Needed - Preventable/Avoidable - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and
- Emergent - ED Care Needed - Not Preventable/Avoidable - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).

CPT codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

See the NYU Center for Health and Public Service Research website for more information: http://wagner.nyu.edu/faculty/billings/nyued-background

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-15: Ambulatory Care (ED rate only)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on: HEDIS® 2014 Technical Specifications for Health Plans (Volume 2), Report ED visit rate only. Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: n/a

DESCRIPTION: This measure summarizes utilization of ambulatory care in the following categories: ED Visits. Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

DENOMINATOR: 1,000 Member Months

NUMERATOR: ED Visits

EXCLUSIONS: The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency (AMB Exclusions Value Set).

MEASURE DETAILS:

CPT Codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

Place of Service Code:

23 - Emergency Room - hospital

VT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on ahrq.gov Archive Appendix B and Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: http://archive.ahrq.gov/data/safetynet/billappb.htm

DESCRIPTION: The number of ED visits for Ambulatory Care-Sensitive Conditions compared to all ED visits. Ambulatory Care Sensitive conditions such as asthma, diabetes or dehydration are hospitalization conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or conditions, controlling an acute episode of an illness or managing a chronic disease or condition. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care.

DENOMINATOR: Total ED Visits

NUMERATOR: Ambulatory Care-Sensitive Condition ED Visits

EXCLUSIONS: Please see table below for details.

MEASURE DETAILS:
CPT Codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

Place of Service Code:

23 - Emergency Room - hospital

Ambulatory Care Sensitive Conditions

http://archive.ahrq.gov/data/safetynet/billappb.htm

The information on this page is archived and provided for reference purposes only.

Appendix B. Ambulatory Care Sensitive Conditions

List of ACS Condition and ICD-9-CM Code(s)

Where only three digits are listed, all diagnoses at the 4th and 5th digit should be included (e.g. asthmas is listed as 493, but you should include 493.00, 493.01, 493.1, 493.10, 493.11, etc.) Where only four digits are listed, all diagnoses at the 5th digit should also be included.

All diagnoses refer to principal diagnosis, unless otherwise specified (e.g. dehydration, iron deficiency, nutritional deficiency, etc.) Where exclusions of surgical patients are specified (e.g., hypertension), search all procedure fields for excluded procedures.

List of ACS Condition and ICD-9-CM Code(s)		
ACS Number	**Ambulatory Care Sensitive conditions and ICD-9_CM Code(s)**	**Comments**
1	Congenital syphilis [090]	Secondary diagnosis for newborns only
2	Immunization-related and preventable conditions [033, 037, 045, 320.0, 390, 391]	Hemophilus meningitis [320.2] age 1-5 only
3	Grand mal status and other epileptic convulsions [345]	
4	Convulsions "A" [780.3]	Age 0-5
5	Convulsions "B" [780.3]	Age >5
6	Severe ear, nose, and throat infections [382, 462, 463, 465, 472.1]	Exclude otitis media cases [382] with myringotomy with insertion of tube [20.01]
7	Pulmonary tuberculosis [011]	
8	Other tuberculosis [012-018]	

9	Chronic obstructive pulmonary disease [491, 492, 494, 496, 466.0]	Acute bronchitis [466.0] only with secondary diagnosis of 491, 492, 494, 496
10	Bacterial pneumonia [481, 482.2, 482.3, 482.9, 483, 485, 486]	Exclude case with secondary diagnosis of sickle cell [282.6] and patients <2 months
11	Asthma [493]	
12	Congestive heart failure [428, 402.01, 402.11, 402.91, 518.4]	Exclude cases with the following surgical procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7
13	Hypertension [401.0, 401.9, 402.00, 402.10, 402.90]	Exclude cases with the following procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7
14	Angina [411.1, 411.8, 413]	Exclude cases with a surgical procedure [01-86.99]
15	Cellulitis [681, 682, 683, 686]	Exclude cases with a surgical procedure [01-86.99], except incision of skin and subcutaneous tissue [86.0] where it is the only listed surgical procedure
16	Skin grafts with cellulitis [DRG 263, DRG 264]	Exclude admissions from skilled nursing facility/intermediate care facility
17	Diabetes "A" [250.1, 250.2, 250.3]	
18	Diabetes "B" [250.8, 250.9]	
19	Diabetes "C" [250.0]	
20	Hypoglycemia [251.2]	
21	Gastroenteritis [558.9]	
22	Kidney/urinary infection [590, 599.0, 599.9]	
23	Dehydration - volume depletion [276.5]	Examine principal and secondary diagnoses separately
24	Iron deficiency anemia [280.1, 280.8, 280.9]	Age 0-5 only, and examine principal and secondary diagnoses separately
25	Failure to thrive [783.4]	Age <1 only
26	Pelvic inflammatory disease [614]	Women only denominator - exclude cases with a surgical procedure of hysterectomy [68.3-68.8]

