OneCare Vermont

2019 Budget Presentation

Green Mountain Care Board

10/24/18

OneCareVermont

onecarevt.org

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All Payer Model – Year 2

2019 Budget Accomplishments

- ✓ **Progress on All Payer Model**
  - Expanded provider network
  - Programs for Medicare, Medicaid, QHP and self-funded plan populations
- ✓ **Hospital Payment Reform**
  - Prospective population payment model for Medicaid and Medicare
  - Continued acceptance of role as local risk-bearing entities on total cost of care
- ✓ **Physician and Community Payment Reform/Investment**
  - Primary Care (independent, FQHC, and hospital-operated) including expansion of the Comprehensive Payment Reform (CPR) program
  - Designated Agencies, Home Health, Area Agencies on Aging
  - SASH, Community Health Teams
  - Specialist Payment Reform Pilot
- ✓ **Advancing Population Health Management**
  - Healthy and Lower Risk (Quadrant 1) - Continued state-wide rollout of RiseVT
  - Moderate and "Rising Risk" (Quadrant 2) – Support for disease-based programs and development of a specialist payment reform incenting early access and consultation
  - High and Very High Risk (Quadrants 3 and 4) - Expansion of Complex Care Coordination program into new communities and providers

2019 Budget – Overview

VERMONT
Green Mountain Care Board

ACO Annual Budget Regulation and Certification

OneCareVermont

CMS | VERMONT AGENCY OF HUMAN SERVICES DEPARTMENT OF VERMONT HEALTH ACCESS | BlueCross BlueShield of Vermont

Source A :Payers and SOV Contribute Through Combination of:
- PHM/Admin PMPM payments (apart from target)
- Extra target "headroom"
- Specific funded programs
- **Total Contributions of $26M**

Risk and Savings/Losses
- Hospitals Bear Risk for All Local HSA Lives
- Reconciled/Settled by Program Annually in Following Year

ACO Payer Programs with Population TCOC Targets
- Set/Negotiated by Payer and Based on Attributed Population Models and Best Available Data

2019 Budget of $851M

ACO Reform Programs and Infrastructure
- Supplemental Pay Reform, PHM Programs, Community Support plus Operations/Infrastructure

2019 Budget of $53M

Payer Paid FFS
- Payments made by payer but accrue against OneCare TCOC Spending Target
- **Applies to all Providers NOT under AIPBP**

Provider Payments Made by Payer

AIPBP (All Inclusive Population Based Payment)
- OneCare designates which participating providers will be under this model
- Selected providers must be OneCare participants and give separate approval to waive FFS
- Monthly payments made from payer to OneCare based on actuarial models
- Payments through this method are also reconciled against OneCare Spending Target

Source B: Hospitals Contribute
Through Decremented Hospital Fixed Payments and Participant Fees
Total Contributions of $29M

- PCP Payment Reform Models
- Specialist Payment Reform Model (NEW)
- Payments to CBOs/DAs under complex risk program
- CHT support payments for Medicare lives
- SASH senior housing program payments
- RiseVT Statewide Program Operations and Community Implementation Funds
- Value Based Incentive Fund
- Community Innovation Support Program (NEW)
- OneCare Clinical, Informatics, Financial Operations

All Payments Made by OCV

Independent PCP Practices Participating in CPR:
Monthly Capitated Payment for Attributed Panel Across Payers

Hospitals:
Monthly Fixed Prospective Payment by OCV for applicable payer programs

Provider Payments Made by OCV

2019 Overview

Payer Programs

Medicare

- Program converting to the Vermont Medicare ACO Initiative (from the Vermont Modified Next Generation Program) in 2019
  - Allows for further modifications of the program to better align with Vermont objectives, clinical priorities and economics

Medicaid

- 2019 will be the third year of the Vermont Medicaid Next Generation program
- OneCare continues to work with the Department of Vermont Health Access (DVHA) to modify and improve the program

BlueCross BlueShield of Vermont (BCBSVT) Qualified Health Plan Program

- 2019 will be the second year of the Qualified Health Plan (QHP) risk program

University of Vermont Medical Center Self-Funded Plan

- Plan to continue the pilot year into a second year under a modified financial model independent from any payer

Self-Funded Expansion

- Budget includes expansion of the self-funded pilot model
- OneCare is working with self-funded plan administrators to implement a program across a number of current contracted plans

