Green Mountain Care Board (GMCB)

All-Payer Total Cost of Care Data Specification

Vermont All-Payer Accountable Care Organization ("ACO") Model Agreement: VHCURES Payments and Enrollment Data for Calculating Total Cost of Care per Member: Commercial, Medicaid, and Medicare Data

January 15, 2019

Version 4

Revision log

V4 updates (1.15.2019):

1. Delivery dates for 2018Q2 and 2018Q3 TCOC reports updated to match current schedule.
2. Shadow claims are used in the computation of the utilization (hospital discharges and ED Visit) measures.

V3 updates (12.7.2018):

1. Members excluded from commercial coverage due to a behavioral health plan carve out for commercial plans are now eligible for inclusion in Medicaid or Medicare FFS.
2. ED costs include all facility outpatient claims with an appropriate revenue code on the date of service

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TABLES

I. INTRODUCTION

The Vermont All-Payer Accountable Care Organization (ACO) Model Agreement is between the Centers for Medicare & Medicaid Services (CMS) and the Governor of Vermont; the Green Mountain Care Board (GMCB); and the Vermont Agency of Human Services (AHS). Each Vermont entity, and CMS, are a party to the Agreement.

The Vermont All-Payer ACO Model Agreement governs the methodology and filing requirements for calculation and reporting of certain performance data by the GMCB. Under the Agreement, the methodology for calculating All-Payer Total Cost of Care (TCOC) per Beneficiary is specified as below:

$$\frac{\textit{Vermont All-Payer TCOC}}{\textit{Vermont All-Payer TCOC Beneficiaries}}$$

The Vermont All-Payer TCOC numerator includes payment data from:

- Medicare claims payments: Relies on data submissions by CMS and validation performed using Medicare eligibility and claims submitted to Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's All-Payer Claims Database. Based on the timing of Medicare claims in VHCURES, quarterly summary reports provided by CMS to track Medicare payments may provide interim results.
- Medicaid claims payments: Relies on data submissions by the Department of Vermont Health Access (DVHA) to VHCURES of Medicaid eligibility and medical claims data.
- Commercial Payers and Self-Insured Plan claims payments: Relies on data submitted by health insurers and third-party administrators (TPAs), including Medicare Advantage plans, to the (VHCURES) for both claims and eligibility.
- Non-claims payments: These payments include shared savings/losses made to providers as well as additional payments outside of claims reporting. Annual calculations rely on data submitted by payers based on the specification developed in Appendix G. Quarterly reports will use preliminary numbers provided by the ACO. Non-claim payments will include adjustments for Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration in the base year as well. (7.5 million).

All-payer Total Cost of Care per Beneficiary Growth will be calculated by Vermont and CMS in aggregate as the compounded annualized growth rate of All-payer Total Cost of Care per Beneficiary across Performance Years (PY) 1 through 5 of this Model, using 2017 as a baseline (PY0). All-payer Total Cost of Care per Beneficiary for any given Performance Year will incorporate the count of all Vermont All-payer beneficiaries and the expenditures associated with All-payer Financial Target Services for all Vermont All-payer beneficiaries. Below is the formula to calculate the benchmark (this example is showing the calculation for 2022, Performance Year 5).

$$\left(\frac{\left(\frac{Vermont\ all-payer\ TCOC_{2022}}{Vermont\ all-payer\ beneficiaries_{2022}}\right)}{\left(\frac{Vermont\ all-payer\ TCOC_{2017}}{Vermont\ all-payer\ beneficiaries_{2017}}\right)}\right)^{\frac{1}{5}} - 1 \leq 0.035$$

In addition to the annual reporting against this benchmark, under the Agreement, GMCB is required to report All-Payer TCOC per Beneficiary to CMS on a quarterly basis (Quarterly Financial Reports). Quarterly financial reports will include cumulative year to date growth rates as well as compounded growth rates from the 2017 base year, based on claims data only. Reporting will be submitted quarterly following the schedule in Table I.1 based on the regular VHCURES submission dates.

Table I.1. All-payer Total Cost per Beneficiary Report Schedule

Report title	Due to CMS	Contractor's delivery date of drafts to GMCB	Service dates included
Test Report - Quarterly Financial	n.a.	8/21/18	1/1/17-9/30/17, paid through 12/31/17[1]
2017 Baseline Quarterly Financial	n.a.	9/28/18	1/1/17 - 12/31/17, paid through 3/31/18
2018Q1 Quarterly Financial	1/31/19	1/15/19	1/1/18 - 3/31/18, paid through 6/30/18
2018Q2 Quarterly Financial	3/29/19	3/8/19	1/1/18 - 6/30/18, paid through 9/30/18
2018Q3 Quarterly Financial	6/28/19	5/10/19	1/1/18 - 9/30/18, paid through 12/31/18
2018Q4 Quarterly and 2018 Annual Financial	9/30/19	8/16/19	1/1/18 - 12/31/18, paid through 3/31/19

[1] VHCURES Medicare claims are generally one quarter behind Medicaid, Commercial claims. All-payer TCOC reporting will use CMS reports to align the reporting timelines.

In order to monitor the growth of cost per beneficiary, the All-Payer TCOC data report to GMCB will include details by major payer category, and for each of these payer categories by member characteristics and by type of service. This document instructs how to combine payer specific calculations above to create the All-payer Total Cost of Care per beneficiary/member and adjustments to the denominator for items such as duplication across payers. The specifications for computing the TCOC for the following payer groups are included as appendices:

1. Appendix D: Commercial (including Medicare Advantage) component of Total Cost of Care specification
2. Appendix E: Medicaid component of Total Cost of Care specification
3. Appendix F: Medicare Fee-for-Service (FFS) component of Total Cost of Care specification
4. Appendix G: Commercial non-claim based payment component of Total Cost of Care specification

The All-Payer ACO Model is an Advanced Alternative Payment Model, facilitated by an ACO, that enables the three main payers of health care in Vermont—Medicaid, Medicare, and commercial insurance—to pay for health care differently than fee-for-service reimbursement, and provides opportunity for alignment across payers. It initially includes Medicare Part A and Part B services and their commercial and Medicaid equivalents. Table I.2 provides a summary of included and excluded services by payer type.

Table I.2. All-payer TCOC Included Services by Payer Type

	Included in All-payer TCOC		
Major Category of Service	**Commercial**	**Medicare**	**Medicaid**
Inpatient	Y	Y	Y
Outpatient Facility Services	Y	Y	Y
Professional	Y	Y	Y
Home Health	Y	Y	Y
Skilled Nursing Facility	Y	Y	N[1]
Long Term Institutional Care	N	Y	N[1]
Hospice	Y	Y	Y
Durable Medical Equipment	Y	Y	Y
Pharmacy (Retail)	N	N	N
Dental	N	N	N
Government Health Care Activities- AHS[2]	N/A	N/A	N
Government Health Care Activities- HCBS[2]	N/A	N/A	N
Government Health Care Activities- Mental Health[2]	N/A	N/A	N

[1]Excluded only in performance years 1-3

[2]The Agreement requires a plan to potentially include these services in the future.

II. OVERVIEW

As described above, VHCURES is the source of all claim-based payment calculations for commercial and Medicaid payments and will be used to validate Medicare payment reports received by the state.[1] VHCURES is the state's all-payer claims database (APCD). Vermont law (Act 79 of 2013, Section 40, Regulation H-2008-01) requires the GMCB to collect data on Vermont residents from commercial health insurers and Vermont's Medicaid program. The VHCURES program previously was managed by the Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), which subsequently became the Department of Financial Regulation (DFR). In 2014 Medicare data were incorporated into VHCURES, making VHCURES a true all-payer claims database. For the purposes of VHCURES data collection, the definition of "health insurers" includes third-party administrators (TPAs), pharmacy benefit managers (PBMs), hospitals and health systems, administrators of self-insured or publicly insured health benefits plans, and any other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to Vermont residents. Regulation H-2008-01 requires covered parties to submit healthcare eligibility and claims data for aggregation, analysis, and reporting using VHCURES, which was established as a "resource for measuring and improving health care system performance" in the State. Covered parties submit data to VHCURES either monthly, quarterly or annually based on their membership volume.

All-payer TCOC calculations will determine Vermont resident eligibility for the TCOC calculation based on denominator selection criteria and assign each eligible member into a specific payer category based on primary payer information submitted. After the members are assigned to a particular payer for a given month, we will identify claims paid by this payer for the services provided in the given month to calculate the total cost of medical services for that member. We will weigh each eligible member by the months enrolled in the TCOC calculations.

In quarterly reports, we will calculate All-Payer TCOC using VHCURES data for Commercial and Medicaid members and CMS data for Medicare members (Table II.1). In annual reports, we will calculate TCOC similarly for the entire program year, except adding non-claims payments to the numerator (Table II.2). Non-claims payments include MAPCP and shared savings/loss adjustments. We will also report quarter and annual growth rates to compare against targets. The target for All-payer TCOC per beneficiary growth is 3.5 percent of less over 5 years.

[1] Current VHCURES submission dates for Medicare claims do not allow calculation of the Medicare TCOC from VHCURES for quarterly reports. GMCB is currently discussing how to improve the timeliness of Medicare claims and ACO eligibility flags to enable TCOC calculations using VHCURES. CMS will provide the state with a quarterly report which will include detailed information by Medicare eligibility, service type etc.

Table II.1. All-payer TCOC Quarterly Calculations by Performance Quarter

Measure	2018Q1	2018Q2	2018Q3	2018Q4
TCOC per VT resident				
Change from previous year (%)				
YTD compounded change from base year (%)[1]				
Numerator ($)				
Commercial claim-based cost				
Commercial *non-claim based payments*				
Medicare claim-based cost				
Medicare non-claim based payments				
Medicaid claim-based cost				
Medicaid non-claim based payments				
Denominator (People)[2]				
Commercial members				
Medicare beneficiaries				
Medicaid enrollees				
Duplicate counts (Minus)				

[1] Year to date will calculate quarterly calculations on a rolling basis.

[2] Weighted by months enrolled during the measurement period.

TCOC = total cost of care; VT= Vermont, YTD= year to date

Table II.2. All-payer TCOC Annual Calculations, by Performance Year

Measure	2017 (PY0)	2018 (PY1)	2019 (PY2)	2020 (PY3)	2021 (PY4)	2022 (PY5)
TCOC per VT resident						
Change from previous year (%)	n.a					
YTD compounded change from base year (%)	n.a.					
Numerator ($)						
Commercial claim-based cost						
Commercial non-claim based payments						
Medicare claim-based cost						
Medicare non-claim based payments						
Medicaid claim-based cost						
Medicaid non-claim based payments						
Denominator (People)[1]						
Commercial members						
Medicare beneficiaries						
Medicaid enrollees						
Duplicate counts (Minus)						

[1] Weighted by months enrolled during the measurement period.

TCOC = total cost of care; PY=Performance Year, VT=Vermont, YTD= Year to Date

III. DENOMINATOR CALCULATION

We will use VHCURES monthly eligibility files to select all members that have the following conditions:

- With Medical Coverage, where ME018 Medical Coverage (ELIGIBLITY_COVERAGE CLASS) = MEDICAL and;
- With primary insurance coverage, where ME028 Primary Insurance Indicator (PRIMARY_INSURANCE_INDICATOR_CODE) = 1 or the member is Medicare FFS defined as ME003 Product Type = AB, MA, or MB[2].

Additional payer group specific criteria for inclusion in the denominator are in Table III.1 and described in greater detail in Appendices D, E, and F. To produce payer specific TCOC calculations and minimize the counting of members more than once, the selected members will be assigned to their primary payer for a given month using the following hierarchy. Example of members with multiple coverage in the same month include members with Commercial primary coverage and Medicare coverage, and persons with Medicaid primary coverage and Medicare coverage.

1. **Commercial**, including Medicare advantage where Insurance Type/Product Code (ME003) is one of the following:

   EP – Exclusive Provider Organization
   HM - Health Maintenance Organization (HMO)
   IN – Indemnity
   PR - Preferred Provider Organization (PPO)
   PS - Point of Service (POS)
   HN - Health Maintenance Organization (HMO) Medicare Advantage / Medicare Part C

2. **Medicare Fee for Service (FFS)** where Insurance Type/Product Code (ME003) is "AB" (Medicare FFS A and B), "MA" (Medicare FFS Part-A only), or "MB" (Medicare Part B FFS)
3. **Medicaid** where Payer Submitter Code (ME001) = "VTG001"

[2] The VHCURES does not have Primary Insurance Indicator information for Medicare Members.

Table III.1. Denominator Criteria by Payer group

Commercial	Medicare FFS	Medicaid
• Residents of Vermont, where ME017 Member ZIP CODE is a valid Vermont ZIP Code. • Insurance Type/Product Code (ME003) in ("EP", "HM", "IN", "PR", "PS", "HN") • Exclude members with fully-insured plans with payers without a Certificate of Authority (COA) • Exclude members in behavioral health carve out plans[3]	• Residents of Vermont, where ME017 Member ZIP CODE is a valid Vermont ZIP Code. • Product Type Code (PRODUCT_TYPE) in ("AB", "MA", "MB")	• Payer Submitter Code (ME001) = "VTG001"[1] • Eligibility code (ME210) = 1[1] • Benefit Summary = "Comprehensive Medical & Pharmacy" AND Next Gen ACO category in ("ABD," "Non-ABD")[2] • Not Dual Eligible: (ME202) = No (0)

[1] Medicaid eligibility files provide monthly membership information. DVHA will be using eligibility as of 15th of the month for validation purposes.
[2]Appendix G Table 2 provides a crosswalk of Benefit Summary, Next Gen ACO category in the TCOC calculation. There will be no restriction on member zip code for Medicaid due to Medicaid eligibility rules stating VT residency as a requirement.
[3] If a member is only excluded from the Commercial category because of behavioral health plan carve out, they remain eligible to be included in the Medicare FFS or Medicaid category.

After sub-setting the VHCURES monthly enrollment data as described above, we have monthly enrollment data for members that reside in Vermont and have Primary Medical coverage from a Vermont commercial or Medicaid plan or enrolled in Medicare.

A. Field Definitions for Denominator Categorization Filters

The member months will be calculated for each of the following member characteristics:

- Member gender (ME013): Female, Male. If gender is UNKNOWN determine gender from other months for the same member (if not unknown), otherwise set to Female.
- Member age group: <1, 1-4, 5-11,12-17,18-34,35-44,45-54,55-64,65-74,75-84,85+
- ACO Participation Indicator (ME031): Yes, No
- Member's Vermont Hospital Service Area of residence using "Residential Zip and Town Lookups to VDH HSA" developed by Blueprint. For Medicaid members, if the member ZIP code is not a Vermont ZIP code then assign this member to an UNKNOWN Hospital Service Area.

The member months will also be calculated by categories specific to Commercial, Medicare, and Medicaid payer-groups (Table III.2). These categories are described in greater detail in Appendices D, E, and F.

Table III.2. Field Definitions for Denominator Categorization Filters by Payer Group

Commercial	Medicare FFS	Medicaid
• Plan type: 1) Medicare Advantage 2) Self-Insured plans 3) Commercially Insured Plans (not self-insured)	• Eligibility Categories: 1) Aged and Disabled 2) ESRD • Product type: 1) A and B 2) Part A only 3) Part B only	• Next Gen ACO Category: 1) ABD 2) Non-ABD

IV. NUMERATOR CALCULATION

Once members are selected from the eligibility file, the total cost of care for these selected members will be calculated from medical claims. By selecting medical claims only, we will be excluding retail pharmacy claims and dental claims. For all-payer groups, we will include the following medical claims:

- Medical Claims with service start date for a member and month included in the denominator
- Medical Claims paid as primary, with MC038 Claim Status (CLAIM_STATUS) = '01' or '19' for the assigned primary payer in the monthly eligibility file.

For Commercial claims, we will include claims with the following Insurance Type/Product Codes in the numerator: 12, 13, 14, 15, 16, HM. For Medicare claims, we will include claims with Insurance Type/Product Codes AB, MA or MB. No additional numerator exclusions apply to Commercial or Medicare claims. Medicaid exclusions are applied using Medicaid claim types and fund sources. Specifically, we will exclude Medicaid Claim Types D and L, Medicaid Behavioral Health Services, Medicaid Home and Community-based services, and other excluded services. Payer group specific medical claims inclusion and exclusion criteria are described in more detail in Appendices D, E, and F.

After sub-setting the medical claims files, we will calculate and report cost information as the numerator. The calculations are as follows (Note that pre-paid amounts are not included in the calculation of Total cost):

- **Total Allowed Amount**= A calculated field for the sum of Total Amount Paid (MC063 PAID AMT), Copay amount (MC065 COPAY_AMT), Coinsurance Amount (MC066 COINSURANCE_AMT), and Deductible Amount (MC067 DEDUCTIBLE_AMT).