27	Dental Conditions [521, 522, 523, 525, 528]	

**VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014**

M&E-17: Generic Dispensing Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The number of generic prescriptions compared to the overall number of prescriptions.

DENOMINATOR: total prescriptions

NUMERATOR: generic prescriptions

EXCLUSIONS: remove prescriptions from denominator with Claim Dispense as Written Product Selection Code = 1 (Substitution not allowed by prescriber),
7 (Substitution not allowed – Brand drug mandated by law), 8 (Substitution allowed – Generic drug not available in marketplace)

MEASURE DETAILS: N/A

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-18: High-end Imaging/1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: n/a

DESCRIPTION: The rate of high-end image visits (image visits / member months) * 12000. Count multiple CPTs from an image type on same visit date as one image visit.

DENOMINATOR: member months

NUMERATOR: High-end imaging visits

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:
Outpatient Radiology - High-end Imaging

CT

0066T
between 70450 and 70498
between 71250 and 71275
between 72125 and 72133
between 72191 and 72194
72292
between 73200 and 73206
between 73700 and 73706
between 74150 and 74178
between 74261 and 74263
between 75571 and 75574
75635
between 76070 and 76071
between 76355 and 76370
76380
73497
between 77011 and 77014
between 77078 and 77079
G0288
between S8092 and S8093

MRI

70336
between 70540 and 70559
between 71550 and 71555
between 72141 and 72159
between 72195 and 72198
between 73218 and 73225
between 73718 and 73725
between 74181 and 74185
between 75552 and 75565
between 76093 and 76094
between 76390 and 76400
76498
between 77021 and 77022
between 77058 and 77059
77084
between S8035 and S8037
S8042

PET

78459
between 78491 and 78492

between 78608 and 78609
between 78810 and 78816
between G0030 and G0047
G0125
between G0210 and G0235
between G0252 and G0254
G0296
between G0330 and G0331
G0336
S8085

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-19: Inpatient Utilization - General Hospital/Acute Care

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications

URL of Specifications: n/a

DESCRIPTION: The rate of General Hospital/Acute Care inpatient visits (admissions/ member months) * 12000.

DENOMINATOR: member months

NUMERATOR: inpatient admissions

EXCLUSIONS: N/A

MEASURE DETAILS: N/A

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-20: Primary care visits/1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications

URL of Specifications: n/a

DESCRIPTION: The rate of primary care visits (unique visits/ member months) * 12000. Roll up re-admissions on same day as discharge to one admission.

DENOMINATOR: member months

NUMERATOR: unique visits with primary care

EXCLUSIONS: N/A

MEASURE DETAILS:
CPT Codes:

between 99201 and 99205
between 99211 and 99215
between 99241 and 99245
between 99304 and 99310
between 99315 and 99316
99318

between 99324 and 99328
between 99334 and 99337
between 99339 and 99345
between 99347 and 99350
between 99354 and 99355
between 99358 and 99359
between 99381 and 99387
between 99391 and 99397
between 99401 and 99404
between 99406 and 99409
between 99411 and 99412
99420
99429
between 99460 and 99465
G0402
G0404
G0438
G0439

Revenue Codes:

521
522
523
524
525

Place of Service Codes:

11 - Office
50 - Federally qualified health center
72 - Rural health clinic

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-21: Skilled Nursing Facility (SNF) Days /1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The rate of days spent in skilled nursing facilities (SNF days/ member months) * 12000. Include all claims within the stay as one SNF stay then calculate patient days from admission through discharge.