Network Participation

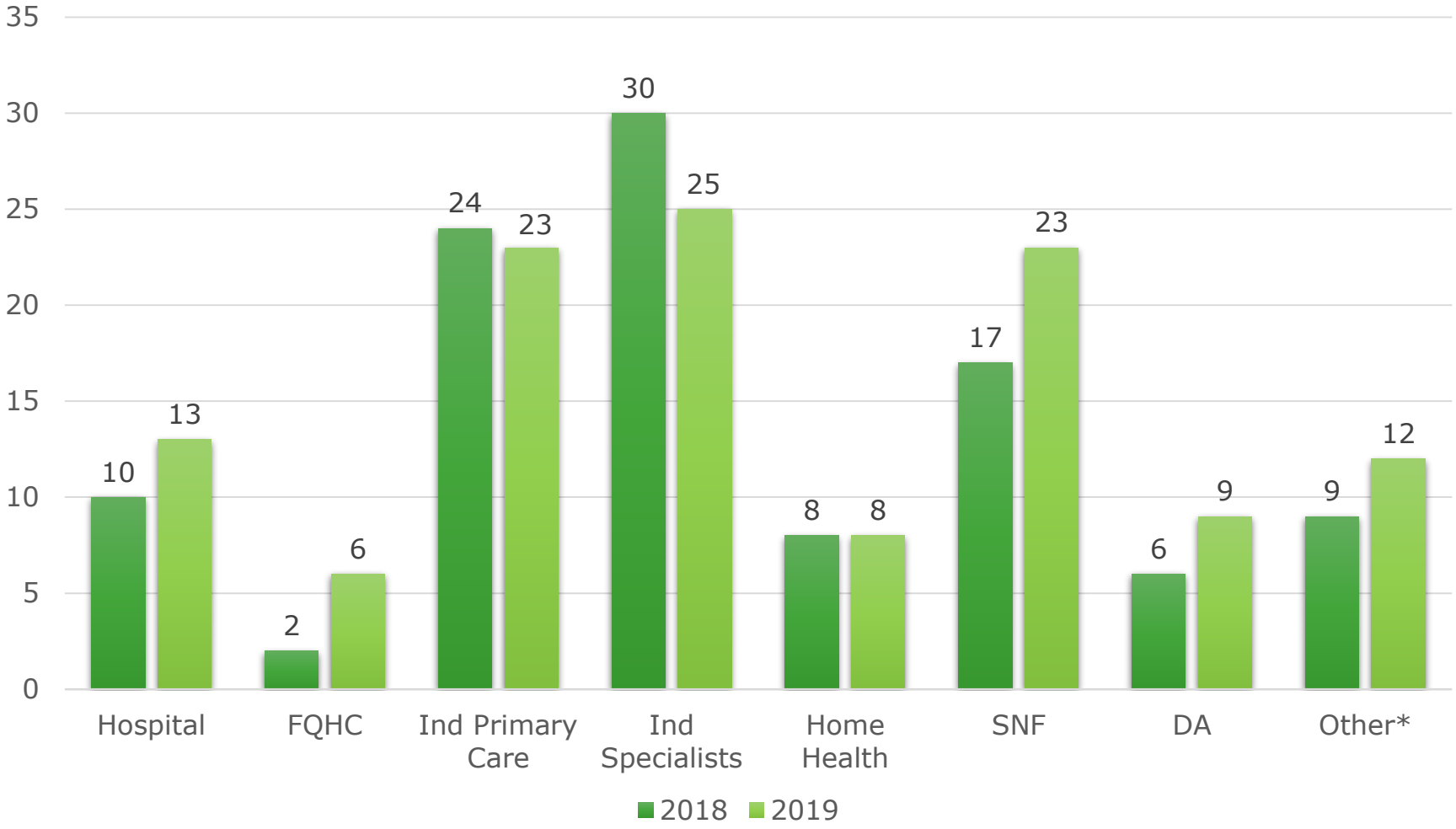
Health Service Area	Home Hospital	2017	2018	2019
Burlington	UVM Medical Center	Medicaid	All Risk Programs	All Risk Programs
Berlin	Central Vermont Medical Center	Medicaid	All Risk Programs	All Risk Programs
Middlebury	Porter Medical Center	Medicaid	All Risk Programs	All Risk Programs
St. Albans	Northwestern Medical Center	Medicaid	All Risk Programs	All Risk Programs
Brattleboro	Brattleboro Memorial Hospital		All Risk Programs	All Risk Programs
Springfield	Springfield Hospital		All Risk Programs	All Risk Programs
Lebanon	Dartmouth Hospital and Clinic		Medicaid and BCBSVT	Medicaid and BCBSVT
Bennington	Southwestern VT Medical Center		Medicaid	**All Risk Programs**
Windsor	Mt Ascutney Hospital		Medicaid	**All Risk Programs**
Newport	North Country Hospital		Medicaid	Medicaid
Rutland	Rutland Regional			**Medicaid**
St. Johnsbury	Northeastern Regional Hospital			**Medicaid**
Randolph	Gifford Medical Center			**Medicaid**
Morrisville	Copley Hospital			
Townshend	Grace Cottage			

Green: Advancing participation from prior year

Key Additions & Changes:

- Bennington and Windsor advancing to participation in all risk programs
- Randolph, Rutland, and St. Johnsbury participating in Medicaid for the first time
- Newport maintaining Medicaid-only participation due to a recent leadership change
- Expansion includes six FQHCs

