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Department of Vermont Health Access
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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

Submitted by
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Department of Vermont Health Access

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June 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 May 2017 and proceeds in three sections. Section A offers a brief overview of the project. Section B sets forth and discusses each Act 25 requirement. Section C contains appendices that provide more detailed information on pilot project performance.

Section A: Vermont Medicaid Next Generation ACO Pilot Program Overview

Introduction

The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Pilot program represents the initial phase of Medicaid's participation in the integrated health care system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement with the Centers for Medicare and Medicaid Services.[2] ACOs are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care. The model's goal is an integrated health care system that has aligned incentives to improve quality and reduce unnecessary costs. The VMNG ACO Pilot program pursues this goal by taking the next step in transitioning the health care revenue model from Fee-for-Service payments to Value-Based payments. This transition is meant to focus health care payments on rewarding value, meaning low cost and high quality, rather than volume of services provided.

The VMNG program allows the Department of Vermont Health Access (DVHA) to partner with a risk-bearing Accountable Care Organization. For Calendar Year 2017, DVHA has partnered with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. Together, DVHA and OneCare are piloting a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health, and lower costs. Primary goals of the program are to increase provider flexibility and support health care professionals to deliver the care they know to be most effective in promoting and managing the health of the population they serve. This will contribute to improving the health of Vermonters and moderating health care spending growth in future.

OneCare Vermont ACO Network

In February of 2017, DVHA contracted with OneCare to participate in the Vermont Medicaid Next Generation ACO Pilot program for the 2017 calendar year with four optional one-year extensions.[3] OneCare Vermont's network of participating providers includes the University of Vermont Medical Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital along with their employed physicians and providers; two Federally Qualified Health Centers; independent practices; home health providers; Designated Agencies; Area Agencies on Aging; and skilled nursing agencies in the four participating communities.[4]

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[1] See http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT025/ACT025%20As%20Enacted.pdf.
[2] See http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf.
[3] See http://dvha.vermont.gov/administration/onecare-aco-32318-final-searchable.pdf.
[4] See https://www.onecarevt.org/NetworkParticipants.

Financial Model

Through the VMNG, DVHA pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) participating with the ACO. This is a monthly, per member payment made in advance of the services being performed. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. The ACO is responsible for both the cost and quality of care for each attributed member. This is true whether that person uses little or no care or whether they require services consistently throughout the year. The following table lists services that are included in and excluded from the total cost of care accountability for attributed members:

Table 1. Medicaid Services for which ACO is Accountable in VMNG Program

Services for which ACO is accountable	Services for which ACO is not accountable
• Inpatient hospital services • Outpatient hospital services • Physician services, primary care and specialty • Nurse practitioner services • Ambulatory surgical center services • Federally Qualified Health Center and Rural Health Clinic services • Home health services • Hospice services *(room and board excluded)* • Physical, occupational and speech therapy services • Chiropractor services • Audiology services • Podiatrist services • Optometrist and optician services • Independent laboratory services • Mental health and substance abuse services funded by DVHA and not funded by other State Departments *(excluding DA & SSA services)* • Ambulance transport – emergent/non-emergent • Durable medical equipment, prosthetics and orthotics *(eyewear excluded)* • Medical supplies • Dialysis facility services • Preventive services • Physician administered drug services billed on institutional claims • Dental services billed on institutional claims	• Pharmacy • Physician administered drug services billed on professional claims • Nursing facility care (SNF) • Dental services billed on professional claims • Non-emergency transportation *(ambulance transportation is not part of this category)* • Services provided by the Designated Agencies or Specialized Service Agencies if not paid by DVHA. • Psychiatric treatment in a state psychiatric hospital • Level 1 (involuntary placement) inpatient psychiatric stays in any hospital • Smoking cessation services

One of the key goals of the prospective payment model is to give providers and Medicaid certainty and predictability regarding revenue for a pre-identified population of Vermonters. This should lead to better incentives and provider investments that improve the quality of care for Vermonters. The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. The ACO will also withhold some of the

payment to providers up front—0.5% in 2017—to support a quality incentive program. The providers in the ACO can earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care and is expected to grow over time.