DENOMINATOR: member months

NUMERATOR: days spent in a skilled nursing facility

EXCLUSIONS: N/A

MEASURE DETAILS:
Place of Service Codes:
31 - Skilled nursing facility
Medicare or Medicaid Claim Type Code = 20 or 30

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-22: Specialty Visits /1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The rate of specialty visits (unique specialty visits/ member months) * 12000. Include all providers not included in PCP provider type.

DENOMINATOR: member months

NUMERATOR: unique specialty visits

EXCLUSIONS: N/A

MEASURE DETAILS:
CPT Codes:

between 99201 and 99205
between 99211 and 99215
between 99241 and 99245
between 99304 and 99310
between 99315 and 99316
99318

between 99324 and 99328
between 99334 and 99337
between 99339 and 99345
between 99347 and 99350
between 99354 and 99355
between 99358 and 99359
between 99381 and 99387
between 99391 and 99397
between 99401 and 99404
between 99406 and 99409
between 99411 and 99412
99420
99429
between 99460 and 99465
G0402
G0404
G0438
G0439

Revenue Codes:

521
522
523
524
525

Place of Service Codes:

11 - Office
50 - Federally qualified health center
72 - Rural health clinic

VT ACO MONITORING AND EVALUATION
MEASURE SET NARRATIVE SPECIFICATIONS
FOR 2014

M&E-23: Annual Dental Visit /1000

Programs Requiring Use of the Measure for 2014:

Commercial: _____ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: N/A

URL of Specifications: N/A

DESCRIPTION: The rate of annual dental visits (annual dental visits/ member months) * 12000.

DENOMINATOR: member months

NUMERATOR: annual dental visits

EXCLUSIONS: N/A

MEASURE DETAILS: N/A

ATTACHMENT M

TIMELINE FOR MEASURE GENERATION AND REPORTING

Contractor Timeline and Process for Reporting Payment, Reporting and Monitoring & Evaluation Measures
Current as of January 16, 2014

Date	Deliverable	Details
October 15, 2014	Baseline quality and utilization report	After receiving the numerators and denominators for M&E measures #10-23 and the **c**laims files for the Claims-based quality measures required for Year One (core measures #1-13) **for the time period covering January 1, 2013 through December 31, 2013** from the payers, the GMCB analytics contractor will compile a report to include quality and utilization information for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO. The analytics contractor will provide the GMCB with all reports and provide each ACO and payer with its respective quality and utilization reports no later than 75 days after receiving the claims files.
November 7, 2014	Quarter 1 and 2 2014 Monitoring and Evaluation utilization measures report	After receiving the numerators and denominators for M&E measures #12-23 **for the time period covering January 1, 2014 through June 30, 2014** from the payers on October 7, 2014 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than one month following the receipt of the numerators and denominators.
November 22, 2015	Six-month 2014 claims-based Payment measures report (Repeat for years 2015 and 2016)	After receiving the claims files for the Claims-based quality measures required for Year One (core measures #1-13) **for the time period covering January 1, 2014 through June 30, 2014** from the payers on October 7, 2014 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile a report to include quality information for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO. The analytics contractor will provide the GMCB with all reports and provide each ACO and payer with its respective quality reports no later than 45 days after receiving the claims files.

