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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

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December 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 November 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 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. This report, the third and final required by Act 25 of 2017, adds three additional months of data. During the last three months, DVHA and OneCare have engaged in negotiations to extend the pilot program to 2018, 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 one of the four optional one-year extensions permitted by the VMNG contract. A one-year extension would enable DVHA and OneCare to continue the program for the 2018 calendar year. DVHA and OneCare highlighted several mutual goals for a 2018 performance year when entering into negotiations:
    - Minimize programmatic changes from 2017 to 2018 to provide stability for ACO-based reform as commercial and Medicare Next Generation ACO programs begin.
    - Increase the number of communities voluntarily participating in the program.
    - Increase the number of Medicaid beneficiaries attributed to the ACO.
    - Ensure programmatic alignment between the VMNG, Medicare, and commercial payer programs in 2018 per the requirements of the Vermont All-Payer ACO Model Agreement.

  Negotiations concluded during the fourth quarter of 2017. Currently, the extension is being reviewed by attorneys for both parties. DVHA and OneCare intend to have an executed agreement by the end of 2017.
- Several modest programmatic adjustments are being made for the 2018 performance year despite the goal of minimizing program changes. These changes include:
    - Expanding the waiver of prior authorizations to all providers (the waiver will still only be available for Medicaid members who are attributed to OneCare, and for services for which the ACO is financially accountable).
    - Removing the ability for specialist providers to attribute members to the ACO (all attribution will be based on an individual's relationship with a primary care provider).
    - Making minor adjustments to the list of quality measures used to evaluate ACO performance (including the addition of patient experience survey measures).

  DVHA is working both internally and with OneCare to identify potential operational and implementation issues. These changes are expected to have minimal impact on day-to-day

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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.

program operations. Moreover, through the collaborative framework established in 2017, DVHA and OneCare will work closely to ensure that any new operational challenges that arise are identified and resolved in a timely manner.
- Building upon recommendations outlined in the 2016 VMNG Readiness Review, DVHA and OneCare collaborated to conduct a one-day site visit in the third quarter of 2017 to assess implementation of OneCare's care coordination model. This site visit, which included network participants from all four 2017 risk-bearing communities, provided the opportunity for DVHA and OneCare to review in greater depth the qualitative aspects of the model's development and implementation to build upon the quantitative information that has been supplied by OneCare in monthly and quarterly reports. General findings of the site visit indicate that although the care coordination model has not reached full saturation for 2017 VMNG attributed lives, incremental progress continues to be made. DVHA and OneCare plan to coordinate similar site visits to further assess implementation of the care coordination model over time, with particular focus on scalability of the model as additional providers participate and as additional Medicaid members are attributed in future.

Key Challenges:
- Proper financial reporting is essential to the success and evaluation of the program. A number of claims were incorrectly processed as ACO Out-of-Network claims, instead of ACO In-Network claims or ACO zero-paid claims during the early part of the year. DVHA, OneCare, and DVHA's claims processor DXC developed a process for reprocessing these claims so they would be classified appropriately in subsequent pilot year reporting, and so that batches of claims could be reprocessed at intervals. The process is working as intended. DVHA and OneCare expect that an additional cycle of claims reprocessing will be needed after the conclusion of the 2017 performance year and before the final 2017 financial reconciliation. Additionally, DVHA, DXC, and OneCare have identified and planned for 2018 systems changes that will improve ACO claims processing accuracy and mitigate the need for such adjustments in future.
- DVHA continues to refine VMNG financial reporting over the course of 2017. As the first year concludes, DVHA, OneCare, and DXC are working together to ensure that reporting strategies are aligned, data sources are consistent, and exclusions are applied uniformly. As DVHA, DXC, and OneCare are independently calculating financial performance on a regular basis, there have been ample opportunities for cross-validation. This iterative process has resulted in notable improvements in recent months, and has highlighted areas for data and system optimization as the program evolves. DVHA, OneCare, and DXC will continue to work together on 2017 program year reporting in the early months of 2018 to ensure all information is available and accurate for conducting the year-end financial reconciliation.

The 2017 pilot year has served as a baseline year and valuable learning experience for both DVHA and OneCare in this partnership. Operationally, both DVHA and OneCare have developed, tested, and refined processes in support of program implementation and oversight. 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 year. Additional coordination between DVHA and OneCare will be required to maintain and optimize operations in a second performance year. 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 eleven months of Calendar Year 2017 (January 1, 2017 – December 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 June through November until later this year; though claims are mostly complete for the first five months of the calendar year, 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. 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.

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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.

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.

At the time of this report, OneCare's overall actual expenditure in March through June, August, and September of 2017 has been higher than the expected expenditure for the corresponding month; actual expenditure in January, February, July, October, and November 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. 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 $860,000 less than expected. Notably, the margin between actual and expected spending is broad when examining financial performance for October and November. This shows the disproportionate impact of the claims lag on the most recent months of performance; however, claims lag also impacts January through September 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. Currently, the program is within approximately 1% of its estimated 2017 Total Cost of Care. 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.