Participating Provider Types



* Includes Naturopaths, Special Services Agencies, Brattleboro Retreat

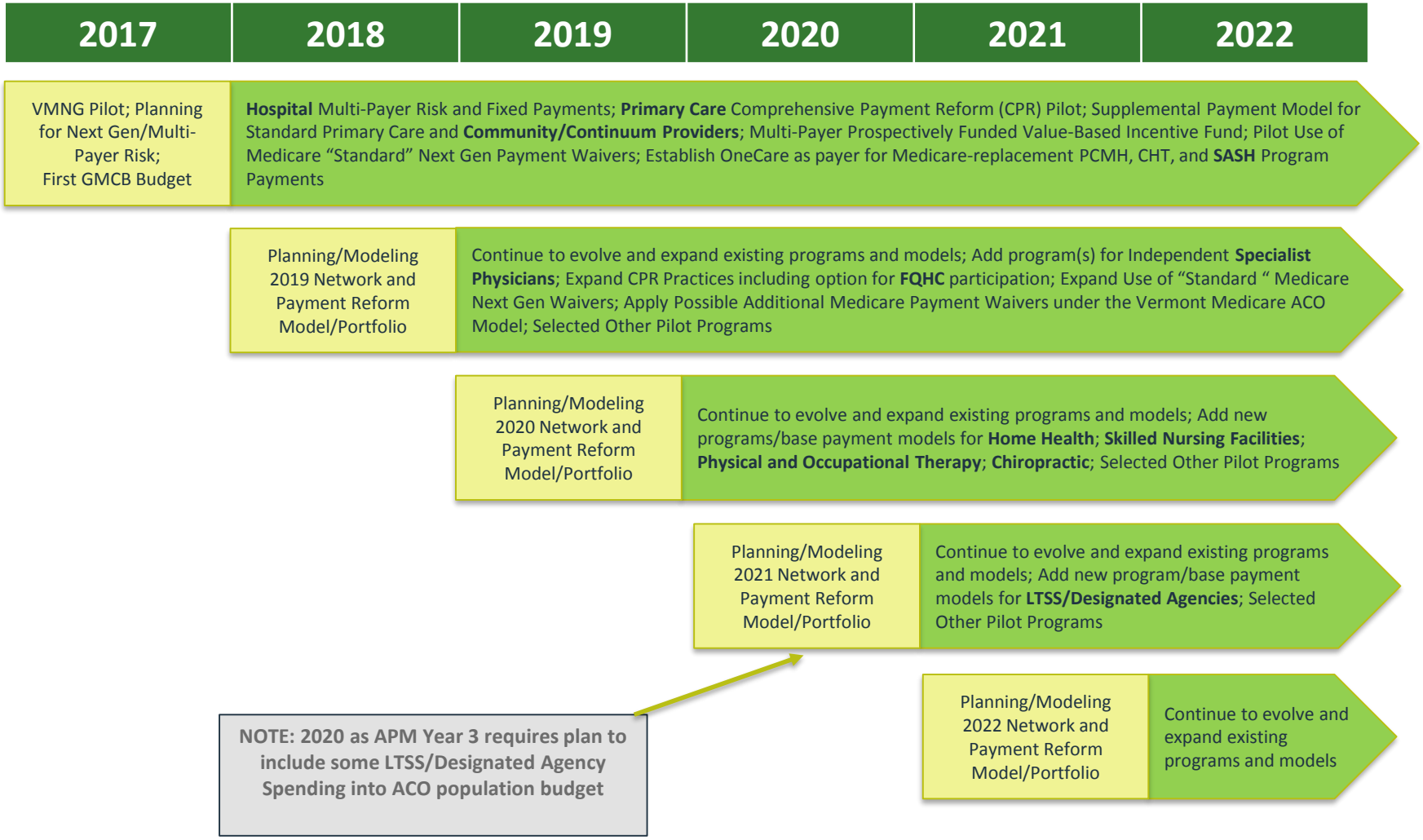
Initial Attribution Estimates

Starting Count	Medicare	Medicaid	BCBS QHP	Self-Fund	Total
Bennington	5,938	5,590	2,234	798	14,560
Berlin	5,430	5,550	3,174	6,279	20,433
Brattleboro	2,621	3,295	978	582	7,476
Burlington	18,307	18,429	8,663	18,944	64,343
Lebanon	0	2,145	1,184	8	3,337
Middlebury	4,211	4,421	1,975	3,372	13,979
Morrisville	0	0	0	0	0
Newport	0	3,805	0	844	4,649
Randolph	0	2,743	0	0	2,743
Rutland	0	4,867	0	779	5,646
Springfield	4,595	2,282	1,433	754	9,064
St. Albans	4,008	6,856	1,533	2,960	15,357
St. Johnsbury	0	5,003	0	0	5,003
Townshend	0	0	0	0	0
Windsor	2,077	1,706	1,328	664	5,775
Total	**47,187**	**66,692**	**22,502**	**35,984**	**172,365**

