State of Vermont
Department of Vermont Health Access
NOB 1 South, 1st Floor
280 State Drive
Waterbury, Vermont 05671

REPORT TO THE GENERAL ASSEMBLY

Vermont Medicaid Next Generation Pilot Program

Act 25 of 2017

Submitted to
House Committee on Appropriations
House Committee on Human Services
House Committee on Health Care
Senate Committee on Appropriations
Senate Committee on Health and Welfare
Health Reform Oversight Committee
Green Mountain Care Board
Office of the Health Care Advocate

Submitted by
Cory Gustafson, Commissioner
Department of Vermont Health Access

Michael Costa, Deputy Commissioner
Department of Vermont Health Access

September 15, 2017

This report is submitted to fulfill the requirements of Act 25 of 2017, *An Act Relating to Next Generation Medicaid ACO Pilot Project Reporting Requirements*.[1] The report provides a summary of pilot project performance from January through August 2017 and proceeds in three sections. Section A offers a brief implementation update. Section B sets forth and discusses each Act 25 requirement. Section C contains appendices that provide more detailed information on pilot project performance. The June 15th report submission includes an overview of the program and its financial model.[2]

Section A: Vermont Medicaid Next Generation ACO Pilot Program Implementation Update

DVHA and OneCare Vermont have partnered in launching and implementing this pilot program since executing the Vermont Medicaid Next Generation contract in February of 2017. This report, the second required by Act 25 of 2017, adds three additional months of data. During the last three months, DVHA and OneCare have worked together to further optimize the collection and reporting of information relating to program implementation and to address operational challenges as they arise.

Key Progress:

- DVHA and OneCare continue to collaborate in developing approaches to monitor program financial performance over time. Since the submission of the June 15th report, methods for assessing financial performance at the hospital-level and Health Service Area-level have been incorporated into financial reports, and additional progress has been made toward the development of a methodology for assessing claims that have been incurred but not reported (IBNR). The IBNR adjustment factor will continue to be refined for incorporation in a future report.
- DVHA, OneCare, and the Office of the Health Care Advocate are exploring different approaches to evaluate member experience in the VMNG program, and to ensure member concerns and needs are met in a productive and coordinated fashion whenever a member might engage in the system with concerns about the program. The three teams will continue to coordinate in developing processes and protocols to address a variety of potential scenarios, and to evaluate programmatic data on an ongoing basis in seeking to understand the impact of the program on members' experiences of care and interactions with their providers.
- OneCare and DVHA continue to convene their operational teams on a weekly basis, and to engage subject matter experts monthly. These forums have allowed the partnering entities to identify, discuss, and resolve multiple operational challenges, and continue to result in process improvement.

Key Challenges:

- Long claims data lags for key reports relating to care management, utilization of services, and quality of care has made it difficult to evaluate the program with respect to these topics during the program's pilot year. Such lags also make it difficult for information to be actionable in a timely manner. These areas will be prioritized for examination in the final quarter of the pilot year, at which point information from the first 6-8 months of program performance should be more readily available.

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[1] See http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT025/ACT025%20As%20Enacted.pdf.
[2] See http://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-ACO-Report-to-Legislature-June-15-2017.pdf.

- As ACO processes for identifying and documenting ACO providers continued to be optimized during the first half of the pilot year, a number of claims were incorrectly processed as ACO Out-of-Network claims, instead of ACO In-Network claims or ACO zero-paid claims. Following a review by DVHA, OneCare, and DVHA's claims processor DXC, a process was identified for reprocessing these claims so they would be classified appropriately in subsequent pilot year reporting. As a result of the claims reprocessing, approximately $75,000 were recouped from providers for services that should have been covered by the prospective payments to OneCare. DVHA, OneCare, and DXC will continue to monitor claims on an ongoing basis to ensure any other reprocessing needs are met in a timely manner. With continual improvements to processes for validating and updating provider rosters, DVHA and OneCare expect the need for similar reprocessing to diminish over time. Additionally, DVHA, DXC, and OneCare are discussing potential systems changes that could mitigate the need for such reprocessing in future.

VMNG program operations have become further streamlined in recent months. Further coordination between DVHA and OneCare will be required to maintain and optimize operations while responding to challenges as they arise. Both partners are committed to this continual process improvement and to transparency in reporting on program performance.

Section B: Vermont Medicaid Next Generation ACO Pilot Project Performance: January 1 - September 15, 2017

Financial Performance

Table 1 sets forth ACO financial performance in the first eight months of Calendar Year 2017 (January 1, 2017 – September 1, 2017 dates of service). The table includes several components:

- Funds paid prospectively to OneCare by DVHA on a monthly basis
- Zero-paid "shadow claims" that are submitted by providers, used to understand what services were delivered and to calculate the cost of services delivered (according to the Medicaid fee-for-service fee schedule) that were covered by the prospective payment from DVHA to OneCare.
- Fee-for-service claims paid by DVHA on behalf of OneCare (claims for services received by Medicaid members attributed to the ACO from providers in the ACO network who have elected to continue to be reimbursed on a fee-for-service basis, and from providers outside the ACO network)

Overall, expenditures for the program to date are compared to expected expenditure as an indicator of general financial performance. The Expected Total Cost of Care is derived based on actuarial projections of the cost of care in 2017 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2017 VMNG program contract.[3,4]

Caution should be exercised when using the information presented to evaluate program performance. The data provided should be viewed as preliminary and subject to change because it still does not have sufficient claims run out to meaningfully assess the program nor does it factor in claims or payments that will need to be reconciled because of attribution changes over time. This program is designed to consider 180 days as a sufficient period of time for claims to have been completed. This means that DVHA will not have complete information on what services were provided to the attributed population during the time period of March through May until later this year; though claims are mostly complete for January and February, information about these months is still subject to change.

Overall, the claims lag will cause the cost of care for members to be understated. Accordingly, we should expect the value of the claims for this time period, and the cost of care, to increase over time until all claims have been reported. In combination, the claims lag and fixed prospective payment will both understate the cost of care, and tend to make the ACO appear better-off financially than it is until the final reconciliation. DVHA and OneCare are working toward a consensus methodology to forecast the incurred but not reported (IBNR) claims in order to have a more timely understanding of member spending. DVHA will update the legislature on this activity in a future report.

Appendix B further breaks out program spending by category, including payments each month allocated for the cost of care, administrative fees, care coordination support, and Primary Care Case Management fees. In addition, DVHA and OneCare have worked together to summarize financial performance at the hospital- and Health Service Area-levels. These are also presented in Appendix B.

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[3] DVHA engaged Wakely Consulting Group to calculate 2017 ACO rates, including the Expected Total Cost of Care. These rates were also reviewed by OneCare and the Green Mountain Care Board, and by the actuarial firms with which they contracted at the time (Milliman and Lewis & Ellis, respectively).

[4] See page 78 here: http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf.

