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REPORT TO THE GENERAL ASSEMBLY

Vermont Medicaid Next Generation Pilot Program

Act 124 of 2018

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
Medicaid and Exchange Advisory Board

Submitted by
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Department of Vermont Health Access

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September 15, 2018

This report is submitted to fulfill the requirements of Act 124 of 2018, *An Act Relating to Reporting Requirements for the Second Year of the Vermont Medicaid Next Generation ACO Pilot Project*.[1] The report provides a summary of pilot project performance from January through August 2018 and proceeds in three sections. Section A offers a brief implementation update. Section B sets forth and discusses each Act 124 requirement. Section C contains appendices that provide more detailed information on pilot project performance. The June 15, 2017 report submission to fulfill the requirements of Act 25 of 2017 includes an overview of the program and its financial model that may serve as a helpful reference to policymakers.[2]

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

DVHA and OneCare Vermont began this pilot program upon executing the Vermont Medicaid Next Generation (VMNG) contract in February of 2017. DVHA and OneCare engaged in negotiations to extend the pilot program to 2018, and executed a contract amendment in December 2017 for the 2018 performance year. In 2018, OneCare Vermont is managing the quality and cost of care for approximately 42,000 Medicaid members in ten communities. This report, the second of three required by Act 124 of 2018, includes information about the first eight months of implementation for the 2018 performance year. Throughout 2017 and into 2018, DVHA and OneCare have worked together to improve the collection and reporting of information relating to program implementation, and to address operational challenges as they arise.

Key Progress:

- DVHA and OneCare elected to exercise a second of the four optional one-year extensions permitted by the VMNG contract. A second one-year extension enables DVHA and OneCare to continue the program for the 2019 calendar year. The extension will likely expand the program by increasing the number of attributed members and participating providers in the ACO. Key focus areas for the 2019 performance year include:
    - Adjusting the program's attribution methodology to more accurately identify Medicaid members having primary care relationships with ACO-participating providers.
    - Clarifying expectations, roles, and responsibilities for Medicaid patient care and safety with regard to the waiver of prior authorizations.
    - Continuing to ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2019 per the requirements of the Vermont All-Payer ACO Model Agreement.
    - Increasing the amount of money tied to performance on quality measures.

  Negotiations are ongoing and an amendment is anticipated to be executed for a start date of January 1, 2019.
- DVHA and OneCare continue to work closely to ensure that any new operational challenges are identified and resolved in a timely manner. In the second quarter of 2018, the teams assessed strategies for improving communication with Medicaid's provider network about the program and engaged DVHA's Member and Provider Relations staff, as well as DXC Technologies (the entity that pays DVHA's claims as a fiscal intermediary), to streamline communication and establish more efficient workflows for fielding provider inquiries related to the ACO program.

[1] See https://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT124/ACT124%20As%20Enacted.pdf.
[2] See http://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-ACO-Report-to-Legislature-June-15-2017.pdf.

- Following the first year of experience with program implementation and reporting, DVHA and DXC Technology have worked together to identify a series of systems changes that will improve DVHA's ability to report on the program's financial performance in a more automated and customizable way. Specific improvements that have been identified for development during 2018 include:
    - Addition of data fields in Medicaid systems that will store information about ACO providers' Hospital Service Area designations, organizational affiliations (e.g. hospital-owned clinics will be identified as being affiliated with a specific ACO-participating hospital), and participation in ACO pilots (for example, the Comprehensive Payment Reform—or CPR—pilot in which independent practices may elect to be paid prospectively instead of fee-for-service).
    - Addition of an "ACO Out-of-Network Fee-for-Service" flag at the time of claims processing, to automate DVHA's ability to report on the ACO's Out-of-Network expenditure (the current process relies on DXC to provide summary information and supporting claims extracts for each report).
    - Creation of new data storage tables for ACO financial information to allow DVHA Business Office and Analytic staff to more easily access the claim-level details that support summary financial reporting (the current process relies on DXC to provide supporting claims extracts for each report).

  The process and technology improvements described above are essential to accurate and timely financial reporting and reducing the risk of variances between ongoing and final financial reporting. Since the June 15th report submission, the State has submitted an Implementation Advanced Planning Document (IAPD) to the Centers for Medicare and Medicaid Services for system changes to support operation and evolution of the VMNG program. If approved, the State would be eligible for 90 percent Federal Financial Participation to fund the planned activities.

Key Challenges:

- Operationalizing the prior authorization waiver feature of the VMNG program continues to be a challenge for both program and clinical staff at DVHA and OneCare. Due to limitations in Medicaid's claims-processing system, some services that qualify for the waiver of prior authorization are treated as though prior authorization is still required, resulting in some providers' claims denying for lack of authorization. The problem was identified by DVHA staff and workflows were implemented within DVHA and with DXC to mitigate systems limitations and to expeditiously re-process all erroneously-denied claims until broader systems improvements can be made for a 2019 performance year. Provider confusion around the prior authorization waiver continues to be a challenge that DVHA and OneCare work collaboratively to address, but the above-mentioned systems changes will further automate and simplify implementation of the prior authorization waiver. DVHA and OneCare will prioritize educating the provider network around these changes before they are implemented for 2019.
- DVHA continues to refine VMNG financial reporting in the 2018 performance year. DVHA, OneCare, and DXC Technologies continue to work together to ensure that reporting strategies are aligned, data sources are consistent, and exclusions are applied uniformly. A barrier to accurate financial reporting and validation between the three entities relates to confidential claims (claims that have been flagged for services related to alcohol or substance use disorder and/or treatment, around which there are strict federal rules regarding how they can be shared and with whom). Because these claims cannot be shared with OneCare at this time, OneCare necessarily has a different claims data set than DVHA and DXC. This poses an ongoing challenge for financial validation, but DVHA, OneCare and DXC are exploring strategies for mitigating this

in future and to ensure accurate information about expenditure is available to OneCare when they are unable to receive detailed claims data for this reason.

- In the third quarter of 2018, DVHA and OneCare staff have been simultaneously engaged in the ongoing operation of the 2018 program year, finalization of financial performance for the 2017 performance year, and planning and contract negotiation for a 2019 performance year. While performing these activities concurrently has been a new challenge for both DVHA and OneCare, it has afforded both organizations an opportunity to find efficiencies in both internal and collaborative workflows, and to develop strategies for future years when program year cycles overlap. DVHA is finalizing information about ACO financial and quality performance for the 2017 pilot year, and it will publish this information no later than September 21, 2018.

Regular meetings between DVHA and OneCare operational teams and a collaborative approach to implementation have ensured that a continuous feedback mechanism is in place, giving staff the ability to make operational adjustments as needed. As a result, VMNG program operations have become further streamlined over the course of the program. Additional coordination between DVHA and OneCare will be required to maintain and optimize operations ongoing. Both partners are committed to this continual process improvement and to transparency in reporting on program performance.