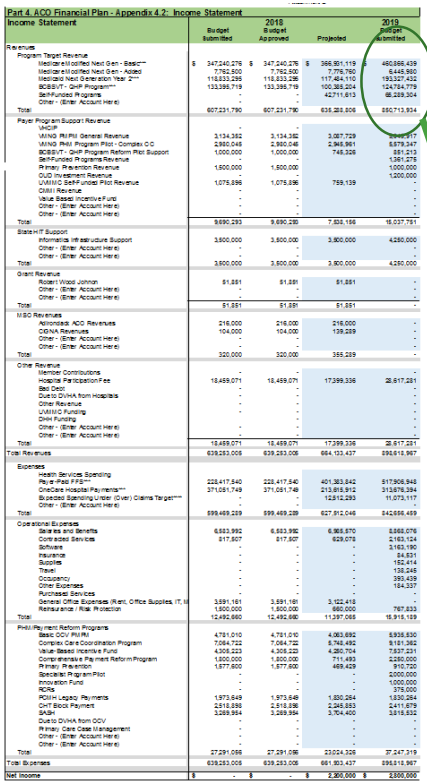
Notes:

- Assumes no major change to attribution methodology at this time
- Numbers represent the estimated starting attribution before any attrition – these are gathered from current attribution and modeling data for any new providers
- Final attribution figures will be calculated in late 2018 or early 2019

Network Development Strategy



Budget Breakdown



Total Cost of Care Targets

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement			
Income Statement	**2018**		**2019**
	Budget Approved	**Projected**	**Budget Submitted**
Revenues			
Program Target Revenue			
Medicare Modified Next Gen - Basic***	$ 347,240,276	$ 366,931,119	$ 460,866,439
Medicare Modified Next Gen - Added	7,762,500	7,776,760	6,445,980
Medicaid Next Generation Year 2***	118,833,295	117,484,110	193,327,432
BCBSVT - QHP Program***	133,395,719	100,385,204	124,784,779
Self-Funded Programs	-	42,711,613	65,289,304
Other - (Enter Account Here)	-		
Total	607,231,790	635,288,806	850,713,934

Approach

- The general philosophy employed is to project the total cost of care (TCOC) targets in a manner that is actuarially sound and aligns with any existing contract terms (for example, the Vermont All Payer Model)

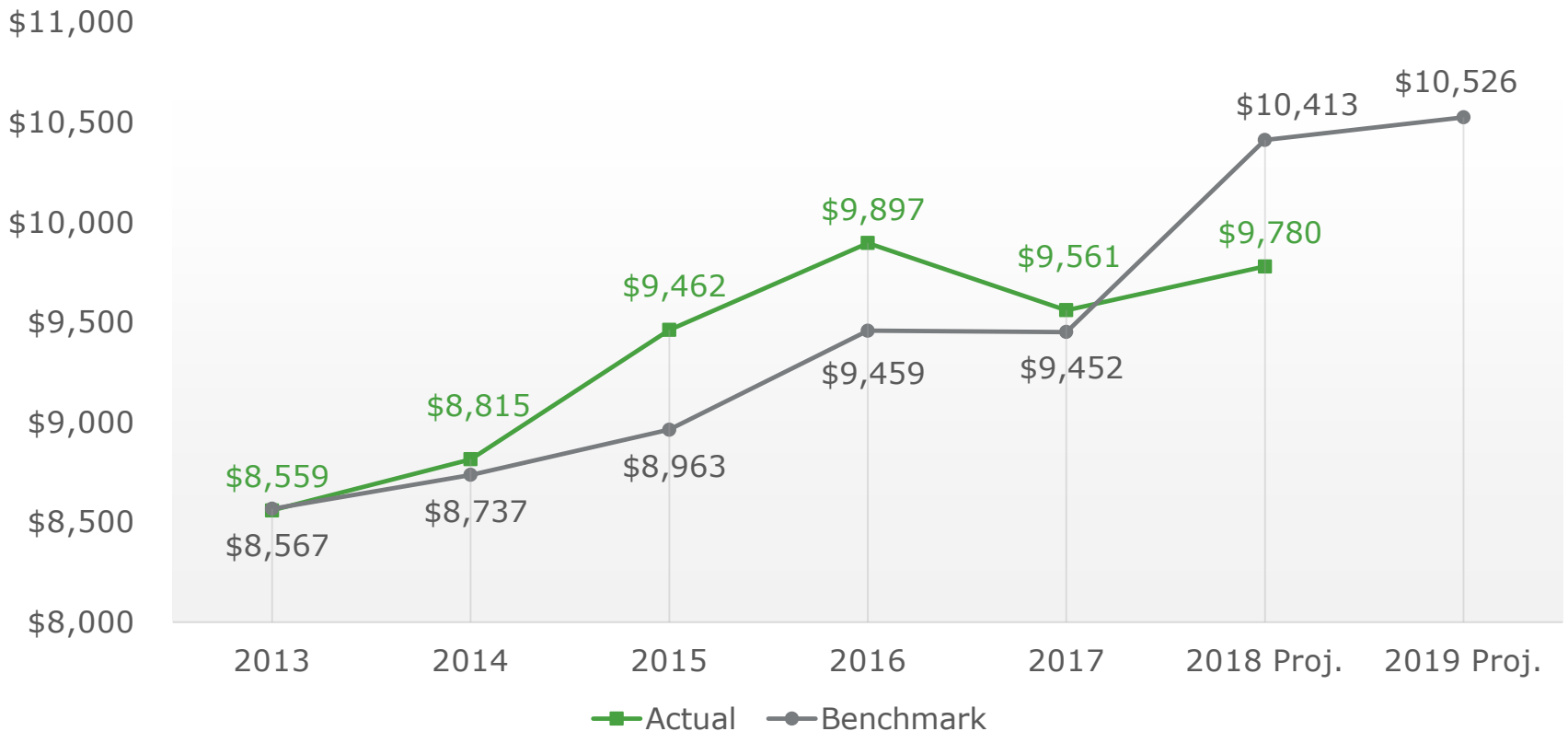
- With the exception of Medicare, program TCOC targets are negotiated with the payer partner