Table 1. Overview of VMNG Financial Performance, January through August, 2017

	January	February	March	April	May	June	July	August	Q1 Total	Q2 Total	Year-to-Date Total
Attribution^	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985			
DVHA Payment to ACO*	$189,170	$5,057,828	$5,000,517	$4,918,984	$4,720,509	$4,670,045	$4,607,386	$4,514,450	$10,247,515	$14,309,538	$33,678,889
Expected Shadow FFS	$ -	$4,796,639	$4,742,352	$4,664,824	$4,476,474	$4,428,791	$4,368,859	$4,280,585	$9,538,991	$13,570,089	$31,758,524
Actual Shadow FFS	$ -	$4,236,080	$4,110,343	$4,211,324	$3,960,957	$3,523,554	$3,091,598	$1,290,585	$8,346,424	$11,695,835	$24,424,441
Shadow FFS Over (Under) Spend	$ -	($560,559)	($632,009)	($453,500)	($515,517)	($905,237)	($1,277,261)	($2,990,000)	**($1,192,567)**	**($1,874,254)**	**($7,334,083)**
Expected FFS	$7,522,630	$2,701,638	$2,671,062	$2,627,395	$2,521,309	$2,494,452	$2,460,696	$2,410,977	$12,895,330	$7,643,156	$25,410,159
Actual FFS - In Network	$4,384,794	$610,129	$630,519	$596,412	$609,819	$543,614	$391,056	$136,221	$5,625,441	$1,749,845	$7,902,563
Actual FFS - Out of Network	$3,816,049	$2,357,409	$2,459,489	$2,399,467	$2,553,795	$2,219,742	$1,868,496	$989,498	$8,632,947	$7,173,005	$18,663,945
Actual FFS – Total	$8,200,842	$2,967,538	$3,090,008	$2,995,879	$3,163,614	$2,763,356	$2,259,551	$1,125,719	$14,258,388	$8,922,849	$26,566,508
FFS Over (Under) Spend	$678,212	$265,900	$418,946	$368,484	$642,305	$268,904	($201,145)	($1,285,258)	**$1,363,058**	**$1,279,693**	**$1,156,349**
Expected Total Cost of Care	$7,522,630	$7,498,277	$7,413,414	$7,292,219	$6,997,783	$6,923,243	$6,829,556	$6,691,562	$22,434,321	$21,213,245	$57,168,684
Actual Total Cost of Care	$8,200,842	$7,764,177	$7,832,432	$7,660,703	$7,640,088	$7,192,147	$6,628,411	$5,406,304	$23,797,451	$22,492,938	$58,325,104
Total Cost of Care Over (Under) Spend	**$678,212**	**$265,900**	**$419,018**	**$368,484**	**$642,305**	**$268,904**	**($201,145)**	**($1,285,258)**	**$1,363,130**	**$1,279,693**	**$1,156,420**

^ Defined after February 1, 2017 as number of individuals for whom a monthly prospective payment was made.

*Includes funds for cost of care, administrative fees, care coordination support, and Primary Care Case Management (PCCM) fees.

Note 1: Additional claims run-out is expected for all months of 2017; however, the impact of the claims-lag is particularly pronounced for the months of July and August.

Note 2: DVHA and OneCare are working together to ensure all program year claims—whether fee-for-service claims or zero-paid shadow claims—were processed correctly and consistently with VMNG program design. OneCare has identified a subset of fee-for-service claims paid to the four risk-bearing hospitals, and is working with DVHA and DXC to determine whether those claims were appropriately classified as fee-for-service claims (according to program design and system logic), or whether those claims ought to have been covered by the prospective payments issued to these hospitals by OneCare, and therefore zero-paid. The process for evaluating this subset of claims at a detailed level is ongoing, and as a result the dollar amounts presented in this September 15th report submission are subject to change if it is found that reclassification of any claims is appropriate and in keeping with the VMNG program design and methodology. DVHA and OneCare will continue to evaluate program expenditures to resolve this and any future questions regarding the classification of claims, and it is expected that such activities will continue until the summer of 2018 when the 2017 pilot year expenditures are examined as part of the final year-end reconciliation.

At the time of this report, OneCare's overall actual expenditure in January through June of 2017 has been higher than the expected expenditure for the corresponding month; actual expenditure in July and August has been lower than the expected expenditure for those months. Zero-paid shadow claims for services included in the prospective payment total to less than the expected amounts in every month of 2017, while the fee-for-service payments that DVHA issues on OneCare's behalf have been higher than expected in the first half of the pilot year. Notably, the margin between actual and expected spending is broad when examining financial performance for July and August. This shows the disproportionate impact of the claims lag on the most recent months of performance; however, claims lag also impacts January through June financial performance as evaluated at this time.

Quality Performance

At the time of this report, quarterly data is not available for the quality indicators specified in the Next Generation Medicaid ACO pilot program agreement. DVHA will update the legislature on quality performance in a future report. As discussed during testimony before legislative committees, not all quality measures will be reported on quarterly during Act 25 updates since some quality performance measures are only reported on an annual basis. Additionally, quality performance measures are affected by the claims lag, similar to measures of financial performance.

Operational Performance

The VMNG Year 1 (2017) Operational Timeline details the schedule by which OneCare and DVHA will exchange information (in the form of reports or data extracts) throughout the pilot year. By monitoring adherence to the timeline and deliverables, DVHA and OneCare can assess compliance with processes described in the contract.

To date, OneCare has submitted all required reports to DVHA, and DVHA has transferred all required data files to OneCare. In some instances, OneCare and DVHA have mutually agreed to adjust deadlines to allow other necessary processes to occur or in response to technological challenges. Since the June 15th report submission, this was the case for 17% of files transferred by DVHA. As a result of internal server issues, one cycle of DVHA's weekly file extraction was delayed by four business days.

DVHA and OneCare will continue to monitor adherence to the operational timeline, and will work together to ensure processes are occurring in a timely manner that best supports program implementation. If these indicators suggest that processes are not occurring according to the Operational Timeline, DVHA and OneCare will work together to implement corrective actions.

Utilization Comparison

Table 2 provides a detailed presentation of utilization data by service category (definitions and exclusions are detailed in Appendix C). For this September 15, 2017 report, utilization data is presented for the combined first and second quarters of Calendar Year 2017 (January 1, 2017 – June 30, 2017 dates of service); data is also presented for the combined first and second quarters of Calendar Years 2015 and 2016 to provide a historical comparison.[5] At this time, there is not sufficient claims run-out to

[5] The 2015 and 2016 baseline data represent utilization for both Medicaid members that were attributed to ACOs during the second and third years of the Vermont Medicaid Shared Savings Program (VMSSP), and members that

calculate performance for the third quarter of Calendar Year 2017 (July 1, 2017 – September 30, 2017 dates of service); performance for the third quarter will be included in the December 15, 2017 report submission. The report includes utilization of services for which the ACO is financially responsible; in addition, information about dental and pharmacy utilization (services for which the ACO is NOT responsible) has been included for each cohort.

Two cohorts are compared for the time periods described above: the first is the population of Medicaid members who were prospectively attributed to OneCare for the 2017 program year; the second is a comparable population of Medicaid members who were considered eligible for ACO attribution but were not attributed because their primary care relationship was with providers outside the OneCare provider network. For each cohort, utilization is presented for the population segment aged 0-17 years and the population segment aged ≥18 years. Utilization rates have been adjusted to allow for comparison across different-sized cohorts. The rates presented show utilization per 1,000 member years.