Alignment with the All-Payer Model:
The VMNG ACO Pilot program was designed with the goal of supporting the implementation of Vermont's All-Payer Model. Most notably, the included services, attribution, and payment methodologies are aligned with the Medicare Next Generation ACO program. Additionally, the majority of quality measures align with the All-Payer Model agreement. DVHA recognizes that the VMNG program will need to scale-up substantially by 2022 in order to reach All-Payer Model scale targets.

Since executing the Vermont Medicaid Next Generation contract in February of 2017, DVHA and OneCare Vermont have partnered in the launch and ongoing implementation of this pilot program.

Key Successes:

- OneCare completed all outstanding Readiness Review items prior to the end of the first quarter of 2017.
- Processes for ongoing data exchange have been implemented, and are regularly evaluated for potential improvements.
- OneCare and DVHA have established a forum for convening operational teams on a weekly basis, and for convening subject matter experts monthly. These forums have allowed the partnering entities to identify, discuss, and resolve multiple operational challenges, and have resulted in several process improvements to date.

Key Challenges:

- Work is ongoing to document the impacts of churn on the prospectively-attributed population of Medicaid members, and to understand operational implications for payment and provider communications. Specifically, the program is designed to provide predictability and sustainability, and churn—whereby prospectively attributed members may lose and re-gain both Medicaid eligibility and ACO attribution eligibility during the performance year—represents a challenge to providing that predictability to DVHA, the ACO, and the ACO provider network.
- DVHA, DXC Technology (formerly Hewlett-Packard Enterprise), and OneCare have been working together to operationalize financial reporting for the program. Building, validating, and automating such financial reporting has required more time than expected; however, as all parties continue to better understand reporting needs, such reporting is expected to improve.

Although operations have become more streamlined in recent months, additional partnership between DVHA and OneCare will be required to achieve an operational steady state. 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 - June 15, 2017

Financial Performance

Table 2 sets forth the funds paid prospectively to OneCare by DVHA in the first five months of Calendar Year 2017 (January 1, 2017 – May 31, 2017 dates of service). As OneCare providers are still required to submit claims for all services, zero-paid "shadow claims" are used 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. Table 2 also includes 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). Expenditure for the program to date is 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.[5,6]

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 January through May 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. DVHA and OneCare are working toward a consensus methodology to forecast the incurred but not reported (IBNR) claims in order to have a more timely understanding of member spending. In addition, DVHA and OneCare are working to develop an approach for assessing financial performance at the hospital- and Health Service Area-levels. DVHA will update the legislature on these tasks in a future report.

Appendix B further breaks out program spending by category, including payments each month allocated for the cost of care, administrative fees, care coordination support, and Primary Care Case Management fees.

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[5] 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).

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

Table 2. Overview of VMNG Financial Performance, January through May, 2017

	January	February	March	April	May	Q1 Total	Year-to-Date Total
Attribution^	29,102	29,021	28,676	28,240	27,115		
DVHA Payment to ACO*	$189,170	$5,057,828	$5,000,517	$4,918,984	$4,720,509	$10,247,515	$19,887,008
Expected Shadow FFS	$ -	$4,796,639	$4,742,352	$4,664,824	$4,476,474	$9,538,991	$18,680,289
Actual Shadow FFS	$ -	$4,395,396	$3,939,699	$3,627,851	$767,957	$8,335,095	$12,730,903
Shadow FFS Over (Under) Spend	$ -	$(401,243)	$(802,653)	$(1,036,973)	$(3,708,517)	**$(1,203,896)**	**$(5,949,386)**
Expected FFS	$7,522,630	$2,701,638	$2,671,062	$2,627,395	$2,521,309	$12,895,330	$18,044,034
Actual FFS – In Network	$4,579,005	$637,956	$649,543	$598,121	$230,352	$5,866,504	$6,694,977
Actual FFS – Out of Network	$2,621,949	$1,860,803	$1,857,211	$1,525,733	$542,343	$6,339,963	$8,408,040
Actual FFS - Total	$7,200,955	$2,498,759	$2,506,753	$2,123,855	$772,695	$12,206,467	$15,103,017
FFS Over (Under) Spend	$(321,675)	$(202,879)	$(164,309)	$(503,540)	$(1,748,614)	**$(688,863)**	**$(2,941,017)**
Expected Total Cost of Care	$7,522,630	$7,498,277	$7,413,414	$7,292,219	$6,997,783	$22,434,321	$36,724,323
Actual Total Cost of Care	$7,200,955	$7,295,398	$7,249,177	$6,788,679	$5,249,169	$21,745,530	$33,783,378
Total Cost of Care Over (Under) Spend	**$(321,675)**	**$(202,879)**	**$(164,237)**	**$(503,540)**	**$(1,748,614)**	**$(688,791)**	**$(2,940,945)**