A. Field Definitions for Numerator Categorization Filters

1. Major Service Categories

The classification is derived primarily from claim Bill Type and Place of Service coding (e.g., claim type, type of setting, and place of setting) developed for VHCURES that classifies different types of claims across all-payer types (e.g., commercial, Medicare Fee-For-Service, and Medicaid). The major service categories ensure that payments can be categorized for the entire claim because payments are not always reported at the service line detail level. The major service categories also align with Medicare Parts A and B submission file type categories and therefore will ensure alignment with All-Payer reporting. These include the following major service categories (see Appendix A for full list of claim type, type of setting, and place of setting allocation to major payer groups):

1. Total (sum of Major Service Categories below, except if noted otherwise)
2. Inpatient Acute (claim type = 1 and type of setting = 1 and place of setting = 1)
3. Outpatient Facility Services (claim type = 1 and type of setting = 2)

4. Hospice (claim type = 3 and type of setting =12)
5. Home Health (claim type = 3 and type of setting = 9)
6. Durable Medical Equipment (claim type = 3 and type of setting = 8)
7. Inpatient Skilled Nursing Facility (claim type = 1 and type of setting = 1 and place of setting = 2,3), not included in Total for Medicaid in baseline or Performance Years 1-3
8. Inpatient Intermediate Care and Residential Facilities (claim type = 1 and type of setting = 1 and place of setting = 4,5), not included in Total for Medicaid in baseline or Performance Years 1-3
9. Professional Services (claim type = 2)
10. All Other Medical Claims (details below, output will include all of the sub-categories below is a single All Other)
    - 10.1 Inpatient Other (claim type = 1 and type of setting = 1 and place of setting = 6)
    - 10.2 Unclassified (claim type = 3 and type of setting = 10)
    - 10.3 Professional Dental (claim type = 3 and type of setting = 6)
    - 10.4 Other Pharmacy (claim type = 3 and type of setting = 7)

2. Other Categories of Care

Unless otherwise noted, these Other Categories of care are computed after apply the numerator exclusions from earlier in this section.

1. Primary Care Cost -- based on taxonomy and procedure codes developed by GMCB Primary care work group. The work group design was augmented to capture Primary Care services in a hospital Outpatient setting. See Appendix B for details on calculating the cost of Primary Care.
2. Specialist Care Cost– based on taxonomy codes developed by GMCB. See Appendix B for details on calculating the cost of Specialist Care.
3. Mental Health and Substance Use Disorder Cost – claims where the primary diagnosis code is F01 – F99. Note that this range includes dementia (F01-F03), substance abuse (F10-F19 including tobacco abuse F172), intellectual disabilities (F70-F79), and pervasive and specific developmental disabilities (F80-F89). This measure applies to all medical claims included in one of the major categories of service above, and will include inpatient mental health hospitalizations and all claims from behavioral health carve out plans if the member has full medical coverage.
4. Outpatient Emergency Department Cost (Facility Charges) – Cost of Claims for Outpatient facility claims with service line revenue codes 0450 – 0459. All Facility Outpatient claims on the date of service where an applicable revenue code is found will be summed to calculate the ED Cost.

In addition there are Medicaid specific Other Categories of Care that include Medicaid Skilled Nursing Care, Medicaid ICF / Residential Care, and Services Unique to Medicaid. See Appendix F for details on these categories.

3. Utilization Measures

In addition to the total cost of care measures included above, two utilization measures are included in the TCOC reports.

- Acute Inpatient Discharges per 1,000 beneficiary years. This results is computed using the Healthcare Effectiveness Data and Information Set (HEDIS) Inpatient Utilization—General Hospital/Acute Care (IPU) definitions (total discharge component). Discharges represented in the VHCURES as shadow claims are included in this measure. This measure excludes discharges for mental health, chemical dependency or rehabilitation, and newborn care. See payer specific Appendix C for more details.

- Emergency Department (ED) visits per 1,000 beneficiary years. This results is computed using the (HEDIS) Ambulatory Care (AMB) definitions (ER visit component). ED visits represented in the VHCURES as shadow claims are included in this measure This measure excludes ED visits that result in Inpatient stay, for mental health, chemical dependency, psychiatry, electroconvulsive therapy, and alcohol or drug rehabilitation or detoxification. See payer specific Appendix C for more details.

V. NON-CLAIMS BASED PAYMENTS

In addition to the claims based payment component of TCOC, there are additional payments to provider of medical services not reported in the claims data. As part of the All-payer model analytics we developed a non-claims data reporting specifications and templates for payers to submit annually. The non-claims payments will be combined with the claims based payments in the All-payer TCOC quarterly calculations and All-payer TCOC annual calculations (see Section VII. below for details on how these non-claims data are incorporated). Below is a summary of non-claim based submissions by payer.

Commercial

Commercial health plans in Vermont make payments for health care services provided to Vermont residents through the claims system or through non-claims methods. The enrollment and claims portion of Commercial and Self-insured Plan TCOC will be calculated by GMCB using data submitted by health insurers and TPAs to the VHCURES. In addition, to fully represent medical service expenditures for Vermont residents, GMCB requires data from certain Vermont Commercial Plans and Vermont Self-Insured Plans regarding Non-Claims Payments associated to the health care services for Vermont residents. GMCB will combine the claims-based expenditures with the non-claims expenditures to represent the full cost of care for Vermont residents. Appendix G contains Data Specification Manual provided to payers to assist in reporting and filing these non-claims data.

Medicaid

DHVA will report Medicaid non-claims payments in the following categories:

- ACO Per Member Per Month (PMPM) Payments
- Blueprint PMPM Payout Amount
- PMPM Capitation Payment
- Medicare Community Health Teams (CHT) Payment (excluded)
- Medicare Blueprint Payment (excluded)
- Women's Health Initiative
- Women's Health Initiative Primary Care

Medicare

For baseline year (2017) a non-claims payment amount of 7.5 million is included in the Total Cost of Care. This payment was defined in the agreement as approximately the sum of Medicare payment to Vermont provider in 2016 as part of the Multi-payer Advance Primary Care Practice demonstration. This is a one-time payment and only included in the baseline year.

VI. QUARTERLY AND ANNUAL REPORTS OUTPUT

A. Step Down Diagnostics

This analysis produces diagnostics that track the status (inclusion / exclusion) of members and allowed amount associated with these members. Table V.1 below show the template for the step-down analysis. This table includes data for the full period covered by the report.

The top portion of the table tracks members excluded from the denominators. The rows of the table indicate the reason a member was excluded. Excluded members are assigned to one row in the hierarchy represented the by the order of the rows in the step-down table. The columns include counts of member months (observations in the eligibility file) and unique members (for selected rows). Additional columns show the impact of these exclusions on the numerator (allowed amount). The bottom portion of the table tracks the same statistics for members included in the denominator by payer category.

Table VI.1. Step Down Table of Members and Allowed Amount

Member Month Category	Member Months	Number of Unique Members	Commercial Claims Allowed Amount (as defined by Commercial spec)	Medicare Claims Allowed Amount (as defined by Medicare spec)	Medicaid Claims Allowed Amount (as defined by Medicaid spec)	Other Claims Allowed Amount (paid as primary, non orphaned claims, not included in any spec)
Total Members (medical or pharmacy eligibility)						
Excluded, no medical coverage (pharmacy eligibility only)		n.a.				
Excluded, not primary coverage		n.a.				
Commercial		n.a.				
Medicaid		n.a.				
Excluded, non-VT ZIP		n.a.				
Commercial		n.a.				
Medicare		n.a.				
Excluded, aid category (Medicaid)		n.a.				
Excluded, not eligble on 15th (Medicaid)		n.a.				
Excluded, Commercial Other Coverage Type		n.a.				
Excluded, Commercial behavioral health submitter		n.a.				
Excluded, other		n.a.				
Excluded, multiple coverage in same month		n.a.				
Medicare		n.a.				
Medicaid		n.a.				
Total Excluded						
Included						
Commercial						
Medicare						
Medicaid						
Total Included						
Unsupported Claims (no Membership Record)	n.a	n.a				

B. Quarterly Key Statistics Data

The quarterly key stats report is an EXCEL workbook containing summary cost and utilization statistics based TCOC data for each payer group, with each payer groups shown in a separate sheet along with a sheet containing all-payer results. The workbook will be name using as follows, where ***zzzzz*** is the name of the report (for example testreport, baseline, Q1, etc.) and ***mmddyyyy*** is the date the report was generated:

Workbook Name: TCOC key stats data***_zzzzz_mmddyyyy***.xlsx

Sheet Names:

- All-payer:
- Commercial
- Medicaid
- Other Medicaid (includes Other Categories of Care that are only reported for Medicaid)
- Medicare

This file will include TCOC per beneficiary results by quarter. Table VI.2 lists the columns included in the data output for the All-payer sheet. Details for the payer specific sheets can be found in the Appendices D, E, and F. Columns 1 will be the same for all records in the file, which will indicate the report date of the file. This file will include a record for each unique combination of Quarter, Year, Payer Group, Age Group, Gender, Member Health Service Area, and ACO Participation.

Table VI.2. Total Cost of Care Output - All-payer data

Variable #	Variable Name	Variable Description	Values
1	REPORT_DATE	Report date	Data of File
2	QUARTER	Quarter	Data Quarter
3	YEAR	Year	Data Year
4	PAYER_GROUP	Payer Group	Commercial Medicare FFS Medicaid
5	AGE_GROUP	Age group	<1 1 - 4 5 - 11 12 - 17 18 – 34 35 - 44 45 - 54 55 - 64 65 - 74 75 - 84 85 Plus
6	GENDER	Gender	Male Female

Variable #	Variable Name	Variable Description	Values
7	HSA	Member Health service area	Barre Bennington Brattleboro Burlington Middlebury Morrisville Newport Randolph Rutland Springfield St. Albans St. Johnsbury White River Junction UNKNOWN
8	ACO_PARTICIPATION	Member ACO Participation	Yes No
9	TOTAL_MONTHS	Total number of beneficiary months enrolled	
10	TOTAL_AA	Total Allowed Amount	
11	TOTAL_AA_PMPM	Total Allowed Amount per beneficiary per month	Variable 10 / Variable 9
12	TOTAL_INP_ACUTE_AA	Total Allowed Amount – Inpatient Acute	
13	TOTAL_INP_ACUTE_AA_PMPM	Total Allowed Amount – Inpatient Acute per beneficiary per month	Variable 12 / Variable 9
14	TOTAL_DISCHARGE	Total Number of Inpatient Acute Discharges	HEDIS measure
15	TOTAL_DISCHARGE_PER_1000_MY	Total Number of Inpatient Acute Discharge per 1,000 beneficiaries years	HEDIS measure
16	TOTAL_INP_SNF_AA	Total Allowed Amount – Inpatient SNF	
17	TOTAL_INP_SNF_AA_PMPM	Total Allowed Amount - Inpatient SNF per beneficiary per month	Variable 16 / Variable 9
18	TOTAL_INP_ICF_RES_AA	Total Allowed Amount – Inpatient Intermediate/ Residential	
19	TOTAL_INP_ICF_RES_AA_PMPM	Total Allowed Amount – Inpatient Intermediate/ Residential per beneficiary per month	Variable 18 / Variable 9
20	TOTAL_FAC_OUTPT_AA	Total Allowed Amount – Outpatient	
21	TOTAL_FAC_OUTPT_AA_PMPM	Total Allowed Amount - Outpatient per beneficiary per month	Variable 20 / Variable 9
22	TOTAL_HOSPICE_AA	Total Allowed Amount – Hospice	
23	TOTAL_HOSPICE_AA_PMPM	Total Allowed Amount – Hospice per beneficiary per month	Variable 22 / Variable 9
24	TOTAL_HOME_HEALTH_AA	Total Allowed Amount – Home Health	

Variable #	Variable Name	Variable Description	Values
25	TOTAL_HOME_HEALTH_AA_PMPM	Total Allowed Amount – Home Health per beneficiary per month	Variable 24 / Variable 9
26	TOTAL_DME_AA	Total Allowed Amount – DME	
27	TOTAL_DME_AA_PMPM	Total Allowed Amount – DME per beneficiary per month	Variable 26 / Variable 9
28	TOTAL_PROF_AA	Total Allowed Amount – Professional Services	
29	TOTAL_PROF_AA_PMPM	Total Allowed Amount – Professional Services per beneficiary per month	Variable 28 / Variable 9
30	TOTAL_OTH_MED_AA	Total Allowed Amount – Other Services	
31	TOTAL_OTH_MED_AA_PMPM	Total Allowed Amount – Other Services per beneficiary per month	Variable 30 / Variable 9
32	TOTAL_PRIM_CARE_AA	Total Allowed Amount – Professional Primary Care	
33	TOTAL_PRIM_CARE_AA_PMPM	Total Allowed Amount – Professional Primary Care per beneficiary per month	Variable 32 / Variable 9
34	TOTAL_SPECIALIST_AA	Total Allowed Amount – Professional Specialist Care	
35	TOTAL_SPECIALIST_AA_PMPM	Total Allowed Amount – Professional Specialist Care per beneficiary per month	Variable 34 / Variable 9
36	TOTAL_BEHAV_HEALTH_AA	Total Allowed Amount – Behavioral Health Services	
37	TOTAL_BEHAV_HEALTH_AA_PMPM	Total Allowed Amount – Behavioral Health Services per beneficiary per month	Variable 36 / Variable 9
38	TOTAL_OUTPATIENT_ER_AA	Total Allowed Amount – Outpatient ER Services	
39	TOTAL_OUTPATIENT_ER_AA_PMPM	Total Allowed Amount – Outpatient ER Services per beneficiary per month	Variable 38 / Variable 9
40	TOTAL_ER_VISITS	Number of Outpatient ER Visits	HEDIS Measure
41	TOTAL_ER_PER_1000_MY	Outpatient ER Visits per 1,000 beneficiaries	HEDIS Measure

C. Quarterly/Annual Report Results

These tables combine the claims based and non-claims based payments, computes cost per member and percent change over time.

- All-payer TCOC quarterly calculations, by performance quarter – Table II.1 in Section II above includes the template for this report. Not produced for baseline report, specifications will be updated for 2018 Q1 report.

- All-payer TCOC annual calculations, by performance year. Table II.2 in Section II above includes the template for this report.

  Workbook Name: TCOC annual_report_PYx_***mmddyyyy***.xlsx (where x is the performance year number, and mmddyyyy is the date the report created).

Column will be populated as follows:

Denominator Rows:

- Commercial Members - Number of Commercial Member Months / 12
- Medicare Members - Number of Medicare FFS Member Months / 12
- Medicare Members - Number of Medicaid Member Months / 12

Numerator Rows:

- Commercial claims-based cost - Sum of Allowed Amount for commercial members
- Commercial non-claim based cost - Sum of Total Non-claims payment reported by commercial payers
- Medicare claims-based cost - Sum of Allowed Amount for Medicare members
- Medicare non-claim based cost – 7.5 million for the baseline (PY0)
- Medicaid claims-based cost - Sum of Allowed Amount for Medicaid members
- Medicaid non-claim based cost – sum of the following Medicaid non-claim categories reported by DHVA:
  - ACO Per Member Per Month (PMPM) Payments
  - Blueprint PMPM Payout Amount
  - PMPM Capitation Payment
  - Women's Health Initiative
  - Women's Health Initiative Primary Care

TCOC per VT resident Row:

Sum of the 6 numerator rows / Sum of the 3 denominator rows

VII. QUARTERLY VHCURES SUBMITTER VALIDATION OUTPUT

For each payer group, we have distinct validation processes.

For the commercial payer group, we produce a summary level file for each report for validation purposes, which aggregates data by ME001 Submitter Code (SUBMITTER_CODE), payer type, and ACO participation. Data will be reported by quarter (Table VII.1).

Table VII.1. Total Cost of Care Output Validation-Commercial Payer

Column #	Column Name	Code book
1	Report date	Data of File
2	Quarter	Data Quarter
3	Year	Data Year
4	Run out period	3-months after the end of reporting quarter
5	Submitter Code	
6	Payer type	All Medicare Advantage Commercially Insured (not Self-Insured) Self-Insured
7	ACO Participation	Yes No
8	Total number of beneficiary months enrolled	
9	Total Allowed Amount	
10	Total Allowed Amount per beneficiary per month	Column 9 / Column 8

Validation of the Medicare Total Cost of Care will be completed by comparing the VHCURES based calculations described above to the Medicare TCOC computed by the Centers for Medicare and Medicaid Service (CMS).

Validation of the Medicaid Total Cost of Care will be possible using the DHVA summary data compared to the Medicaid Total Cost of Care Output described above.