DVHA and OneCare continue to work together to summarize and validate data about the financial and quality performance for the 2018 program year. Both parties are committed to ensuring the accuracy of data used to evaluate program performance, and evaluating the consistency across DVHA, DXC, and OneCare data sources is a key, ongoing activity.

Section B: Vermont Medicaid Next Generation ACO Pilot Project Performance: January 1 – September 15, 2018

Financial Performance

Table 1 sets forth ACO financial performance in the first seven months of Calendar Year 2018 (January 1, 2018 – July 31, 2018 dates of service). At the time of this report submission, DVHA has not yet received reports from DXC summarizing expenditure for August of 2018. 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 in 2018 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 2018 for the population of prospectively attributed Medicaid members, as detailed in Attachment B of the 2018 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 July until later this year.

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. OneCare has adopted a methodology to forecast the incurred but not reported (IBNR) claims in order to have a more timely understanding of member spending. DVHA and OneCare have consulted on OneCare's use of the IBNR factor in its reporting to the OneCare network, but the IBNR factor is not included in this report submission to ensure alignment with DVHA's and DXC's current records of program expenditure.

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

[3] DVHA engaged Wakely Consulting Group to calculate 2018 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 71 here: http://dvha.vermont.gov/administration/onecare-32318-am2-final-signed.pdf.

fees. In prior reports regarding implementation of the 2017 VMNG performance year, DVHA and OneCare worked together to summarize financial performance at the hospital- and Health Service Area-levels. DVHA continues to work with DXC to enhance reporting capabilities at these levels. As such, information about 2018 financial performance at the hospital- and Health Service Area-levels is not available at this time. This information will be included in Appendix B in future report submissions.

At the time of this report, OneCare's overall actual expenditure in January through May 2018 has been higher than the expected expenditure for the corresponding month; actual expenditure in June and July 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 2018 to date. This is consistent with the intent of the incentives of the payment model, and results in a smaller loss against the true delivery expense to deliver the services. This will help ensure provider commitment to the predictable model, and improvements in access and quality for Medicaid enrollees. The fee-for-service payments that DVHA issues on OneCare's behalf have been higher than expected in some months and lower than expected in others. In total, OneCare's actual expenditure to date is approximately $410,500 more than expected, which is within one percent of expected expenditure. Notably, the margin between actual and expected spending is broad when examining financial performance for July. This shows the disproportionate impact of the claims lag on the most recent month of performance; however, claims lag also impacts January through June financial performance as evaluated at this time.

Overall, the focus of the ACO program is on improving health and delivering high quality health care while creating a financial model capable of producing predictable and sustainable health care costs. DVHA will continue to analyze the financial, clinical, and quality performance of the program to determine its efficacy and to determine whether the ACO program generally, and the fixed prospective payments to hospitals specifically, are contributing to an overall moderation in DVHA health care spending.

DVHA is finalizing information about ACO financial and quality performance for the 2017 pilot year, and it will publish this information no later than September 21, 2018.

Table 1. Overview of VMNG Financial Performance, January through July, 2018

	January	February	March	April	May	June	July	Q1	Q2	Year-to-Date
Attribution^	42,342	42,005	41,545	41,169	40,769	39,936	39,033			
DVHA Payment to ACO*	$ 6,415,190	$ 6,364,814	$ 6,291,544	$ 6,227,134	$ 6,165,800	$ 6,030,309	$ 5,885,731	$ 19,071,547	$ 18,423,243	$ 43,380,522
Total Expected Shadow FFS	$ 6,034,112	$ 5,986,769	$ 5,917,639	$ 5,856,613	$ 5,798,879	$ 5,670,885	$ 5,534,434	$ 17,938,519	$ 17,326,377	$ 40,799,331
Total Actual Shadow FFS	$ 5,706,194	$ 5,212,722	$ 5,109,715	$ 5,099,225	$ 5,452,830	$ 4,713,643	$ 3,929,820	$ 16,028,631	$ 15,265,699	$ 35,224,150
Shadow FFS Over (Under) Spend	$ (327,918)	$ (774,046)	$ (807,924)	$ (757,388)	$ (346,049)	$ (957,242)	$ (1,604,614)	$ (1,909,888)	$ (2,060,679)	$ (5,575,180)
Total Expected FFS	$ 4,465,897	$ 4,427,542	$ 4,378,286	$ 4,331,570	$ 4,289,738	$ 4,202,053	$ 4,106,793	$ 13,271,724	$ 12,823,362	$ 30,201,879
Actual FFS - In Network	$ 2,329,552	$ 2,387,067	$ 2,327,601	$ 2,089,023	$ 2,179,282	$ 2,160,772	$ 1,618,453	$ 7,044,220	$ 6,429,076	$ 15,091,750
Actual FFS - Out of Network	$ 2,440,684	$ 2,264,913	$ 2,264,432	$ 2,277,195	$ 2,530,738	$ 1,971,755	$ 1,770,968	$ 6,970,030	$ 6,779,688	$ 15,520,686
Total Actual FFS	$ 4,770,236	$ 4,651,981	$ 4,592,033	$ 4,366,218	$ 4,710,019	$ 4,132,527	$ 3,389,421	$ 14,014,250	$ 13,208,764	$ 30,612,435
FFS Over (Under) Spend	$ 304,339	$ 224,439	$ 213,747	$ 34,648	$ 420,281	$ (69,527)	$ (717,372)	$ 742,525	$ 385,402	$ 410,556
Expected Total Cost of Care	$ 10,500,008	$ 10,414,310	$ 10,295,925	$ 10,188,183	$ 10,088,618	$ 9,872,939	$ 9,641,227	$ 31,210,244	$ 30,149,739	$ 71,001,210
Actual Total Cost of Care	$ 10,804,348	$ 10,638,749	$ 10,509,672	$ 10,222,831	$ 10,508,898	$ 9,803,412	$ 8,923,855	$ 31,952,769	$ 30,535,141	$ 71,411,765
Total Cost of Care Over (Under) Spend	$ 304,339	$ 224,439	$ 213,747	$ 34,648	$ 420,281	$ (69,527)	$ (717,372)	$ 742,525	$ 385,402	$ 410,555

Report: Claims Runout through 08/31/2018

^ Defined 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 2018; however, the impact of the claims-lag is particularly pronounced for the month of July.

Note 2: As noted in Section A of this report, DVHA and DXC have worked together to identify a series of systems changes that will improve DVHA's ability to report on the program's financial performance. One such change will improve DVHA's ability to report on the ACO's Out-of-Network expenditure. The monthly Out of Network totals in this report are subject to ongoing validation with DVHA, DXC, and OneCare to ensure all of the appropriate exclusions have been applied.

Quality Performance

At the time of this report, 2018 quarterly data is not available for the quality indicators included in the VMNG contract for the 2018 performance year. DVHA will update the legislature on 2018 quality performance in a future report. As discussed during 2017 testimony before legislative committees, not all quality measures will be reported quarterly during Act 124 updates because some quality performance measures are only calculated and reported on an annual basis. Additionally, claims-based quality performance measures are affected by the claims lag, similar to measures of financial performance.