^ 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: 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 April and May

To date, OneCare's actual expenditure in each month of 2017 has been lower than the expected expenditure for the corresponding month. This is true with respect to both the prospective payments made by DVHA to OneCare—zero-paid shadow claims for services included in the prospective payment total to less than the expected amounts—and the fee-for-service payments that DVHA issues on OneCare's behalf. Notably, the margin between actual and expected spending is narrower when examining financial performance for quarter 1, and broader when examining financial performance for all months in 2017 to date. This shows the disproportionate impact of the claims lag on the most recent months of performance; however, claims lag also impacts January through March financial performance as evaluated at this time.

Quality Performance

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

Operational Performance

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

To date, OneCare has submitted all required reports to DVHA, and DVHA has transferred all required data files to OneCare. In some instances, OneCare and DVHA have mutually agreed to adjust deadlines to allow other necessary processes to occur. This was the case for 12% of reports submitted by OneCare, and 23% of files transferred by DVHA. For example, DVHA and OneCare agreed to extend the deadlines for OneCare's submission of four reports in March because OneCare would require claims-data to complete those reports, and DVHA's initial claims-sharing could not occur until members had been notified of their initial opportunity to opt-out of having DVHA share their claims data with OneCare.

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 3 provides a detailed presentation of utilization data by service category (definitions and exclusions are detailed in Appendix C). For this June 15, 2017 report, utilization data is presented for the first quarter of Calendar Year 2017 (January 1, 2017 – March 31, 2017 dates of service); data is also presented for the first quarter of Calendar Years 2015 and 2016 to provide a historical comparison.[7] At this time, there is not sufficient claims run-out to calculate performance for the second quarter of Calendar Year 2017 (April 1, 2017 – June 30, 2017 dates of service); performance for the second quarter will be included in the September 15, 2017 report submission. The report includes utilization of services for which the ACO is financially responsible; in addition, information about dental and pharmacy utilization (services for which the ACO is NOT responsible) has been included for each cohort.

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

[7] 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.