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

	January	February	March	April	May	June	July	August	September	October	November	Q1	Q2	Q3	Year-to-Date
Attribution^	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985	25,197	24,642	24,332				
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	$ 4,352,537	$ 4,263,747	$ 4,205,500	$ 10,247,515	$ 14,309,538	$ 13,474,373	$ 46,500,674
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	$ 4,125,764	$ 4,041,969	$ 3,986,512	$ 9,538,991	$ 13,570,089	$ 12,775,208	$ 43,912,769
Total Actual Shadow FFS	$ -	$ 4,231,151	$ 4,126,396	$ 4,353,496	$ 4,056,891	$ 3,615,256	$ 3,444,461	$ 3,441,072	$ 3,359,831	$ 3,001,474	$ 1,086,392	$ 8,357,546	$ 12,025,644	$ 10,245,363	$ 34,716,420
Shadow FFS Over (Under) Spend	$ -	$ (565,488)	$ (615,956)	$ (311,328)	$ (419,583)	$ (813,534)	$ (924,399)	$ (839,513)	$ (765,933)	$ (1,040,495)	$ (2,900,120)	$ (1,181,445)	$ (1,544,445)	$ (2,529,845)	$ (9,196,350)
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	$ 2,323,774	$ 2,276,578	$ 2,245,342	$ 12,895,330	$ 7,643,156	$ 7,195,447	$ 32,255,853
Actual FFS - In Network	$ 4,393,596	$ 610,198	$ 630,904	$ 597,909	$ 613,828	$ 554,967	$ 454,776	$ 489,489	$ 481,024	$ 531,550	$ 207,438	$ 5,634,698	$ 1,766,704	$ 1,425,289	$ 9,565,678
Actual FFS - Out of Network	$ 2,639,429	$ 1,978,305	$ 2,049,273	$ 2,046,081	$ 2,192,078	$ 1,943,762	$ 1,991,154	$ 2,055,638	$ 1,910,554	$ 1,715,095	$ 683,587	$ 6,667,007	$ 6,181,920	$ 5,957,347	$ 21,204,956
Total Actual FFS	$ 7,033,025	$ 2,588,503	$ 2,680,176	$ 2,643,990	$ 2,805,905	$ 2,498,728	$ 2,445,930	$ 2,545,127	$ 2,391,578	$ 2,246,645	$ 891,025	$ 12,301,705	$ 7,948,623	$ 7,382,636	$ 30,770,634
FFS Over (Under) Spend	$ (489,605)	$ (113,135)	$ 9,114	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ (593,625)	$ 305,467	$ 187,189	$ (1,485,219)
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	$ 6,449,538	$ 6,318,547	$ 6,231,854	$ 22,434,321	$ 21,213,245	$ 19,970,655	$ 76,168,623
Actual Total Cost of Care	$ 7,655,673	$ 7,385,142	$ 7,422,600	$ 7,308,814	$ 7,282,379	$ 6,927,519	$ 6,814,790	$ 6,825,712	$ 6,517,342	$ 6,288,614	$ 4,877,537	$ 22,463,415	$ 21,518,712	$ 20,157,844	$ 75,306,123
Total Cost of Care Over (Under) Spend	$ 133,043	$ (113,135)	$ 9,186	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ 29,094	$ 305,467	$ 187,189	$ (862,499)

^ 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. DVHA and OneCare will continue to monitor 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.

Quality Performance

As discussed during testimony before legislative committees, not all quality measures will be reported quarterly during Act 25 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 analysis of 2017 performance measures will not be available until Quarter 2 of 2018, allowing sufficient time for claims run-out to ensure that complete information is available.

Table 2 below includes an assessment of quality performance on a sub-set of claims-based performance measures included in the VMNG contract. Results were calculated by OneCare Vermont using available data for dates of service of January 1, 2017 through October 31, 2017. Caution should be exercised when using the information presented to evaluate program performance, as the data used for this preliminary assessment has several limitations. As noted above, claims lag will affect quality measurement data until there is sufficient claims run-out, meaning that a full picture of quality performance in 2017 will not emerge until the second quarter of 2018. Additionally, the below assessment does not include claims for members who have opted out of sharing their claims data with OneCare, nor does it include any claims related to alcohol or substance use disorder treatment. Several of the 2017 performance measures are new or newly endorsed, and national benchmarks are not available as a comparison for these measures at this time. Small denominators for some measures preclude presenting statistically valid results. Consequently, measures with denominators smaller than 50 were excluded from this report. Finally, the results presented below have not been annualized; because these represent only 10 months of performance, they are not directly comparable to the benchmarks below that have been established for a full year of performance.

Table 2. VMNG Performance for Claims-Based Quality Measures, January through October, 2017

Measure	OneCare Performance, January - October 2017			Quality Compass 2017 (CY 2016) National Medicaid Benchmark Percentiles			
	Score	Numerator	Denominator	25th	50th	75th	90th
Adolescent Well Care Visits	43.34	2,555	5,895	43.06	50.12	59.72	68.06
30 Day Follow-Up after Discharge from ED for Mental health	66.34	136	205	N/A	N/A	N/A	N/A
Developmental Screening in the First 3 years of Life - Composite	60.83	1,174	1,930	N/A	N/A	N/A	N/A
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	50.65	39	77	34.00	46.36	56.22	65.01
Timeliness of Prenatal Care[5]	24.14	49	203	77.66	83.56	88.59	91.67

Given the limitations described above, it is not possible to draw definitive conclusions about quality performance at this time. It should also be noted that quality measures selected for inclusion in the VMNG contract were largely chosen 1) to ensure alignment with measures included in the All Payer ACO Model Agreement, and 2) where opportunities for improvement in Vermont were present. As such, high performance relative to national benchmarks would not be expected during an interim evaluation

[5] This measure is no longer endorsed by the National Quality Forum (NQF). See: www.qualityforum.org/Projects/n-r/Perinatal_2015-2016/Draft_Report.aspx

of performance in a pilot year. DVHA, OneCare, and the Green Mountain Care Board will continue to monitor quality performance as final data becomes available for the 2017 performance year, and will seek to understand ACO performance not only relative to national benchmarks, but also relative to performance for the broader Vermont Medicaid population and for the full population of Vermonters.

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 September 15th 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 92% 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 December 15, 2017 report, utilization data is presented for the combined first, second, and third quarters of Calendar Year 2017 (January 1, 2017 – September 30, 2017 dates of service); data is also presented for the combined first, second, and third quarters of Calendar Years 2015 and 2016 to provide a historical comparison.[6] At this time, there is not sufficient claims run-out to calculate performance for the fourth quarter of Calendar Year 2017 (October 1, 2017 – December 31, 2017 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.