APPENDIX A

MAJOR SERVICE CATEGORY CLAIMS LINES CATEGORIZATIONS

Table A.1 Service Claims Lines Categorizations

claim_type_id	claim_type_desc	type_of_setting_id	type_of_setting_desc	place_of_setting_id	place_of_setting_desc	Major Service Category for TCOC Calculations
1	Facility	1	Inpatient	1	Acute inpatient or hospital	Inpatient Acute
1	Facility	1	Inpatient	2	Swing Beds	Inpatient Skilled Nursing Facility
1	Facility	1	Inpatient	3	SNF	
1	Facility	1	Inpatient	4	ICF	Inpatient Intermediate Care and Residential Facilities
1	Facility	1	Inpatient	5	Residential	
1	Facility	1	Inpatient	6	Other	All Other Medical Claims
1	Facility	2	Outpatient	7	Hospital	Outpatient Facility Services
1	Facility	2	Outpatient	8	Free-Standing Ambulatory Surgery	
1	Facility	2	Outpatient	9	FQHC	
1	Facility	2	Outpatient	10	Rural Health Clinic	
1	Facility	2	Outpatient	11	Mental health Clinics	
1	Facility	2	Outpatient	3	SNF	
1	Facility	2	Outpatient	6	Other	
2	Professional	3	Provider	1	Acute inpatient or hospital	Professional Service Specialty, Primary Care, or Other based on Taxonomy code
				3	SNF	
				4	ICF	
				5	Residential	
				7	Hospital	
				8	Free-Standing Ambulatory Surgery	
				9	FQHC	
				10	Rural Health Clinic	
				11	Mental health Clinics	
				13	Office	
				6	Other	
2	Professional	4	Independent Labs	12	Not applicable	Professional Services Other
2	Professional	5	Ambulance	12	Not applicable	
2	Professional	6	Dental	12	Not applicable	All Other Medical Claims
3	Other services	7	Pharmacy	12	Not applicable	All Other Medical Claims
3	Other services	8	DME (Durable Medical Equipment)	12	Not applicable	DME
3	Other services	9	Home Health	12	Not applicable	Home Health
3	Other services	10	Unclassified/other	12	Not applicable	All Other Medical Claims
3	Other services	12	Hospice	12	Not applicable	Hospice

APPENDIX B

PRIMARY CARE AND SPECIALIST COST OF CARE MEAURE SPECIFICATIONS

A. Primary Care Cost

From the medical claims meeting the numerator exclusion criteria compute the cost of Primary Care. This cost is the sum of Allowed Amount (claim line for Professional setting, and claim level for other settings) for medical claims that meet ANY of the following criteria:

- Primary Care in Professional Setting:
  - Where claim type = 2 (Professional Claim) and;
  - Procedure code matches a code listed in Table B.1 and;
  - Rendering provider taxonomy matches a code listed in Table B.2
- Primary Care in Federal Qualified Health Center (FQHC) or Rural Health Center (RHC):
  - Where type of setting = 2 (Outpatient) and;
  - Where claim type = 1 (Facility) and;
  - Bill Type is 71, 73, or 77 (FQHC or RHC)
  - Revenue Center Code matches a code listed in Table B.4 and
  - Procedure code matches a code listed in Table B.1 and;
  - Attending physician taxonomy matches a codes listed in Table B.2
- Primary Care in Critical Access Hospital (CAH):
  - Where type of setting = 2 (Outpatient) and;
  - Where claim type = 1 (Facility) and;
  - Bill Type is 85 (CAH)
  - Revenue Center Code matches a code listed in Table B.5and;
  - Procedure code matches a code listed in Table B.1 and;
  - Attending physician taxonomy matches a codes listed in Table B.2
- Primary Care in Other Hospital:
  - Where type of setting = 2 (Outpatient) and;
  - Where claim type = 1 (Facility) and;
  - Bill Type is 13 (Other Hospital)
  - Revenue Center Code matches a code listed in Table B.6and;
  - Procedure code matches a code listed in Table B.1 and;
  - Attending physician taxonomy matches a codes listed in Table B.2

Table B.1. Primary Care Taxonomy Codes

Taxonomy	Taxonomy Description
207V00000X	Obstetrics & Gynecology
207VG0400X	Gynecology
175F00000X	Naturopath
208D00000X	General Practice
207Q00000X	Family Medicine
207QB0002X	Bariatric Medicine
207QA0401X	Addiction Medicine
207QA0000X	Adolescent Medicine
207QA0505X	Adult Medicine
207QH0002X	Hospice and Palliative Medicine
207QS0010X	Family Medicine - Sports Medicine
207QS1201X	Sleep Medicine
207R00000X	Internal Medicine
207RG0300X	Geriatric Medicine – Internal Medicine
207QG0300X	Geriatric Medicine – Family
363L00000X	Nurse Practitioner
363LF0000X	Nurse Practitioner – Family
363LP0200X	Nurse Practitioner – Pediatrics
363LP2300X	Nurse Practitioner – Primary Care
363A00000X	Physician Assistant
363AM0700X	Physician Assistant - Medical
208000000X	Pediatrics

Table B.2. Primary Care Procedure Codes

Procedure Code	Description	Group
99201-99205, 99211-99215	Office Visit	Office Visit
99354, 99355, 99358, 99359	Prolong Service Office Visit	Office Visit
T1015	Clinic Services (FQHC)	Encounter Payment
99381-99387, 99391-99397	Comprehensive Preventive Medicine	Preventive Visit
99401-99404, 99411, 99412	Preventive Counseling	Preventive Visit
99406, 99407	Smoking Cessation Counseling	Preventive Visit
99408, 99409	Alcohol/Substance Abuse Screening	Preventive Visit
99420	Health Risk Assessment	Preventive Visit
99429	Unlisted Preventive Service	Preventive Visit
G0402	Initial Preventive Physical Exam	Preventive Visit
G0438, G0439	Annual Wellness Visit	Preventive Visit
90460, 90461, 90471-90474	Immunization Administration	Vaccine Administration
G0008	Flu Vaccine Administration	Vaccine Administration
G0009	Pneumonia Vaccine Administration	Vaccine Administration
99495, 99496	Transitional Care Management	Care Management
99490, 99487, 99489, G0506	Chronic Care Management	CCM Codes
54900, 59510, 59610, 59618	Routine Obstetrical Care	OB/GYN
99460-99465	Evaluation & Management Services	OB/GYN
99304-99310, 99315, 99316, 99318	Nursing Facility Care	Nursing Facility
99341-99350	New/Established Patient Care	Home Services
99324-99328, 99334, 99337	New/Established Patient Care	Domiciliary/Rest Home/ Custodial Care

B. Specialist Care Cost

From the medical claims meeting the numerator exclusion criteria compute the cost of Specialist Care as the sum of Allowed Amount for medical claims that meet ANY of the following criteria:

- Specialist Care in Professional Setting:

    - Where claim type = 2 (Professional Claim) and;
    - Rendering physician taxonomy matches a code listed in Table B.3

- Specialist Care in Federal Qualified Health Center (FQHC) or Rural Health Center (RHC):

    - Where type of setting = 2 (Outpatient) and;
    - Where claim type = 1 (Facility) and;
    - Bill Type is 71, 73, or 77 (FQHC or RHC)
    - Revenue Center Code matches a codes listed in Table B.4and;
    - Attending physician taxonomy matches a codes listed in Table B.3

- Specialist Care in Critical Access Hospital (CAH):

    - Where type of setting = 2 (Outpatient) and;
    - Where claim type = 1 (Facility) and;
    - Bill Type is 85 (CAH)
    - Revenue Center Code is matches a codes listed in Table B.5 and;
    - Attending physician taxonomy matches a codes listed in Table B.3

- Specialist Care in Other Hospital

    - Where type of setting = 2 (Outpatient) and;
    - Where claim type = 1 (Facility) and;
    - Bill Type is 13 (Other Hospital)
    - Revenue Center Code matches a codes listed in Table B.6 and;
    - Attending physician taxonomy matches a codes listed in Table B.3

Table B.3. Specialist Care Taxonomy Codes

Table B.3 Specialist Care Taxonomy Codes		
Provider Specialty	Specialties Included	Taxonomy Codes
Medical Provider Specialist	Allergy & Immunology, Cardiology, Dermatology, Emergency Medicine, Endocrinology, Gastroenterology, Hematology, Hematology, Hepatology, Hospice and Palliative Medicine, Infectious Disease, Nephrology, Neurology, Nurse Practitioner Medical Specialists, Oncology, Pain Medicine, Pediatric Medical Specialists, Pulmonary Disease, Rheumatology, Sleep Medicine, Sports Medicine, Urology	204C00000X, 204D00000X, 207K00000X, 207KA0200X, 207KI0005X, 207N00000X, 207ND0101X, 207ND0900X, 207NI0002X, 207NP0225X, 207NS0135X, 207P00000X, 207PE0004X, 207PE0005X, 207PH0002X, 207PP0204X, 207PS0010X, 207PT0002X, 207QH0002X, 207QS0010X, 207RA0201X, 207RC0000X, 207RC0001X, 207RC0200X, 207RE0101X, 207RG0100X, 207RH0000X, 207RH0002X, 207RH0003X, 207RI0001X, 207RI0008X, 207RI0011X, 207RI0200X, 207RM1200X, 207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207RS0012X, 207RX0202X, 207U00000X, 207UN0901X, 207UN0902X, 207UN0903X, 2080H0002X, 2080I0007X, 2080N0001X, 2080P0006X, 2080P0008X, 2080P0201X, 2080P0202X, 2080P0203X, 2080P0204X, 2080P0205X, 2080P0206X, 2080P0207X, 2080P0208X, 2080P0210X, 2080P0214X, 2080P0216X, 2080S0010X, 2080S0012X, 2080T0002X, 208100000X, 2081H0002X, 2081P0004X, 2081P0010X, 2081P2900X, 2081S0010X, 2083A0100X, 2083P0011X, 2083P0500X, 2083P0901X, 2083S0010X, 2083T0002X, 2083X0100X, 2084D0003X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0005X, 2084P2900X, 2084S0010X, 2084S0012X, 2084V0102X, 208800000X, 2088P0231X, 208VP0000X, 208VP0014X, 363LA2100X, 363LC0200X, 363LC1500X, 363LN0000X, 363LN0005X, 363LP0222X, 363LP1700X, 363LS0200X, 363LW0102X, 363LX0001X, 363LX0106X
Surgical Provider Specialist	General, Neurological, Ophthalmology, Oral/Maxillofacial, Orthopaedic, Otolaryngology, Pediatric, Plastic/Reconstructive, Podiatrist, Hand, Thoracic, Transplant, Vascular	204E00000X, 204F00000X, 207T00000X, 207W00000X, 207X00000X, 207XP3100X, 207XS0106X, 207XS0114X, 207XS0117X, 207XX0004X, 207XX0005X, 207XX0801X, 207Y00000X, 207YP0228X, 207YS0012X, 207YS0123X, 207YX0007X, 207YX0602X, 207YX0901X, 207YX0905X, 208200000X, 2082S0099X, 2082S0105X, 208600000X, 2086H0002X, 2086S0102X, 2086S0105X, 2086S0120X, 2086S0122X, 2086S0127X, 2086S0129X, 2086X0206X, 208C00000X, 208G00000X, 213E00000X, 213EG0000X, 213EP0504X, 213EP1101X, 213ER0200X, 213ES0000X, 213ES0103X, 213ES0131X, 363AS0400X
Radiologist Provider	Radiologist Provider	2085R0001X, 2085R0202X, 2085R0204X
Pathologist Provider	Pathologist Provider	207ZB0001X, 207ZC0500X, 207ZD0900X, 207ZF0201X, 207ZH0000X, 207ZI0100X, 207ZM0300X, 207ZN0500X, 207ZP0007X, 207ZP0101X, 207ZP0102X, 207ZP0104X, 207ZP0105X, 207ZP0213X
Anesthesiologist Provider	Anesthesiologist Provider	207L00000X, 207LA0401X, 207LC0200X, 207LH0002X, 207LP2900X, 207LP3000X, 367500000X, 367H00000X
OB/GYN Provider	OB/GYN Provider	207V00000X, 207VC0200X, 207VE0102X, 207VG0400X, 207VH0002X, 207VM0101X, 207VX0000X, 207VX0201X
Behavioral Provider	Psychiatrist, LCSW, Psychologist, Psychiatric Nurse	103T00000X, 103TA0400X, 103TA0700X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TE1000X, 103TE1100X, 103TF0000X, 103TF0200X, 103TH0004X, 103TH0100X, 103TM1700X, 103TM1800X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 103TS0200X, 103TW0100X, 1041C0700X, 207QA0401X, 207RA0401X, 2084A0401X, 2084F0202X, 2084H0002X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 363LP0808X, 364SP0807X, 364SP0808X, 364SP0809X, 364SP0810X, 364SP0811X, 364SP0812X, 364SP0813X

Table B.3 Specialist Care Taxonomy Codes		
Provider Specialty	Specialties Included	Taxonomy Codes
Other Provider	Audiologist, Chiropractor, Dietitian, Occupational Therapist, Optometrist, Orthotist, Physical Therapist, Prosthetist, Speech-Language Pathologist, Other Physician Assistants and Nurse Practitioners	111N00000X, 111NI0013X, 111NI0900X, 111NN0400X, 111NN1001X, 111NR0200X, 111NR0400X, 111NS0005X, 111NT0100X, 111NX0100X, 111NX0800X, 133V00000X, 133VN1004X, 133VN1005X, 133VN1006X, 152W00000X, 152WC0802X, 152WL0500X, 152WP0200X, 152WS0006X, 152WV0400X, 152WX0102X, 156FX1800X, 222Z00000X, 224P00000X, 225100000X, 2251C2600X, 2251E1200X, 2251E1300X, 2251G0304X, 2251H1200X, 2251H1300X, 2251N0400X, 2251P0200X, 2251S0007X, 2251X0800X, 225X00000X, 225XE1200X, 225XH1200X, 225XH1300X, 225XN1300X, 225XP0200X, 225XR0403X, 231H00000X, 231HA2400X, 235Z00000X, 364S00000X, 364SA2100X, 364SC0200X, 364SC1501X, 364SC2300X, 364SE0003X, 364SE1400X, 364SH0200X, 364SH1100X, 364SI0800X, 364SL0600X, 364SM0705X, 364SN0000X, 364SN0800X, 364SP1700X, 364SP2800X, 364SR0400X, 364SS0200X, 364ST0500X, 364SW0102X, 364SX0106X, 364SX0200X, 364SX0204X, 367A00000X

Table B.3. Revenue Center Codes for FQHC and RHC

Revenue Center Code	Revenue Center Code Description
0521	Free-standing clinic-Clinic visit by a member to RHC/FQHC
0522	Free-standing clinic-Home visit by RHC/FQHC practitioner
0524	Free-standing clinic - visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility

Table B.4. Revenue Center Codes for CAH

Revenue Center Code	Revenue Center Code Description
0510	Clinic-general classification
0511	Clinic-chronic pain center
0512	Clinic-dental center
0513	Clinic-psychiatric
0514	Clinic-OB-GYN
0515	Clinic-pediatric
0516	Clinic-urgent care clinic
0517	Clinic-family practice clinic
0519	Clinic-other
0960	Professional fees-general classification
0961	Professional fees-psychiatric
0962	Professional fees-ophthalmology
0963	Professional fees-anesthesiologist (MD)
0964	Professional fees-anesthetist (CRNA)
0969	Professional fees-other NOTE: 097X is an extension of 096X
0971	Professional fees-laboratory
0972	Professional fees-radiology diagnostic
0973	Professional fees-radiology therapeutic

Revenue Center Code	Revenue Center Code Description
0974	Professional fees-nuclear medicine
0975	Professional fees-operating room
0976	Professional fees-respiratory therapy
0977	Professional fees-physical therapy
0978	Professional fees-occupational therapy
0979	Professional fees-speech pathology NOTE: 098X is an extension of 096X & 097X
0981	Professional fees-emergency room
0982	Professional fees-outpatient services
0983	Professional fees-clinic
0984	Professional fees-medical social services
0985	Professional fees-EKG
0986	Professional fees-EEG
0987	Professional fees-hospital visit
0988	Professional fees-consultation
0989	Professional fees-private duty nurse

Table B.5. Revenue Center Codes for Other Hospital

Revenue Center Code	Revenue Center Code Description
0510	Clinic-general classification
0511	Clinic-chronic pain center
0512	Clinic-dental center
0513	Clinic-psychiatric
0514	Clinic-OB-GYN
0515	Clinic-pediatric
0516	Clinic-urgent care clinic
0517	Clinic-family practice clinic
0519	Clinic-other

APPENDIX C

ACUTE INPATIENT DISCHARGES AND EMERGENCY DEPARTMENT VISIT CALCULATION DETAILS

Inpatient Utilization—General Hospital/Acute Care (IPU)

Summary of Changes to HEDIS 2018

- Revised the data elements tables to indicate that rates are calculated for the Discharges/1,000 Member Months/Years in the unknown category.

Description

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Total inpatient.

Calculations

Note: *Members in hospice are excluded from this measure. Refer to General Guideline 20: Members in Hospice.*

Member months	For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Utilization Tables* for more information.

Use the following steps to identify and categorize inpatient discharges.

Step 1 Identify all acute inpatient discharges on or between January 1 and December 31 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Step 2 Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set), or an MS-DRG for mental health, chemical dependency or rehabilitation (IPU Exclusions MS-DRG Value Set).

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set) or the presence of a code from the Newborn/Neonates MS-DRG Value Set. Organizations must develop methods to differentiate between the mother's claim and the newborn's claim, if needed.

Step 3 Report total inpatient, using all discharges identified after completing steps 1 and 2.

Emergency Department Ambulatory Care (AMB)

Summary of Changes to HEDIS 2018

- Clarified how to identify an ED visit that resulted in an inpatient stay.
- Removed the AOD Rehab and Detox Value Set from the required exclusions (exclusions will be identified based on a principal diagnosis of chemical dependency).

Description

This measure summarizes utilization of ambulatory care in the following categories:

- ED Visits.

Calculations

Note: *Members in hospice are excluded from this measure. Refer to General Guideline 20: Members in Hospice.*

Member months For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to *Specific Instructions for Utilization Tables* for more information.

Counting multiple services *For combinations of multiple ambulatory services* falling in different categories on the same day, report each service that meets the criteria in the appropriate category.

ED visits Count each visit to an ED 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).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or one calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

Exclusions (required)

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. Any of the following meet criteria:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

APPENDIX D

VHCURES COMMERCIAL PAYMENTS AND ENROLLMENT DATA FOR CALCULATING TOTAL COST OF CARE PER MEMBER

A. Overview

This document is the specification for the commercial component of Total Cost of Care. The specifications describes the methods for computing the Commercial TCOC per beneficiary, as well as the strategy for validating the results. The commercial component of Total Cost of Care will be computed from eligibility and claims data submitted to the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES).

The commercial TCOC calculations will include Vermont Commercial Plans, which include health insurance plans holding a certificate of authority from Vermont's Commissioner of Financial Regulation. Coverage for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage if benefits for health services are secondary or incidental to other insurance benefits are excluded. Medicare Advantage plans are included, but Medicare Supplemental insurance is excluded. Likewise, stand-alone dental, vision, long term care, specified disease, and other limited benefit coverage is excluded.