Final information about ACO quality performance for the 2017 pilot year of the Vermont Medicaid Next Generation ACO program will be summarized in the report issued no later than September 21, 2018.

Operational Performance

The VMNG Year 2 (2018) 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 2018 report submission, all files transferred by DVHA to the ACO adhered to the operational timeline. In the same time period, OneCare met its reporting deadlines for 98% of its required reports.

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, 2018 report, utilization data is presented for the first half of Calendar Year 2018 (January 1, 2018 – June 30, 2018 dates of service); data is also presented for the first half of Calendar Years 2016 and 2017 to provide a historical comparison.[5] At this time, there is not sufficient claims run-out to calculate performance for the third quarter of Calendar Year 2018 (July 1, 2018 – September 30, 2018 dates of service). 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.

[5] The 2016 baseline data represent utilization for both Medicaid members that were attributed to ACOs during the third year of the Vermont Medicaid Shared Savings Program (VMSSP), and members that 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 2018; 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 2018.

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 2018 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 12,000 member months.

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 primary care 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. Adults in the cohort of attributed members also had fewer claims for diagnostic laboratory services than the comparison cohort. As further information about utilization becomes available, DVHA will work with OneCare to conduct more robust statistical analyses to determine whether any of these differences between cohorts are significant, and to understand the impact of cohort changes (i.e. individuals moving from the comparison cohort in 2017 to the attributed cohort in 2018) on utilization patterns over time. These analyses will allow for a better understanding of the impact of program implementation on utilization for attributed Medicaid members.

Appendix C includes a comparison of the same utilization categories across ACO risk strata (low risk, medium risk, high risk, very high risk). With few exceptions, utilization tends to be lowest in all categories for the low risk segment of the attributed population, and highest in all categories for the very high risk segment of the attributed population. When comparing the average utilization presented in Table 2, above, rates for the full attributed population in each utilization category tend to be between those of the low and medium risk population segments. For this September 15, 2018 report submission, similar stratification is also available for the comparison population of Medicaid beneficiaries who are not attributed to an ACO.[6] Utilization comparisons across risk strata for this cohort are also presented in Appendix C. There are relatively few differences in utilization between the attributed and non-attributed cohorts in the low and medium risk segments; the differences in adult utilization of pharmacy and diagnostic laboratory services noted above are more pronounced for the high and very high risk segments.

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 2018 program performance. At the time of this report submission, utilization information is only available for the first half of the performance year. Furthermore, the program is subject to claims lag. 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 half of 2018 will be subject to change as further claims data run-out it is available.

[6] OneCare stratified the ACO-attributed population using claims data that *excluded* information about substance use disorder diagnoses and treatment; DVHA used the same risk grouping algorithm to stratify the comparison population of Medicaid members who are eligible for attribution using *complete* Medicaid claims data.

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: Three Month Average						
	VMNG Attributed Members			**Members Eligible for Attribution but not Attributed**		
	CY '16	**CY '17**	**CY '18**	**CY '16**	**CY '17**	**CY '18**
	Q1-Q2	**Q1-Q2**	**Q1-Q2**	**Q1-Q2**	**Q1-Q2**	**Q1-Q2**
Ages 0-17	21,003	22,228	21,274	25,800	26,701	25,985
Ages 18+	16,795	18,909	19,506	29,406	32,221	33,929
Total	**37,798**	**41,136**	**40,780**	**55,206**	**58,923**	**59,914**
Ages 0-17: Rate per 12,000 member months						
Inpatient Facility	22	20	20	29	27	24
Outpatient Facility - ED	470	457	453	569	564	527
Outpatient Facility - Medical/Surgical	624	827	823	605	790	755
Home Health and Hospice	142	140	125	108	111	94
Physician Services and other Professional Fees						
PCP Office Visit	3,860	3,861	3,297	1,949	2,141	1,848
Specialist Office Visit	224	209	208	220	221	209
DME/Supp/Prosthetics/Orthotics	553	519	545	622	604	608
Mental Health Outpatient^	7,526	8,185	8,968	6,617	7,248	7,925
Substance Use Diagnosis Outpatient	33	28	43	12	42	46
Diagnostic X-ray	423	398	314	485	502	344
Diagnostic Lab	582	814	812	699	805	831
Ambulance	32	34	36	37	38	37
*Dental**	1,648	1,690	1,780	1,619	1,617	1,699
*Pharmacy/Medications**	5,754	5,618	5,682	5,647	5,571	5,630
Ages 18+: Rate per 12,000 member months						
Inpatient Facility	104	98	104	111	117	104
Outpatient Facility - ED	898	879	767	951	872	785
Outpatient Facility - Medical/Surgical	2,730	3,371	3,161	2,596	3,016	2,697
Home Health and Hospice	414	468	476	360	438	431
Physician Services and other Professional Fees						
PCP Office Visit	3,768	3,840	3,445	2,204	2,165	2,016
Specialist Office Visit	752	721	665	690	709	625
DME/Supp/Prosthetics/Orthotics	760	798	801	659	704	657
Mental Health Outpatient^	5,553	5,638	5,531	5,038	5,069	4,607
Substance Use Diagnosis Outpatient	733	864	781	1,491	1,431	1,149
Diagnostic X-ray	1,672	1,693	1,321	1,613	1,591	1,190
Diagnostic Lab	2,803	2,635	2,609	4,013	3,611	3,228
Ambulance	151	152	155	142	154	156
*Dental**	949	993	978	945	976	949
*Pharmacy/Medications**	21,146	21,719	21,016	18,833	20,023	18,695

^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.