- The adequacy and reasonableness of projected targets will be a critical factor to determine whether or not OneCare moves forward with programs

TCOC Estimate – Medicare Trend

The OneCare budget builds the Total Cost of Care target by estimating the 2018 PMPM spend for the assumed 2019 network and trending forward using 3.8%

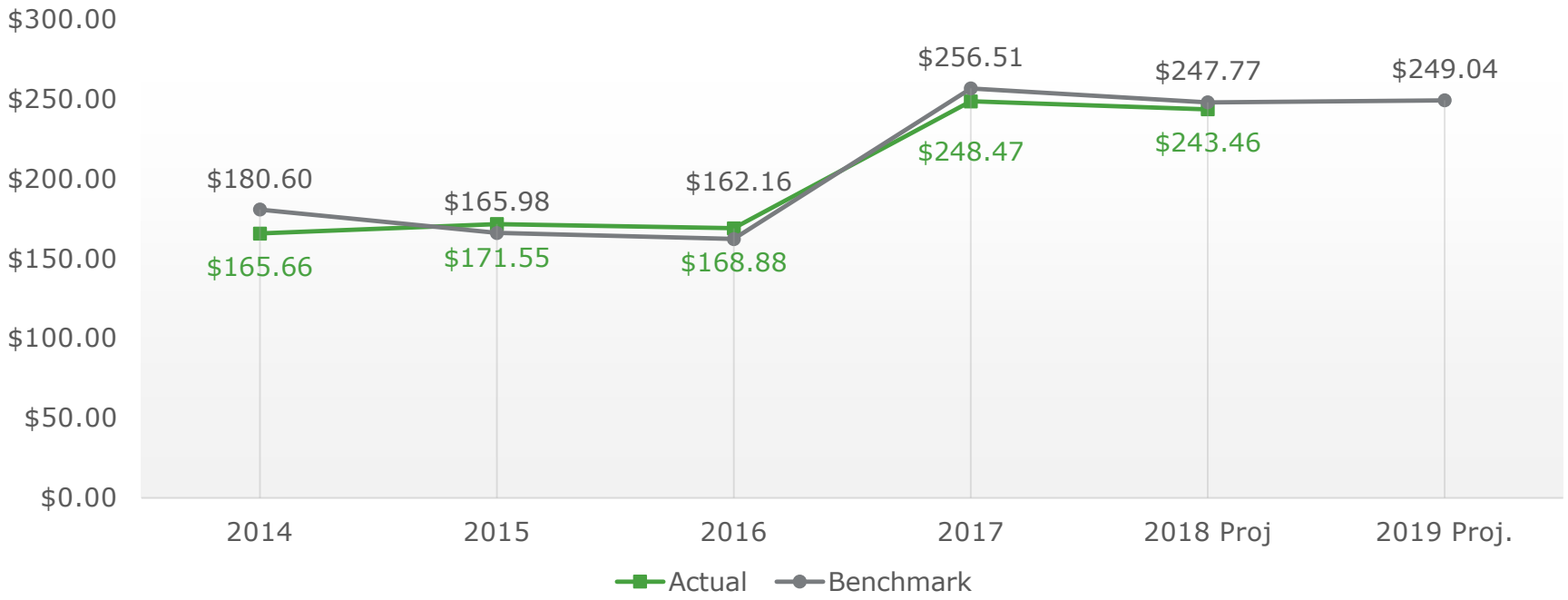
- Trend rate derived from the Vermont All Payer Model agreement
- 2019 target includes estimated shared savings carryforward