Date	Deliverable	Details
January 21, 2015	Quarter 3 2014 Monitoring and Evaluation utilization measures report (Repeat for years 2015 and 2016)	After receiving the numerators and denominators for M&E measures #12-23 **for the time period covering January 1, 2014 through September 30, 2014** from the payers on January 7, 2015, (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than two weeks following the receipt of the numerators and denominators.
February 22, 2015	Nine-month 2014 claims-based Payment measures report (Repeat for years 2015 and 2016)	After receiving the claims files for the Claims-based quality measures required for Year One (core measures #1-13**) for the time period covering January 1, 2014 through September 30, 2014** from the payers on January 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile a report to include quality information for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO. The analytics contractor will provide the GMCB with all reports and provide each ACO and payer with its respective quality reports no later than 45 days after receiving the claims files.
May 22, 2015	Quarter 4/Final 2014 Monitoring and Evaluation measures report (Repeat for years 2015 and 2016)	After receiving the numerators and denominators from the payers for M&E measures #1-6 and #10-23, from the appropriate state agencies for M&E measures #8 and 9, and the Vermont Assembly of Home Health and Hospice Agencies for M&E measure #7 **for the time period covering January 1, 2014 through December 31, 2014** on April 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the rates for all of the Monitoring and Evaluation measures for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB. This report, due no later than 45 days after receiving the numerators and denominators, will summarize all of the M&E measures for the entire performance year.
July 21, 2015	Quarter 1 2015 Monitoring and Evaluation utilization measures report (Repeat for year 2016)	After receiving the numerators and denominators for M&E measures #12-23 **for the time period covering January 1, 2015 through March 31, 2015** from the payers on July 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than two weeks following the receipt of the numerators and denominators.

Date	Deliverable	Details
August 31, 2015	Final (18-month) 2014 quality measures report used to inform savings distribution (Repeat for years 2015 and 2016)	After receiving on July 15, 2015: • the final claims files for the claims-based quality measures required for Year One (core measures #1-13) **for the time period covering January 1, 2014 through December 31, 2014** from the payers; • the numerators and denominators for the clinical data-based reporting measures (core measures #14-20) **for the time period covering January 1, 2014 through December 31, 2014** from the ACOs, and • the patient experience measures (core measures #21-29) **for the time period covering January 1, 2014 through December 31, 2014** from the state's survey contractor, the GMCB analytics contractor will conduct a final assessment of each ACO's Year 1 performance on both the payment and reporting measures. (The analytics contractor will also assess the implications of ACO quality performance on distribution of any earned savings. See Attachment H.) The GMCB analytics contractor will compile the final quality measures report data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO and submit the report to the GMCB no later than 45 days following the receipt of the final claims files.
October 21, 2015	Quarter 2 2015 Monitoring and Evaluation utilization measures report (Repeat for year 2016)	After receiving the numerators and denominators for M&E measures #12-23 **for the time period January 1, 2015 to June 30, 2015** from the payers on October 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than two weeks following the receipt of the numerators and denominators.

ATTACHMENT N
METHODOLOGY FOR DETERMINING DISTRIBUTION OF SAVINGS BASED ON QUALITY PERFORMANCE- COMMERCIAL

For Performance in Year 1 (2014)
As of December 26, 2013

Methodology for distribution of shared savings: In order to retain savings for which the ACO is eligible, the ACO must meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating Commercial ACOs. For year one of the Commercial pilot, compare the ACO's performance on the payment measures (see Table 1 below) to the Commercial targets. The targets are based on national HEDIS benchmarks for Commercial PPOs. 1, 2 or 3 points will be assigned to the ACO based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure (using the rate from the ACO's total attributed population regardless of commercial payer).

The "Gate": In 2014 for the Commercial pilot, there are 21 total possible points. The ACO must earn 55% of the eligible points 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. If the ACO meets the overall quality gate, it may retain at least 75% and up to 100% of the savings for which it is eligible (see Table 2).

The "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 (see Table 2).

Table 1. Payment Measures and Associated Targets for All Commercial ACOs in Performance Year 2014

#	Measure	Brief Description	Data Source	2012 HEDIS Benchmark (PPO)	2012 BCBSVT (VHP) Performance
Core-1	Plan All-Cause Readmissions NQF #1768, HEDIS	For members 18–64 years of age, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance	Claims	3 pt: Nat. 75th: 0.73 2 pt: Nat. 50th: 0.78 1 pt: Nat. 25th: 0.83 *Please note, when interpreting this measure, a lower rate is better.	0.7309 Nat: 50th
Core-2	Adolescent Well-Care Visits HEDIS AWC	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Claims	3 pt: Nat. 75th: 46.32 2 pt: Nat. 50th: 38.66 1 pt: Nat. 25th: 32.14	49.57 Nat.: 75th

Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)[16] HEDIS	The precentage of members 18-75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percuntaneous coronary interventions (PCI) from January 1 - November 1 of the year prior to the measurement year, or who had diagnosis of ischemic vascular disease (IVD) during the measurement year: LDL-C Screening.	Claims	3 pt: Nat. 75th: 87.94 2 pt: Nat. 50th: 84.67 1 pt: Nat. 25th: 81.27	88.95 Nat.: 75th
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, HEDIS FUH	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 2: The percentage of members who received follow-up within 7 days of discharge.	Claims	3 pt: Nat. 75th: 60.00 2 pt: Nat. 50th: 53.09 1 pt: Nat. 25th: 45.70	72.31 Nat.: 90th

[16] Core-3 is counted in both the "payment" and "pending" categories since the claims-based HEDIS measures "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) will be used for payment until the clinical data-based Complete Lipid Panel and LDL Control are ready to be used for payment, at which point, it will replace LDL screening.

Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, HEDIS IET	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis, and b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Claims	3 pt: Nat. 75th: 31.94 2 pt: Nat. 50th: 27.23 1 pt: Nat. 25th: 24.09	26.54 Nat.: 25th
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, HEDIS AAB	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	Claims	3 pt: Nat. 75th: 24.30 2 pt: Nat. 50th: 20.72 1 pt: Nat. 25th: 17.98	19.69 Nat.: 25th
Core-7	Chlamydia Screening in Women NQF #0033, HEDIS CHL	Assesses the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Claims	3 pt: Nat. 75th: 47.30 2 pt: Nat. 50th: 40.87 1 pt: Nat. 25th: 36.79	45.57 Nat.: 50th
	TOTAL (21 possible points for Commercial)				

Table 2. Commercial ACO Pilot Allocation Model:

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Core Measure 5, the Initiation and Engagement for Substance Abuse Treatment composite measure, is comprised of two components below. The national benchmarks above were created by taking the average of the two components for the percentiles at each level. Likewise, the Commercial composite performance was determined by taking the average performance of the two components below.

#	Measure	Brief Description	Data Source	2012 HEDIS Benchmark (PPO)	2012 BCBSVT (VHP) Performance
Core - 5a	Initiation and Engagement for Substance Abuse Treatment: Initiation of AOD Treatment NQF #0004, HEDIS IET	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	Claims	Nat. 75th: 45.93 Nat. 50th: 40.08 Nat. 25th: 36.45	34.17
Core - 5b	Initiation and Engagement for Substance Abuse Treatment: Engagement of AOD Treatment. NQF #0004, HEDIS IET	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Claims	Nat. 75th: 17.95 Nat. 50th: 14.38 Nat. 25th: 11.72	18.91

ATTACHMENT O
METHODOLOGY FOR DETERMINING DISTRIBUTION OF SAVINGS BASED ON QUALITY PERFORMANCE - MEDICAID

For Performance in Year 1 (2014)
As of December 26, 2013

Methodology for distribution of shared savings: In order to retain savings for which the ACO is eligible, the ACO must meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating Medicaid ACOs. For year one of the Medicaid pilot, compare the ACO's performance on the payment measures (see Table 1 below) to the Medicaid targets. The targets are either based on national HEDIS benchmarks for Medicaid or state-developed Medicaid benchmarks.[17] When the targets are based on national HEDIS benchmarks for Medicaid, 1, 2 or 3 points will be assigned based on whether the ACO is 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 baseline, 2 points for no statistically significant change over baseline, and 3 points for a statistically significant improvement over baseline performance. The ACO-specific baselines will be calculated (and therefore specific performance targets finalized) in early 2014 based on initial ACO attribution determinations.

The "Gate": In 2014 for the Medicaid pilot, there are 24 total possible points. The ACO must earn 35% of the eligible points 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. If the ACO meets the overall quality gate, it may retain at least 75% and up to 100% of the savings for which it is eligible (see Table 2).

The "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 (see Table 2).