The commercial TCOC per beneficiary will be calculated in total and by subcategory. The subcategory results will:

- allow validation of results by the commercial carriers that submitted the VHCURES enrollment and claims data;
- allow analysis by Vermont on trend by subgroups of beneficiaries and services provided;
- maintain consistency with the Agreement, so that results can be combined with other sources to compute the All-payer Total Cost of Care.

For each reporting period, the claims run-out period will be consistent at 3 months after the service period end date. This consistency will allow calculation of change in cost of care by member over time to meet the Agreement requirements.

This specification describes the calculation of the Commercial Total Cost of Care per Member which is defined as:

$$\frac{Total\ cost\ of\ care\ for\ Vermont\ residents\ with\ commercial\ insurance}{Vermont\ resisents\ with\ commercial\ insurance\ weighted\ by\ member\ months}$$

B. Denominator Calculation

The commercial payer denominator calculation is based on monthly eligibility data included in the VHCURES. The denominator **INCLUDES** member months that meet **ALL** of the following conditions:

- Residents of Vermont, where ME017 Member ZIP CODE is a valid Vermont ZIP Code.
- With Medical Coverage, where ME018 Medical Coverage (ELIGIBLITY_COVERAGE CLASS) = MEDICAL;
- With primary insurance coverage, where ME028 Primary Insurance Indicator (PRIMARY_INSURANCE_INDICATOR_CODE) = 1
- For a Vermont commercial plan, where ME003 Insurance Type/Product Code (PRODUCT) one of the following:
  - EP – Exclusive Provider Organization
  - HM - Health Maintenance Organization (HMO)
  - IN – Indemnity
  - PR - Preferred Provider Organization (PPO)
  - PS - Point of Service (POS)
  - HN - Health Maintenance Organization (HMO) Medicare Advantage / Medicare Part C

In addition to the above exclusion criteria, the denominator **EXCLUDES** member months that meet **ANY** of the following conditions:

- Member in a Commercially Insured Plans (not Self-Insured) that does not have a Certificate of Authorization (COA) in Vermont. Where ME003 Insurance Type/Product Code (PRODUCT) ne HN; and ME029 Coverage Type (COVERAGE_TYPE_CODE) not ASO and not ASW); and ME001 (Payer) is one of the following;

VTC0587	Blue Cross Blue Shield of MA HMO Blue Inc.
VTC0591	Blue Shield of California
VTC0620	Excellus Health Plan, Inc.
VTC0586	Blue Cross Blue Shield of MA
VTC0511	Harvard Pilgrim Insurance Company
VTT0199	Tufts Benefit Administrators, Inc.
VTC0213	Harvard Pilgrim Health Care
VTT0499	Anthem Inc
VTC0617	Highmark, Inc.

- Member in a Behavioral Health Carve-out Plan where ME001 (Payer) is one of the following (if a member is excluded from the Commercial denominator for this reason only, they are eligible to be included in the Medicare FFS or Medicaid denominator if eligible):
  - VTT0202 United Behavioral Health
  - VTT0202A United Behavioral Health - (Facets)
  - VTT0043 Cigna Behavioral Health, Inc.

After sub-setting the VHCURES monthly enrollment data as described above, we have monthly enrollment data for commercial members that reside in Vermont, with Primary Medical coverage from a Vermont commercial plan that is self-insured, Medicare Advantage, or with a COA.

Field Definitions for Denominator Categorization Filters

The member months will be calculated for each of the following member characteristics:

- Member gender (ME013): Female, Male. If gender is UNKNOWN determine gender from other months for the same member (if not unknown), otherwise set to Female.
- Member age group: <1, 1-4, 5-11,12-17,18-34,35-44,45-54,55-64,65-74,75-84,85+
- Payer Submitter Code: Identifies the submitting entity through the submitter code (ME001) – for validation purposes only
- Payer type: using ME003 Insurance Type / Product Code (PRODUCT_CODE) and ME029 Coverage Type (COVERAGE_TYPE_CODE):
  - Medicare Advantage, HN
  - Self-Insured plans, ASO, ASW
  - Commercially Insured Plans (not Self-Insured), Others
- ACO Participation Indicator (ME031): Yes, No
- Member's Vermont Hospital Service Area of residence Member's Vermont Hospital Service Area of residence using "Residential Zip and Town Lookups to VDH HSA" developed by Blueprint.

C. Numerator Calculation

Once members are selected from the eligibility file, the total cost of care for these selected members will be calculated from medical claims where the commercial payer is a primary payer. By selecting medical claims only, we will be excluding retail pharmacy claims and dental claims.

We include the following medical claims:

- Medical Claims with service start date for a member and month included in the denominator.
- Medical Claims paid as primary, with MC038 Claim Status (CLAIM_STATUS) = '01' or '19'.
- Medical Claims paid for by a Vermont Commercial Plan, where MC003 Insurance Type/Product Code (PRODUCT) one of the following:
  - 12 - Preferred Provider Organization (PPO)
  - 13 - Point of Service (POS)
  - 14 – Exclusive Provider Organization (EPO)
  - 15 - Indemnity Insurance
  - 16 - Health Maintenance Organization (HMO) Medicare Advantage / Medicare Part C
  - HM - Health Maintenance Organization (HMO)

After sub-setting the Medical claims file, we will calculate and report the following cost information for the numerators, (Note that pre-paid amounts are not included in the calculation of Total cost):

- **Total Allowed Amount**= A calculated field for the sum of Total Amount Paid (MC063 PAID AMT), Copay amount (MC065 COPAY_AMT), Coinsurance Amount (MC066 COINSURANCE_AMT), and Deductible Amount (MC067 DEDUCTIBLE_AMT).

D. Quarterly Data Output

Quarterly Report

Table D.1 lists the columns included in the Commercial sheet. Columns 1 will be the same for all rows in the file, which will indicate the report date of the file. This file will include a record for each unique combination of Quarter, Year, Payer Type, Age Group, Gender, Member Health Service Area, and ACO Participation. See Section VII. in base section of this document for worksheet naming conventions.

Table D.1. Commercial Total Cost of Care Output

Table D.1 Commercial Total Cost of Care Output

Variable #	Variable Name	Variable Description	Values
1	REPORT_DATE	Report date	Data of File
2	QUARTER	Quarter	Data Quarter
3	YEAR	Year	Data Year
4	PAYER_TYPE	Payer type	Medicare Advantage Commercially Insured (not Self-Insured) Self-Insured
5	AGE_GROUP	Age group	<1 1 - 4 5 - 11 12 - 17 18 – 34 35 - 44 45 - 54 55 - 64 65 - 74 75 - 84 85 Plus
6	GENDER	Gender	Male Female
7	HSA	Member Health service area	Barre Bennington Brattleboro Burlington Middlebury Morrisville Newport Randolph Rutland Springfield St. Albans St. Johnsbury White River Junction
8	ACO_PARTICIPATION	ACO Participation	Yes No
9	TOTAL_MONTHS	Total number of beneficiary months enrolled	
10	TOTAL_AA	Total Allowed Amount	

Table D.1 Commercial Total Cost of Care Output			
Variable #	**Variable Name**	**Variable Description**	**Values**
11	TOTAL_AA_PMPM	Total Allowed Amount per beneficiary per month	Variable 10 / Variable 9
12	TOTAL_INP_ACUTE_AA	Total Allowed Amount – Inpatient Acute	
13	TOTAL_INP_ACUTE_AA_PMPM	Total Allowed Amount – Inpatient Acute per beneficiary per month	Variable 12 / Variable 9
14	TOTAL_DISCHARGE	Total Number of Inpatient Acute Discharges	HEDIS measure
15	TOTAL_DISCHARGE_PER_1000_MY	Total Number of Inpatient Acute Discharge per 1,000 member years	HEDIS measure
16	TOTAL_INP_SNF_AA	Total Allowed Amount – Inpatient SNF	
17	TOTAL_INP_SNF_AA_PMPM	Total Allowed Amount - Inpatient SNF per beneficiary per month	Variable 16 / Variable 9
18	TOTAL_INP_ICF_RES_AA	Total Allowed Amount – Inpatient Intermediate/ Residential	
19	TOTAL_INP_ICF_RES_AA_PMPM	Total Allowed Amount – Inpatient Intermediate/ Residential per beneficiary per month	Variable 18 / Variable 9
20	TOTAL_FAC_OUTPT_AA	Total Allowed Amount – Outpatient	
21	TOTAL_FAC_OUTPT_AA_PMPM	Total Allowed Amount - Outpatient per beneficiary per month	Variable 20 / Variable 9
22	TOTAL_HOSPICE_AA	Total Allowed Amount – Hospice	
23	TOTAL_HOSPICE_AA_PMPM	Total Allowed Amount – Hospice per beneficiary per month	Variable 22 / Variable 9
24	TOTAL_HOME_HEALTH_AA	Total Allowed Amount – Home Health	
25	TOTAL_HOME_HEALTH_AA_PMPM	Total Allowed Amount - Home Health per beneficiary per month	Variable 24 / Variable 9
26	TOTAL_DME_AA	Total Allowed Amount – DME	
27	TOTAL_DME_AA_PMPM	Total Allowed Amount – DME per beneficiary per month	Variable 26 / Variable 9
28	TOTAL_PROF_AA	Total Allowed Amount – Professional Services	
29	TOTAL_PROF_AA_PMPM	Total Allowed Amount - Professional Services per beneficiary per month	Variable 28 / Variable 9
30	TOTAL_OTH_MED_AA	Total Allowed Amount – Other Services	
31	TOTAL_OTH_MED_AA_PMPM	Total Allowed Amount - Other Services per beneficiary per month	Variable 30 / Variable 9
32	TOTAL_PRIM_CARE_AA	Total Allowed Amount – Professional Primary Care	
33	TOTAL_PRIM_CARE_AA_PMPM	Total Allowed Amount - Professional Primary Care per beneficiary per month	Variable 32 / Variable 9
34	TOTAL_SPECIALIST_AA	Total Allowed Amount – Professional Specialist Care	

Table D.1 Commercial Total Cost of Care Output			
Variable #	**Variable Name**	**Variable Description**	**Values**
35	TOTAL_SPECIALIST_AA_PMPM	Total Allowed Amount - Professional Specialist Care per beneficiary per month	Variable 34 / Variable 9
36	TOTAL_BEHAV_HEALTH_AA	Total Allowed Amount – Behavioral Health Services	
37	TOTAL_BEHAV_HEALTH_AA_PMPM	Total Allowed Amount - Behavioral Health Services per beneficiary per month	Variable 36 / Variable 9
38	TOTAL_OUTPATIENT_ER_AA	Total Allowed Amount – Outpatient ER Services	
39	TOTAL_OUTPATIENT_ER_AA_PMPM	Total Allowed Amount - Outpatient ER Services per beneficiary month	Variable 38 / Variable 9
40	TOTAL_ER_VISITS	Number of Outpatient ER Visits	HEDIS measures
41	TOTAL_ER_PER_1000_MY	Outpatient ER Visits per 1,000 beneficiaries	HEDIS measures

Validation

We will produce a summary level file for each report for validation purposes, which will aggregate data by ME001 Submitter Code (SUBMITTER_CODE), payer type, and ACO participation. Data will be reported by quarter (Table D.2).

Table D.2. Commercial Total Cost of Care Output Validation

Column #	Column Name	Code book
1	Report date	Data of File
2	Quarter	Data Quarter
3	Year	Data Year
4	Run out period	3-months after the end of reporting quarter
5	Submitter Code	
6	Payer type	Medicare Advantage Commercially Insured (not Self-Insured) Self-Insured
7	ACO Participation	Yes No
8	Total number of beneficiary months enrolled	
9	Total Allowed Amount	
10	Total Allowed Amount per beneficiary per month	Column 9 / Column 8

APPENDIX E

VHCURES MEDICARE PAYMENTS AND ENROLLMENT DATA FOR CALCULATING TOTAL COST OF CARE PER MEMBER

A. Overview

This document is the specification for the Medicare component of Total Cost of Care. The specification describe the methods for computing the Medicare TCOC per beneficiary to validate CMS calculations until timely Medicare claims are acquired through VHCURES submission.

The Medicare TCOC per beneficiary will be calculated in total and by subcategory. The subcategory results will:

- allow validation of results by CMS to data submitted to VHCURES enrollment and claims data;
- allow analysis by Vermont on trend by subgroups of beneficiaries and services provided;
- maintain consistency with the Agreement, so that results can be combined with other sources to compute the All-payer Total Cost of Care.

For each reporting period, the claims run-out period will be consistent at 3 months after the service period end date. This consistency will allow calculation of change in cost of care by member over time to meet the Agreement requirements.

This specification describes the calculation of the Medicare Total Cost of Care per Member which is defined as:

$$\frac{Total\ cost\ of\ care\ for\ Vermont\ residents\ with\ Medicare\ FFS\ coverage}{Vermont\ residents\ with\ comprehensive\ Medicare\ \text{FFS coverage}\ weighted\ by\ member\ months}$$

B. Denominator Calculation

The Medicare payer denominator calculation is based on monthly eligibility data included in the VHCURES. The denominator includes member months that meet all of the following conditions:

- Medicare Fee-for-Service (FFS) is a primary insurance using VHCURES member month tables
- Residents of Vermont, where ME017 Member ZIP CODE is a valid Vermont ZIP Code.
- With Medical Coverage, where ME018 Medical Coverage (ELIGIBLITY_COVERAGE CLASS) = MEDICAL;

After sub-setting the VHCURES monthly enrollment data as described above, we have monthly enrollment data for members that are enrolled in Medicare Parts A or B, reside in Vermont, and have Primary Medical coverage.

Field Definitions for Denominator Categorization Filters

The member months will be calculated for each of the following member characteristics:

- Member gender (ME013): Female, Male. If gender is UNKNOWN determine gender from other months for the same member (if not unknown), otherwise set to Female.
- Member age group: <1, 1-4, 5-11,12-17,18-34,35-44,45-54,55-64,65-74,75-84,85+
- ACO Participation Indicator (ME031): Yes (1), No (0) when it is available. It will be missing until then.
- Member's Vermont Hospital Service Area of residence Member's Vermont Hospital Service Area of residence using "Residential Zip and Town Lookups to VDH HSA" developed by Blueprint.
- Product Group: where ME003 Product Type in ("AB" (Medicare FFS A and B), "MA" (Medicare FFS Part-A only, "MB" (Medicare Part B FFS)
- Eligibility Category: Current eligibility reason filed (ME407) Aged and Disabled, ESRD

C. Numerator Calculation

Once members are selected from the eligibility file, the total cost of care for these selected members will be calculated from medical claims where Medicare FFS is the primary payer. We will include the following medical claims:

1. Medical Claims with service start date for a member and month included in the denominator.
2. Medical Claims paid as primary, with MC038 Claim Status (CLAIM_STATUS) = '01' or '19'.
3. Medical Claims for Medicare FFS, with MC003 Insurance Type / Product Code = 'MA' or 'MB' or 'AB'

After selecting the Medical claims file, we will calculate and report the following cost information for the numerators, (Note that pre-paid amounts are not included in the calculation of Total cost):

Total Allowed Amount= A calculated field for the sum of Total Amount Paid (MC063 PAID AMT), Copay amount (MC065 COPAY_AMT), Coinsurance Amount (MC066 COINSURANCE_AMT), and Deductible Amount (MC067 DEDUCTIBLE_AMT).

D. Quarterly Data Output

Quarterly Report

Table E.1 lists the columns included in the Medicare sheet. Columns 1 will be the same for all rows in the file, which will indicate the report date of the file. This file will include a row for each unique combination of Quarter, Year, Age Group, Gender, Member Health Service Area, ACO Participation, Product Group, and Eligibility Category. See Section VII. in base section of this document for worksheet naming conventions.