Medicaid TCOC

The OneCare budget builds the Total Cost of Care target by calculating the 2017 PMPM spend for the assumed 2019 network and trending forward using conservative inflationary factors

- Current inflation factor used in budget from 2018 to 2019 is 0.5%
- The actual trend rates will be agreed-upon by OneCare and DVHA and will be supported by actuarial analyses prepared by two separate firms
- The budget model also assumes maintaining the 0.2% discount/efficiency factor

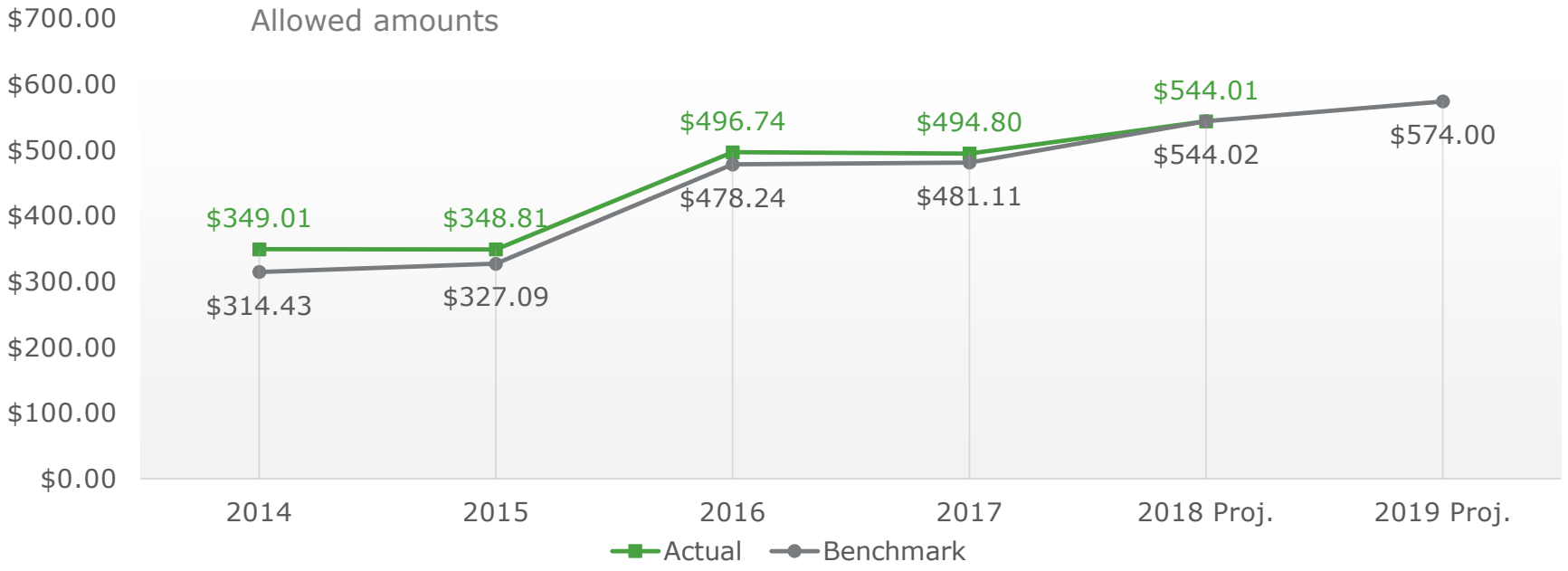


The services for which the ACO was at risk changed from 2016 to 2017, which led to the significant increase

BCBSVT QHP TCOC

The OneCare budget builds the Total Cost of Care target by calculating the 2017 PMPM spend based on the "allowed amount" for the assumed 2019 network and trending forward using the GMCB-approved 2018 QHP trend and the requested 2019 trend

- OneCare will utilize actuarial contractor to ensure the rates are reasonable and produce a fair target
- The presented total cost of care on the income statement has been converted to the "paid amount" to display the spend for which OneCare is at risk
- 2018 target has not been finalized with BCBSVT