Table 1. Payment Measures and Associated Targets for All Medicaid ACOs in Performance Year 2014

#	Measure	Brief Description	Data Source	Medicaid ACO Targets	2012 VT Medicaid Performance
Core-1	All-Cause Readmissions NQF #1768	Average Adjusted Probability of Readmission (Expected Rate). For members 18–64 years of age, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	Claims	National benchmark not available. 3 pt: statistically significant improvement over baseline[18] 2 pt: no statistically significant change over baseline 0 pt: statistically significant decline over baseline	16.60
Core-2	Adolescent Well-Care Visits HEDIS AWC	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Claims	3 pt: Nat. 75th: 57.07 2 pt: Nat. 50th: 47.24 1 pt: Nat. 25th: 41.72	46.27
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)[19] HEDIS	The precentage of members 18-75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percuntaneous coronary interventions (PCI) from January 1 - November 1 of the year prior to the measurement year, or who had diagnosis of ischemic vascular disease (IVD) during the measurement year: LDL-C Screening.	Claims	3 pt: Nat. 75th: 85.20 2 pt: Nat. 50th: 82.36 1 pt: Nat. 25th: 78.44	45.67

[18] Please note that for this measure, a lower score indicates better performance.
[19] Core-3 is counted in both the "payment" and "pending" categories since the claims-based HEDIS measures "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) will be used for

#	Measure	Brief Description	Data Source	Medicaid ACO Targets	2012 VT Medicaid Performance
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, HEDIS FUH	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are specified by NCQA. Of these, Rate 2 is used in the shared savings distribution methodology. Rate 2 is defined as the percentage of members who received follow-up within 7 days of discharge.	Claims	3 pt: Nat. 75th: 54.64 2 pt: Nat. 50th: 43.95 1 pt: Nat. 25th: 30.91	42.01

payment until the clinical data-based Complete Lipid Panel and LDL Control are ready to be used for payment, at which point, it will replace LDL screening.

#	Measure	Brief Description	Data Source	Medicaid ACO Targets	2012 VT Medicaid Performance
Core - 5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)[20] NQF #0004, HEDIS IET	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis, and b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Claims	3 pt: Nat. 75th: 29.64 2 pt: Nat. 50th: 24.75 1 pt: Nat. 25th: 20.59	33.22
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, HEDIS AAB	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	Claims	3 pt: Nat. 75th: 28.07 2 pt: Nat. 50th: 22.14 1 pt: Nat. 25th: 17.93	28.62
Core-7	Chlamydia Screening in Women NQF #0033, HEDIS CHL	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Claims	3 pt: Nat. 75th: 63.72 2 pt: Nat. 50th: 57.15 1 pt: Nat. 25th: 50.97	51.18

[20] Please see the components that make up the composite on page 5.

#	Measure	Brief Description	Data Source	Medicaid ACO Targets	2012 VT Medicaid Performance
Core-8	Developmental Screening in the First Three Years of Life (Medicaid-only measure)	The percentage of children ages one, two and three years who had a developmental screening performed using a standardized tool by their first, second and third birthdays.	Claims	National benchmark not available. 3 pt: statistically significant improvement over baseline 2 pt: no statistically significant change over baseline 0 pt: statistically significant decline over baseline	30.17
Total				**24 possible points**	

Table 2. Medicaid's Allocation Model:

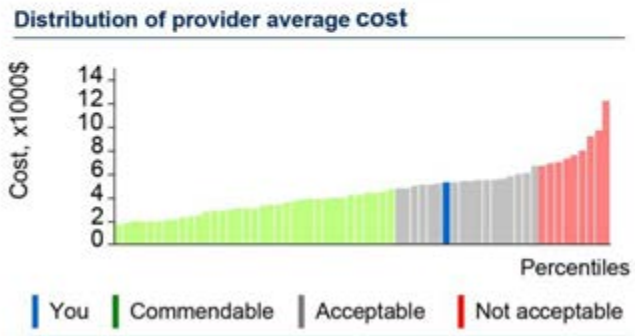
% of eligible points	% of earned savings
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

Core Measure 5, the Initiation and Engagement for Substance Abuse Treatment composite measure is comprised of two components below. The national benchmarks above were created by taking the average of the two components for the percentiles at each level. Likewise, the Medicaid composite performance was determined by taking the average performance of the two components below.