Table E.1 Medicare Total Cost of Care Output

Variable #	Variable Name	Variable Description	Values
1	REPORT_DATE	Report date	Data of File
2	QUARTER	Quarter	Data Quarter
3	YEAR	Year	Data Year
4	AGE_GROUP	Age group	<1 1 - 4 5 - 11 12 - 17 18 – 34 35 - 44 45 - 54 55 - 64 65 - 74 75 - 84 85 Plus
5	GENDER	Gender	Male Female
6	HSA	Member Health service area	Barre Bennington Brattleboro Burlington Middlebury Morrisville Newport Randolph Rutland Springfield St. Albans St. Johnsbury White River Junction
7	ACO_PARTICIPATION	ACO Participation	Yes No
8	PRODUCT_GROUP	Product Group	Parts A and B Part A only Part B only
9	ELIGIBILITY_CATEGORY	Eligibility Categories	Aged and Disabled ESRD
10	TOTAL_MONTHS	Total number of beneficiary months enrolled	
11	TOTAL_AA	Total Allowed Amount	
12	TOTAL_AA_PMPM	Total Allowed Amount per beneficiary per month	Variable 11 / Variable 10
13	TOTAL_INP_ACUTE_AA	Total Allowed Amount – Inpatient Acute	

Variable #	Variable Name	Variable Description	Values
14	TOTAL_INP_ACUTE_AA_PMPM	Total Allowed Amount – Inpatient Acute per beneficiary per month	Variable 13 / Variable 10
15	TOTAL_DISCHARGE	Total Number of Inpatient Acute Discharges	HEDIS Measure
16	TOTAL_DISCHARGE_PER_1000_MY	Total Number of Inpatient Acute Discharge per 1,000 beneficiaries	HEDIS Measure
17	TOTAL_INP_SNF_AA	Total Allowed Amount – Inpatient SNF	
18	TOTAL_INP_SNF_AA_PMPM	Total Allowed Amount - Inpatient SNF per beneficiary per month	Variable 17 / Variable 10
19	TOTAL_INP_ICF_RES_AA	Total Allowed Amount – Inpatient Intermediate/ Residential	
20	TOTAL_INP_ICF_RES_AA_PMPM	Total Allowed Amount – Inpatient Intermediate/ Residential per beneficiary per month	Variable 19 / Variable 10
21	TOTAL_FAC_OUTPT_AA	Total Allowed Amount – Outpatient	
22	TOTAL_FAC_OUTPT_AA_PMPM	Total Allowed Amount - Outpatient per beneficiary per month	Variable 21 / Variable 10
23	TOTAL_HOSPICE_AA	Total Allowed Amount – Hospice	
24	TOTAL_HOSPICE_AA_PMPM	Total Allowed Amount – Hospice per beneficiary per month	Variable 23 / Variable 10
25	TOTAL_HOME_HEALTH_AA	Total Allowed Amount – Home Health	
26	TOTAL_HOME_HEALTH_AA_PMPM	Total Allowed Amount – Home Health per beneficiary per month	Variable 25 / Variable 10
27	TOTAL_DME_AA	Total Allowed Amount – DME	
28	TOTAL_DME_AA_PMPM	Total Allowed Amount – DME per beneficiary per month	Variable 27 / Variable 10
29	TOTAL_PROF_AA	Total Allowed Amount – Professional Services	
30	TOTAL_PROF_AA_PMPM	Total Allowed Amount – Professional Services per beneficiary per month	Variable 29 / Variable 10
31	TOTAL_OTH_MED_AA	Total Allowed Amount – Other Services	
32	TOTAL_OTH_MED_AA_PMPM	Total Allowed Amount - Other Services per beneficiary per month	Variable 31 / Variable 10
33	TOTAL_PRIM_CARE_AA	Total Allowed Amount – Professional Primary Care	
34	TOTAL_PRIM_CARE_AA_PMPM	Total Allowed Amount – Professional Primary Care per beneficiary per month	Variable 33 / Variable 10
35	TOTAL_SPECIALIST_AA	Total Allowed Amount – Professional Specialist Care	
36	TOTAL_SPECIALIST_AA_PMPM	Total Allowed Amount – Professional Specialist Care per beneficiary per month	Variable 35 / Variable 10
37	TOTAL_BEHAV_HEALTH_AA	Total Allowed Amount – Behavioral Health Services	
38	TOTAL_BEHAV_HEALTH_AA_PMPM	Total Allowed Amount – Behavioral Health Services per beneficiary per month	Variable 37 / Variable 10
39	TOTAL_OUTPATIENT_ER_AA	Total Allowed Amount – Outpatient ER Services	
40	TOTAL_OUTPATIENT_ER_AA_PMPM	Total Allowed Amount – Outpatient ER Services per beneficiary per month	Variable 39 / Variable 10
41	TOTAL_ER_VISITS	Number of Outpatient ER Visits	HEDIS Measure
42	TOTAL_ER_PER_1000_MY	Outpatient ER Visits per 1,000 beneficiaries	HEDIS Measure

Validation

Validation of the Medicare Total Cost of Care will be completed by comparing the VHCURES based calculations described above to the Medicare TCOC computed by the Centers for Medicare and Medicaid Service (CMS). As of now we do not have detail on the CMS tabulation to provide more details for this section.

APPENDIX F

VHCURES MEDICAID PAYMENTS AND ENROLLMENT DATA FOR CALCULATING TOTAL COST OF CARE PER MEMBER

A. Overview

This document is the specification for the Medicaid component of Total Cost of Care. The specification describe the methods for computing the Medicaid TCOC per beneficiary, as well as the strategy for validating the results.

The Medicaid component of Total Cost of Care will be computed from eligibility and claims data submitted by the Department of Vermont Health Access (DVHA) to the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES).

The Medicaid TCOC per beneficiary will be calculated in total and by subcategory. The subcategory results will:

- allow validation of results by DHVA to data submitted to VHCURES enrollment and claims data;
- allow analysis by Vermont on trend by subgroups of beneficiaries and services provided;
- maintain consistency with the Agreement, so that results can be combined with other sources to compute the All-payer Total Cost of Care.

For each reporting period, the claims run-out period will be consistent at 3 months after the service period end date. This consistency will allow calculation of change in cost of care by member over time to meet the Agreement requirements.

This specification describes the calculation of the Medicaid Total Cost of Care per Member which is defined as:

$$\frac{\textit{Total cost of care for Vermont residents with comprehensive Medicaid coverage}}{\textit{Vermont residents with comprehensive Medicaid insurance weigthed by member months}}$$

B. Denominator Calculation

The Medicaid payer denominator calculation is based on monthly eligibility data included in the VHCURES. The denominator includes member months that meet all of the following conditions:

- Medicaid payer, where ME001 Payer Submitter Code = VTG0001
- With Medical Coverage, where ME018 Medical Coverage (ELIGIBLITY_COVERAGE CLASS) = MEDICAL;
- With primary insurance coverage, where ME028 Primary Insurance Indicator (PRIMARY_INSURANCE_INDICATOR_CODE) = 1.
- With comprehensive Medicaid benefit coverage and Eligible for ACO attribution based on ME201 (AID Eligibility Category) where Benefit Summary = "Comprehensive Medical & Pharmacy" and NextGen ACO category = ABD or non-ABD in Benefit Summary crosswalk (see Table F2). The AID categories meeting this criteria are indicated with a YES in the INCLUDE IN TCOC column.
- Not Dual Eligible: (ME202) = No (0)
- Eligibility_Code (ME210) = 1 (Identifies coverage on the 15th of the month)

After sub-setting the VHCURES monthly enrollment data as described above, we have monthly enrollment data for members that reside in Vermont, have Primary Medical coverage, have Comprehensive Medicaid benefit, are eligible for ACO attribution, and are not dual eligible.

Field Definitions for Denominator Categorization Filters

The member months will be calculated for each of the following member characteristics:

- Member gender (ME013): Female, Male. . If gender is UNKNOWN determine gender from other months for the same member (if not unknown), otherwise set to Female.
- Member age group: <1, 1-4, 5-11,12-17,18-34,35-44,45-54,55-64,65-74,75-84,85+
- NextGen ACO Category: ABD , Non-ABD (based on ME201 (AID Eligibility Category) in Appendix Table D.2)
- ACO Participation Indicator (ME031): Yes (1), No (0)
- Member's Vermont Hospital Service Area of residence Member's Vermont Hospital Service Area of residence using "Residential Zip and Town Lookups to VDH HSA" developed by Blueprint. If the member ZIP code is not a Vermont ZIP code then assign this member to an UNKNOWN Hospital Service Area.

C. Numerator Calculation

Once members are selected from the eligibility file, the total cost of care for these selected members will be calculated from medical claims where Medicaid is the primary. We will include the following medical claims:

- Medical Claims with service start date for a member and month included in the denominator.
- Medical Claims paid as primary, with MC038 Claim Status (CLAIM_STATUS) = '01' or '19'.

We will also exclude the following claims from all cost calculations:

1. Pharmacy claims – Medicaid Claim Type = D
2. Dental claims –Medicaid Claim Type = L
3. Medicaid Behavioral Health Services, and Medicaid Home and Community-based

   services:

   a. Fund Source (MC215) = B, C, E, G, H, I, J, K, L, R, S, Z, and 9 (see Table F.3) **or** in one of the following service categories:
   b. DHVA funded Designated Agency/Statewide Service Agency (Mental Health) payments – Category of Care codes of 19xx and Provider Type = 40 and Specialty = S12
   c. HCBS Services – Category of Service codes of 27xx
   d. Residential Treatment – Category of Service codes of 33xx
   e. ADAP Services – Category of Service codes of 35xx
   f. Rehab/Recovery – Category of Service codes of 36xx

4. Transportation – Category of Service codes of 22xx
5. Personal Care Services -- Category of Service codes of 29xx
6. D&P Services (Education and Other agencies) – Category of Service codes of 37xx
7. Capitation – Medicaid Claim Type code = C
8. Vision – Medicaid Claim Type code = P

After selecting the Medical claims file, we will calculate and report the following cost information for the numerators, (Note that pre-paid amounts are not included in the calculation of Total cost):

- **Total Allowed Amount**= A calculated field for the sum of Total Amount Paid (MC063 PAID AMT), Copay amount (MC065 COPAY_AMT), Coinsurance Amount (MC066 COINSURANCE_AMT), and Deductible Amount (MC067 DEDUCTIBLE_AMT).

Field Definitions for Numerator Categorization Filters:

Unique Medicaid Service Categories

1. Inpatient Intermediate Care and Residential Facilities Cost (Medicaid claim type=N and COS 60X). This category include claims that meet the Medical claim type and COS criteria above and are included in one of the Major Service Categories above.
2. Medicaid SNF cost- Category of Service codes of 05xx and Medicaid Claim type code = N, This category include claims that meet the Medical claim type and COS criteria above and are included in one of the Major Service Categories above.

Unique to Medicaid cost – Category of Service Code where Unique to Medicaid = 'Y' in Appendix Table F.4. This category include claims that meet the COS criteria above and are included in one of the Major Service Categories listed in Section IV.A.1.

D. Quarterly Data Output

Quarterly Report

Table F.1a lists the columns included in the Medicaid sheet, and Table F.1b list the columns included in the Other Medicaid sheet. Columns 1 will be the same for all rows in the file, which will indicate the report date of the file. Each file will include a row for each unique combination of Quarter, Year, Age Group, Gender, Member Health Service Area, ACO Participation, and NextGen ACO category. See Section VII. in base section of this document for worksheet naming conventions.

Table F.1a Medicaid Total Cost of Care Output

Variable #	Variable Name	Variable Description	Values
1	REPORT_DATE	Report date	Data of File
2	QUARTER	Quarter	Data Quarter
3	YEAR	Year	Data Year
4	AGE_GOUPR	Age group	<1 1 - 4 5 - 11 12 - 17 18 – 34 35 - 44 45 - 54 55 - 64 65 - 74 75 - 84 85 Plus
5	GENDER	Gender	Male Female
6	HSA	Member Health service area	Barre Bennington Brattleboro Burlington Middlebury Morrisville Newport Randolph Rutland Springfield St. Albans St. Johnsbury White River Junction UNKNOWN
7	ACO_PARTICIPATION	ACO Participation	Yes No
8	NEXTGEN_ACO_CATEGORY	NextGen ACO category	ABD Non-ABD
9	TOTAL_MONTHS	Total number of beneficiary months enrolled	
10	TOTAL_AA	Total Allowed Amount	
11	TOTAL_AA_PMPM	Total Allowed Amount per beneficiary per month	Variable 10 / Variable 9

Variable #	Variable Name	Variable Description	Values
12	TOTAL_INP_ACUTE_AA	Total Allowed Amount – Inpatient Acute	
13	TOTAL_INP_ACUTE_AA_PMPM	Total Allowed Amount – Inpatient Acute per beneficiary per month	Variable 12 / Variable 9
14	TOTAL_DISCHARGE	Total Number of Inpatient Acute Discharges	HEDIS Measure
15	TOTAL_DISCHARGE_PER_1000_MY	Total Number of Inpatient Acute Discharge per 1,000 beneficiaries	HEDIS Measure
16	TOTAL_FAC_OUTPT_AA	Total Allowed Amount – Outpatient	
17	TOTAL_FAC_OUTPT_AA_PMPM	Total Allowed Amount - Outpatient per beneficiary per month	Variable 16 / Variable 9
18	TOTAL_HOSPICE_AA	Total Allowed Amount – Hospice	
19	TOTAL_HOSPICE_AA_PMPM	Total Allowed Amount – Hospice per beneficiary per month	Variable 18 / Variable 9
20	TOTAL_HOME_HEALTH_AA	Total Allowed Amount – Home Health	
21	TOTAL_HOME_HEALTH_AA_PMPM	Total Allowed Amount – Home Health per beneficiary per month	Variable 20 / Variable 9
22	TOTAL_DME_AA	Total Allowed Amount – DME	
23	TOTAL_DME_AA_PMPM	Total Allowed Amount – DME per beneficiary per month	Variable 22 / Variable 9
24	TOTAL_PROF_AA	Total Allowed Amount – Professional Services	
25	TOTAL_PROF_AA_PMPM	Total Allowed Amount – Professional Services per beneficiary per month	Variable 24 / Variable 9
26	TOTAL_OTH_MED_AA	Total Allowed Amount – Other Services	
27	TOTAL_OTH_MED_AA_PMPM	Total Allowed Amount – Other Services per beneficiary per month	Variable 26 / Variable 9
28	TOTAL_PRIM_CARE_AA	Total Allowed Amount – Professional Primary Care	
29	TOTAL_PRIM_CARE_AA_PMPM	Total Allowed Amount – Professional Primary Care per beneficiary per month	Variable 28 / Variable 9
30	TOTAL_SPECIALIST_AA	Total Allowed Amount – Professional Specialist Care	
31	TOTAL_SPECIALIST_AA_PMPM	Total Allowed Amount – Professional Specialist Care per beneficiary per month	Variable 30 / Variable 9
32	TOTAL_BEHAV_HEALTH_AA	Total Allowed Amount – Behavioral Health Services	
33	TOTAL_BEHAV_HEALTH_AA_PMPM	Total Allowed Amount – Behavioral Health Services per beneficiary per month	Variable 32 / Variable 9
34	TOTAL_OUTPATIENT_ER_AA	Total Allowed Amount – Outpatient ER Services	
35	TOTAL_OUTPATIENT_ER_AA_PMPM	Total Allowed Amount – Outpatient ER Services per beneficiary per month	Variable 34 / Variable 9
36	TOTAL_ER_VISITS	Number of Outpatient ER Visits	HEDIS Measure
37	TOTAL_ER_PER_1000_MY	Number of Outpatient ER Visits per 1,000 beneficiary months	HEDIS Measure

Table F.1b Other Medicaid Total Cost of Care Output

Variable #	Variable Name	Variable Description	Values
1	REPORT_DATE	Report date	Data of File
2	QUARTER	Quarter	Data Quarter
3	YEAR	Year	Data Year
4	AGE_GROUP	Age group	<1 1 - 4 5 - 11 12 - 17 18 – 34 35 - 44 45 - 54 55 - 64 65 - 74 75 - 84 85 Plus
5	GENDER	Gender	Male Female
6	HSA	Member Health service area	Barre Bennington Brattleboro Burlington Middlebury Morrisville Newport Randolph Rutland Springfield St. Albans St. Johnsbury White River Junction UNKNOWN
7	ACO_PARTICIPATION	ACO Participation	Yes No
8	NEXTGEN_ACO_CATEGORY	NextGen ACO category	ABD Non-ABD
9	TOTAL_MONTHS	Total number of beneficiary months enrolled	
10	TOTAL_MCAID_SNF_AA	Total Allowed Amount – Medicaid SNF costs	
11	TOTAL_MCAID_SNF_AA_PMPM	Total Allowed Amount – Medicaid SNF costs per beneficiary per month	Variable 11 / Variable 9
12	TOTAL_MCAID_INT_RES_AA	Total Allowed Amount – Inpatient Intermediate/ Residential - Medicaid	
13	TOTAL_MCAID_INT_RES_AA_PMPM	Total Allowed Amount – Inpatient Intermediate/ Residential per beneficiary – Medicaid	Variable 13 / Variable 9
14	TOTAL_UNIQUE_TO_MCAID_AA	Total Allowed Amount – Unique to Medicaid costs	
15	TOTAL_UNIQUE_TO_MCAID_AA_PMPM	Total Allowed Amount – Unique to Medicaid costs per beneficiary	Variable 14 / Variable 9

Validation

Validation of the Medicaid Total Cost of Care will be possible using the DHVA summary data compared to the Medicaid Total Cost of Care Output described above. We will produce counts/ total allowed amounts for selected excluded categories.