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

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[6] 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 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.

comparison across different-sized cohorts. The rates presented show utilization per 1,000 member years.

Table 3. 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: Nine Month Average	**VMNG Attributed Members**			**Members Eligible for Attribution but not Attributed**		
	CY '15 Q1 – Q3	**CY '16 Q1 – Q3**	**CY '17 Q1 – Q3**	**CY '15 Q1 – Q3**	**CY '16 Q1 – Q3**	**CY '17 Q1 – Q3**
Ages 0-17	14,198	14,783	13,703	35,533	36,252	34,656
Ages 18+	12,335	13,775	13,227	37,573	41,900	41,723
Total	**26,532**	**28,558**	**26,930**	**73,106**	**78,152**	**76,379**
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	44	37	18	49	41	19
Hospital Outpatient ED	426	406	382	547	532	491
Hospital Outpatient non-ED	564	602	721	622	666	747
Home Health and Hospice	139	172	129	86	101	81
Physician Services and other Professional Fees						
PCP Office Visit	3,846	3,745	3,253	2,279	2,133	1,918
Non-PCP Office Visit	453	475	423	447	450	401
DME/Supp/Prosth/Orth	627	602	614	555	578	570
Mental Health^	8,146	8,604	9,779	5,455	5,966	6,513
Diagnostic X-ray	387	396	355	444	458	423
Diagnostic Lab	571	605	758	699	662	703
Ambulance	37	34	32	35	35	31
*Dental**	1,699	1,712	1,801	1,549	1,567	1,604
*Pharmacy/Medications**	5,362	5,354	5,392	5,572	5,596	5,476
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	120	123	108	127	128	115
Hospital Outpatient ED	878	847	773	951	902	805
Hospital Outpatient non-ED	2,640	2,942	3,136	2,559	2,729	2,707
Home Health and Hospice	342	379	443	345	402	467
Physician Services and other Professional Fees						
PCP Office Visit	4,204	4,359	3,824	2,424	2,498	2,226
Non-PCP Office Visit	1,506	1,536	1,367	1,453	1,431	1,179
DME/Supp/Prosth/Orth	727	773	783	654	700	688
Mental Health^	5,787	5,763	5,730	4,441	4,628	4,537
Diagnostic X-ray	1,651	1,673	1,493	1,560	1,604	1,437
Diagnostic Lab	3,430	3,596	2,830	3,076	3,535	2,967
Ambulance	133	148	137	141	144	149
*Dental**	972	1,011	1,006	834	895	872
*Pharmacy/Medications**	20,410	21,179	21,222	18,543	19,121	19,517

^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.

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, mental health visits, and dental 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. As complete information about utilization in the 2017 performance year is 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 determine whether 2017 was significantly different than 2015 or 2016 for either cohort. These analyses will allow for a better understanding of the impact of program implementation on utilization for attributed Medicaid members.

Appendix C newly 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 3, above, rates for the full attributed population in each utilization category tend to be between those of the low and medium risk population segments. Similar stratification is not available at this time for the comparison population of Medicaid beneficiaries who are not attributed to an ACO. DVHA will continue to work toward comparable stratification as complete information about utilization in the 2017 performance year becomes available.

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, utilization information is only available for the first three quarters of the performance year. Furthermore, the program is subject to claims lag.[7] 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 September until later this year. The utilization rates presented here for the first three quarters of 2017 will be subject to change as further claims data run-out it is available.

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 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.[8]

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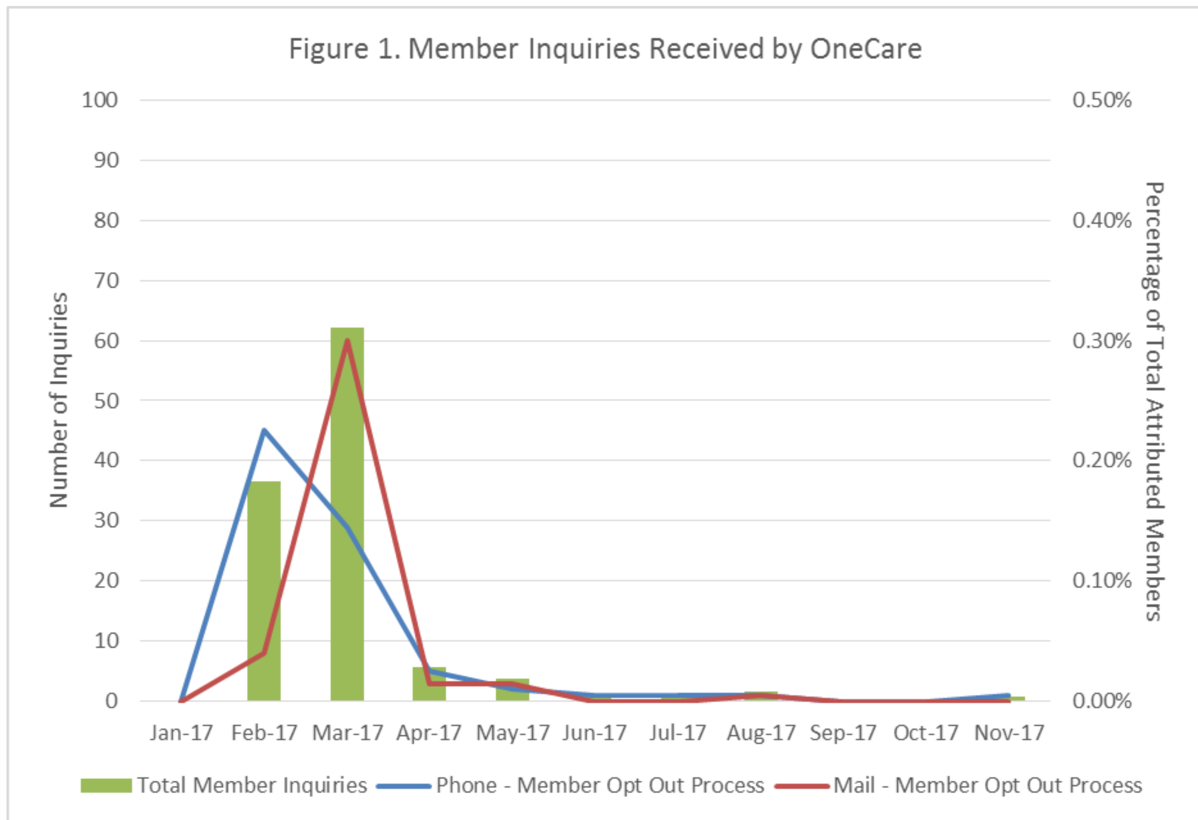
[7] Beyond the claims lag, health care utilization is subject to seasonality. DVHA and OneCare are discussing how to incorporate seasonality into both future financial and utilization forecasting and reporting.