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: Three 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	**Q1**	**Q1**	**Q1**	**Q1**	**Q1**
Ages 0-17	14,091	14,952	14,478	37,331	38,568	34,567
Ages 18+	11,990	13,732	14,265	47,821	53,792	42,851
Total	**26,081**	**28,685**	**28,744**	**85,151**	**92,360**	**77,418**
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	36	37	16	38	40	18
Hospital Outpatient ED	446	448	376	564	546	480
Hospital Outpatient non-ED	623	553	751	634	630	764
Home Health and Hospice	153	178	115	85	101	75
Physician Services and other Professional Fees						
PCP Office Visit	4,265	4,267	3,518	2,419	2,252	2,070
Non-PCP Office Visit	448	497	438	439	461	407
DME/Supp/Prosth/Orth	612	655	641	570	593	562
Mental Health^	8,923	9,032	10,129	5,534	5,834	6,761
Diagnostic X-ray	361	393	329	446	461	427
Diagnostic Lab	683	613	852	834	731	779
Ambulance	39	37	30	36	33	27
*Dental**	1,677	1,773	1,783	1,442	1,510	1,522
*Pharmacy/Medications**	5,711	5,702	5,521	5,833	5,734	5,664
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	111	121	102	127	113	113
Hospital Outpatient ED	832	864	759	863	825	787
Hospital Outpatient non-ED	2,573	2,724	3,075	2,438	2,402	2,710
Home Health and Hospice	322	368	387	315	332	438
Physician Services and other Professional Fees						
PCP Office Visit	4,268	4,599	3,873	2,311	2,392	2,267
Non-PCP Office Visit	1,487	1,569	1,377	1,330	1,351	1,199
DME/Supp/Prosth/Orth	715	775	739	602	633	662
Mental Health^	5,641	5,702	5,484	3,987	4,037	4,465
Diagnostic X-ray	1,637	1,738	1,435	1,485	1,548	1,408
Diagnostic Lab	3,453	3,515	2,901	2,729	3,070	2,878
Ambulance	131	151	131	131	129	138
*Dental**	1,004	1,099	1,042	818	890	911
*Pharmacy/Medications**	20,216	21,134	20,963	16,864	17,126	18,997

^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 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.

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. The second quarter of program performance is not yet complete, meaning the pilot program is not yet halfway through its performance year. Furthermore, the program is subject to claims lag.[8] 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 March until later this year. The utilization rates presented here for the first quarter of 2017 will be subject to change in subsequent reports as further claims data run-out it is available. Subsequent reports will include updates to the data presented for the first quarter, new information for additional quarters as available, and comparisons by care management level.

Complaints, Grievances, and Appeals Tracking

OneCare operates a call center for attributed members and participating providers; OneCare also accepts communications in writing from members and providers via mail and e-mail/website forms. 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 member and provider communications have been categorized as inquiries; no complaints, grievances, or appeals have been filed to date.[9]

Thus far, all member inquiries have related to the process by which members may opt out of having their Medicaid claims data shared with OneCare.[10] 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 in April and May.

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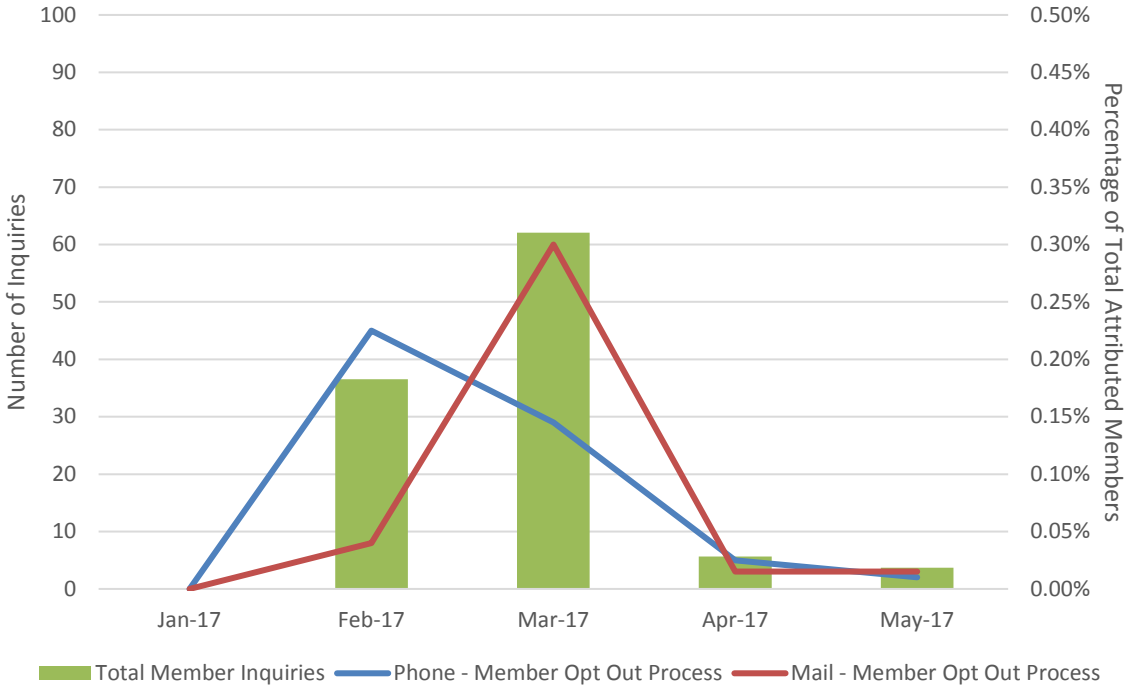
[8] Beyond the claims lag, health care utilization is subject to seasonality. DVHA and OneCare are discussing how to incorporate seasonality into both future financial and utilization forecasting and reporting.