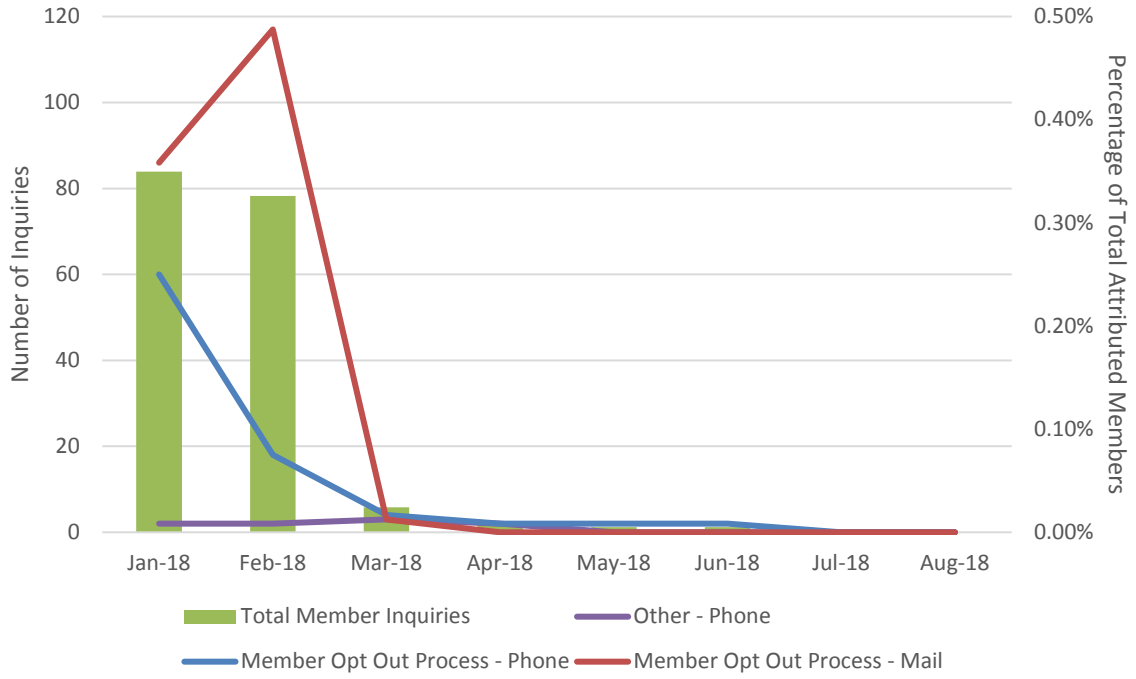
REPORT DATE: 09/07/18

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 in 2018 from members and providers by phone and in writing. Detailed counts are available in Appendix D. In 2018, 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, the majority of 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. As in 2017, most member inquiries regarding the opt-out process occurred in January and February, after OneCare mailed a communication to attributed members notifying them of their option to do so; relatively few member inquiries occurred in March through August.

Figure 1. Member Inquiries Received by OneCare



Note: The *total* number of member inquiries received between January and August of 2018 (n=303) equates to approximately 7 inquiries per 1,000 Medicaid members attributed to OneCare for the VMNG program.

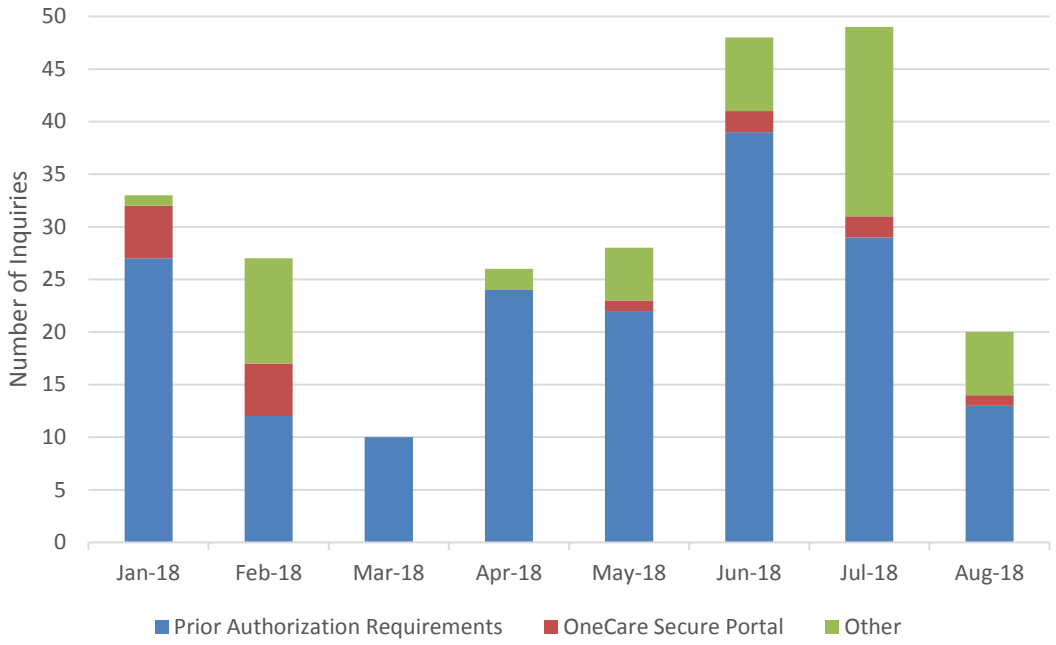
[7] DVHA, OneCare, and the Office of the Health Care Advocate are engaged in ongoing conversations about how best to monitor and address complaints, grievances, and appeals relating to the VMNG program.

[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. 243 members (0.6% of total attributed lives) have opted out of having their data shared with OneCare thus far in 2018; an additional 268 members who had opted out of data sharing during the Vermont Medicaid Shared Savings Program (2014-2016) and the 2017 VMNG performance year had their preferences extended to 2018, for a total of 511 members (1.2% of total attributed lives).

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 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 questions pertaining to care coordination services.

Overall, OneCare has received a modest number of communications from members and providers. As mentioned above, slight spikes in member and provider inquiries to OneCare occur in the first several months after members receive opt out notification letters. 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 2018 (n=241) equates to approximately 70 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 summarizes the counts of primary care and specialist providers participating in the Vermont Medicaid Next Generation program network for all Quarters in 2017 and for Quarters 1 and 2 of 2018. Provider participation remained fairly constant throughout 2017, and increased notably from 2017 to 2018.

[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 2018 VMNG Network

ACO Network Providers	CY '17 Quarter 1	CY '17 Quarter 2	CY '17 Quarter 3	CY '17 Quarter 4	CY '18 Quarter 1	CY '18 Quarter 2
Primary Care Providers	529	518	533	542	732	737
Specialists	1,521	1,508	1,566	1,555	2,644	2,690
TOTAL	2,050	2,026	2,099	2,097	3,376	3,427

Attributed Medicaid Population Reporting

Table 4 shows monthly changes in attribution of Medicaid members in the 2018 VMNG Program. Appendix E summarizes monthly changes in attribution since the beginning of the VMNG pilot in 2017. Attribution of Medicaid members to the ACO occurs prospectively, at the start of each program year. In this way, the ACO is aware of the full population for which it is accountable at the program year'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

Between January and September, approximately 87.11% of prospectively attributed members remained continuously eligible for ACO attribution. In the same interval, an additional 3.17% of prospectively attributed members have lost and subsequently re-gained ACO attribution eligibility. As of the beginning of September 2018, 9.72% of prospectively attributed members are not considered eligible for ACO attribution due to the reasons described above (8.20% for loss of Medicaid eligibility OR additional source of insurance coverage; 1.36% for limited Medicaid benefits package; and 0.16% 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 will continue to monitor information about churn in ACO programs nationally, and will continue to work with OneCare to develop strategies to adjust rates for anticipated changes in the composition of the attributed population due to churn in future program years.