[8] 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.

Thus far, all member inquiries but one have related to the process by which members may opt out of having their Medicaid claims data shared with OneCare.[9] 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 November.



Note: The *total* number of member inquiries received between January and November of 2017 (n=160) 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 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.

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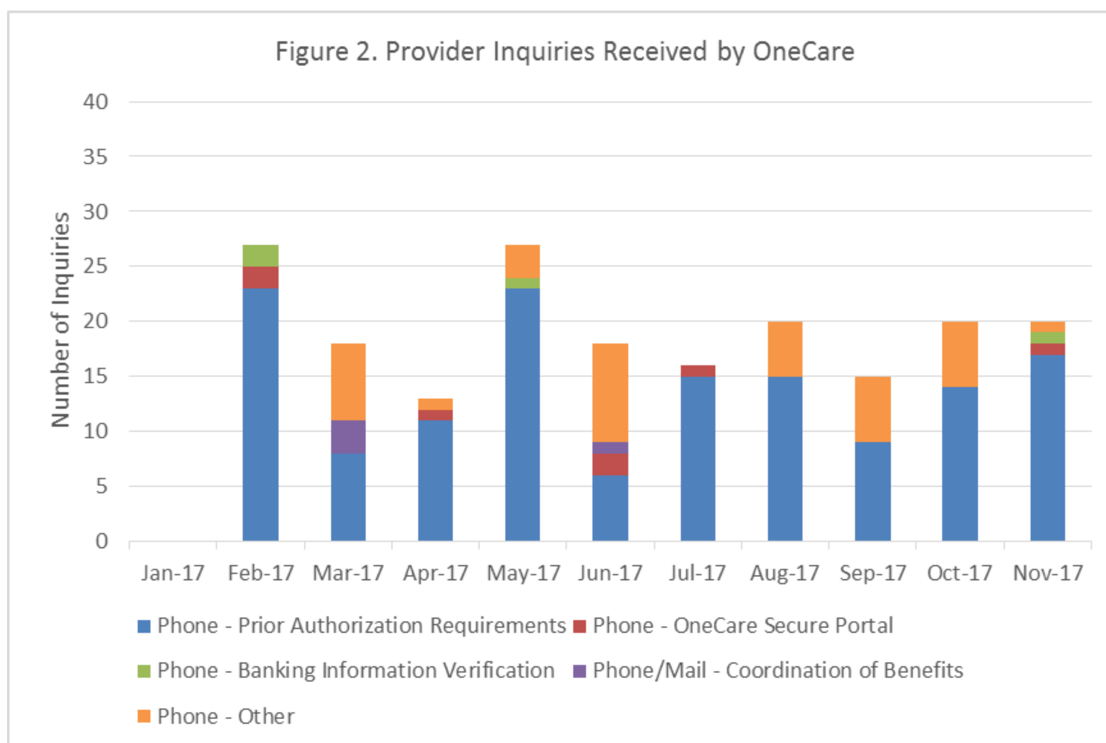
[9] Members may not opt out of being attributed to an ACO. If a member opts out of having their data shared with an ACO, the ACO continues to be accountable for the cost and quality of care for that member, and the member's expenditure is included in all program calculations, though DVHA does not provide 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).

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.



Note: The *total* number of provider inquiries received between January and November of 2017 (n=194) equates to approximately 90 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.[10] Table 3 captures the counts of primary care and specialist providers participating in the Vermont Medicaid Next Generation program network for Quarters 1, 2, 3, and 4 (through December 1, 2017). Provider participation has remained fairly constant throughout the pilot year.

Table 4. Participating Providers in OneCare's 2017 VMNG Network

ACO Network Providers	**CY '17 Quarter 1**	**CY '17 Quarter 2**	**CY '17 Quarter 3**	**CY '17 Quarter 4 (through 12/1/17)**
Primary Care Providers	529	518	533	553
Specialists	1,521	1,508	1,566	1,591
TOTAL	2,050	2,026	2,099	2,144

[10] 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.

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[11]
- 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 December, approximately 77.7% of prospectively attributed members remained continuously eligible for ACO attribution. In the same interval, an additional 4.9% of prospectively attributed members have lost and subsequently re-gained ACO attribution eligibility. As of the beginning of December 2017, 17.4% of prospectively attributed members are not considered eligible for ACO attribution due to the reasons described above (13.8% for loss of Medicaid eligibility OR additional source of insurance coverage; 1.7% for practice contract termination; 1.6% for limited Medicaid benefits package; and 0.3% 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. A 2017 Health Affairs publication on the subject of both member and provider churn within a large Medicare Pioneer Accountable Care Organization reports that nearly one-third of beneficiaries became part of or left the ACO population during the period 2012-2014, and more than half of physicians either joined (41%) or left (18%) the ACO during the same period.[12] As this study was focused on a single ACO and a population of attributed Medicare beneficiaries, the churn experienced may not be directly comparable to that observed in the first year of the VMNG program. 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.