Comparison of the two cohorts over time does not reveal trends that vary notably for most service categories. Across all years and both age groups, the cohort of attributed members has had higher utilization of PCP office-visits and mental health visits than the cohort of members who are not attributed. Adults in the cohort of attributed members have also had more pharmacy prescriptions than adults in the cohort of members who are not attributed.

Table 2. Utilization of Health Care Services by Service Category and Age Group for Members Attributed to the ACO and Members Not Attributed to the ACO

Population Counts: Six Month Average						
	VMNG Attributed Members			**Members Eligible for Attribution but not Attributed**		
	CY '15	**CY '16**	**CY '17**	**CY '15**	**CY '16**	**CY '17**
	Q1 & Q2	**Q1 & Q2**	**Q1 & Q2**	**Q1 & Q2**	**Q1 & Q2**	**Q1 & Q2**
Ages 0-17	14,018	14,771	14,033	37,760	38,535	34,171
Ages 18+	12,052	13,627	13,729	48,862	53,550	41,951
Total	**26,070**	**28,398**	**27,762**	**86,622**	**92,085**	**76,122**
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	36	35	16	38	39	16
Hospital Outpatient ED	436	425	289	565	540	370
Hospital Outpatient non-ED	589	550	593	620	613	610
Home Health and Hospice	146	172	126	85	101	77
Physician Services and other Professional Fees						
PCP Office Visit	4,047	4,025	2,585	2,321	2,154	1,509
Non-PCP Office Visit	466	502	393	451	457	343
DME/Supp/Prosth/Orth	625	626	524	552	576	459

were not attributed to an ACO during that interval. Some members who were attributed to an ACO for the VMSSP are also attributed to OneCare for the VMNG in 2017; other members who were attributed to an ACO for the VMSSP are represented in the comparison cohort because they are not attributed to OneCare for the VMNG in 2017.

Mental Health^	8,787	9,027	10,250	5,409	5,766	6,592
Diagnostic X-ray	378	398	273	451	461	326
Diagnostic Lab	614	567	615	745	658	548
Ambulance	37	32	27	35	33	23
*Dental**	1,701	1,737	1,176	1,519	1,544	1,037
*Pharmacy/Medications**	5,532	5,529	4,868	5,630	5,562	4,950
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	119	125	101	122	118	102
Hospital Outpatient ED	865	846	664	873	822	666
Hospital Outpatient non-ED	2,645	2,794	2,886	2,453	2,428	2,428
Home Health and Hospice	326	364	410	311	337	450
Physician Services and other Professional Fees						
PCP Office Visit	4,231	4,535	3,460	2,326	2,387	1,979
Non-PCP Office Visit	1,540	1,571	1,328	1,365	1,332	1,096
DME/Supp/Prosth/Orth	733	771	709	613	634	633
Mental Health^	5,832	5,778	5,567	4,022	4,068	4,451
Diagnostic X-ray	1,662	1,695	1,349	1,487	1,501	1,229
Diagnostic Lab	3,446	3,583	2,579	2,786	3,130	2,685
Ambulance	133	149	122	130	129	129
*Dental**	986	1,066	842	812	856	720
*Pharmacy/Medications**	20,346	21,191	19,839	16,932	17,156	17,870

^Mental Health category includes a combination of services for which the ACO is and is not financially responsible (i.e. includes all fund sources, and Designated Agency utilization).
*Services for which ACO is not financially responsible.

While this information is helpful to understand how utilization patterns generally compare for members who are attributed to OneCare and members who are not attributed to OneCare, caution should be exercised when using the utilization information presented to evaluate 2017 program performance. At the time of this report submission, the pilot program is only two-thirds through its performance year. Furthermore, the program is subject to claims lag.[6] This means that DVHA will not have complete information on what services were provided to the attributed population during the time period of January through June until later this year. The utilization rates presented here for the first and second quarters of 2017 will be subject to change in subsequent reports as further claims data run-out it is available. Subsequent reports will incorporate updates to the data presented for the combined first and second quarters, new information for additional quarters as available, and comparisons by care management level.

Complaints, Grievances, and Appeals Tracking

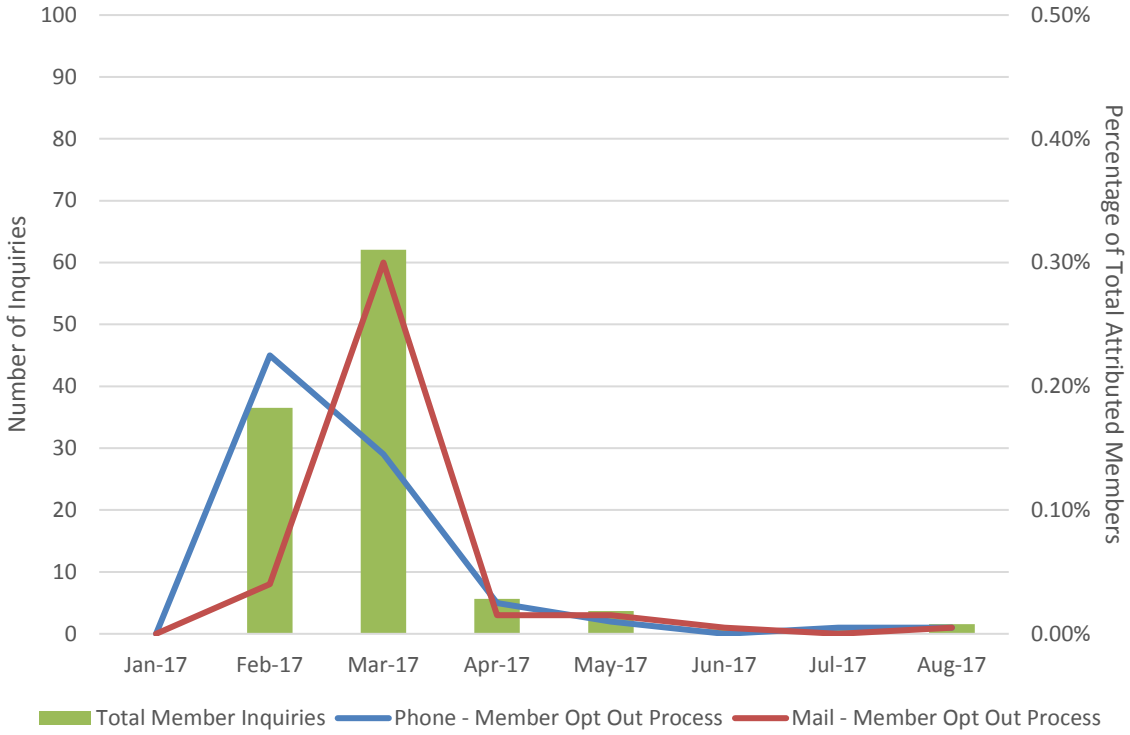
OneCare operates a call center for attributed members and participating providers and accepts all forms of communications, both by phone and in writing (including e-mail, mail, and website submissions). The Figures 1 and 2 below summarize communications received to date from members and providers by

[6] Beyond the claims lag, health care utilization is subject to seasonality. DVHA and OneCare are discussing how to incorporate seasonality into both future financial and utilization forecasting and reporting.

phone and in writing. Detailed counts are available in Appendix D. All but one member and provider communications have been categorized as inquiries; OneCare has received one member complaint. No grievances or appeals have been filed to date.[7]

Thus far, all member inquiries have related to the process by which members may opt out of having their Medicaid claims data shared with OneCare.[8] Members have the option of calling OneCare to notify them of their desire to opt-out of having their claims data shared, or to complete a form and return it by mail. Most member inquiries regarding the opt-out process occurred in February and March, after OneCare mailed a communication to attributed members notifying them of their option to do so; relatively few member inquiries occurred April through August.