BCBSVT QHP Trend Rate

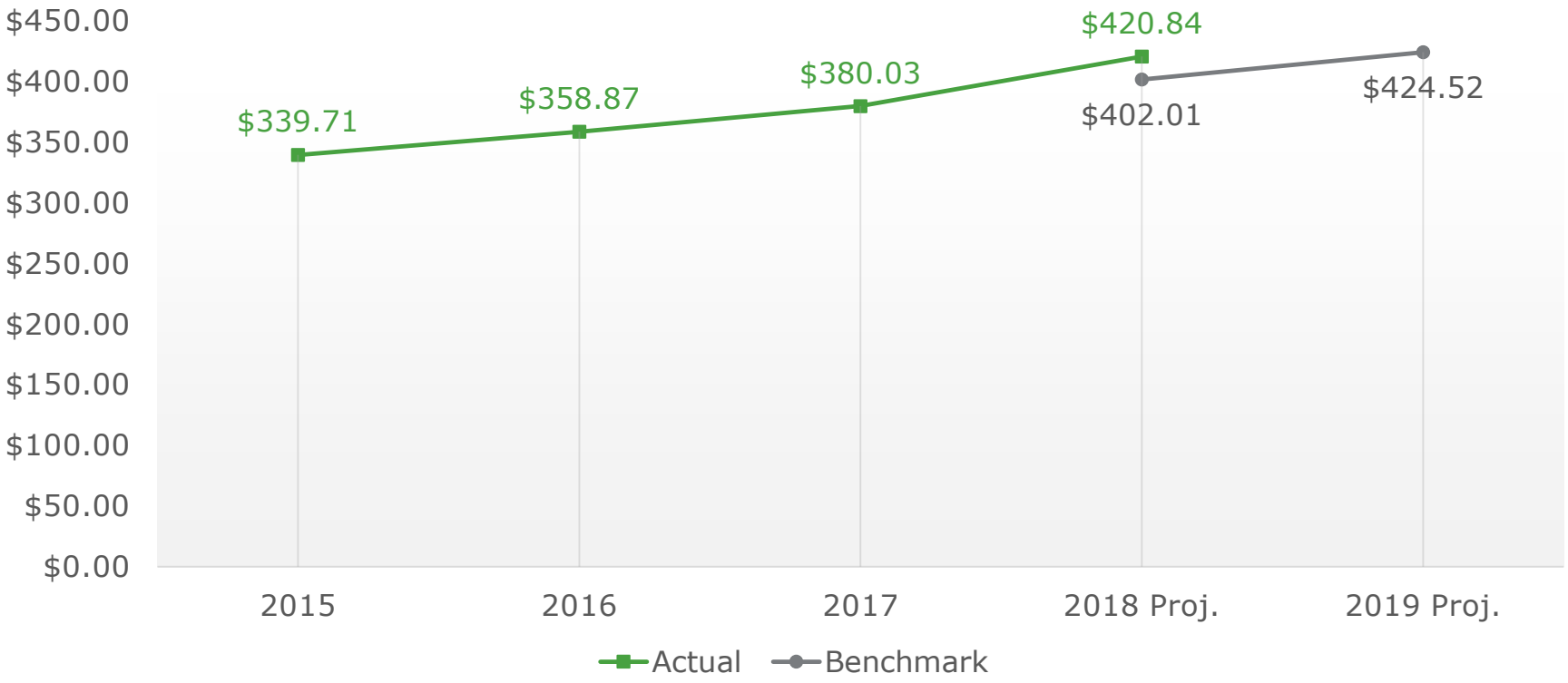
The OneCare budget builds the Total Cost of Care target by calculating the 2017 PMPM spend and trending forward using the factors related to the expected cost of claims in the BCBSVT QHP rate filing

- Trend factors included in the Total Cost of Care target that were approved by the GMCB include:
  - Unit cost trend
  - Utilization trend
  - Population morbidity
  - Changes in other factors (includes impact of removal of penalty for individual mandate)
  - Benefit changes
- Added an additional 2.3% trend for the expected increase in the QHP program due to healthier small group employers leaving the QHP market to enroll in the new AHP market
- Reasons for the variation from GMCB approved trends:
  - All actuaries agreed this trend was reasonable
  - OneCare does not have the same offsetting sources of revenue:
    - No profit from AHP market
    - No member or employer funded reserves
    - No large AMT tax refund
- No changes that are not related to the Total Cost of Care were included such as those for:
    - Administrative costs
    - Contributions to Reserves
    - Tax/fee impact
    - Changes for risk adjustment

Self-Funded TCOC

OneCare is currently working with payers and employer health plans to incorporate them into the All Payer Model and increase the number of qualifying attributed lives