Table 4. Medicaid Members Attributed to OneCare for the 2018 VMNG Program

Attributed Medicaid Members*	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
% of 42,342	**100.00%**	**99.20%**	**98.12%**	**97.23%**	**96.29%**	**94.32%**	**92.19%**	**91.09%**	**90.28%**
Total	42,342	42,005	41,545	41,169	40,769	39,936	39,033	38,569	38,228
Aged, Blind, Disabled	2,757	2,705	2,686	2,632	2,613	2,607	2,587	2,578	2,571
General Adult	18,097	18,006	17,769	17,609	17,422	16,929	16,431	16,168	15,972
General Child	21,488	21,294	21,090	20,928	20,734	20,400	20,015	19,823	19,685

*Defined as number of individuals for whom a monthly prospective payment was made.

[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.

Section C: Appendices

Appendix A. Section 1 of Act 124 of the Acts of 2018.

Sec. 1. VERMONT MEDICAID NEXT GENERATION ACO PILOT PROJECT REPORTS

(a) On or before June 15, September 15, and December 15, 2018, 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, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate written updates on the implementation of the Vermont Medicaid Next Generation ACO Pilot Project (Pilot Project). The updates shall include the following information:

(1) the amount of Medicaid funds provided by the Department to the accountable care organization (ACO) in each of the three months preceding the month of the report; the June report shall also include the amounts for January and February 2018 and the total amount of Medicaid funds provided since the beginning of the Pilot Project;

(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, the June report shall also include the amounts for January and February 2018 and the total amount of funds expended on behalf of attributed Medicaid beneficiaries since the beginning of the Pilot Project;

(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 Vermont Medicaid Next Generation Medicaid ACO Pilot Project Year 2 (2018) Operational Timeline;

(5) to the extent data are 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 second year of the Pilot Project 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 second year of the Pilot Project 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 Project;

(7) current information on the size of the participating provider network since the beginning of the Pilot Project and since the previous report; and

(8) any change in the size of the Medicaid population attributed to the ACO since the beginning of the Pilot Project and since the previous report.

(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 Vermont Medicaid Next Generation 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 in 2018 after adjournment of the General Assembly. 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 through July 2018

	January	February	March	April	May	June	July	Q1	Q2	Year-to-Date
Attribution^	42,342	42,005	41,545	41,169	40,769	39,936	39,033			
DVHA Payment to ACO*	$ 6,415,190	$ 6,364,814	$ 6,291,544	$ 6,227,134	$ 6,165,800	$ 6,030,309	$ 5,885,731	$ 19,071,547	$ 18,423,243	$ 43,380,522
Fixed Prospective Payment (FPP)	$ 5,876,612	$ 5,830,554	$ 5,763,200	$ 5,703,790	$ 5,647,550	$ 5,522,791	$ 5,389,817	$ 17,470,365	$ 16,874,131	$ 39,734,313
Quality Withhold	$ 157,500	$ 156,215	$ 154,439	$ 152,823	$ 151,329	$ 148,094	$ 144,617	$ 468,154	$ 452,246	$ 1,065,016
Primary Care Case Management (PCCM) Fee	$ 105,855	$ 105,013	$ 103,863	$ 102,923	$ 101,923	$ 99,840	$ 97,583	$ 314,730	$ 304,685	$ 716,998
Care Coordination Payment (CCP)	$ 137,612	$ 136,516	$ 135,021	$ 133,799	$ 132,499	$ 129,792	$ 126,857	$ 409,149	$ 396,091	$ 932,097
Administrative Fee	$ 137,612	$ 136,516	$ 135,021	$ 133,799	$ 132,499	$ 129,792	$ 126,857	$ 409,149	$ 396,091	$ 932,097
Total ACO Payments to Providers	$ 6,120,078	$ 6,072,083	$ 6,002,084	$ 5,940,512	$ 5,881,972	$ 5,752,423	$ 5,614,257	$ 18,194,244	$ 17,574,906	$ 41,383,408
Total Expected Shadow FFS	$ 6,034,112	$ 5,986,769	$ 5,917,639	$ 5,856,613	$ 5,798,879	$ 5,670,885	$ 5,534,434	$ 17,938,519	$ 17,326,377	$ 40,799,331
Total Actual Shadow FFS	$ 5,706,194	$ 5,212,722	$ 5,109,715	$ 5,099,225	$ 5,452,830	$ 4,713,643	$ 3,929,820	$ 16,028,631	$ 15,265,699	$ 35,224,150
Shadow FFS Over (Under) Spend	$ (327,918)	$ (774,046)	$ (807,924)	$ (757,388)	$ (346,049)	$ (957,242)	$ (1,604,614)	$ (1,909,888)	$ (2,060,679)	$ (5,575,180)
Total Expected FFS	$ 4,465,897	$ 4,427,542	$ 4,378,286	$ 4,331,570	$ 4,289,738	$ 4,202,053	$ 4,106,793	$ 13,271,724	$ 12,823,362	$ 30,201,879
Actual FFS - In Network	$ 2,329,552	$ 2,387,067	$ 2,327,601	$ 2,089,023	$ 2,179,282	$ 2,160,772	$ 1,618,453	$ 7,044,220	$ 6,429,076	$ 15,091,750
Actual FFS - Out of Network	$ 2,440,684	$ 2,264,913	$ 2,264,432	$ 2,277,195	$ 2,530,738	$ 1,971,755	$ 1,770,968	$ 6,970,030	$ 6,779,688	$ 15,520,686
Total Actual FFS	$ 4,770,236	$ 4,651,981	$ 4,592,033	$ 4,366,218	$ 4,710,019	$ 4,132,527	$ 3,389,421	$ 14,014,250	$ 13,208,764	$ 30,612,435
FFS Over (Under) Spend	$ 304,339	$ 224,439	$ 213,747	$ 34,648	$ 420,281	$ (69,527)	$ (717,372)	$ 742,525	$ 385,402	$ 410,556
Expected Total Cost of Care	$ 10,500,008	$ 10,414,310	$ 10,295,925	$ 10,188,183	$ 10,088,618	$ 9,872,939	$ 9,641,227	$ 31,210,244	$ 30,149,739	$ 71,001,210
Actual Total Cost of Care	$ 10,804,348	$ 10,638,749	$ 10,509,672	$ 10,222,831	$ 10,508,898	$ 9,803,412	$ 8,923,855	$ 31,952,769	$ 30,535,141	$ 71,411,765
Total Cost of Care Over (Under) Spend	$ 304,339	$ 224,439	$ 213,747	$ 34,648	$ 420,281	$ (69,527)	$ (717,372)	$ 742,525	$ 385,402	$ 410,555

Report: Claims Runout through 08/31/2018

^ Defined 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 2018; however, the impact of the claims-lag is particularly pronounced for the month of July.

Note 2: As noted in Section A of this report, DVHA and DXC have worked together to identify a series of systems changes that will improve DVHA's ability to report on the program's financial performance. One such change will improve DVHA's ability to report on the ACO's Out-of-Network expenditure. The monthly Out of Network totals in this report are subject to ongoing validation with DVHA, DXC, and OneCare to ensure all of the appropriate exclusions have been applied.