Figure 1. Member Inquiries Received by OneCare



Note: The *total* number of member inquiries received between January and August of 2017 (n=159) equates to approximately 5 inquiries per 1,000 Medicaid members attributed to OneCare for the VMNG program.

To date, provider inquiries have primarily focused on prior authorization requirements as waived by the Vermont Medicaid Next Generation program. Other provider inquiries have related to OneCare's secure

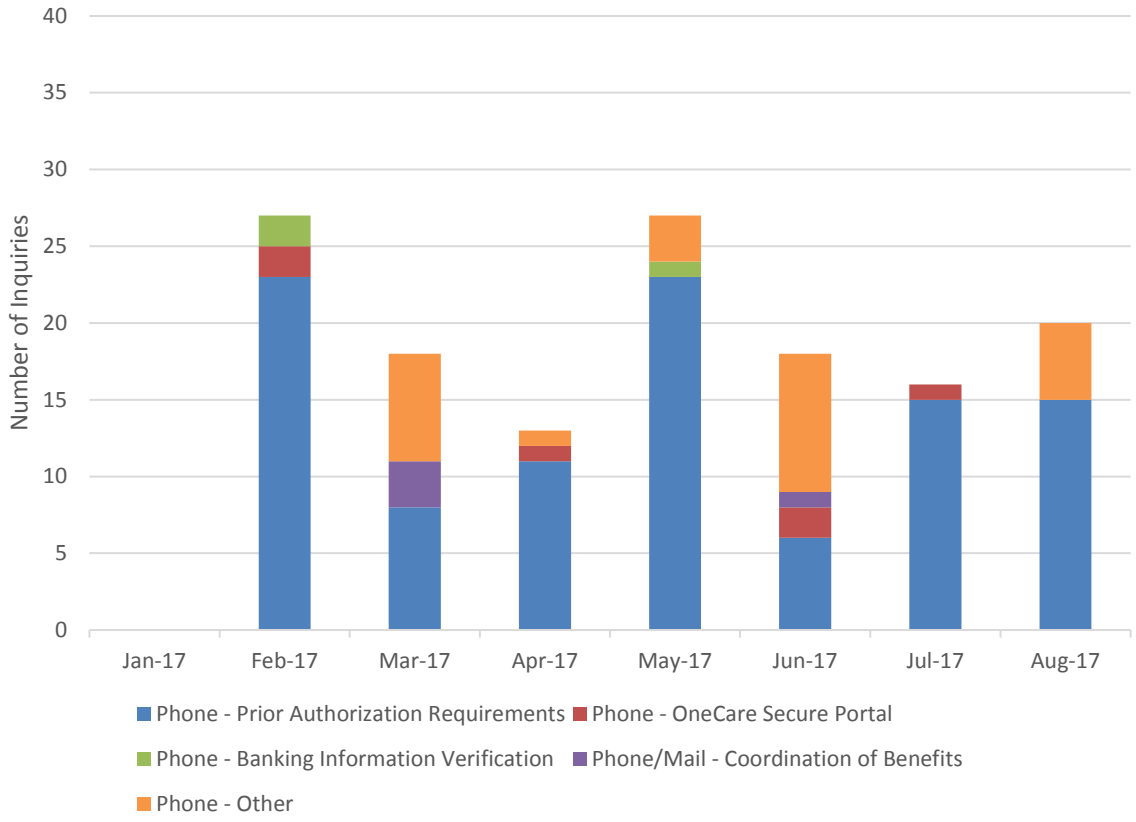
[7] DVHA, OneCare, and the Office of the Health Care Advocate are engaged in ongoing conversations about how best to monitor and address complaints, grievances, and appeals relating to the VMNG program.

[8] Members may not opt out of being attributed to an ACO. If a member opts out of having their data shared with an ACO, the ACO continues to be accountable for the cost and quality of care for that member, and the member's expenditure is included in all program calculations, though DVHA does not provide detailed claims data to OneCare for that member. 127 members (0.4% of total attributed lives) have opted out of having their data shared with OneCare thus far in 2017; an additional 328 members who had opted out of data sharing during the Vermont Medicaid Shared Savings Program (2014-2016) had their preferences extended to the VMNG, for a total of 455 members (1.6% of total attributed lives).

provider portal, verification of banking information for providers receiving payments from OneCare, questions about member Medicaid eligibility and coordination of benefits when Medicaid members attributed to the VMNG program are found to have other sources of insurance coverage (such as commercial insurance or Medicare), and other non-VMNG topics, including the Vermont All-Payer ACO Model Agreement.

Overall, OneCare has received a modest number of communications from members and providers during the first several months of program implementation. The volume and topics of communications will continue to be tracked on a monthly basis.

Figure 2. Provider Inquiries Received by OneCare



Note: The *total* number of provider inquiries received between January and August of 2017 (n=139) equates to approximately 66 inquiries per 1,000 providers participating in OneCare's network for the VMNG program.

Provider Network Reporting

OneCare supplies DVHA with Network Composition reports on a quarterly basis.[9] Table 3 captures the counts of primary care and specialist providers participating in the Vermont Medicaid Next Generation program network for Quarters 1, 2, and 3 (through September 5, 2017). Provider participation has remained fairly constant over the first three quarters of the pilot year.

[9] The Network Composition report classifies all participating OneCare providers according to their specialties, and is used to monitor changes to the provider network during a program year.

Table 3. Participating Providers in OneCare's 2017 VMNG Network

ACO Network Providers	**CY '17 Quarter 1**	**CY '17 Quarter 2**	**CY '17 Quarter 3 (through 9/5/17)**
Primary Care Providers	529	518	531
Specialists	1,521	1,508	1,549
TOTAL	2,050	2,026	2,080

Attributed Medicaid Population Reporting

Table 4 shows monthly changes in attribution of Medicaid members in the 2017 VMNG Program. Attribution of Medicaid members to the ACO occurs prospectively, at the start of the program year. In this way, the ACO is aware of the full population for which it is accountable at the program's outset, and can use that information to identify and engage members most effectively. Although no members can be added during the course of a program year, some of the prospectively attributed members may become ineligible for attribution during the course of the program year. Members may become ineligible for attribution due to:

- Becoming ineligible for Medicaid coverage[10]
- Switching to a limited Medicaid benefits package (e.g. pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g. commercial or Medicare)
- Death

A member may also become ineligible for attribution if the primary care practice through which they were attributed terminates its contract with the ACO in the middle of the year. Effective May 1, 2017, a practice of four primary care providers seeing approximately 500 of the prospectively attributed Medicaid members terminated its contract with OneCare Vermont for the 2017 performance year because it was acquired by an organization that is not a part of OneCare's 2017 VMNG network. As a result, the table below shows a more pronounced drop in attribution from April to May than any of the preceding or following months.