[9] 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.

[10] 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. 125 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 453 members (1.6% of total attributed lives).

Figure 1. Member Inquiries Received by OneCare

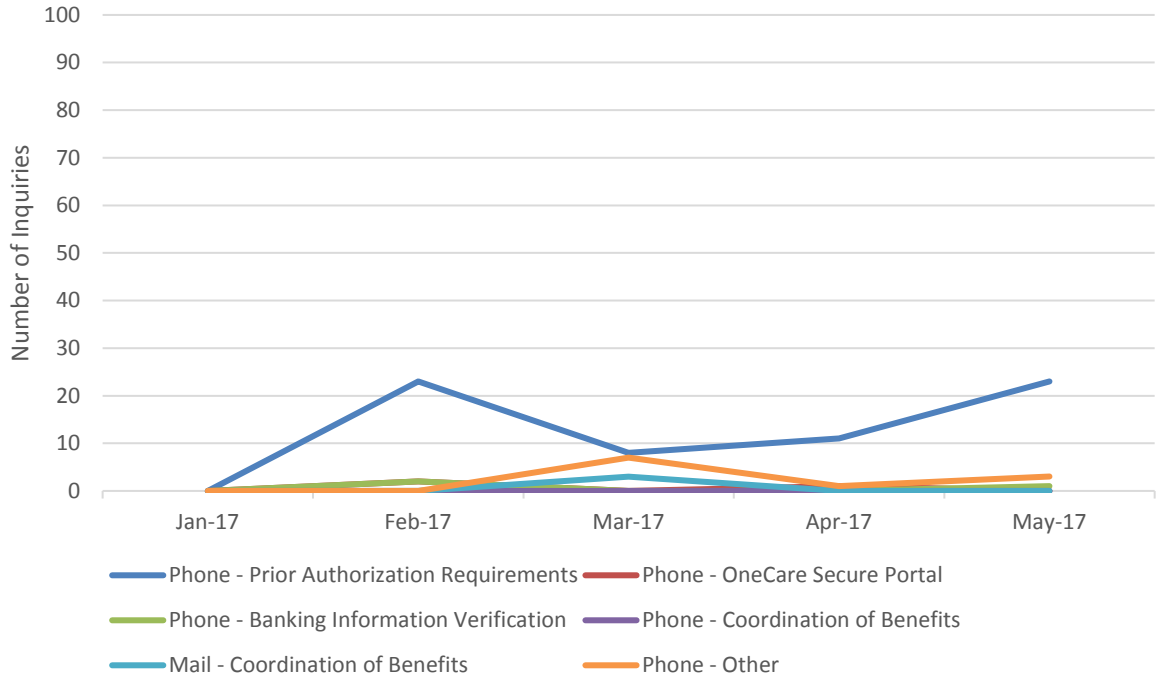


Note: The *total* number of member inquiries received between January and May of 2017 (n=155) equates to approximately 5 inquiries per 1,000 Medicaid members attributed to OneCare for the VMNG program.

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, and questions about 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).