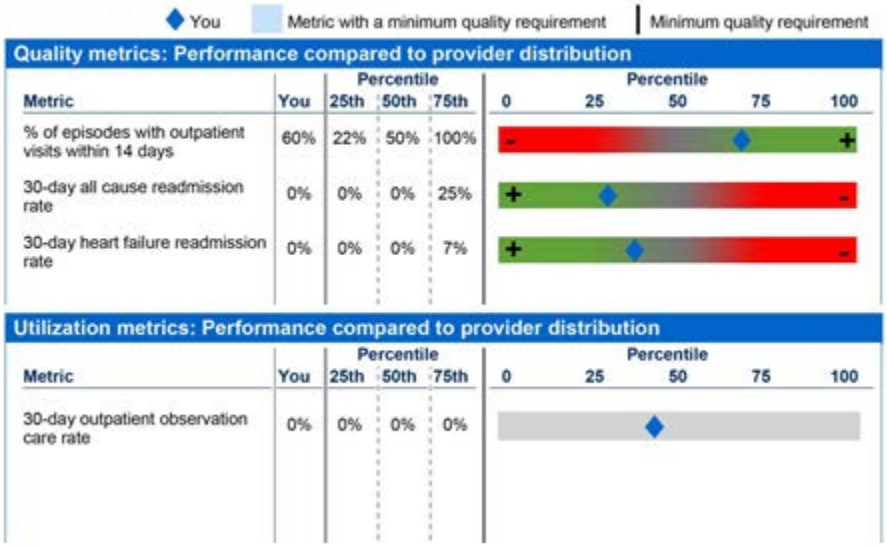
#	Measure	Brief Description	Data Source	2012 Medicaid HEDIS Benchmark	2012 VT Medicaid Performance
Core -5a	Initiation and Engagement for Substance Abuse Treatment: Initiation of AOD Treatment NQF #0004, HEDIS IET	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	Claims	Nat. 75th: 43.11 Nat. 50th: 39.13 Nat. 25th: 36.03	49.01%
Core -5b	Initiation and Engagement for Substance Abuse Treatment: Engagement of AOD Treatment. NQF #0004, HEDIS IET	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Claims	Nat. 75th: 16.17 Nat. 50th: 10.37 Nat. 25th: 5.14	17.43%

ATTACHMENT P
POSSIBLE AD HOC REPORT CONTENT AND FORMATS

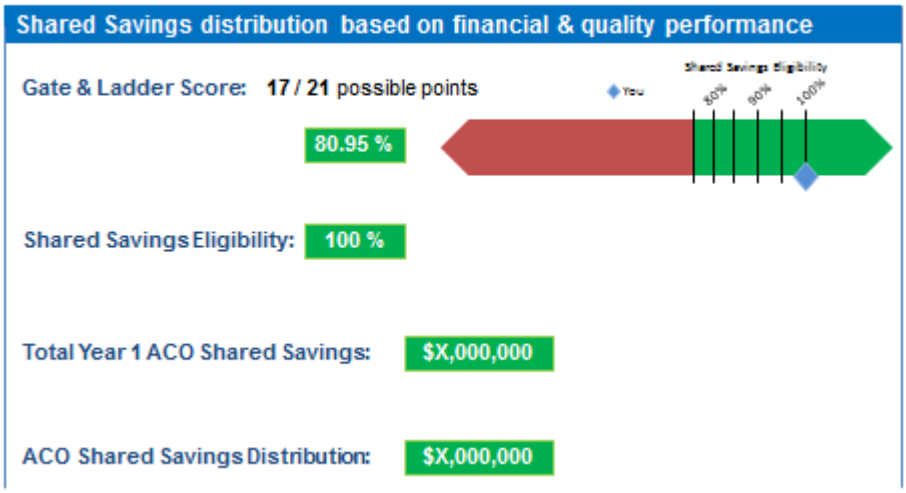
Cost Detail



Quality and Utilization Detail



Summary & Financial Reconciliation



ATTACHMENT Q
GMCB BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between **the State of Vermont** ("Covered Entity") and **Contractor** ("Business Associate"). This Agreement supplements and is made a part of the Contract to which it is an attachment.
Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including the Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 ("Privacy Rule") and the Security Standards at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by subtitle D of the Health Information Technology for Economic and Clinical Health Act.