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

[UPDATED FOR 2018 REPORTS] Specialist Office Visit
Office visit CPT/HCPCS code and place of services and with specialist provider specialty.

Specialist provider specialty:
003 - ALLERGY/IMMUNOLOGY
004 - OTALARYNGOLOGY
006 - CARDIOLOGY
007 - DERMATOLOGY
010 - GASTROENTEROLOGY
013 - NEUROLOGY
016 - OBSTETRICS/GYNECOLOGY
017 - PPNE GYNECOLOGY
029 - PULMONARY DISEASE
034 - UROLOGY
039 - NEPHROLOGY
044 - INFECTIOUS DISEASE
046 - ENDOCRINOLOGY
048 - PODIATRY
066 - RHEUMATOLOGY
083 - HEMATOLOGY/ONCOLOGY
090 - MEDICAL ONCOLOGY
S17 - OTHER CERTIFIED NURSE PRACTITIONER

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).

[UPDATED FOR 2018 REPORTS] Mental Health (MH) Outpatient
MH, psychological, and psychiatry claims (type of services 9) and mental health primary diagnosis outpatient claims based on HEDIS[4] definitions of stand-alone visits with mental health practitioners. Includes mental health services paid by DVHA and other Departments within the Agency of Human Services.

[NEW FOR 2018 REPORTS] Substance Use Disorder (SUD) Outpatient

[4] Healthcare Effectiveness Data and Information Set

Substance Use Disorder primary diagnosis outpatient claims based on HEDIS definitions of stand-alone visits with chemical dependency practitioners.

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 attribution in the VMNG program.

Outpatient clinic facility claims (revenue codes 510-519) were excluded in the baseline years (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: Three Month Average	VMNG Attributed Members			Members Eligible for Attribution but not Attributed		
	CY '16	**CY '17**	**CY '18**	**CY '16**	**CY '17**	**CY '18**
	Q1-Q2	**Q1-Q2**	**Q1-Q2**	**Q1-Q2**	**Q1-Q2**	**Q1-Q2**
Ages 0-17	21,003	22,228	21,274	25,800	26,701	25,985
Ages 18+	16,795	18,909	19,506	29,406	32,221	33,929
Total	**37,798**	**41,136**	**40,780**	**55,206**	**58,923**	**59,914**
Ages 0-17: Rate per 12,000 member months						
Inpatient Facility	22	20	20	29	27	24
Outpatient Facility - ED	470	457	453	569	564	527
Outpatient Facility - Medical/Surgical	624	827	823	605	790	755
Home Health and Hospice	142	140	125	108	111	94
Physician Services and other Professional Fees						
PCP Office Visit	3,860	3,861	3,297	1,949	2,141	1,848
Specialist Office Visit	224	209	208	220	221	209
DME/Supp/Prosthetics/Orthotics	553	519	545	622	604	608
Mental Health Outpatient^	7,526	8,185	8,968	6,617	7,248	7,925
Substance Use Diagnosis Outpatient	33	28	43	12	42	46
Diagnostic X-ray	423	398	314	485	502	344
Diagnostic Lab	582	814	812	699	805	831
Ambulance	32	34	36	37	38	37
*Dental**	1,648	1,690	1,780	1,619	1,617	1,699
*Pharmacy/Medications**	5,754	5,618	5,682	5,647	5,571	5,630
Ages 18+: Rate per 12,000 member months						
Inpatient Facility	104	98	104	111	117	104
Outpatient Facility - ED	898	879	767	951	872	785
Outpatient Facility - Medical/Surgical	2,730	3,371	3,161	2,596	3,016	2,697
Home Health and Hospice	414	468	476	360	438	431
Physician Services and other Professional Fees						
PCP Office Visit	3,768	3,840	3,445	2,204	2,165	2,016
Specialist Office Visit	752	721	665	690	709	625
DME/Supp/Prosthetics/Orthotics	760	798	801	659	704	657
Mental Health Outpatient^	5,553	5,638	5,531	5,038	5,069	4,607
Substance Use Diagnosis Outpatient	733	864	781	1,491	1,431	1,149
Diagnostic X-ray	1,672	1,693	1,321	1,613	1,591	1,190
Diagnostic Lab	2,803	2,635	2,609	4,013	3,611	3,228
Ambulance	151	152	155	142	154	156
*Dental**	949	993	978	945	976	949
*Pharmacy/Medications**	21,146	21,719	21,016	18,833	20,023	18,695

^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: 09/07/18

Population Counts: Three Month Average	Low Risk VMNG Attributed Members			Medium Risk VMNG Attributed Members			High Risk VMNG Attributed Members			Very High Risk VMNG Attributed Members		
	CY '16	CY '17	CY '18	CY '16	CY '17	CY '18	CY '16	CY '17	CY '18	CY '16	CY '17	CY '18
	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2
Ages 0-17	13,965	15,113	14,744	6,088	6,185	5,686	513	495	448	438	435	396
Ages 18+	2,486	2,953	3,312	9,134	10,285	10,585	3,297	3,618	3,600	1,878	2,052	2,010
Total	**16,451**	**18,066**	**18,055**	**15,223**	**16,469**	**16,271**	**3,810**	**4,114**	**4,048**	**2,315**	**2,487**	**2,406**
Ages 0-17: Rate per 12,000 member months												
Hospital Inpatient	9	2	8	30	25	32	74	153	107	270	428	217
Hospital Outpatient ED	367	330	363	605	650	604	1,111	1,248	933	1,134	1,243	1,115
Hospital Outpatient non-ED	459	513	610	804	1,241	1,108	2,106	3,226	2,695	1,673	3,153	2,553
Home Health and Hospice	57	23	44	196	267	175	647	892	1,017	1,504	1,574	1,438
Physician Services and other Professional Fees												
PCP Office Visit	3,377	3,180	2,855	4,573	5,010	4,076	6,181	7,704	5,895	6,619	6,776	5,616
Specialist Office Visit	149	112	148	321	343	290	772	913	799	631	870	611
DME/Supp/Prosthetics/Orthotics	297	285	336	653	598	639	2,118	2,184	2,004	5,504	5,629	5,344
Mental Health Outpatient^	2,079	1,795	2,987	12,551	13,094	15,181	31,710	41,806	43,555	83,122	122,246	103,236
Substance Use Diagnosis Outpatient	19	8	13	62	74	111	74	65	71	0	9	126
Diagnostic X-ray	298	250	241	568	580	429	1,158	1,345	727	1,541	1,892	913
Diagnostic Lab	484	637	689	710	1,049	990	1,232	2,209	1,861	1,161	2,039	1,680
Ambulance	16	13	18	41	52	55	97	162	152	325	336	318
*Dental**	1,583	1,637	1,782	1,758	1,795	1,763	2,040	1,922	1,914	1,751	1,800	1,786
*Pharmacy/Medications**	2,733	2,386	2,840	9,569	10,180	9,917	20,065	21,279	20,470	32,329	35,231	33,951
Ages 18+: Rate per 12,000 member months												
Hospital Inpatient	26	8	24	50	30	57	140	146	149	405	480	403
Hospital Outpatient ED	456	262	368	691	629	590	1,275	1,291	1,119	1,823	2,295	1,723
Hospital Outpatient non-ED	1,443	899	1,237	2,141	2,483	2,516	3,648	5,051	4,722	5,690	8,419	6,935
Home Health and Hospice	21	0	7	59	44	54	311	402	486	2,837	3,381	3,451
Physician Services and other Professional Fees												
PCP Office Visit	1,945	1,541	1,675	3,309	3,267	3,055	5,047	5,497	4,820	6,172	7,101	5,954
Specialist Office Visit	376	227	319	573	497	502	1,060	1,117	952	1,576	1,854	1,580
DME/Supp/Prosthetics/Orthotics	298	224	233	413	404	429	837	872	937	2,925	3,465	3,458
Mental Health Outpatient^	1,565	1,205	1,516	3,876	3,999	3,978	7,050	7,577	7,387	16,359	16,814	17,009
Substance Use Diagnosis Outpatient	367	295	332	764	855	799	909	1,280	1,018	762	997	995
Diagnostic X-ray	823	394	587	1,272	1,109	1,044	2,265	2,598	1,928	3,699	4,894	2,905
Diagnostic Lab	1,007	751	1,268	2,638	2,223	2,307	3,848	4,236	4,081	4,153	4,585	3,775
Ambulance	41	21	37	74	58	78	208	212	237	574	706	603
*Dental**	907	809	949	951	1,004	962	968	1,055	1,006	963	1,095	1,059
*Pharmacy/Medications**	4,449	2,942	4,055	14,414	14,391	14,632	33,183	35,843	34,406	54,869	60,558	58,605