Table F.2 Medicaid AID Category to Benefit Summary Crosswalk

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
A3	PCPLUS - CASH ASSISTANCE - SSI/AABD –AGED	Comprehensive Medical & Pharmacy	ABD	Yes
A4	PCPLUS - CASH ASSISTANCE - SSI/AABD - BLIND ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
A5	PCPLUS - CASH ASSISTANCE - ANFC – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
A6	PCPLUS - CASH ASSISTANCE - SSI/AABD - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
A8	PCPLUS - CASH ASSISTANCE - ANFC - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
A9	PCPLUS - CASH ASSISTANCE - SSI/AABD - BLIND/DIABLED CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
AA	FFS - CASH ASSISTANCE - SSI/AABD –AGED	Comprehensive Medical & Pharmacy	ABD	Yes
AB	FFS - CASH ASSISTANCE - SSI/AABD - BLIND ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
AC	FFS - CASH ASSISTANCE - ANFC – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
AD	FFS - CASH ASSISTANCE - SSI/AABD - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
AR	FFS - CASH ASSISTANCE - ANFC - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
AZ	FFS - CASH ASSISTANCE - SSI/AABD - BLIND/DIABLED CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
B3	PCPLUS - NON CASH ASSISTANCE - MISC ELIGIBILITY CONDITIONS – AGED	Comprehensive Medical & Pharmacy	ABD	Yes
B4	PCPLUS - MEDICAID PICKLE ELIGIBLES	Comprehensive Medical & Pharmacy	ABD	Yes
B5	PCPLUS - NON CASH ASSISTANCE - MISC ELIGIBILITY CONDITIONS – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
B6	PCPLUS - MEDICAID WORKING DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
B7	PCPLUS - NON CASH ASSISTANCE - MISC ELIGIBILITY CONDITIONS – PREGNANT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
B8	PCPLUS - NON CASH ASSISTANCE - MISC ELIG CONDITIONS - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
BA	FFS - NON CASH ASSISTANCE - MISC ELIGIBILITY CONDITIONS – AGED	Comprehensive Medical & Pharmacy	ABD	Yes
BB	FFS - MEDICAID PICKLE ELIGIBLES	Comprehensive Medical & Pharmacy	ABD	Yes
BC	FFS - NON CASH ASSISTANCE - MISC ELIGIBILITY CONDITIONS – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
BD	FFS - MEDICAID WORKING DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
BG	FFS - BREAST OR CERVICAL CANCER TREATMENT GROUP – MEDICAID	Comprehensive Medical & Pharmacy	ABD	Yes
BH	PCPLUS - BREAST OR CERVICAL CANCER TREATMENT GROUP – MEDICAID	Comprehensive Medical & Pharmacy	ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
BP	FFS - NON CASH ASSISTANCE - MISC ELIGIBILITY CONDITIONS – PREGNANT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
BR	FFS - NON CASH ASSISTANCE - MISC ELIG CONDITIONS - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C0	FFS - MEDICAID - DR. DYNASAUR CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C1	FFS - STATE ONLY - DR. DYNASAUR CHILD (OBSOLETE)--Note:May be DAIL cat now	Unknown	Non-NextGen ACO	No
C2	FFS - UNINSURED EXPANDED DR. DYNASAUR CHILD - 300% FPL - TITLE XXI – SCHIP	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C3	FFS - UNDERINSURED DR. DYNASAUR CHILD - 300% FPL - MEDICAID 1115 WAIVER	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C4	PCPLUS - MEDICAID - DR. DYNASAUR CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C5	PCPLUS COMMITTED CHILD - IV-E ELIGIBLE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C6	PCPLUS UNINSURED EXPANDED DR. DYNASAUR CHILD - 300% FPL - TITLE XXI – SCHIP	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C7	PCPLUS COMMITTED CHILD - CHILD PLACEMENT AGENCY	Comprehensive Medical & Pharmacy	Non-NextGen ACO	No
C8	PCPLUS COMMITTED CHILD - REFUGEE RESETTLEMENT PROGRAM PARTICIPANT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
C9	PCPLUS UNDERINSURED DR. DYNASAUR CHILD - 300% FPL - MEDICAID WAIVER	Comprehensive Medical & Pharmacy	Non-ABD	Yes
CC	FFS - COMMITTED CHILD - IV-E ELIGIBLE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
CG	FFS - UNINSURED SCHIP MEMBER OF FEDERALLY RECOGNIZED AMERICAN NATIVE TRIBE	Unknown	Non-NextGen ACO	No
CH	Unknown	Unknown	Non-NextGen ACO	No
CO	Unknown (likely a mistype of C0 and included in crosswalk for that reason)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
CP	FFS - COMMITTED CHILD - CHILD PLACEMENT AGENCY	Comprehensive Medical & Pharmacy	Non-ABD	Yes
CR	Unknown	Comprehensive Medical & Pharmacy	Non-ABD	Yes
CR	FFS - COMMITTED CHILD - REFUGEE RESETTLEMENT PROGRAM PARTICIPANT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
D5	PCPLUS TRANSITIONAL MEDICAID - ANFC ENDED - INCREASED CHILD SUPPORT – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
D8	PCPLUS TRANSITIONAL MEDICAID - ANFC ENDED - INCREASED CHILD SUPPORT – PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
DC	FFS TRANSITIONAL MEDICAID - ANFC ENDED - INCREASED CHILD SUPPORT – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
DR	FFS TRANSITIONAL MEDICAID - ANFC ENDED - INCREASED CHILD SUPPORT – PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
E5	Unknown	Comprehensive Medical & Pharmacy	Non-ABD	Yes
E8	ACCESS CATEGORY CODE ONLY - CONVERTED TO A8 FOR EDS	Comprehensive Medical & Pharmacy	Non-ABD	Yes
EA	FFS - FEDERAL ESSENTIAL PERSON - SSI - AABD - AGED (OBSOLETE)	Comprehensive Medical & Pharmacy	ABD	Yes
EB	FFS - FEDERAL ESSENTIAL PERSON - SSI - AABD - BLIND (OBSOLETE)	Unknown	Non-NextGen ACO	No
EC	ACCESS CATEGORY CODE ONLY - CONVERTED TO AC FOR EDS	Comprehensive Medical & Pharmacy	Non-ABD	Yes
ED	FFS - FEDERAL ESSENTIAL PERSON - SSI - AABD - DISABLED (OBSOLETE)	Unknown	Non-NextGen ACO	No
ER	ACCESS CATEGORY CODE ONLY - CONVERTED TO AR FOR EDS	Comprehensive Medical & Pharmacy	Non-ABD	Yes
F5	PCPLUS - COMMITTED CHILD - NON IV-E ELIGIBLE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
FC	FFS - COMMITTED CHILD - NON IV-E ELIGIBLE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
FI	FITP - FAMILY INFANT TODDLER PROGRAM	Limited Medical Benefit	Non-NextGen ACO	No
G5	PCPLUS - TRANSITIONAL MEDICAID NON-ANFC COVERAGE - INCREASE EARNINGS - CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
G8	PCPLUS - TRANSITIONAL MEDICAID NON-ANFC COVERAGE - INCREASE EARNINGS - PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
GA	GENERAL ASSISTANCE (STATE ONLY)	Limited Medical Benefit	Non-NextGen ACO	No
GC	FFS - TRANSITIONAL MEDICAID NON-ANFC COVERAGE - INCREASE EARNINGS - CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
GE	GENERAL ASSISTANCE - EMERGENCY ASSISTANCE ELIGIBLE	Unknown	Non-NextGen ACO	No
GR	FFS - TRANSITIONAL MEDICAID NON-ANFC COVERAGE - INCREASE EARNINGS - PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
H3		Comprehensive Medical & Pharmacy	ABD	Yes
H4		Comprehensive Medical & Pharmacy	ABD	Yes
H5		Comprehensive Medical & Pharmacy	ABD	Yes
H6		Comprehensive Medical & Pharmacy	ABD	Yes
H8		Comprehensive Medical & Pharmacy	ABD	Yes
H9		Comprehensive Medical & Pharmacy	ABD	Yes
HA	FFS - HOSPICE AGED	Comprehensive Medical & Pharmacy	ABD	Yes
HB		Comprehensive Medical & Pharmacy	ABD	Yes
HC		Comprehensive Medical & Pharmacy	ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
HD	FFS - HOSPICE DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
HR		Comprehensive Medical & Pharmacy	ABD	Yes
HT	FFS - HIV/AIDS DRUG COVERAGE ONLY	Limited Medical & Limited Pharmacy	Non-NextGen ACO	No
HV	FFS - HIV/AIDS INSURANCE PREMIUM COVERAGE ONLY	Unknown	Non-NextGen ACO	No
HZ		Comprehensive Medical & Pharmacy	ABD	Yes
I5	PCPLUS - TRANSITIONAL MEDICAID NON-ANFC - INCREASED CHILD SUPPORT - CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
I8	PCPLUS - TRANSITIONAL MEDICAID NON-ANFC - INCREASED CHILD SUPPORT - PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
IA	FFS - MEDICAID SLMB - AGED	Comprehensive Medical & Pharmacy	ABD	Yes
IC	FFS - TRANSITIONAL MEDICAID NON-ANFC - INCREASED CHILD SUPPORT - CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
ID	FFS - MEDICAID SLMB - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
IR	FFS - TRANSITIONAL MEDICAID NON-ANFC - INCREASED CHILD SUPPORT - PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
J3		Comprehensive Medical & Pharmacy	ABD	Yes
J4		Comprehensive Medical & Pharmacy	ABD	Yes
J5	PCPLUS - MEDICALLY NEEDY-SELECT PCPLUS INSTEAD OF SPEND-DOWN - CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
J6	PCPLUS - MEDICALLY NEEDY-SELECT PCPLUS INSTEAD OF SPEND-DOWN - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
J7		Comprehensive Medical & Pharmacy	ABD	Yes
J8	PCPLUS - MEDICALLY NEEDY-SELECT PCPLUS INSTEAD OF SPEND-DOWN - PARENT	Comprehensive Medical & Pharmacy	ABD	Yes
K5	PCPLUS - KATIE BECKETT CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
K9	PCPLUS - SPECIAL NEEDS ADOPTION	Comprehensive Medical & Pharmacy	Non-ABD	Yes
KC	FFS - KATIE BECKETT CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
KZ	FFS - SPECIAL NEEDS ADOPTION	Comprehensive Medical & Pharmacy	Non-ABD	Yes
L3	PCPLUS - NURSING HOME - INCOME LESS INSTITUTIONAL INCOME LEVEL - AGED	Comprehensive Medical & Pharmacy	ABD	Yes
L4	PCPLUS - NURSING HOME - INCOME LESS INSTITUTIONAL INCOME LEVEL - BLIND ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
L5	PCPLUS - NURSING HOME - INCOME LESS INSTITUTIONAL INCOME LEVEL - CHILD	Comprehensive Medical & Pharmacy	ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
L6	PCPLUS - NURSING HOME - INCOME LESS INSTITUTIONAL INCOME LEVEL - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
L8	PCPLUS - NURSING HOME - INCOME LESS INSTITUTIONAL INCOME LEVEL - PARENT	Comprehensive Medical & Pharmacy	ABD	Yes
L9	PCPLUS - NURSING HOME - INCOME LESS INSTITUTIONAL INCOME LEVEL - BLIND DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
LA	AGED	Comprehensive Medical & Pharmacy	ABD	Yes
LB	BLIND	Comprehensive Medical & Pharmacy	ABD	Yes
LC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
LD	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
LF	LADIES FIRST PROGRAM	Limited Medical Benefit	Non-NextGen ACO	No
LR	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
LZ	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
M3	MEDICALLY NEEDY/UNDER PIL – AGED	Comprehensive Medical & Pharmacy	ABD	Yes
M4	MEDICALLY NEEDY/UNDER PIL - BLIND ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
M5	MEDICALLY NEEDY/UNDER PIL – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
M6	MEDICALLY NEEDY/UNDER PIL - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
M7	MEDICALLY NEEDY/UNDER PIL - PREGNANT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
M8	MEDICALLY NEEDY/UNDER PIL - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
MA	AGED	Comprehensive Medical & Pharmacy	ABD	Yes
MB	BLIND	Comprehensive Medical & Pharmacy	ABD	Yes
MC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
MD	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
ME	Unknown	Unknown	Non-NextGen ACO	No
MH	MENTAL HEALTH ONLY RECIPIENT	Limited Medical Benefit	Non-NextGen ACO	No
MP	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
MR	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
MU	MENTAL HEALTH UNDERINSURED/UNINSURED	Limited Medical Benefit	Non-NextGen ACO	No
NA	AGED	Comprehensive Medical & Pharmacy	ABD	Yes
NB	BLIND	Comprehensive Medical & Pharmacy	ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
NC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
ND	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
NP	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
NR	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
O5	OLDER CHILD - 100% FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
OC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
P1	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
P2	DR. DYNASAUR PARENT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
P3	MEDICALLY NEEDY - SPEND-DOWN – AGED	Comprehensive Medical & Pharmacy	ABD	Yes
P4	MEDICALLY NEEDY - SPEND-DOWN - BLIND ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
P5	MEDICALLY NEEDY - SPEND-DOWN – CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
P6	MEDICALLY NEEDY - SPEND-DOWN - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
P7	MEDICALLY NEEDY - SPEND-DOWN - PREGNANT	Comprehensive Medical & Pharmacy	ABD	Yes
P8	MEDICALLY NEEDY - SPEND-DOWN - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	ABD	Yes
PA	AGED	Comprehensive Medical & Pharmacy	ABD	Yes
PB	BLIND	Comprehensive Medical & Pharmacy	ABD	Yes
PC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
PD	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
PP	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
PQ	PURE QMB/PDP-MEDICARE PREMIUMS, DEDUCTIBLES, AND COPAY/PHARMACY DISCOUNT	Medical Part A/B Premiums, Deductibles, Coinsurance (No Pharmacy)	Non-NextGen ACO	No
PR	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	ABD	Yes
PS	PURE SLMB/PDP-MEDICARE PART B PREMIUM/PHARMACY DISCOUNT	Medical Part B Premiums (No Pharmacy)	Non-NextGen ACO	No
Q3	QMB - AGED	Comprehensive Medical & Pharmacy	ABD	Yes
Q6	QMB - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
QA	AGED	Comprehensive Medical & Pharmacy	ABD	Yes
QD	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
QI	PART B PREMIUM PAID	Medical Part B Premiums (No Pharmacy)	Non-NextGen ACO	No
QW	Unknown	Unknown	Non-NextGen ACO	No

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
R0	LEGAL IMMIGRANT MEDICAID/DR DYNASAUR CHILDREN 0 - 224% FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
R1	REFUGEE RESETTLEMENT PROGRAM PARTICIPANT	Comprehensive Medical & Pharmacy	Non-ABD	Yes
R2	LEGAL IMMIGRANT UNINSURED EXPANDED DR. DYNASAUR CHILD - 300% FPL - (SCHIP)	Comprehensive Medical & Pharmacy	Non-NextGen ACO	No
R3	LEGAL IMMIGRANT UNDERINSURED EXPANDED MEDICAID DR. DYNASAUR CHILD - 300% FPL	Comprehensive Medical & Pharmacy	Non-NextGen ACO	No
R4	PCPLUS - LEGAL IMMIGRANT MEDICAID/DR DYNASAUR CHILDREN 0 - 224% FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
R6	PCPLUS - LEGAL IMMIGRANT UNINSURED EXPANDED DR. DYNASAUR CHILD-300% FPL-(SCHIP)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
R7	PCPLUS - LEGAL IMMIGRANT PREGNANT WOMEN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
R9	PCPLUS - LEGAL IMMIGRANT UNDERINSURED EXPANDED DR. DYNASAUR CHILD - 300% FPL	Comprehensive Medical & Pharmacy	Non-NextGen ACO	No
RF	LEGAL IMMIGRANT MEDICAID/DR DYNASAUR CHILDREN 0 - 224% FPL 18 YEARS OF AGE	Comprehensive Medical & Pharmacy	Non-NextGen ACO	No
RG	PCPLUS - LEGAL IMMIGRANT CHILDREN 0 - 224% FPL 19 AND 20 YEARS OF AGE	Comprehensive Medical & Pharmacy	Non-NextGen ACO	No
RH	LEGAL IMMIGRANT CHILDREN 0 - 224% FPL 19 AND 20 YEARS OF AGE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
RI	PCPLUS - LEGAL IMMIGRANT DR DYNASAUR CHILDREN 0 - 224% FPL 18 YEARS OF AGE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
RJ	LEGAL IMMIGRANT PREGNANT WOMEN 185%-200%	Comprehensive Medical & Pharmacy	Non-ABD	Yes
RK	PCPLUS - LEGAL IMMIGRANT PREGNANT WOMEN 185%-200%	Comprehensive Medical & Pharmacy	Non-ABD	Yes
RP	LEGAL IMMIGRANT PREGNANT WOMEN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
RR	OTHER	Comprehensive Medical & Pharmacy	Non-ABD	Yes
S5	INFANTS AT 185% FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
S7	PREGNANT WOMEN AT 185% FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
SC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
SH	CSHN - CHILDREN WITH SPECIAL HEALTH NEEDS	Limited Medical Benefit	Non-NextGen ACO	No
SP	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
T5	TRANSITIONAL MEDICAID - CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
T8	TRANSITIONAL MEDICAID - PARENT/CARETAKER RELATIVE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
TC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
TR	ADULTS IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
TV	JOINT AZT AND HIV/AIDS	Limited Medical & Limited Pharmacy	Non-NextGen ACO	No
U1	VHAP-UNINSURED - 25% OF FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
U2	VHAP-UNINSURED - 50% OF FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
U3	VHAP-UNINSURED - 100% OF FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
U4	VHAP-UNINSURED - 125% OF FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
U5	VHAP-UNINSURED - 150% OF FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
U6	VHAP - MEDICAID EXPANSION - PARENTS MC	Comprehensive Medical & Pharmacy	Non-ABD	Yes
UA	VHAP-UNINSURED - 25% OF FPL (FEE FOR SERVICE)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
UB	VHAP-UNINSURED - 50% OF FPL (FEE FOR SERVICE)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
UC	VHAP-UNINSURED - 100% OF FPL (FEE FOR SERVICE)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
UD	VHAP-UNINSURED - 125% OF FPL (FEE FOR SERVICE)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
UE	VHAP-UNINSURED - 150% OF FPL (FEE FOR SERVICE)	Comprehensive Medical & Pharmacy	Non-ABD	Yes
UF	VHAP - MEDICAID EXPANSION - PARENTS FFS	Comprehensive Medical & Pharmacy	Non-ABD	Yes
V1	VHAP - PHARMACY - 100% OF FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
V2	VHAP - PHARMACY - 125% OF FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
V3	VHAP - PHARMACY - 150% OF FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
V4	VHAP - PHARMACY/QMB - 100% OF FPL	Unknown	Non-NextGen ACO	No
V5	VHAP - PHARMACY/QMB - 125% OF FPL	Unknown	Non-NextGen ACO	No
V6	VHAP - PHARMACY/QMB - 150% OF FPL	Unknown	Non-NextGen ACO	No
V7	VSCRIPT - AGED/QMB	Unknown	Non-NextGen ACO	No
V8	VSCRIPT - DISABLED/QMB	Unknown	Non-NextGen ACO	No
VA	VSCRIPT AGED	Comprehensive Pharmacy	Non-NextGen ACO	No
VB	VSCRIPT AGED 200 PERCENT FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
VC	VSCRIPT AGED 225 PERCENT FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
VD	V-PHARM-1: < - 150% FPL	Limited Medical (Vision) and Comprehensive Pharmacy	Non-NextGen ACO	No
VE	V-PHARM-2: > 150% - < 175% FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
VF	V-PHARM - 3: >175% < 225% FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
VG	V-PHARM-1: < 150% FPL & QMB	Limited Medical (Vision), Part A/B Premiums, Deductibles, Coinsurance, & Comprehensive Pharmacy	Non-NextGen ACO	No