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

Figure 2. Provider Inquiries Received by OneCare



Note: The *total* number of provider inquiries received between January and May of 2017 (n=85) equates to approximately 42 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.[11] Table 4 captures the counts of primary care and specialist providers participating in the Vermont Medicaid Next Generation program network for Quarter 1 and Quarter 2 (through June 12, 2017). Provider participation has remained fairly constant over the first two quarters of the pilot year.

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

	CY'17 Quarter 1			**CY '17 Quarter 2 (through 6/12/17)**		
	Primary Care Providers	Specialists	TOTAL	Primary Care Providers	Specialists	TOTAL
ACO Network Providers	529	1,521	2,050	511	1,490	2,001

Attributed Medicaid Population Reporting

Table 5 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

[11] 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.

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[12]
- Switching to a limited Medicaid benefits package (e.g. pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g. commercial or Medicare)
- Death

DVHA is working to quantify the number of members that have become ineligible for attribution for each of the reasons above, and the number of members that have become eligible for attribution again after losing eligibility in an earlier point in the year. 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 update the legislature on these activities in a future report.

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 months.

Table 5. Medicaid Members Attributed to OneCare for the 2017 VMNG Program

Attributed Medicaid Members*	**Jan**	**Feb**	**March**	**April**	**May**
% of 29,102	**100.00%**	**99.72%**	**98.54%**	**97.04%**	**93.17%**
Total	29,102	29,021	28,676	28,240	27,115
Aged, Blind, Disabled	1,910	1,907	1,906	1,878	1,819
General Adult	12,987	12,933	12,754	12,525	11,980
General Child	14,205	14,181	14,016	13,837	13,316

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

[12] 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 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 - May, 2017

	January	February	March	April	May	Q1	Year-to-Date
Attribution	29,102	29,021	28,676	28,240	27,115		
DVHA Payment to ACO	$ 189,170	$ 5,057,828	$ 5,000,517	$ 4,918,984	$ 4,720,509	$ 10,247,515	$ 19,887,008
Fixed Prospective Payment (FPP)	$ -	$ 4,796,639	$ 4,742,424	$ 4,664,824	$ 4,476,474	$ 9,539,063	$ 18,680,361
Quality Withhold	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Primary Care Case Management (PCCM) Fee	$ -	$ 72,553	$ 71,693	$ 70,600	$ 67,788	$ 144,246	$ 282,634
Care Coordination Payment (CCP)	$ 94,585	$ 94,318	$ 93,200	$ 91,780	$ 88,124	$ 282,103	$ 462,007
Administrative Fee	$ 94,585	$ 94,318	$ 93,200	$ 91,780	$ 88,124	$ 282,103	$ 462,007
Total ACO Payments to Providers	$ 189,170	$ 5,057,828	$ 5,000,517	$ 4,918,984	$ 4,720,509	$ 10,247,515	$ 19,887,008
Total Expected Shadow FFS	$ -	$ 4,796,639	$ 4,742,352	$ 4,664,824	$ 4,476,474	$ 9,538,991	$ 18,680,289
Actual FFS - Claims Pending Adjustment^	$ -	$ 384,803	$ 95,374	$ 179,754	$ 21,404	$ 480,177	$ 681,336
Actual FFS - Shadow Claims	$ -	$ 4,010,593	$ 3,844,325	$ 3,448,097	$ 746,553	$ 7,854,918	$ 12,049,567
Total Actual Shadow FFS	$ -	$ 4,395,396	$ 3,939,699	$ 3,627,851	$ 767,957	$ 8,335,095	$ 12,730,903
Shadow FFS Over (Under) Spend	$ -	$ (401,243)	$ (802,653)	$ (1,036,973)	$ (3,708,517)	$ (1,203,896)	$ (5,949,386)
Total Expected FFS	$ 7,522,630	$ 2,701,638	$ 2,671,062	$ 2,627,395	$ 2,521,309	$ 12,895,330	$ 18,044,034
Actual FFS - In Network	$ 4,579,005	$ 637,956	$ 649,543	$ 598,121	$ 230,352	$ 5,866,504	$ 6,694,977
Actual FFS - Out of Network	$ 2,621,949	$ 1,860,803	$ 1,857,211	$ 1,525,733	$ 542,343	$ 6,339,963	$ 8,408,040
IBNR Adjustment Factor*	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Actual FFS	$ 7,200,955	$ 2,498,759	$ 2,506,753	$ 2,123,855	$ 772,695	$ 12,206,467	$ 15,103,017
FFS Over (Under) Spend	$ (321,675)	$ (202,879)	$ (164,309)	$ (503,540)	$ (1,748,614)	$ (688,863)	$ (2,941,017)
Expected Total Cost of Care	$ 7,522,630	$ 7,498,277	$ 7,413,414	$ 7,292,219	$ 6,997,783	$ 22,434,321	$ 36,724,323
Actual Total Cost of Care	$ 7,200,955	$ 7,295,398	$ 7,249,177	$ 6,788,679	$ 5,249,169	$ 21,745,530	$ 33,783,378
Total Cost of Care Over (Under) Spend	$ (321,675)	$ (202,879)	$ (164,237)	$ (503,540)	$ (1,748,614)	$ (688,791)	$ (2,940,945)