^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: 09/07/18

Population Counts: Three Month Average	Low Risk Members Eligible for Attribution but not Attributed			Medium Risk Members Eligible for Attribution but not Attributed			High Risk Members Eligible for Attribution but not Attributed			Very High Risk Members Eligible for Attribution but not Attributed		
	CY '16	CY '17	CY '18	CY '16	CY '17	CY '18	CY '16	CY '17	CY '18	CY '16	CY '17	CY '18
	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2	Q1-Q2
Ages 0-17	17,975	19,100	19,092	6,739	6,556	5,968	639	609	532	447	436	394
Ages 18+	6,437	6,709	8,043	15,484	17,254	17,846	4,751	5,218	5,158	2,734	3,041	2,883
Total	**24,412**	**25,809**	**27,135**	**22,223**	**23,810**	**23,813**	**5,390**	**5,827**	**5,689**	**3,182**	**3,477**	**3,277**
Ages 0-17: Rate per 12,000 member months												
Hospital Inpatient	12	3	9	37	39	39	172	197	139	385	692	350
Hospital Outpatient ED	458	407	429	758	846	730	1,205	1,600	1,197	1,243	1,752	1,275
Hospital Outpatient non-ED	431	464	541	857	1,292	1,096	1,525	2,901	2,152	2,481	4,608	4,032
Home Health and Hospice	42	26	24	190	195	162	538	703	523	930	1,706	1,904
Physician Services and other Professional Fees												
PCP Office Visit	1,683	1,719	1,548	2,411	2,985	2,479	3,350	3,930	3,500	3,666	5,411	4,616
Specialist Office Visit	147	118	141	344	405	329	689	1,015	715	621	871	990
DME/Supp/Prosthetics/Orthotics	355	320	347	785	828	811	2,511	2,668	2,630	6,161	6,809	7,470
Mental Health Outpatient^	2,096	1,799	2,739	12,286	13,760	15,246	37,315	54,746	59,661	59,025	81,712	78,587
Substance Use Diagnosis Outpatient	4	4	4	29	121	165	16	145	196	112	390	30
Diagnostic X-ray	343	304	275	697	806	476	1,240	1,804	850	1,896	2,797	1,051
Diagnostic Lab	571	601	705	885	1,121	1,040	1,653	2,356	1,938	1,686	2,815	2,311
Ambulance	19	14	20	58	57	58	178	269	207	237	495	350
*Dental**	1,549	1,533	1,676	1,766	1,834	1,762	1,766	1,725	1,735	1,990	1,862	1,767
*Pharmacy/Medications**	2,665	2,337	2,837	10,275	11,252	11,151	21,245	23,566	21,821	33,474	36,692	35,477
Ages 18+: Rate per 12,000 member months												
Hospital Inpatient	28	8	33	58	30	57	161	165	153	527	774	504
Hospital Outpatient ED	520	307	428	781	661	665	1,440	1,423	1,187	2,085	2,371	1,800
Hospital Outpatient non-ED	1,316	842	1,348	2,237	2,404	2,306	3,757	4,918	4,075	5,620	8,017	6,414
Home Health and Hospice	16	1	28	117	131	156	555	604	693	2,203	2,857	2,798
Physician Services and other Professional Fees												
PCP Office Visit	1,269	987	1,099	1,927	1,872	1,842	3,304	3,290	2,934	4,061	4,499	4,011
Specialist Office Visit	325	208	323	564	535	518	1,059	1,193	979	1,620	1,973	1,495
DME/Supp/Prosthetics/Orthotics	285	231	261	434	425	411	867	967	932	2,451	2,876	2,790
Mental Health Outpatient^	2,450	1,664	1,934	4,226	4,069	3,920	7,897	8,320	7,686	10,761	12,672	10,809
Substance Use Diagnosis Outpatient	459	298	399	1,515	1,274	1,040	2,603	2,654	2,076	1,853	2,719	2,266
Diagnostic X-ray	804	417	641	1,330	1,170	1,041	2,233	2,572	1,713	4,043	4,885	2,710
Diagnostic Lab	1,240	778	1,122	3,759	3,055	2,974	7,084	6,836	5,805	6,649	7,486	6,062
Ambulance	52	23	51	85	65	85	202	223	233	573	832	744
*Dental**	918	855	909	943	1,006	943	1,001	1,046	1,019	920	955	971
*Pharmacy/Medications**	4,809	2,608	4,594	14,389	14,323	14,383	33,317	37,471	34,877	51,848	60,851	55,773