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[11] 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.
[12] See https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1107

Table 5. 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

*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 - November 2017

	January	February	March	April	May	June	July	August	September	October	November	Q1	Q2	Q3	Year-to-Date
Attribution	29,102	29,021	28,676	28,240	27,115	26,806	26,503	25,985	25,197	24,642	24,332				
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	$ 4,352,537	$ 4,263,747	$ 4,205,500	$ 10,247,515	$ 14,309,538	$ 13,474,373	$ 46,500,674
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	$ 4,092,268	$ 4,011,433	$ 3,955,256	$ 9,539,063	$ 13,351,851	$ 12,674,039	$ 43,531,642
Quality Withhold	$ -	$ -	$ -	$ -	$ -	$ 218,238	$ 34,178	$ 33,496	$ 32,355	$ 31,677	$ 31,256	$ -	$ 218,238	$ 100,029	$ 381,200
Primary Care Case Management (PCCM) Fee	$ -	$ 72,553	$ 71,693	$ 70,600	$ 67,788	$ 67,015	$ 66,258	$ 64,963	$ 62,993	$ 61,605	$ 60,830	$ 144,246	$ 205,403	$ 194,213	$ 666,296
Care Coordination Payment (CCP)	$ 94,585	$ 94,318	$ 93,200	$ 91,780	$ 88,124	$ 87,120	$ 86,135	$ 84,451	$ 81,890	$ 80,087	$ 79,079	$ 282,103	$ 267,023	$ 252,476	$ 960,768
Administrative Fee	$ 94,585	$ 94,318	$ 93,200	$ 91,780	$ 88,124	$ 87,120	$ 86,135	$ 84,451	$ 81,890	$ 80,087	$ 79,079	$ 282,103	$ 267,023	$ 252,476	$ 960,768
Total ACO Payments to Providers	$ 189,170	$ 5,057,828	$ 5,000,517	$ 4,918,984	$ 4,720,509	$ 4,670,045	$ 4,607,387	$ 4,514,450	$ 4,351,396	$ 4,264,888	$ 4,205,500	$ 10,247,515	$ 14,309,538	$ 13,473,233	$ 46,500,673
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	$ 4,125,764	$ 4,041,969	$ 3,986,512	$ 9,538,991	$ 13,570,089	$ 12,775,208	$ 43,912,769
Total Actual Shadow FFS	$ -	$ 4,231,151	$ 4,126,396	$ 4,353,496	$ 4,056,891	$ 3,615,256	$ 3,444,461	$ 3,441,072	$ 3,359,831	$ 3,001,474	$ 1,086,392	$ 8,357,546	$ 12,025,644	$ 10,245,363	$ 34,716,420
Shadow FFS Over (Under) Spend	$ -	$ (565,488)	$ (615,956)	$ (311,328)	$ (419,583)	$ (813,534)	$ (924,399)	$ (839,513)	$ (765,933)	$ (1,040,495)	$ (2,900,120)	$ (1,181,445)	$ (1,544,445)	$ (2,529,845)	$ (9,196,350)
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	$ 2,323,774	$ 2,276,578	$ 2,245,342	$ 12,895,330	$ 7,643,156	$ 7,195,447	$ 32,255,853
Actual FFS - In Network	$ 4,393,596	$ 610,198	$ 630,904	$ 597,909	$ 613,828	$ 554,967	$ 454,776	$ 489,489	$ 481,024	$ 531,550	$ 207,438	$ 5,634,698	$ 1,766,704	$ 1,425,289	$ 9,565,678
Actual FFS - Out of Network	$ 2,639,429	$ 1,978,305	$ 2,049,273	$ 2,046,081	$ 2,192,078	$ 1,943,762	$ 1,991,154	$ 2,055,638	$ 1,910,554	$ 1,715,095	$ 683,587	$ 6,667,007	$ 6,181,920	$ 5,957,347	$ 21,204,956
Total Actual FFS	$ 7,033,025	$ 2,588,503	$ 2,680,176	$ 2,643,990	$ 2,805,905	$ 2,498,728	$ 2,445,930	$ 2,545,127	$ 2,391,578	$ 2,246,645	$ 891,025	$ 12,301,705	$ 7,948,623	$ 7,382,636	$ 30,770,634
FFS Over (Under) Spend	$ (489,605)	$ (113,135)	$ 9,114	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ (593,625)	$ 305,467	$ 187,189	$ (1,485,219)
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	$ 6,449,538	$ 6,318,547	$ 6,231,854	$ 22,434,321	$ 21,213,245	$ 19,970,655	$ 76,168,623
Actual Total Cost of Care	$ 7,655,673	$ 7,385,142	$ 7,422,600	$ 7,308,814	$ 7,282,379	$ 6,927,519	$ 6,814,790	$ 6,825,712	$ 6,517,342	$ 6,288,614	$ 4,877,537	$ 22,463,415	$ 21,518,712	$ 20,157,844	$ 75,306,123
Total Cost of Care Over (Under) Spend	$ 133,043	$ (113,135)	$ 9,186	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ 29,094	$ 305,467	$ 187,189	$ (862,499)