Report: Claims Runout through 05/26/2017

^FFS claims paid to hospitals for services included in the prospective payment. DVHA, OneCare, and DXC are working to adjust these claims to be zero-paid.

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

PCP provider specialty:
001 - GENERAL PRACTICE

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

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

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

Dental
Dental claims (claim type L)

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

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

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

Diagnostic Lab
Claims for labs (type of services 5)

Ambulance
Ambulance claims (type of services C)

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

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

EXCLUSIONS

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

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

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

Population Counts: Three 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	**Q1**	**Q1**	**Q1**	**Q1**	**Q1**
Ages 0-17	14,091	14,952	14,478	37,331	38,568	34,567
Ages 18+	11,990	13,732	14,265	47,821	53,792	42,851
Total	**26,081**	**28,685**	**28,744**	**85,151**	**92,360**	**77,418**
Ages 0-17: Rate per 12,000 member months						
Hospital Inpatient	36	37	16	38	40	18
Hospital Outpatient ED	446	448	376	564	546	480
Hospital Outpatient non-ED	623	553	751	634	630	764
Home Health and Hospice	153	178	115	85	101	75
Physician Services and other Professional Fees						
PCP Office Visit	4,265	4,267	3,518	2,419	2,252	2,070
Non-PCP Office Visit	448	497	438	439	461	407
DME/Supp/Prosth/Orth	612	655	641	570	593	562
Mental Health^	8,923	9,032	10,129	5,534	5,834	6,761
Diagnostic X-ray	361	393	329	446	461	427
Diagnostic Lab	683	613	852	834	731	779
Ambulance	39	37	30	36	33	27
*Dental**	1,677	1,773	1,783	1,442	1,510	1,522
*Pharmacy/Medications**	5,711	5,702	5,521	5,833	5,734	5,664
Ages 18+: Rate per 12,000 member months						
Hospital Inpatient	111	121	102	127	113	113
Hospital Outpatient ED	832	864	759	863	825	787
Hospital Outpatient non-ED	2,573	2,724	3,075	2,438	2,402	2,710
Home Health and Hospice	322	368	387	315	332	438
Physician Services and other Professional Fees						
PCP Office Visit	4,268	4,599	3,873	2,311	2,392	2,267
Non-PCP Office Visit	1,487	1,569	1,377	1,330	1,351	1,199
DME/Supp/Prosth/Orth	715	775	739	602	633	662
Mental Health^	5,641	5,702	5,484	3,987	4,037	4,465
Diagnostic X-ray	1,637	1,738	1,435	1,485	1,548	1,408
Diagnostic Lab	3,453	3,515	2,901	2,729	3,070	2,878
Ambulance	131	151	131	131	129	138
*Dental**	1,004	1,099	1,042	818	890	911
*Pharmacy/Medications**	20,216	21,134	20,963	16,864	17,126	18,997

^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: 6/9/17

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

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

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