^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: 09/07/18

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

	Jan-18			Feb-18			Mar-18			Apr-18			May-18			Jun-18			Jul-18			Aug-18		
	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	Phone	Written	Month Total
1. Inquiries																								
a. Member Inquiries																								
Beneficiary Opt Out Process	60	86	**146**	18	117	**135**	4	3	**7**	2	0	**2**	2	0	**2**	2	0	**2**	0	0	**0**	0	0	**0**
Other	2	0	**2**	2	0	**2**	3	0	**3**	2	0	**2**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Total Member Inquiries			**148**			**137**			**10**			**4**			**2**									
b. Provider Inquiries																								
Prior Authorization Requirements	27	0	**27**	12	0	**12**	10	0	**10**	23	1	**24**	22	0	**22**	39	0	**39**	29	0	**29**	13	0	**13**
OneCare Secure Portal	5	0	**5**	5	0	**5**	0	0	**0**	0	0	**0**	1	0	**1**	2	0	**2**	2	0	**2**	1	0	**1**
Other	1	0	**1**	10	0	**10**	0	0	**0**	2	0	**2**	5	0	**5**	6	1	**7**	18	0	**18**	6	0	**6**
Total Provider Inquiries			**33**			**27**			**10**			**26**			**28**									
Total Member and Provider Inquiries	**95**	**86**	**181**	**47**	**117**	**164**	**17**	**3**	**20**	**29**	**1**	**30**	**30**	**0**	**30**	**49**	**1**	**50**	**49**	**0**	**49**	**20**	**0**	**20**
2. Complaints																								
a. Member Complaints																								
Total Member Complaints	0	0	**0**	0	0	**0**	0	0	**0**	1	0	**1**	0	0	**0**	0	0	**0**	0	0	**0**	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**	0	0	**0**
Total Member and Provider Complaints	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**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**	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**	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**	**0**	**0**	**0**

Appendix E. Medicaid Members Attributed to OneCare Vermont for the 2017-2018 VMNG Program Years

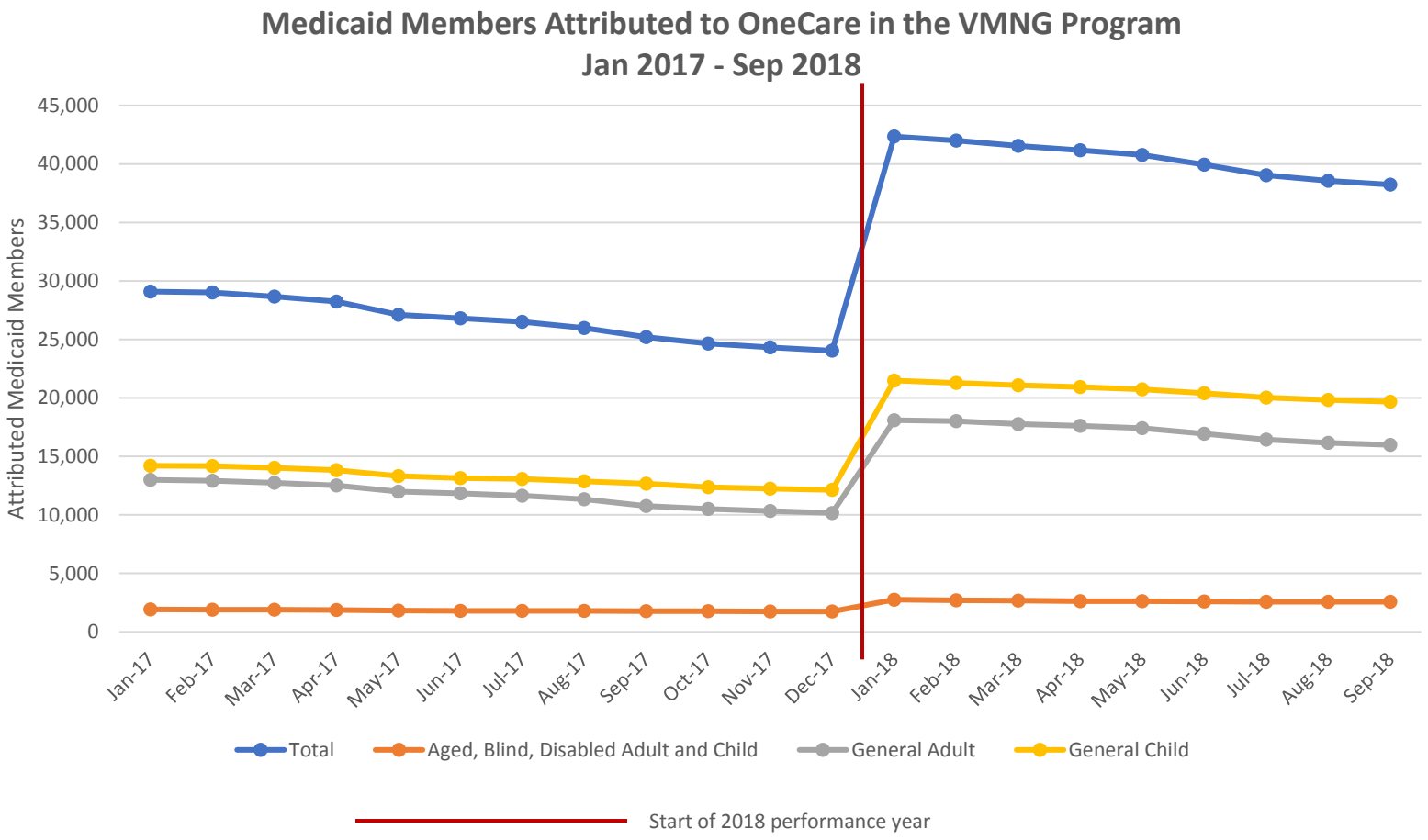
Medicaid Members Attributed to OneCare for the 2017 VMNG Program

Attributed Medicaid Members*	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
% of 29,102	**100.00%**	**99.72%**	**98.54%**	**97.04%**	**93.17%**	**92.11%**	**91.07%**	**89.29%**	**86.58%**	**84.67%**	**83.61%**	**82.60%**
Total	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985	25,197	24,642	24,332	24,038
Aged, Blind, Disabled	1,910	1,907	1,906	1,878	1,819	1,808	1,790	1,791	1,773	1,764	1,755	1,742
General Adult	12,987	12,933	12,754	12,525	11,980	11,845	11,646	11,331	10,764	10,512	10,326	10,164
General Child	14,205	14,181	14,016	13,837	13,316	13,153	13,067	12,863	12,660	12,366	12,251	12,132

Medicaid Members Attributed to OneCare for the 2018 VMNG Program

Attributed Medicaid Members*	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
% of 42,342	**100.00%**	**99.20%**	**98.12%**	**97.23%**	**96.29%**	**94.32%**	**92.19%**	**91.09%**	**90.28%**
Total	42,342	42,005	41,545	41,169	40,769	39,936	39,033	38,569	38,228
Aged, Blind, Disabled	2,757	2,705	2,686	2,632	2,613	2,607	2,587	2,578	2,571
General Adult	18,097	18,006	17,769	17,609	17,422	16,929	16,431	16,168	15,972
General Child	21,488	21,294	21,090	20,928	20,734	20,400	20,015	19,823	19,685

* Defined as number of individuals for whom a monthly prospective payment was made.


Medicaid Members Attributed to OneCare in the VMNG Program
Jan 2017 - Sep 2018
Attributed Medicaid Members
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Total
Aged, Blind, Disabled Adult and Child
General Adult
General Child
Start of 2018 performance year