Report: Claims Runout through 12/01/2017

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

	January	February	March	April	May	June	July	August	September	October	November	Q1	Q2	Q3	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	$ 2,323,774	$ 2,276,578	$ 2,245,342	$ 12,895,330	$ 7,643,156	$ 7,195,447	$ 32,255,853
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	$ 1,191,399	$ 1,167,202	$ 1,151,187	$ 6,611,436	$ 3,918,646	$ 3,689,106	$ 10,560,565
Berlin	$ 1,707,637	$ 613,272	$ 606,331	$ 596,419	$ 572,337	$ 566,241	$ 558,578	$ 547,292	$ 527,497	$ 516,783	$ 509,693	$ 2,927,240	$ 1,734,996	$ 1,633,366	$ 4,675,733
Middlebury	$ 938,824	$ 337,164	$ 333,349	$ 327,899	$ 314,659	$ 311,308	$ 307,095	$ 300,890	$ 290,007	$ 284,117	$ 280,219	$ 1,609,337	$ 953,866	$ 897,992	$ 2,570,623
St. Albans	$ 1,019,316	$ 366,072	$ 361,929	$ 356,012	$ 341,637	$ 337,998	$ 333,424	$ 326,687	$ 314,871	$ 308,476	$ 304,244	$ 1,747,317	$ 1,035,648	$ 974,983	$ 2,791,021
Total Actual FFS	$ 7,033,025	$ 2,588,503	$ 2,680,176	$ 2,643,990	$ 2,805,905	$ 2,498,728	$ 2,445,930	$ 2,545,127	$ 2,391,578	$ 2,246,645	$ 891,025	$ 12,301,705	$ 7,948,623	$ 7,382,636	$ 30,770,634
Burlington	$ 2,292,042	$ 614,571	$ 609,289	$ 744,407	$ 741,831	$ 585,552	$ 617,432	$ 644,251	$ 598,306	$ 542,343	$ 193,550	$ 3,515,902	$ 2,071,791	$ 1,859,988	$ 8,183,573
Berlin	$ 2,800,182	$ 1,511,907	$ 1,649,037	$ 1,452,716	$ 1,597,749	$ 1,486,980	$ 1,417,862	$ 1,535,531	$ 1,378,024	$ 1,352,168	$ 571,468	$ 5,961,126	$ 4,537,445	$ 4,331,418	$ 16,753,625
Middlebury	$ 662,846	$ 233,950	$ 163,102	$ 204,155	$ 179,845	$ 158,283	$ 174,814	$ 162,290	$ 179,490	$ 137,235	$ 53,539	$ 1,059,898	$ 542,283	$ 516,594	$ 2,309,548
St. Albans	$ 1,277,954	$ 228,075	$ 258,748	$ 242,712	$ 286,481	$ 267,913	$ 235,823	$ 203,055	$ 235,759	$ 214,900	$ 72,468	$ 1,764,778	$ 797,105	$ 674,636	$ 3,523,888
FFS Over (Under) Spend	$ (489,605)	$ (113,135)	$ 9,114	$ 16,595	$ 284,596	$ 4,276	$ (14,766)	$ 134,151	$ 67,805	$ (29,933)	$ (1,354,317)	$ (593,626)	$ 305,467	$ 187,189	$ (1,485,220)
Burlington	$ (1,564,810)	$ (770,558)	$ (760,165)	$ (602,658)	$ (550,844)	$ (693,354)	$ (644,167)	$ (591,857)	$ (593,093)	$ (608,844)	$ (6,417,886)	$ (3,095,534)	$ (1,846,856)	$ (1,829,118)	$ (13,798,237)
Berlin	$ 1,092,545	$ 898,635	$ 1,042,706	$ 856,298	$ 1,025,411	$ 920,739	$ 859,284	$ 988,239	$ 850,528	$ 842,475	$ (2,355,772)	$ 3,033,886	$ 2,802,449	$ 2,698,051	$ 7,021,089
Middlebury	$ (275,978)	$ (103,215)	$ (170,246)	$ (123,744)	$ (134,815)	$ (153,024)	$ (132,281)	$ (138,600)	$ (110,517)	$ (142,984)	$ (1,555,798)	$ (549,439)	$ (411,583)	$ (381,398)	$ (3,041,202)
St. Albans	$ 258,638	$ (137,997)	$ (103,181)	$ (113,300)	$ (55,157)	$ (70,085)	$ (97,602)	$ (123,632)	$ (79,113)	$ (89,344)	$ (1,674,849)	$ 17,461	$ (238,543)	$ (300,347)	$ (2,285,621)