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
VH	V-PHARM-2: >150% < 175% FPL & QMB	Medical Part A/B Premiums, Deductibles, Coinsurance & Comprehensive Pharmacy	Non-NextGen ACO	No
VI	V-PHARM-3: >175% < 225% FPL & QMB	Medical Part A/B Premiums, Deductibles, Coinsurance & Comprehensive Pharmacy	Non-NextGen ACO	No
VJ	V-PHARM-1: < 150% FPL & SLMB	Limited Medical (Vision), Part B Premiums & Comprehensive Pharmacy	Non-NextGen ACO	No
VK	V-PHARM-2: >150% < 175% FPL & SLMB	Medical Part B Premiums & Comprehensive Pharmacy	Non-NextGen ACO	No
VL	V-PHARM-3: >175% < 225% FPL & SLMB	Medical Part B Premiums & Comprehensive Pharmacy	Non-NextGen ACO	No
VM	V-PHARM-1: <150% FPL & QI	Limited Medical (Vision), Part B Premiums & Comprehensive Pharmacy	Non-NextGen ACO	No
VN	V-PHARM-2: >150% < 175% FPL & QI	Medical Part B Premiums & Comprehensive Pharmacy	Non-NextGen ACO	No
VO	V-PHARM-3: > 175% < 225% FPL & QI	Medical Part B Premiums & Comprehensive Pharmacy	Non-NextGen ACO	No
VP	PHARMACY DISCOUNT PROGRAM (PDP)	Comprehensive Pharmacy	Non-NextGen ACO	No
VS	VSCRIPT DISABLED	Comprehensive Pharmacy	Non-NextGen ACO	No
VT	VSCRIPT DISABLED 200 PERCENT FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
VU	VSCRIPT DISABLED 225 PERCENT FPL	Comprehensive Pharmacy	Non-NextGen ACO	No
W3	HOME/COMMUNITY BASED WAIVER – AGED	Comprehensive Medical & Pharmacy	ABD	Yes
W4	Unknown	Comprehensive Medical & Pharmacy	ABD	Yes
W6	HOME/COMMUNITY BASED WAIVER - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes
W9	HOME/COMMUNITY BASED WAIVER - BLIND DISABLED CHILD	Comprehensive Medical & Pharmacy	ABD	Yes
WA	AGE	Comprehensive Medical & Pharmacy	ABD	Yes
WB	BLIND	Comprehensive Medical & Pharmacy	ABD	Yes
WD	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
WM	WAIVER MODERATE	Limited Medical Benefit	Non-NextGen ACO	No
WZ	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
X3	ADULTS WITHOUT CHILD(REN) - MANAGED CARE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
X4	ELIGIBLE FOR CASH ASSISTANCE/NOT RECEIVING - BLIND ADULT	Unknown	Non-NextGen ACO	No
X5	ELIGIBLE FOR CASH ASSISTANCE/NOT RECEIVING – CHILD	Comprehensive Medical & Pharmacy	Non-ABD	Yes
X6	ELIGIBLE FOR CASH ASSISTANCE/NOT RECEIVING - DISABLED ADULT	Comprehensive Medical & Pharmacy	ABD	Yes

AidCat	CurrentAidCategoryDescription	BenefitSummary	NextGen ACOCategory	Include in TCOC
X8	ADULTS WITH CHILD(REN) - MANAGED CARE	Comprehensive Medical & Pharmacy	Non-ABD	Yes
XA	ADULTS WITHOUT CHILD(REN) - FFS	Comprehensive Medical & Pharmacy	Non-ABD	Yes
XC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
XD	DISABLED	Comprehensive Medical & Pharmacy	ABD	Yes
XR	ADULTS WITH CHILD(REN) - FFS	Comprehensive Medical & Pharmacy	Non-ABD	Yes
Y5	YOUNGER CHILD AT 133% FPL	Comprehensive Medical & Pharmacy	Non-ABD	Yes
YC	CHILDREN IN FAMILIES WITH DEPENDENT CHILDREN	Comprehensive Medical & Pharmacy	Non-ABD	Yes
Z9	CORRECTIONAL FACILITY RESIDENTS - INPATIENT COVERAGE	Limited Medical Benefit	Non-NextGen ACO	No
ZA	ESIA VHAP	Medical Premiums, Medical Wrap Around, and Pharmacy Wrap Around	Non-NextGen ACO	No
ZB	ESIA Only	Medical Premiums, Medical Wrap Around, and Pharmacy Wrap Around	Non-NextGen ACO	No
ZC	CHAP	Medical Premiums	Non-NextGen ACO	No

Table F.3 Medicaid Fund Source Table

FUND_SOURCE_CODE	FUND_SOURCE_DESC	TCOC
A	Office of Vermont Health Access - Medicaid	Include
B	DAIL - DS Services	Exclude
C	General Assistance (GA) - OVHA	Exclude
D	VScript - OVHA - State Fund	Include
E	HIV Drug - DOH	Exclude
F	HIV Insurance - OVHA - State Fund	Include
G	DMH - Mental Health Medicaid	Exclude
H	Department of Education (DOE) - Medicaid	Exclude
I	DCF - Medicaid	Exclude
J	Department of Health (VDH) - Medicaid	Exclude
K	Office of Alcohol and Drug Abuse Programs (ADAP) - Medicaid	Exclude
L	DAIL - Medicaid	Exclude
M	ESIA VHAP	Include
N	Medicaid Managed Care - Traditional - no longer used per SLOG38037- refer to Fund A	Include
O	VHAP Pharmacy Drug Program	Include
P	VHAP Limited - Fee for Service Limited Expanded Eligibles	Include
Q	VHAP - Mental Health Clinic	Include
R	VHAP - ADAP Services	Exclude
S	DMH - CRT Case Rate	Exclude
T	Medicaid Expansion	Include
U	PCPlus VHAP Managed Care	Include
V	PCPlus Traditional Managed Care	Include
W	Healthy Vermonters Pharmacy Program	Include
X	DCF - HBKF and FIT Program	Include
Y	Civil Unions	Include
Z	Ladies First Program	Exclude
5	ESI Only & CHAP	Include
9	All Funds (used for fiscal pend processing)	Exclude

Table F.4 Unique to Medicaid Category of Care Services

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
Y	0	Default COS
N	101	Inpatient
Y	102	Inpatient XO
N	103	Inpatient Sterilization
N	104	Inpatient Abortion
N	105	Inpatient Family Planning
N	106	Inpatient Recovery, TPL
N	107	Inpatient Recovery, Other
N	108	Inpatient, Disproportionate Share
N	109	Inpatient Cost Settlement
N	110	Inpatient Insurance Premium
N	111	Hospital Lump Sum
N	112	Hospital Supplemental Payment
N	113	Hospital Special Program Payment
N	201	Outpatient
Y	202	Outpatient XO
N	203	Outpatient Sterilization
N	204	Outpatient Abortion
N	205	Outpatient Family Planning
N	206	Outpatient Periodic Screen
N	207	Outpatient Interper. Screen
N	213	Outpatient Recovery, TPL
N	214	Outpatient Recovery, Other
N	215	Outpatient Cost Settlement
N	216	Outpatient Insurance Premium
N	301	Physician
Y	302	Physician Crossover
N	303	Physician Lab Services
Y	304	Physician Lab Crossover
N	305	Physician X-Ray
Y	306	Physician X-Ray Crossover
Y	307	Physician Case Mgt.
N	308	Physician Sterilization
N	309	Physician Abortion
N	310	Physician Family Planning
N	311	Physician Periodic Screen
N	312	Physician Interperiodic Screen
N	313	Physician Recovery, TPL
N	314	Physician Recovery, Other
N	315	Physician Insurance Premium
N	316	Physician Lump Sum
N	317	PCPlus Lump Sum
N	318	Ladies First Lump Sum
N	319	Physician Supplemental Payment
N	320	Physician Special Program Payment
N	401	Prescribed Drugs
N	402	Drugs, Family Planning
Y	403	Drug Crossover
N	404	Drug Recovery, TPL
N	405	Drug Recovery, Other
N	406	Drug Insurance Premium
N	407	Drug Rebate Offset
N	408	Drug State Sidebar
N	409	Drug Lump Sum
N	410	Drug Rebate Interest
Y	501	NH Medicare Participating
Y	502	NH Non Medicare Participating

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
Y	503	NH Swing Bed
Y	504	NH Vermont State Hospital
Y	505	NH Recovery, TPL
Y	506	NH Recovery, Other
Y	507	NH Insurance Premium
Y	508	NH Crossover Part A
Y	509	NH Crossover Part B
Y	510	NH Lump Sum
Y	511	Nursing Home Therapy
Y	512	Nursing Home Supplemental Payment
Y	601	ICF/MR State
Y	602	ICF/MR Other Public
Y	603	ICF/MR Private
Y	604	ICF/MR Recovery TPL
Y	605	ICF/MR Recovery Other
Y	606	ICF/MR Disp Shr. Public
Y	607	ICF/MR Disp Shr. Private
Y	608	ICF/MR Lump Sum
Y	701	MH Facility, Aged
Y	702	MH Facility under 22
Y	703	MH Facility Other
Y	704	MH Facility Disp. Share
Y	705	MH Facility Recovery, TPL
Y	706	MH Facility Recovery, Other
Y	707	MH Facility Outpatient
Y	708	MH Facility Crossover Part A
Y	709	MH Facility Crossover Part B
Y	710	MH Facility Lump Sum
Y	801	Dental Adult
Y	802	Dentures, Adult
Y	803	Dental Insurance Premium
Y	804	Dental Recovery. TPL
Y	805	Dental Recovery, Other
Y	806	Dental Children
Y	807	Dentures, Children
Y	808	Dental Lump Sum
Y	809	PCD Lump Sum
Y	810	Dental Supplemental Payment and Dental Incentive Payment
Y	811	Dental Special Program Payment
N	901	MH Clinic
Y	902	MH Clinic Crossover
Y	903	MR Clinic
Y	904	MR Clinic Crossover
N	905	Clinic, Other
Y	906	Clinic, Other Crossover
N	907	MH Clinic Recovery, TPL
N	908	MH Clinic Recovery, Other
Y	909	MR Clinic Recovery, TPL
Y	910	MR Clinic Recovery, Other
N	911	Clinic, Other Recovery, TPL
N	912	Clinic, Other Recovery, Other
N	913	MH Clinic Lump Sum
Y	914	MR Clinic Lump Sum
N	915	Clinic, Other Lump Sum
Y	916	DDMHS Case Rate
Y	917	MH Clinic Case Rate CRT Recovery, TPL
Y	918	MH Clinic Case Rate CRT Recovery, Other
Y	919	MH Clinic Case Rate CRT Lump Sum
N	1001	Independent Lab

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
Y	1002	Independent Lab Crossover
N	1003	Indep Radiology
Y	1004	Indep Radiology Crossover
N	1005	Indep Lab Family Planning
N	1006	Indep Lab Abortion
N	1007	Indep Lab Recovery, TPL
N	1008	Indep Lab Recovery, Other
N	1009	Indep X-Ray Recovery, TPL
N	1010	Indep X-Ray Recovery, Other
N	1011	Indep Lab Lump Sum
N	1012	Indep X-Ray Lump Sum
N	1101	Home Health Private
N	1102	Home Health Nonprofit
Y	1103	Home Health Crossover
N	1104	Home Health Recovery, TPL
N	1105	Home Health Recovery, Other
N	1106	Home Health Cost Settlement
N	1107	Home Health Lump Sum
N	1201	Rural Health Clinic
N	1202	RHC Nurse Midwife
N	1203	RHC Sterilization
N	1204	RHC Abortion
N	1205	RHC Family Planning
N	1206	RHC Periodic Screen
N	1207	RHC Interperiodic Screen
N	1208	RHC Recovery, TPL
N	1209	RHC Recovery, Other
N	1210	RHC Cost Settlement
Y	1211	RHC Crossover
N	1212	RHC Lump Sum
N	1213	RHC PCPlus Lump Sum
N	1214	RHC Special Program Payment
N	1301	Hospice
Y	1302	Hospice Crossover
N	1303	Hospice Recovery, TPL
N	1304	Hospice Recovery, Other
N	1305	Hospice Lump Sum
N	1401	FQHC
Y	1402	FQHC Crossover
N	1403	FQHC Sterilization
N	1404	FQHC Abortion
N	1405	FQHC Family Planning
N	1406	FQHC Periodic Screen
N	1407	FQHC Interperiodic Screen
N	1408	FQHC Recovery, TPL
N	1409	FQHC Recovery, Other
N	1410	FQHC Cost Settlement
N	1411	FQHC Lump Sum
N	1412	FQHC PCPlus Lump Sum
N	1413	FQHC Supplemental Payment
N	1414	FQHC Special Program Payment
N	1501	Chiropractor
N	1502	Chiropractor Recovery, TPL
N	1503	Chiropractor Recovery, Other
Y	1504	Chiropractor Crossover
N	1505	Chiropractor Lump Sum
N	1601	Nurse Practitioner
N	1602	Nurse Practitioner, Abortion
N	1603	Nurse Practitioner, Family Planning

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
N	1604	Nurse Practitioner, Periodic Screen
N	1605	Nurse Practitioner, Interperiodic Screen
N	1606	Nurse Practitioner, Recovery, TPL
N	1607	Nurse Practitioner, Recovery, Other
N	1608	Nurse Practitioner Lump Sum
Y	1609	Nurse Practitioner Crossover
N	1610	Nurse Practioner Mid-Wife
N	1611	Nurse Practioner Mid-Wife Family Planning
Y	1612	Nurs Practioner Mid-Wife Crossover
N	1613	Nurs Practioner Mid-Wife Lump Sum
N	1614	Nurse Practitioner PCPlus Lump Sum
N	1615	Nurse Practitioner Special Program Payment
N	1701	Nursing Lic. Nurse
N	1702	Nursing-Public Health Nurse
N	1703	Nursing-School Nurse
N	1704	Nursing-Private Duty
N	1705	Nursing Recovery, TPL
N	1706	Nursing Recovery, Other
N	1707	Nursing Lump Sum
N	1801	Podiatrist Services
Y	1802	Podiatrist Crossover
N	1803	Podiatrist Recovery, TPL
N	1804	Podiatrist Recovery, Other
N	1805	Podiatrist Lump Sum
N	1901	Psychologist Services
Y	1902	Psychologist Crossover
N	1903	Psychologist Recovery, TPL
N	1904	Psychologist, Recovery, Other
N	1905	Psychologist Lump Sum
N	2001	Optometrist Services
N	2002	Optometrist Supplies
Y	2003	Optometrist Crossover
N	2004	Optometrist Recovery, TPL
N	2005	Optometrist Recovery, Other
N	2006	Optometrist Lump Sum
N	2101	Optician Services
N	2102	Optician Supplies
N	2103	Optician Recovery, TPL
N	2104	Optician Recovery, Other
Y	2105	Optician Crossover
N	2106	Optician Lump Sum
Y	2201	Transportation DSW
Y	2203	Transportation DMHMR
Y	2204	Transportation Education
Y	2205	Transportation Recovery, TPL
Y	2206	Transportation Recovery, Other
Y	2207	Transportation Lump Sum
N	2301	Physical Therapy
Y	2302	Physical Therapy Crossover
N	2303	Occupational Therapy
Y	2304	Occupational Therapy Crossover
N	2305	Audiologist
Y	2306	Audiologist Crossover
N	2307	Audiologist Supplies
N	2308	Speech Pathologist
N	2309	Therapy Recovery, TPL
N	2310	Therapy Recovery, Other
N	2311	Audiologist/Speech Pathologist Recovery, TPL
N	2312	Audiologist/Speech Pathologist Recovery, Other