Between January and August, approximately 84% of prospectively attributed members remained continuously eligible for ACO attribution. In the same interval, an additional 2.6% of prospectively attributed members have lost and subsequently re-gained ACO attribution eligibility. As of the end of August, 13.4% of prospectively attributed members are not considered eligible for ACO attribution due to the reasons described above (10.3% for loss of Medicaid eligibility OR additional source of insurance coverage; 1.7% for practice contract termination; 1.2% for limited Medicaid benefits package; and 0.2% for death). Developing an approach for benchmarking rates of churn in the VMNG program will allow for comparisons to rates of churn in the broader Medicaid population, and rates observed for other ACO programs nationally. DVHA is continuing its research into benchmarking strategies, and will update the legislature on these activities in a future report.

[10] If a member has lost Medicaid coverage but later becomes eligible for Medicaid again during the performance year, they may also become eligible for attribution again at that time.

Table 4. Medicaid Members Attributed to OneCare for the 2017 VMNG Program

Attributed Medicaid Members*	**Jan**	**Feb**	**March**	**April**	**May**	**June**	**July**	**August**
% of 29,102	**100.00%**	**99.72%**	**98.54%**	**97.04%**	**93.17%**	**92.11%**	**91.07%**	**89.29%**
Total	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985
Aged, Blind, Disabled	1,910	1,907	1,906	1,878	1,819	1,808	1,790	1,791
General Adult	12,987	12,933	12,754	12,525	11,980	11,845	11,646	11,331
General Child	14,205	14,181	14,016	13,837	13,316	13,153	13,067	12,863

*Defined after February 1, 2017 as number of individuals for whom a monthly prospective payment was made.

Section C: Appendices

Appendix A. Section 1 of Act 25 of the Acts of 2017.

Sec. 1. NEXT GENERATION MEDICAID ACO PILOT PROJECT

REPORTS

(a) On or before June 15, September 15, and December 15, 2017, the Department of Vermont Health Access shall provide to the House Committees on Appropriations, on Human Services, and on Health Care, the Senate Committees on Appropriations and on Health and Welfare, the Health Reform Oversight Committee, the Green Mountain Care Board, and the Office of the Health Care Advocate written updates on the implementation of the Next Generation Medicaid ACO pilot using a reporting template developed by the Department in consultation with the Office of Legislative Council and the Joint Fiscal Office. The updates shall include the following information:

(1) the amount of Medicaid funds provided by the Department to the accountable care organization in each of the three months preceding the month of the report, except that for the June report, the Department shall report the amount of Medicaid funds provided in each month since the beginning of the pilot;

(2) the amount of funds expended by the accountable care organization on behalf of attributed Medicaid beneficiaries in each of the three months preceding the month of the report, except that for the June report, the Department shall report the amount of funds expended on behalf of attributed Medicaid beneficiaries in each month since the beginning of the pilot;

(3) the extent to which the accountable care organization has met the quality indicators specified in the Next Generation Medicaid ACO pilot project agreement signed on February 1, 2017 for which quarterly data is available;

(4) the extent to which the Department and the accountable care organization have met the reporting benchmarks identified in the Department's Next Generation Medicaid ACO Year 1 (2017) Operational Timeline;

(5) to the extent data is available, a comparison of:

(A) utilization of health care services by service category and by care management level for the Medicaid population attributed to the ACO during the pilot year with the utilization of services for the same population in prior years; and

(B) utilization of health care services by service category and by care management level for the Medicaid population attributed to the ACO during the pilot year with the utilization of services for Medicaid beneficiaries not attributed to the ACO;

(6) statistical information regarding the numbers and topics of patient and provider complaints, grievances, and appeals for attributed Medicaid beneficiaries and participating providers, as well as any available information regarding patient and provider satisfaction with the pilot;

(7) current information on the size of the participating provider network since the beginning of the pilot and since the previous report, if applicable; and

(8) any change in the size of the Medicaid population attributed to the ACO since the beginning of the pilot and since the previous report, if applicable.

(b) In addition to the written updates required by subsection (a) of this section, the Department of Vermont Health Access shall provide testimony on implementation of the Next Generation Medicaid ACO pilot project at a meeting of the Health Reform Oversight Committee at least once every two months or more frequently if so requested by the Committee. The testimony shall include the information specified in subsection (a) of this section, as well as any other information the Department deems relevant to the Committee's oversight of the pilot project during the 2017 legislative interim. The Committee shall also provide an opportunity for the Office of the Health Care Advocate to testify at the same meetings as the Department regarding issues related to the pilot project, including information on complaints, grievances, and appeals reported to or requiring investigation or other action by the Office.