Report: Claims Runout through 12/01/2017

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

	January	February	March	April	May	June	July	August	September	October	November	Q1	Q2	Q3	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	$ 4,125,764	$ 4,041,969	$ 3,986,512	$ 9,538,991	$ 13,570,088	$ 12,775,208	$ 43,912,770
UVMMC	$ -	$ 2,724,008	$ 2,693,220	$ 2,649,151	$ 2,486,168	$ 2,387,916	$ 2,454,493	$ 2,409,345	$ 2,316,510	$ 2,276,013	$ 2,242,848	$ 5,417,228.00	$ 7,523,235.51	$ 7,180,348.58	$ 24,639,673
CVMC	$ -	$ 938,797	$ 928,186	$ 912,998	$ 901,196	$ 824,310	$ 852,693	$ 830,726	$ 806,161	$ 784,378	$ 777,723	$ 1,866,983.00	$ 2,638,503.81	$ 2,489,579.31	$ 8,557,168
Porter	$ -	$ 339,694	$ 335,854	$ 330,359	$ 321,172	$ 299,578	$ 307,351	$ 299,929	$ 289,283	$ 285,974	$ 278,907	$ 675,548.00	$ 951,108.87	$ 896,562.16	$ 3,088,101
NMC	$ -	$ 794,140	$ 785,164	$ 772,316	$ 767,939	$ 698,749	$ 720,144	$ 707,090	$ 680,314	$ 665,068	$ 655,778	$ 1,579,304.00	$ 2,239,003.56	$ 2,107,548.87	$ 7,246,702
Total Actual Shadow FFS	$ -	$ 4,231,151	$ 4,126,396	$ 4,353,496	$ 4,056,891	$ 3,615,256	$ 3,444,461	$ 3,441,072	$ 3,359,831	$ 3,001,474	$ 1,086,392	$ 8,357,546	$ 12,025,644	$ 10,245,363	$ 34,716,420
UVMMC	$ -	$ 2,353,399	$ 2,303,414	$ 2,723,376	$ 2,324,899	$ 2,078,924	$ 1,963,446	$ 1,948,218	$ 2,000,004	$ 1,608,462	$ 567,573	$ 4,656,813	$ 7,127,199	$ 5,911,668	$ 19,871,713
CVMC	$ -	$ 902,039	$ 691,945	$ 713,867	$ 829,161	$ 757,977	$ 657,028	$ 676,378	$ 523,997	$ 669,796	$ 256,563	$ 1,593,985	$ 2,301,005	$ 1,857,403	$ 6,678,751
Porter	$ -	$ 304,136	$ 304,740	$ 362,202	$ 304,653	$ 250,459	$ 294,482	$ 280,991	$ 229,287	$ 221,035	$ 52,523	$ 608,876	$ 917,315	$ 804,760	$ 2,604,510
NMC	$ -	$ 671,576	$ 826,297	$ 554,050	$ 598,178	$ 527,897	$ 529,505	$ 535,484	$ 606,543	$ 502,181	$ 209,733	$ 1,497,873	$ 1,680,126	$ 1,671,532	$ 5,561,445
Shadow FFS Over (Under) Spend	$ -	$ (565,488)	$ (615,957)	$ (311,328)	$ (419,583)	$ (813,534)	$ (924,399)	$ (839,513)	$ (765,933)	$ (1,040,495)	$ (2,900,120)	$ (1,181,445)	$ (1,544,445)	$ (2,529,845)	$ (9,196,350)
UVMMC	$ -	$ (370,609)	$ (389,806)	$ 74,225	$ (161,269)	$ (308,993)	$ (491,048)	$ (461,127)	$ (316,506)	$ (667,551)	$ (1,675,275)	$ (760,415)	$ (396,037)	$ (1,268,681)	$ (4,767,960)
CVMC	$ -	$ (36,758)	$ (236,241)	$ (199,131)	$ (72,035)	$ (66,334)	$ (195,665)	$ (154,348)	$ (282,163)	$ (114,582)	$ (521,160)	$ (272,998)	$ (337,499)	$ (632,176)	$ (1,878,416)
Porter	$ -	$ (35,558)	$ (31,114)	$ 31,843	$ (16,518)	$ (49,119)	$ (12,868)	$ (18,938)	$ (59,996)	$ (64,939)	$ (226,384)	$ (66,672)	$ (33,794)	$ (91,802)	$ (483,590)
NMC	$ -	$ (122,564)	$ 41,133	$ (218,266)	$ (169,760)	$ (170,852)	$ (190,639)	$ (171,606)	$ (73,772)	$ (162,886)	$ (446,045)	$ (81,431)	$ (558,878)	$ (436,017)	$ (1,685,257)

Report: Claims Runout through 12/01/2017

UVMMC: University of Vermont Medical Center

CVMC: Central Vermont Medical Center

NMC: Northwestern Medical Center

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

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[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: Nine 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 – Q3	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**
Ages 0-17	14,198	14,783	13,703	35,533	36,252	34,656
Ages 18+	12,335	13,775	13,227	37,573	41,900	41,723
Total	**26,532**	**28,558**	**26,930**	**73,106**	**78,152**	**76,379**
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	44	37	18	49	41	19
Hospital Outpatient ED	426	406	382	547	532	491
Hospital Outpatient non-ED	564	602	721	622	666	747
Home Health and Hospice	139	172	129	86	101	81
Physician Services and other Professional Fees						
PCP Office Visit	3,846	3,745	3,253	2,279	2,133	1,918
Non-PCP Office Visit	453	475	423	447	450	401
DME/Supp/Prosth/Orth	627	602	614	555	578	570
Mental Health^	8,146	8,604	9,779	5,455	5,966	6,513
Diagnostic X-ray	387	396	355	444	458	423
Diagnostic Lab	571	605	758	699	662	703
Ambulance	37	34	32	35	35	31
*Dental**	1,699	1,712	1,801	1,549	1,567	1,604
*Pharmacy/Medications**	5,362	5,354	5,392	5,572	5,596	5,476
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	120	123	108	127	128	115
Hospital Outpatient ED	878	847	773	951	902	805
Hospital Outpatient non-ED	2,640	2,942	3,136	2,559	2,729	2,707
Home Health and Hospice	342	379	443	345	402	467
Physician Services and other Professional Fees						
PCP Office Visit	4,204	4,359	3,824	2,424	2,498	2,226
Non-PCP Office Visit	1,506	1,536	1,367	1,453	1,431	1,179
DME/Supp/Prosth/Orth	727	773	783	654	700	688
Mental Health^	5,787	5,763	5,730	4,441	4,628	4,537
Diagnostic X-ray	1,651	1,673	1,493	1,560	1,604	1,437
Diagnostic Lab	3,430	3,596	2,830	3,076	3,535	2,967
Ambulance	133	148	137	141	144	149
*Dental**	972	1,011	1,006	834	895	872
*Pharmacy/Medications**	20,410	21,179	21,222	18,543	19,121	19,517