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
N	2313	Therapy Lump Sum
N	2314	Audiologist/Speech Pathologist Lump Sum
N	2315	Autism Services
N	2401	Prosthetic/Orthotic
Y	2402	Prosthetic/Orthotic Crossover
N	2403	P/O Recovery, TPL
N	2404	P/O Recovery, Other
N	2405	P/O Lump Sum
N	2501	Medical Supplies
N	2601	Durable Medical Equipment
Y	2602	Durable Medical Equipment/Supplies Crossover
N	2603	DME Recovery, TPL
N	2604	DME Recovery, Other
N	2605	DME Lump Sum
Y	2701	HCBS Aged/Disabled
Y	2702	HCBS-Mental Health
Y	2703	HCBS Mental Retardation
Y	2704	DA&D HCBS Recovery, TPL
Y	2705	DA&D HCBS Recovery, Other
Y	2706	MH HCBS Recovery. TPL
Y	2707	MH HCBS Recovery, Other
Y	2708	MR HCBS Recovery, TPL
Y	2709	MR HCBS Recovery, Other
Y	2710	HCBS Mental Health Lump Sum
Y	2711	HCBS Mental Retardation Lump Sum
Y	2712	DA&D HCBS Lump Sum
Y	2713	HCBS TBI
Y	2714	HCBS TBI Recovery, TPL
Y	2715	HCBS TBI Recovery, Other
Y	2716	HCBS TBI Lump Sum
Y	2717	Enhanced Residential Care
Y	2801	Comm. Supp Living Public (CSL)
Y	2802	CSL Private
Y	2803	CSL Recovery, TPL
Y	2804	CSL Recovery, Other
Y	2805	CSL Lump Sum
Y	2901	Personal Care Services
Y	2902	Personal Care Services Recovery, TPL
Y	2903	Personal Care Services Recovery, Other
Y	2904	Personal Care Services Lump Sum
Y	2905	Personal Care Services Crossover
Y	3001	Targeted Case Management MH
Y	3002	Targeted Case Management MR
Y	3003	Target Case Mgt Other
Y	3004	Targeted Case Mgt Other Lump Sum
Y	3005	Targeted Case Mgt Other Recovery, TPL
Y	3006	Targeted Case Mgt Other Recovery, Other
Y	3301	Residential Tx SRS
Y	3302	MHMR Clinic Transportation
Y	3303	Residential Tx MR
Y	3304	Residential Tx Nonmedical
Y	3305	Residential Tx DOE
Y	3306	Residential Tx Lump Sum
Y	3307	Residential Tx Recovery, TPL
Y	3308	Residential Tx Recovery, Other
Y	3401	Day Treatment MH
Y	3402	Day Tx MR
Y	3403	Day Tx Adult
Y	3404	Day Tx Other

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
Y	3405	Day Treatment Recovery, TPL
Y	3406	Day Treatment Recovery, Other
Y	3407	Day Treatment Lump Sum
Y	3501	OADAP-Resident Treatment
Y	3502	OADAP Day Treatment
Y	3503	OADAP List
Y	3504	OADAP Lump Sum
Y	3505	OADAP Recovery, Other
Y	3506	OADAP Crossover
Y	3507	OADAP Intensive Family Outpatient Services
N	3601	Rehab Nursing Home
N	3602	Rehab Hospital
Y	3603	Rehab Crossover
N	3604	Rehab Lump Sum
N	3605	Rehab Recovery, TPL
N	3606	Rehab Recovery, Other
Y	3701	D&P School District
Y	3702	D&P School
Y	3703	D&P Dept of Education
Y	3704	D&P Local Health Office
Y	3705	D&P Development Disability Agency
Y	3706	D&P Vocational Rehab Agency
Y	3707	D&P SRS
Y	3708	D&P Children's Medical Services
Y	3709	D&P Dept Health
Y	3710	D&P School District Lump Sum
Y	3711	D&P School Lump Sum
Y	3712	D&P Dept of Education Lump Sum
Y	3713	D&P Local Health Office Lump Sum
Y	3714	D&P Development Disability Agency Lump Sum
Y	3715	D&P Vocational Rehab Agency Lump Sum
Y	3716	D&P SRS Lump Sum
Y	3717	D&P Children's Medical Services Lump Sum
Y	3718	D&P Dept Health
Y	3719	D&P Recovery, TPL
Y	3720	D&P Recovery, Other
Y	3801	HMO Capitation
Y	3802	HMO Noncov Services
Y	3803	Capitated Payments for Primary Care Case Management (PCCM)
Y	3804	HMO Lump Sum
Y	3805	PACE Capitation
Y	3806	PACE Lump Sum
Y	3901	Part A Premiums
Y	3902	Part B Premiums
Y	3903	Coins/Deduct-Non M'Care
Y	3904	Group Health Plan (Premiums)
Y	3905	Per Capita Enrollment
Y	3906	Other Health Insurance (Catastrophic Premiums)
Y	3907	Insurance Recovery, TPL
Y	3908	Insurance Recovery, Other
Y	3909	Health Insurance Lump Sum
Y	3910	ESIA/CHAP Premium Assistance
Y	3911	PDP Part C and D Premiums
N	4001	Ambulance
Y	4002	Ambulance Crossover
N	4003	Ambulance Recovery, TPL
N	4004	Ambulance Recovery, Other
N	4005	Ambulance Lump Sum
N	4101	Dialysis Facility

UNIQUE TO MEDICAID FLAG	CATEGORY OF SERVICE CODE	CATEGORY_OF_SERVICE_DESC
Y	4102	Dialysis Facility Crossover
N	4103	Dialysis Facility Recovery, TPL
N	4104	Dialysis Facility Recovery, Other
N	4105	Dialysis Facility Lump Sum
N	4201	Ambulatory Surgery Center (ASC)
N	4202	Ambulatory Surgery Center (Hosp)
Y	4203	ASC Crossover
Y	4204	Ambulatory Surgery Center (Hosp) Crossover
N	4205	ASC Recovery, TPL
N	4206	ASC Recovery, Other
N	4207	ASC Lump Sum
N	4301	Outpatient Rehab. CORF
Y	4302	Outpatient Rehab Crossover
N	4303	Outpatient Rehab. Recovery, TPL
N	4304	Outpatient Rehab. Recovery, Other
N	4305	Outpatient Rehab Lump Sum
N	4401	Indian Health Center
Y	4402	Indian Health Center Crossover
N	4403	Indian Health Center Recovery, TPL
N	4404	Indian Health Center Recovery, Other
N	4405	Indian Health Center Lump Sum
N	4501	Unknown-default
N	4502	Other
N	4503	Lay Mid-Wife
N	4504	Lay Mid-Wife Family Planning
N	4505	Polysomnographic Technologist
N	4506	Registered Dietician
Y	4507	FITP Autism Specialist
N	4508	Lay Mid-Wife Special Program Payment
Y	4601	Recipient, Other (non-claim specific financial transaction)
Y	4602	Provider, (non-claim specific financial transaction)

APPENDIX G

NON-CLAIM BASED COMMERCIAL PAYMENTS DATA FOR CALCULATING TOTAL COST OF CARE PER MEMBER

A. Introduction

Commercial health plans in Vermont make payments for health care services provided to Vermont residents through the claims system or through non-claims methods. The enrollment and claims portion of Commercial and Self-insured Plan TCOC will be calculated by GMCB using data submitted by health insurers and TPAs to the VHCURES. In addition, to fully represent medical service expenditures for Vermont residents, GMCB requires data from certain Vermont Commercial Plans and Vermont Self-Insured Plans regarding Non-Claims Payments associated to the health care services for Vermont residents. GMCB will combine the claims-based expenditures with the non-claims expenditures to represent the full cost of care for Vermont residents. This Data Specification Manual provides technical details to assist payers in reporting and filing these non-claims data.

Table E.1. All-payer Total Cost per Beneficiary Report Schedule

Non-Claims Payments Filing Schedule			
Report Due Date	**Reporting Period(s)**	**Actuals Paid Through**	**Filename (replace 'PAYER' with the submitter code)**
June 29, 2018	CY 2017 Actual CY 2017 Estimated Outstanding	April 30, 2018	NONCLAIMS_<PAYER>_2018.xlsx
June 28, 2019	CY 2017 Actual CY 2017 Estimated Outstanding CY 2018 Actual CY 2018 Estimated Outstanding	April 30, 2019	NONCLAIMS_PAYER_2019.xlsx
June 30, 2020	CY 2018 Actual CY 2018 Estimated Outstanding CY 2019 Actual CY 2019 Estimated Outstanding	April 30, 2020	NONCLAIMS_PAYER_2020.xlsx
June 30, 2021	CY 2019 Actual CY 2019 Estimated Outstanding CY 2020 Actual CY 2020 Estimated Outstanding	April 30, 2021	NONCLAIMS_PAYER_2021.xlsx
June 30, 2022	CY 2020 Actual CY 2020 Estimated Outstanding CY 2021 Actual CY 2021 Estimated Outstanding	April 30, 2022	NONCLAIMS_PAYER_2022.xlsx
June 30, 2023	CY 2021 Actual CY 2021 Estimated Outstanding CY 2022 Actual CY 2022 Estimated Outstanding	April 30, 2023	NONCLAIMS_PAYER_2022.xlsx

*Submitted should note if there is any change/difference in paid through period.

B. Authority

Commercial health plans in Vermont pay providers for health care services rendered to Vermont residents thru the claims system or through non-claims payments. To fully represent medical service expenditures for Vermont residents, GMCB requires data from certain Vermont Commercial Plans and Vermont Self-Insured Plans regarding Non-Claims Payments for health care services provided to Vermont residents. GMCB will combine the claims-based expenditures

with the non-claims expenditures to represent the full cost of care for Vermont residents. This specification provides technical details to assist payers in reporting and filing these data.

The GMCB is requesting this data under its authority to collect information from health insurers in 18 V.S.A. § 9551 and 18 V.S.A. § 9410, which requires health insurers to submit data, including "information relating to health care costs, prices, quality, utilization, or resources [,]" necessary to carry out its statutory mandate. 18 V.S.A. § 9410(c)(3). The GMCB may reduce or eliminate reporting requirements under this specification for individual Vermont Commercial Plans or Vermont Self-Insured Plans (see definition below), consistent with its discretion under 18 V.S.A. § 9410(d).

C. Overview

The non-claims payments data includes non-claims payments to Vermont Commercial Plans and Vermont self-insured plans. Vermont Commercial plans include health insurance plans holding a certificate of authority from Vermont's Commissioner of Financial Regulation.

Coverage for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage if benefits for health services are secondary or incidental to other insurance benefits are excluded.

Medicare Advantage plans are included, but Medicare Supplemental insurance is excluded. Likewise, stand-alone dental, vision, long term care, specified disease, and other limited benefit coverage is excluded.[3] Vermont Self-Insured Plan means plans provided to a Vermont resident by an employer operating in Vermont who is self-insured. Self-insured plans excludes federal employee health benefit plans, TRICARE, and other military coverage, and other employer-based plans for employers operating outside of Vermont.

Submitters should report all Non-Claims Payments by Vermont Commercial Plans to health care providers or provider organizations associated with services provided during the reporting period to Vermont residents. Non-Claims Payments are payments made by a Vermont Commercial Plan or Vermont Self-Insured Plan to any health care provider, provider organization, or accountable care organization associated with care delivered to Vermont residents, where such payments are not reported to VHCURES. For the purposes of the Agreement and this specification, Non-Claims Payments are limited to Blueprint payments, Community Health Team payments, capitation payments, and Risk Settlements for members included in VHCURES reporting. Additional details about Non-Claims Payments – including certain exclusions – are provided in the Field Definitions below.

Payers should report the sum of all Actual Payments (payments related to the Reporting Period that were made prior to the Paid Through date indicated in the table below) and Estimated Outstanding Payments (payments related to the Reporting Period that the reporting entity

[3] This definition is part of the Vermont All-Payer Accountable Care Organization Model Agreement (section 1.bb.), and should be considered in context with 18 V.S.A. § 9402, and 8 V.S.A. § 4511 concerning the definition of "health insurer."

anticipates making after the Paid Through date indicated in the table above, based on best available information).

This reporting is intended to supplement payments associated with claims reported to VHCURES, and so:

1. Submitters should only report non-claims payments related to members whose enrollment and claims data are submitted to VHCURES on a mandatory or voluntary basis.
    1. Submitters should only report non-claim payments for members for whom they are the primary payer.

GMCB intends to facilitate a validation process between the submitting commercial payers and the VHCURES data in order to ensure that the data sources are complementary. Reporting should include Non-Claims Payments made pursuant to pilot programs or other arrangements that only apply to certain Vermont residents. As noted in the specification below, submitters should exclude certain categories of payments, consistent with the Agreement.

D. Exclusions

Submitters should exclude non-claims payments related to members not reported in VHCURES.

To the extent possible, submitters should exclude payments that have no connection to a Vermont resident. If this is not feasible, submitters should proportionately allocate payments for included and excluded populations and include a note to this effect on their submission.

No payments should be reported that meet the following definitions:

- **Non-Claims: Retail Pharmacy.** All payments made to providers relating specifically to retail pharmacy services. However, if payment is made to a provider on the basis of total cost of care, such payment should be included even retail pharmacy spending is included in total cost of care for the calculation of such payments.
- **Other non-clinical:** Payments made pursuant to the payer's contract with a provider that were not made on the basis of medical services and that cannot be properly classified in the included categories below. Examples include infrastructure incentive payments, EMR/HIT adoption incentive payments, governmental payer shortfall payments, grants, or other surplus payments.
- **Other Federal:** Payments made on behalf of members enrolled in the Federal Employees' Health Benefit Program, TRICARE, or other military programs. Payments made for Medicare Advantage members should be included.
- **Non-Claims: Care Management.** Payments made to providers for providing care management, utilization review, discharge planning, and other care management programs.
- **Vaccine payments:** Any payments made to the Vermont Vaccine Purchasing Program (VVPP) or similar programs.

- **Secondary payer payments:** Any payments paid for members where the carrier is a secondary payer.

D. Data Submission

The Non-Claims Template should be submitted to the GMCB through SFTP (https://gs-sftp.ahs.state.vt.us/EFTClient/Account/Login.htm). Users without access credentials must contact the GMCB to establish an account (GMCB.DATA@vermont.gov).

Each submission should be accompanied by a cover note with any appropriate comments about the data included, such as a description of the methodology for any estimates used in developing the submission.

If a payer needs to resubmit a particular report, the following file format should be used:

`NONCLAIMS_<SUBMITTERCODE>_<REPORTING PERIOD>_VERSION.xlsx where`

Where `VERSION` is replaced by the version number (e.g. "2").

E. Field Definitions

- **Submitter Code:** Please use your submitter code for VHCURES as assigned by Onpoint Health Data. If you submit under multiple submitter codes to VHCURES:
  - If you can assign Non-Claims Payments to specific submitter codes please report Non-Claims Payments separately by submitter codes.
  - If your Non-Claims Payments are related to multiple VHCURES submitter codes but you can't assign or allocate them to specific submitter codes, please choose the submitter code reflecting the largest volume.
- **Reporting Period:** The period of time represented by the reported data (calendar year). Payments should be listed according to the calendar year of the underlying medical services, performance period, or contractual period, not based on the date of actual payment.
- **Submission Period Indicator:** Indicates whether file contains preliminary or final data. Data is expected to be finalized according to the Filing Schedule above, but a submitter may finalize data earlier if there are no additional future payments anticipated.
- **Actual or Estimated Outstanding:** Indicates if the non-claim payments were actually paid, or estimate of future non-claim payments.
- **Insurance Category Code (Table E.2):** A number that indicates the insurance category that is being reported. Non-Claims Payments associated with different insurance categories should be reported on separate lines.

Table E.2. Insurance Category Codes

Insurance Category Code	Definition
1	Medicare Advantage
2	Commercial – Fully Insured
3	Self Insured – Federal employee health benefit plans (EXCLUDED – this code should not be used)
4	Self Insured – Other
5	Other Federal (e.g. TRICARE, other military) (EXCLUDED – this code should not be used)
6	Other (describe)

- **Medical Service Incentive Programs:** Payments made to providers for Blueprint Primary Care Medical Home and Community Health Team payments. Other payments (e.g. pay-for-performance, performance bonuses associated with hospital, post-acute, or professional care or DME, infrastructure payments EMR/HIT adoption incentives) should not be included.
- **Capitation and Risk Settlements:** Payments made to providers as a reconciliation of other payments made (e.g. risk settlements) and payments made *not* on the basis of claims (e.g. capitated amounts). This includes such payments made as part of the ACO Shared Savings program. Risk settlements that result in the provider paying amounts to the payer should be reported as negative Non-Claims Payments. Amounts reported as Capitation and Risk Settlement should not include any separate incentive or performance bonuses. Risk settlements based in part on performance on retail pharmacy spending should be included; any settlements based solely on retail pharmacy performance should be excluded. Capitation payments that include payment for retail pharmacy expenditures should be adjusted proportionally to remove the component attributable to retail pharmacy.
- **Member Months:** Total number of member months for Vermont residents during the reporting period associated with this submitter code, excluding federal employee health benefit plans, TRICARE, and other military coverage. This count includes all members for which the submitter is a primary payer regardless of whether they had non-claims based services. This count of member months will be used for validation to the claims data reported in VHCURES.
- **Number of Unique Members:** Total number of Vermont residents enrolled during the reporting period associated with this submitter code, excluding federal employee health benefit plans, TRICARE, and other military coverage. This count includes all members for which the submitted is a primary payer regardless of whether they had non-claims based services. This count of members will be used for validation to the claims data reported in VHCURES.

Table G.1 Commercial payer non-claims data submission template

Vermont All-Payer Accountable Care Organization ("ACO") Model Agreement (GMCB)								
Commercial Non-Claims Report		**Friday, June 29, 2018**						
Submitter Name								
Submitter Code								
Reporting Period								
Paid Through Date								
File Name								
2017 Member								
2017 Unique Members								
						A1	A2	A3 = SUM(A1:A2)
Submitter Code	**Reporting Period (Calendar Year)**	**Submission Period Indicator (Preliminary or Final)**	**Actual or Estimated Outstanding**	**Comments**	**Insurance Category Code**	**Non-Claims: Medical Service Incentive Programs**	**Non-Claims: Capitation and Risk Settlements**	**Total Non-claims Payments**