Appendix B. VMNG Financial Performance, January - August 2017

	January	February	March	April	May	June	July	August	Q1	Q2	Year-to-Date
Attribution	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985			
DVHA Payment to ACO	$ 189,170	$ 5,057,828	$ 5,000,517	$ 4,918,984	$ 4,720,509	$ 4,670,045	$ 4,607,387	$ 4,514,450	$ 10,247,515	$ 14,309,538	$ 33,678,890
Fixed Prospective Payment (FPP)	$ -	$ 4,796,639	$ 4,742,424	$ 4,664,824	$ 4,476,474	$ 4,210,553	$ 4,334,682	$ 4,247,090	$ 9,539,063	$ 13,351,851	$ 31,472,685
Quality Withhold	$ -	$ -	$ -	$ -	$ -	$ 218,238	$ 34,178	$ 33,496	$ -	$ 218,238	$ 285,912
Primary Care Case Management (PCCM) Fee	$ -	$ 72,553	$ 71,693	$ 70,600	$ 67,788	$ 67,015	$ 66,258	$ 64,963	$ 144,246	$ 205,403	$ 480,869
Care Coordination Payment (CCP)	$ 94,585	$ 94,318	$ 93,200	$ 91,780	$ 88,124	$ 87,120	$ 86,135	$ 84,451	$ 282,103	$ 267,023	$ 719,712
Administrative Fee	$ 94,585	$ 94,318	$ 93,200	$ 91,780	$ 88,124	$ 87,120	$ 86,135	$ 84,451	$ 282,103	$ 267,023	$ 719,712
Total ACO Payments to Providers	$ 189,170	$ 5,057,828	$ 5,000,517	$ 4,918,984	$ 4,720,509	$ 4,670,045	$ 4,607,386	$ 4,514,450	$ 10,247,515	$ 14,309,537	$ 33,678,889
Total Expected Shadow FFS	$ -	$ 4,796,639	$ 4,742,352	$ 4,664,824	$ 4,476,474	$ 4,428,791	$ 4,368,859	$ 4,280,585	$ 9,538,991	$ 13,570,089	$ 31,758,524
Total Actual Shadow FFS	$ -	$ 4,236,080	$ 4,110,343	$ 4,211,324	$ 3,960,957	$ 3,523,554	$ 3,091,598	$ 1,290,585	$ 8,346,424	$ 11,695,835	$ 24,424,441
Shadow FFS Over (Under) Spend	$ -	$ (560,559)	$ (632,009)	$ (453,500)	$ (515,517)	$ (905,237)	$ (1,277,261)	$ (2,990,000)	$ (1,192,567)	$ (1,874,254)	$ (7,334,083)
Total Expected FFS	$ 7,522,630	$ 2,701,638	$ 2,671,062	$ 2,627,395	$ 2,521,309	$ 2,494,452	$ 2,460,696	$ 2,410,977	$ 12,895,330	$ 7,643,156	$ 25,410,159
Actual FFS - In Network	$ 4,384,794	$ 610,129	$ 630,519	$ 596,412	$ 609,819	$ 543,614	$ 391,056	$ 136,221	$ 5,625,441	$ 1,749,845	$ 7,902,563
Actual FFS - Out of Network	$ 3,816,049	$ 2,357,409	$ 2,459,489	$ 2,399,467	$ 2,553,795	$ 2,219,742	$ 1,868,496	$ 989,498	$ 8,632,947	$ 7,173,005	$ 18,663,945
IBNR Adjustment Factor*	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Actual FFS	$ 8,200,842	$ 2,967,538	$ 3,090,008	$ 2,995,879	$ 3,163,614	$ 2,763,356	$ 2,259,551	$ 1,125,719	$ 14,258,388	$ 8,922,849	$ 26,566,508
FFS Over (Under) Spend	$ 678,212	$ 265,900	$ 418,946	$ 368,484	$ 642,305	$ 268,904	$ (201,145)	$ (1,285,258)	$ 1,363,058	$ 1,279,693	$ 1,156,349
Expected Total Cost of Care	$ 7,522,630	$ 7,498,277	$ 7,413,414	$ 7,292,219	$ 6,997,783	$ 6,923,243	$ 6,829,556	$ 6,691,562	$ 22,434,321	$ 21,213,245	$ 57,168,684
Actual Total Cost of Care	$ 8,200,842	$ 7,764,177	$ 7,832,432	$ 7,660,703	$ 7,640,088	$ 7,192,147	$ 6,628,411	$ 5,406,304	$ 23,797,451	$ 22,492,938	$ 58,325,104
Total Cost of Care Over (Under) Spend	$ 678,212	$ 265,900	$ 419,018	$ 368,484	$ 642,305	$ 268,904	$ (201,145)	$ (1,285,258)	$ 1,363,130	$ 1,279,693	$ 1,156,421

Report: Claims Runout through 09/01/2017

*To be determined in collaboration between DVHA and OneCare. Will be applied to future reports.

Note: DVHA and OneCare are working together to ensure all program year claims—whether fee-for service claims or zero-paid shadow claims—were processed correctly and consistently with VMNG program design. OneCare has identified a subset of fee-for-service claims paid to the four risk-bearing hospitals, and is working with DVHA and DXC to determine whether those claims were appropriately classified as fee-for-service claims (according to program design and system logic), or whether those claims ought to have been covered by the prospective payments issued to these hospitals by OneCare, and therefore zero-paid. The process for evaluating this subset of claims at a detailed level is ongoing, and as a result the dollar amounts presented in this September 15th report submission are subject to change if it is found that reclassification of any claims is appropriate and in keeping with the VMNG program design and methodology. DVHA and OneCare will continue to evaluate program expenditures to resolve this and any future questions regarding the classification of claims, and it is expected that such activities will continue until the summer of 2018 when the 2017 pilot year expenditures are examined as part of the final year-end reconciliation.

ACO Fee-For-Service Expenditure by Heath Service Area, January - August 2017

	January	February	March	April	May	June	July	August	Q1	Q2	Year-to-Date
Total Expected FFS	$ 7,522,630	$ 2,701,638	$ 2,671,062	$ 2,627,395	$ 2,521,309	$ 2,494,452	$ 2,460,696	$ 2,410,977	$ 12,895,330	$ 7,643,156	$ 25,410,159
Burlington	$ 3,856,852	$ 1,385,130	$ 1,369,453	$ 1,347,065	$ 1,292,675	$ 1,278,906	$ 1,261,599	$ 1,236,108	$ 4,144,212	$ 3,918,646	$ 10,560,565
Berlin	$ 1,707,637	$ 613,272	$ 606,331	$ 596,419	$ 572,337	$ 566,241	$ 558,578	$ 547,292	$ 1,834,867	$ 1,734,996	$ 4,675,733
Middlebury	$ 938,824	$ 337,164	$ 333,349	$ 327,899	$ 314,659	$ 311,308	$ 307,095	$ 300,890	$ 1,008,772	$ 953,866	$ 2,570,623
St. Albans	$ 1,019,316	$ 366,072	$ 361,929	$ 356,012	$ 341,637	$ 337,998	$ 333,424	$ 326,687	$ 1,095,262	$ 1,035,648	$ 2,791,021
Total Actual FFS	$ 8,200,842	$ 2,967,538	$ 3,090,008	$ 2,995,879	$ 3,163,614	$ 2,763,356	$ 2,259,551	$ 1,125,719	$ 14,258,388	$ 8,922,849	$ 26,566,508
Burlington	$ 3,523,066	$ 1,375,632	$ 1,462,797	$ 1,506,904	$ 1,567,291	$ 1,303,627	$ 1,022,540	$ 535,993	$ 6,361,496	$ 4,377,821	$ 12,297,850
Berlin	$ 1,890,200	$ 631,014	$ 673,848	$ 620,216	$ 613,505	$ 576,942	$ 542,259	$ 229,613	$ 3,195,062	$ 1,810,664	$ 5,777,597
Middlebury	$ 985,772	$ 407,361	$ 345,017	$ 336,635	$ 364,662	$ 298,230	$ 230,101	$ 120,349	$ 1,738,149	$ 999,528	$ 3,088,127
St. Albans	$ 1,801,803	$ 553,532	$ 608,346	$ 532,124	$ 618,156	$ 584,557	$ 464,651	$ 239,764	$ 2,963,682	$ 1,734,837	$ 5,402,934
FFS Over (Under) Spend	$ 678,212	$ 265,900	$ 418,946	$ 368,484	$ 642,305	$ 268,904	$ (201,145)	$ (1,285,258)	$ 1,363,058	$ 1,279,693	$ 1,156,349
Burlington	$ (333,786)	$ (9,498)	$ 93,344	$ 159,839	$ 274,615	$ 24,721	$ (239,059)	$ (700,115)	$ (249,940)	$ 459,175	$ (729,939)
Berlin	$ 182,563	$ 17,742	$ 67,517	$ 23,797	$ 41,168	$ 10,702	$ (16,319)	$ (317,679)	$ 267,822	$ 75,667	$ 9,491
Middlebury	$ 46,948	$ 70,196	$ 11,668	$ 8,736	$ 50,003	$ (13,077)	$ (76,994)	$ (180,541)	$ 128,812	$ 45,662	$ (83,061)
St. Albans	$ 782,487	$ 187,460	$ 246,418	$ 176,112	$ 276,519	$ 246,558	$ 131,226	$ (86,923)	$ 1,216,365	$ 699,189	$ 1,959,857