^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: 12/5/17

Population Counts: Nine Month Average												
	Low Risk VMNG Attributed Members			**Medium Risk VMNG Attributed Members**			**High Risk VMNG Attributed Members**			**Very High Risk VMNG Attributed Members**		
	CY '15	**CY '16**	**CY '17**	**CY '15**	**CY '16**	**CY '17**	**CY '15**	**CY '16**	**CY '17**	**CY '15**	**CY '16**	**CY '17**
	Q1 – Q3	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**	**Q1 – Q3**
Ages 0-17	11,018	11,701	10,940	2,461	2,380	2,138	340	327	283	375	372	342
Ages 18+	3,586	4,110	4,030	5,006	5,584	5,341	1,994	2,191	2,080	1,748	1,890	1,775
Total	**14,604**	**15,811**	**14,970**	**7,467**	**7,965**	**7,479**	**2,335**	**2,518**	**2,363**	**2,124**	**2,262**	**2,117**
Ages 0-17: Rate per 12,000 member months												
Hospital Inpatient	28	16	7	54	58	33	219	310	108	270	333	176
Hospital Outpatient ED	352	312	312	601	660	584	890	1,029	844	1,023	1,192	952
Hospital Outpatient non-ED	436	396	540	770	1,062	1,112	1,787	2,470	2,536	1,876	2,510	2,571
Home Health and Hospice	76	60	50	208	339	250	799	1,106	665	959	1,805	1,443
Physician Services and other Professional Fees												
PCP Office Visit	3,493	3,256	2,877	4,643	5,177	4,421	6,435	7,378	6,255	6,624	6,797	5,528
Non-PCP Office Visit	309	285	275	780	973	855	1,395	1,805	1,414	1,670	2,098	1,623
DME/Supp/Prosth/Orth	309	293	317	839	779	760	4,687	4,977	5,807	4,886	5,350	4,896
Mental Health^	2,493	2,419	3,551	18,965	20,178	22,547	19,736	19,995	22,855	92,731	119,069	118,486
Diagnostic X-ray	284	253	279	522	719	513	1,485	1,825	1,013	1,524	1,561	1,252
Diagnostic Lab	483	485	649	730	893	1,093	1,497	1,837	1,763	1,286	1,450	1,319
Ambulance	21	17	19	65	69	75	137	184	75	210	218	176
*Dental**	1,654	1,671	1,798	1,855	1,895	1,854	1,905	1,833	1,833	1,809	1,748	1,549
*Pharmacy/Medications**	2,902	2,646	2,866	10,957	12,275	12,310	20,986	24,237	23,279	26,711	29,679	28,194
Ages 18+: Rate per 12,000 member months												
Hospital Inpatient	65	15	20	76	65	52	166	192	215	307	446	355
Hospital Outpatient ED	432	250	329	724	689	641	1,261	1,327	1,106	1,796	2,054	1,786
Hospital Outpatient non-ED	1,352	951	1,215	2,284	2,499	2,761	3,622	4,504	4,786	5,179	6,770	6,695
Home Health and Hospice	23	12	6	59	56	77	624	675	779	1,480	1,791	2,145
Physician Services and other Professional Fees												
PCP Office Visit	2,309	1,818	1,819	4,092	4,368	3,844	5,785	6,196	5,364	6,605	7,726	6,512
Non-PCP Office Visit	558	360	363	1,286	1,214	1,181	2,276	2,506	2,168	3,201	3,919	3,268
DME/Supp/Prosth/Orth	268	240	248	441	444	489	994	1,078	1,038	2,185	2,550	2,586

Mental Health^	2,145	1,680	1,848	4,860	5,160	5,039	7,194	7,360	7,387	14,308	14,575	14,680
Diagnostic X-ray	819	457	587	1,360	1,291	1,220	2,254	2,678	2,215	3,503	4,283	3,526
Diagnostic Lab	1,251	892	1,069	4,070	4,300	3,053	4,878	5,513	4,334	4,416	5,172	4,396
Ambulance	39	23	36	78	79	80	227	257	210	377	495	450
*Dental**	910	878	910	996	1,064	1,017	998	1,067	1,042	998	1,078	1,146
*Pharmacy/Medications**	5,255	3,546	4,389	17,188	17,533	17,859	31,992	34,984	34,827	47,505	54,291	53,615

^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: 12/5/17

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		
	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**
Other	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Total Member Inquiries			**53**			**89**			**8**			**5**			**1**
b. Provider Inquiries															
Prior Authorization Requirements	23	0	**23**	8	0	**8**	11	0	**11**	23	0	**23**	6	0	**6**
OneCare Secure Portal	2	0	**2**	0	0	**0**	1	0	**1**	0	0	**0**	2	0	**2**
Banking Information Verification	2	0	**2**	0	0	**0**	0	0	**0**	1	0	**1**	0	0	**0**
Coordination of Benefits	0	0	**0**	0	3	**3**	0	0	**0**	0	0	**0**	0	1	**1**
Other	0	0	**0**	7	0	**7**	1	0	**1**	3	0	**3**	6	0	**6**
All Payer Waiver	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	1	0	**1**
Member Eligibility	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	2	0	**2**
Total Provider Inquiries			**27**			**18**			**13**			**27**			**18**
Total Member and Provider Inquiries	**72**	**8**	**80**	**44**	**63**	**107**	**18**	**3**	**21**	**29**	**3**	**32**	**17**	**2**	**19**
2. Complaints															
a. Member Complaints															
Total Member Complaints	0	0	**0**	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**
Total Member and Provider Complaints	**0**	**0**	**0**	**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**
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**
Total Member and Provider Grievances and Appeals	**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.

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

	Jul-17			Aug-17			Sep-17			Oct-17			Nov-17		
	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	1	0	**1**	1	1	**2**	0	0	**0**	0	0	**0**	0	0	**0**
Other	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	1	0	**1**
Total Member Inquiries			**1**			**2**			**0**			**0**			**1**
b. Provider Inquiries															
Prior Authorization Requirements	15	0	**15**	15	0	**15**	9	0	**9**	14	0	**14**	17	0	**17**
OneCare Secure Portal	1	0	**1**	0	0	**0**	0	0	**0**	0	0	**0**	1	0	**1**
Banking Information Verification	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	1	0	**1**
Coordination of Benefits	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Other	0	0	**0**	5	0	**5**	6	0	**6**	6	0	**6**	1	0	**1**
All Payer Waiver	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Member Eligibility	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**
Total Provider Inquiries			**16**			**20**			**15**			**20**			**20**
Total Member and Provider Inquiries	**17**	**0**	**17**	**21**	**1**	**22**	**15**	**0**	**15**	**20**	**0**	**20**	**21**	**0**	**21**
2. Complaints															
a. Member Complaints															
Total Member Complaints	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**
Total Member and Provider Complaints	**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**
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**
Total Member and Provider Grievances and Appeals	**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.