The parties agree as follows:

1. Definitions. All capitalized terms in this Agreement have the meanings identified in this Agreement, 45 CFR Part 160, or 45 CFR Part 164.

The term "Services" includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR 160.103 under the definition of Business Associate.

The term "Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

The term "Breach" means the acquisition, access, use or disclosure of protected health information (PHI) in a manner not permitted under the HIPAA Privacy Rule, 45 CFR part 164, subpart E, which compromises the security or privacy of the PHI. "Compromises the security or privacy of the PHI" means poses a significant risk of financial, reputational or other harm to the individual.

2. Permitted and Required Uses/Disclosures of PHI.

2.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying contract with Covered Entity. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

2.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents (including subcontractors) in accordance with Sections 8 and 16 or (b) as otherwise permitted by Section 3.

3. **Business Activities**. Business Associate may use PHI received in its capacity as a "Business Associate" to Covered Entity if necessary for Business Associate's proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as "Business Associate" to Covered Entity for Business Associate's proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if (a) Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person and (b)
the person notifies Business Associate, within three business days (who in turn will notify Covered Entity within three business days after receiving notice of a Breach as specified in Section 5.1), in writing of any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in this Section must be of the minimum amount of PHI necessary to accomplish such purposes.

4. **Safeguards**. Business Associate shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

5. **Documenting and Reporting Breaches**.

5.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI as soon as it (or any of its employees or agents) become aware of any such Breach, and in no case later than three (3) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

5.2 Business Associate shall provide Covered Entity with the names of the individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR §164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it.

5.3 When Business Associate determines that an impermissible acquisition, use or disclosure of PHI by a member of its workforce does not pose a significant risk of harm to the affected individuals, it shall document its assessment of risk. Such assessment shall include: 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons

supporting the determination of low risk of harm. When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity.

6. Mitigation and Corrective Action. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity.

7. Providing Notice of Breaches.

7.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate's employees or agents was responsible constitutes a Breach as defined in 45 CFR §164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individuals whose PHI was the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

7.2 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

7.3 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR §164.404(c).

7.4 Business Associate shall notify individuals of Breaches as specified in 45 CFR §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR §164.406.

8. Agreements by Third Parties. Business Associate shall ensure that any agent (including a subcontractor) to whom it provides PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity agrees in a written agreement to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. For example, the written contract must include those restrictions and conditions set forth in Section 14. Business Associate must enter into the written agreement before any use or disclosure of PHI by such agent. The written agreement must identify Covered Entity as a direct and

intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of PHI to any agent without the prior written consent of Covered Entity.

9. **Access to PHI**. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

10. **Amendment of PHI**. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

11. **Accounting of Disclosures**. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

12. **Books and Records**. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity (without regard to the attorney-client or other applicable legal privileges) upon Covered Entity's request in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

13. **Termination.**

13.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created

or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 17.7.

13.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide
an opportunity for Business Associate to cure the breach and Covered Entity may terminate this Contract without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate this Contract without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under this Contract, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

14. Return/Destruction of PHI.

14.1 Business Associate in connection with the expiration or termination of this Contract shall return or destroy, at the discretion of the Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this Contract that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

14.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI.

15. Penalties and Training. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in training regarding the use, confidentiality, and security of PHI.

16. Security Rule Obligations. The following provisions of this Section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

16.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

16.2 Business Associate shall ensure that any agent (including a subcontractor) to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any agent without the prior written consent of Covered Entity.

16.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an agent, including a subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident and in no case later than three (3) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

16.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

17. <u>Miscellaneous</u>.

17.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the Contract, the terms of this Agreement shall govern with respect to its subject matter. Otherwise the terms of the Contract continue in effect.

17.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

17.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

17.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule) in construing the meaning and effect of this Agreement.

17.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

17.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity under this Contract even if some of that information relates to specific services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

17.7 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 11 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

(AHS Rev: 8/31/10)