Report: Claims Runout through 09/01/2017

ACO Fee-For-Service "Shadow Claims" by Hospital, January - August 2017

	January	February	March	April	May	June	July	August	Q1	Q2	Year-to-Date
Total Expected Shadow FFS	$ -	$ 4,796,639	$ 4,742,352	$ 4,664,824	$ 4,476,474	$ 4,428,791	$ 4,368,859	$ 4,280,585	$ 9,538,991.00	$ 13,570,088.71	$ 31,758,524
UVMMC	$ -	$ 2,724,008	$ 2,693,182	$ 2,649,151	$ 2,486,168	$ 2,511,567	$ 2,473,867	$ 2,428,376	$ 5,417,189.70	$ 7,646,886.34	$ 17,966,319
CVMC	$ -	$ 938,797	$ 928,078	$ 912,998	$ 901,196	$ 867,157	$ 859,398	$ 837,282	$ 1,866,875.29	$ 2,681,350.74	$ 6,244,907
Porter	$ -	$ 339,694	$ 335,759	$ 330,359	$ 321,172	$ 314,887	$ 309,752	$ 302,209	$ 675,452.52	$ 966,417.60	$ 2,253,832
NMC	$ -	$ 794,140	$ 785,333	$ 772,316	$ 767,939	$ 735,179	$ 725,842	$ 712,717	$ 1,579,473.49	$ 2,275,433.98	$ 5,293,467
Total Actual Shadow FFS	$ -	$ 4,236,080	$ 4,110,343	$ 4,211,324	$ 3,960,957	$ 3,523,554	$ 3,091,598	$ 1,290,585	$ 8,346,424	$ 11,695,835	$ 24,424,441
UVMMC	$ -	$ 2,361,182	$ 2,289,194	$ 2,582,060	$ 2,250,716	$ 2,053,183	$ 1,785,651	$ 760,983	$ 4,650,376	$ 6,885,959	$ 14,082,968
CVMC	$ -	$ 905,018	$ 699,043	$ 714,866	$ 811,474	$ 704,755	$ 606,418	$ 289,097	$ 1,604,061	$ 2,231,095	$ 4,730,671
Porter	$ -	$ 304,086	$ 304,318	$ 362,029	$ 302,878	$ 246,067	$ 283,525	$ 94,998	$ 608,404	$ 910,974	$ 1,897,901
NMC	$ -	$ 665,794	$ 817,789	$ 552,368	$ 595,889	$ 519,549	$ 416,004	$ 145,507	$ 1,483,582	$ 1,667,806	$ 3,712,901
Shadow FFS Over (Under) Spend	$ -	$ (560,559)	$ (632,009)	$ (453,500)	$ (515,517)	$ (905,237)	$ (1,277,261)	$ (2,990,000)	$ (1,192,567)	$ (1,874,254)	$ (7,334,083)
UVMMC	$ -	$ (362,826)	$ (403,988)	$ (67,091)	$ (235,452)	$ (458,384)	$ (688,216)	$ (1,667,393)	$ (766,814)	$ (760,927)	$ (3,883,350)
CVMC	$ -	$ (33,779)	$ (229,035)	$ (198,132)	$ (89,722)	$ (162,402)	$ (252,980)	$ (548,185)	$ (262,814)	$ (450,256)	$ (1,514,235)
Porter	$ -	$ (35,608)	$ (31,440)	$ 31,670	$ (18,293)	$ (68,820)	$ (26,228)	$ (207,212)	$ (67,048)	$ (55,443)	$ (355,931)
NMC	$ -	$ (128,346)	$ 32,455	$ (219,948)	$ (172,050)	$ (215,630)	$ (309,838)	$ (567,210)	$ (95,891)	$ (607,628)	$ (1,580,567)

UVMMC: University of Vermont Medical Center
CVMC: Central Vermont Medical Center
NMC: Northwestern Medical Center

Report: Claims Runout through 09/01/2017

Appendix C. Utilization of Health Care Services by Service Category and Age Group for Members Attributed to the ACO and Members Not Attributed to the ACO

DEFINITIONS

Annualized utilization per 1,000 members (rates per 12,000 member months, or rates per 1,000 members with 12 months of enrollment in a year). The total number of medical claims in a service category in the specified time period is divided by the total number of member months in that period, and multiplied by 12,000 to represent the number of events based on 1,000 members with 12 months of continuous enrollment (annualized utilization per 1,000 members). Adjusting the rates in this way ensures rates can be compared between two different sized populations with otherwise similar characteristics.

Hospital Inpatient
Inpatient and Inpatient Crossover claims[1] (claim types: I, W)

Hospital Outpatient Emergency Department (ED)
Outpatient and Outpatient Crossover claims (claim types O, X) with one or more ED revenue code (450-459) or CPT[2]/HCPCS[3] code (99281-99288, G0378, G0384)

Hospital Outpatient Non-Emergency Department (ED)
Outpatient and Outpatient Crossover claims (claim types O, X) with no ED revenue code or CPT/HCPCS code

Home Health and Hospice
Home Health or Hospice claims (claim types Q, H)

Physician Services and other Professional Fees
Primary Care Provider (PCP) Office Visit: office visit (CPT/HCPCS), place of services, and PCP provider specialty

Office visit (CPT/HCPCS):
99201-99205, 99211-99215, 99241-99245, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99339-99345, 99347-99350, 99354-99355, 99358-99359, 99381-99387, 99391-99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, 99460-99465, G0402, G0404, G0438, G0439, G9001-G9011

Office place of services:
11 - office
19 - off campus outpatient
22 - on campus outpatient
50 – FQHC (Federally Qualified Health Center)
72 - rural health clinic

PCP provider specialty:
001 - GENERAL PRACTICE

[1] Crossover claims are claims for a member who is eligible for both Medicare and Medicaid, where Medicare pays a portion of the claim and DVHA is billed for any remaining deductible and/or coinsurance). Crossover claims are largely filtered from the analysis by the exclusion of members who are dually eligible for Medicare and Medicaid.
[2] CPT: Current Procedural Terminology
[3] HCPCS: Healthcare Common Procedure Coding System

008 - FAMILY PRACTICE
011 - INTERNAL MEDICINE
016 - OBSTETRICS/GYNECOLOGY
037 - PEDIATRIC MEDICINE
038 - GERIATRIC MEDICINE
050 - NURSE PRACTITIONER
084 - PREVENTIVE MEDICINE
S14 - COST BASED CLINIC
S15 - CERTIFIED FAMILY PRACTITIONER
S16 - CERTIFIED PEDIATRIC PRACTITIONER
S36 - NATUROPATHIC PHYSICIAN WITH CHILDBIRTH ENDORSEMENT
S37 - NATUROPATHIC PHYSICIAN W/O CHILDBIRTH ENDORSEMENT

Non-PCP Office Visit
Office visit CPT/HCPCS code and place of services and no PCP provider specialty

Dental
Dental claims (claim type L)

Durable Medical Equipment (DME)/Supplies/Prosthetics/Orthotics
Durable medical equipment, supplies, prosthetics, and orthotics professional claims (type of services A, B, H, K, L)

Mental Health (MH)
MH, psychological, and psychiatry claims (type of services 9). Includes mental health services paid by DVHA and other Departments within the Agency of Human Services.

Diagnostic X-ray
Diagnostic x-ray claims (type of services 4)

Diagnostic Lab
Claims for labs (type of services 5)

Ambulance
Ambulance claims (type of services C)

Pharmacy/Medications
Pharmacy and professional services drugs (claim type D or type of services D, E)

These service categories may expand and be refined as needed during continued reporting. Definitions will be updated accordingly, and differences from prior reports will be highlighted.

EXCLUSIONS

Inpatient claims for newborns (at the time of birth) are often billed under the mother's Medicaid coverage. As newborns are not being attributed to the ACO population, inpatient utilization for newborn diagnosis related groups (DRG) 765-782 codes were not included in this report.

Members (and claims for members) with dual Medicare and Medicaid coverage were not included, as members who are dually eligible are attributed to ACOs through Medicare programs. Dually eligible members are considered ineligible for the VMNG program.

Outpatient clinic facility claims (revenue codes 510-519) were excluded in the baseline years (2015 and 2016). As provider-based billing included separate facility and doctors' claims, only the doctors' (professional) claim portions were considered in the baseline calculations for this report. This exclusion ensures that calculations in the baseline years and the program year are comparable, as provider-based billing was eliminated effective July 1, 2016.

Population Counts: Six Month Average						
	VMNG Attributed Members			**Members Eligible for Attribution but not Attributed**		
	CY '15	**CY '16**	**CY '17**	**CY '15**	**CY '16**	**CY '17**
	Q1 & Q2	**Q1 & Q2**	**Q1 & Q2**	**Q1 & Q2**	**Q1 & Q2**	**Q1 & Q2**
Ages 0-17	14,018	14,771	14,033	37,760	38,535	34,171
Ages 18+	12,052	13,627	13,729	48,862	53,550	41,951
Total	**26,070**	**28,398**	**27,762**	**86,622**	**92,085**	**76,122**
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	36	35	16	38	39	16
Hospital Outpatient ED	436	425	289	565	540	370
Hospital Outpatient non-ED	589	550	593	620	613	610
Home Health and Hospice	146	172	126	85	101	77
Physician Services and other Professional Fees						
PCP Office Visit	4,047	4,025	2,585	2,321	2,154	1,509
Non-PCP Office Visit	466	502	393	451	457	343
DME/Supp/Prosth/Orth	625	626	524	552	576	459
Mental Health^	8,787	9,027	10,250	5,409	5,766	6,592
Diagnostic X-ray	378	398	273	451	461	326
Diagnostic Lab	614	567	615	745	658	548
Ambulance	37	32	27	35	33	23
*Dental**	1,701	1,737	1,176	1,519	1,544	1,037
*Pharmacy/Medications**	5,532	5,529	4,868	5,630	5,562	4,950
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	119	125	101	122	118	102
Hospital Outpatient ED	865	846	664	873	822	666
Hospital Outpatient non-ED	2,645	2,794	2,886	2,453	2,428	2,428
Home Health and Hospice	326	364	410	311	337	450
Physician Services and other Professional Fees						
PCP Office Visit	4,231	4,535	3,460	2,326	2,387	1,979
Non-PCP Office Visit	1,540	1,571	1,328	1,365	1,332	1,096
DME/Supp/Prosth/Orth	733	771	709	613	634	633
Mental Health^	5,832	5,778	5,567	4,022	4,068	4,451
Diagnostic X-ray	1,662	1,695	1,349	1,487	1,501	1,229
Diagnostic Lab	3,446	3,583	2,579	2,786	3,130	2,685
Ambulance	133	149	122	130	129	129
*Dental**	986	1,066	842	812	856	720
*Pharmacy/Medications**	20,346	21,191	19,839	16,932	17,156	17,870

^Mental Health category includes a combination of services for which the ACO is and is not financially responsible (i.e. includes all fund sources, and Designated Agency utilization).

*Services for which ACO is not financially responsible.

REPORT DATE: 9/6/17

Appendix D. Member and Provider Communications by Type and Topic - Vermont Medicaid Next Generation Program

	Feb-17			Mar-17			Apr-17			May-17			Jun-17			Jul-17			Aug-17		
	Phone	Written	Month Total	Phone	Written	Month Total	Phone	Written	Month Total	Phone	Written	Month Total	Phone	Written	Month Total	Phone	Written	Month Total	Phone	Written	Month Total
1. Inquiries																					
a. Member Inquiries																					
Beneficiary Opt Out Process	45	8	**53**	29	60	**89**	5	3	**8**	2	3	**5**	0	1	**1**	1	0	**1**	1	1	**2**
Total Member Inquiries			**53**			**89**			**8**			**5**			**1**			**1**			**2**
b. Provider Inquiries																					
Prior Authorization Requirements	23	0	**23**	8	0	**8**	11	0	**11**	23	0	**23**	6	0	**6**	15	0	**15**	15	0	**15**
OneCare Secure Portal	2	0	**2**	0	0	**0**	1	0	**1**	0	0	**0**	2	0	**2**	1	0	**1**	0	0	**0**
Banking Information Verification	2	0	**2**	0	0	**0**	0	0	**0**	1	0	**1**	0	0	**0**	0	0	**0**	0	0	**0**
Coordination of Benefits	0	0	**0**	0	3	**3**	0	0	**0**	0	0	**0**	0	1	**1**	0	0	**0**	0	0	**0**
Other	0	0	**0**	7	0	**7**	1	0	**1**	3	0	**3**	9	0	**9**	0		**0**	5	0	**5**
Total Provider Inquiries			**27**			**18**			**13**			**27**			**18**			**16**			**20**
Total Member and Provider Inquiries	**72**	**8**	**80**	**44**	**63**	**107**	**18**	**3**	**21**	**29**	**3**	**32**	**17**	**2**	**19**	**17**	**0**	**17**	**21**	**1**	**22**
2. Complaints																					
a. Member Complaints																					
Total Member Complaints	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	1	0	**1**	0	0	**0**
b. Provider Complaints																					
Total Provider Complaints	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Total Member and Provider Complaints	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**
3. Grievances and Appeals																					
a. Member Grievances and Appeals																					
Total Member *Grievances and Appeals*	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
b. Provider Grievances and Appeals																					
Total Provider *Grievances and Appeals*	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Total Member and Provider Grievances and Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Note: Communications not received prior to contract execution in February 2017.