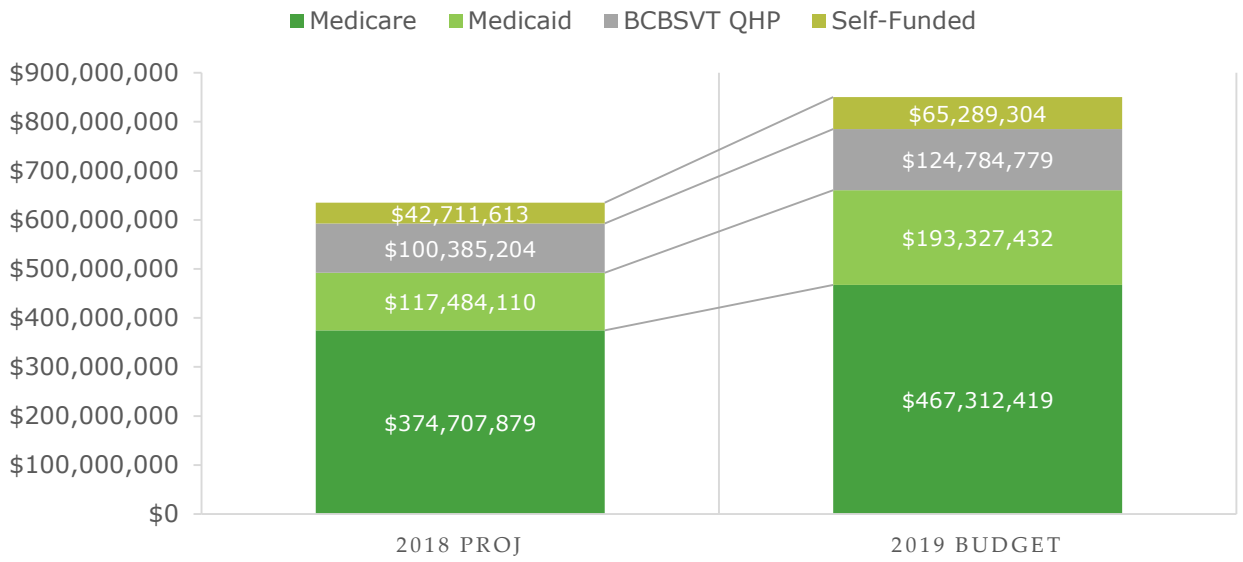
- Targets to be set using actuarial support and negotiated trend rates
- Data are limited at this time as the participating payers and plans are not finalized



* 2015 through 2017 actual estimated to reflect attributed population

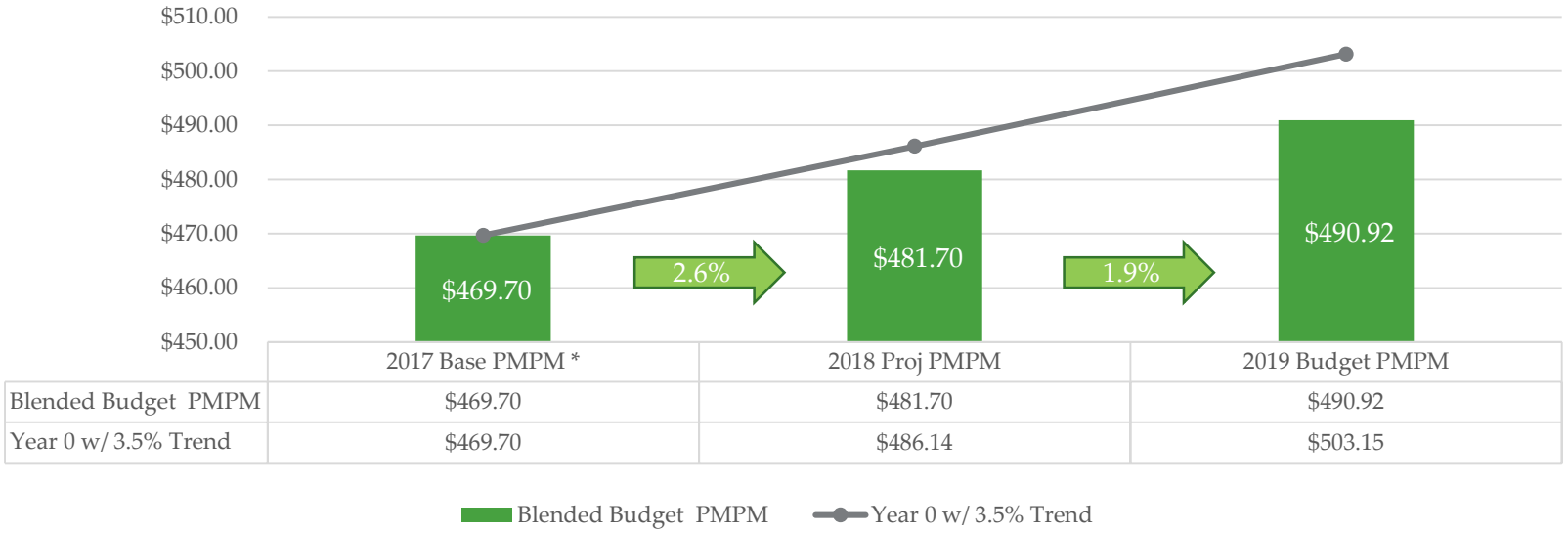
Estimated Total Cost of Care Targets

Program	2018 Projection	2019 Budget	$ Growth	% Growth
Medicare	$374,707,879	$467,312,419	$92,604,540	25%
Medicaid	$117,484,110	$193,327,432	$75,843,322	65%
BCBSVT QHP	$100,385,204	$124,784,779	$24,399,574	24%
Self-Funded	$42,711,613	$65,289,304	$22,577,692	53%
Total	**$635,288,806**	**$850,713,934**	**$215,425,128**	**34%**



All estimates dependent on final PMPM rates being set and incorporation of 2018 performance for the Medicare program

Blended Total Cost of Care Targets



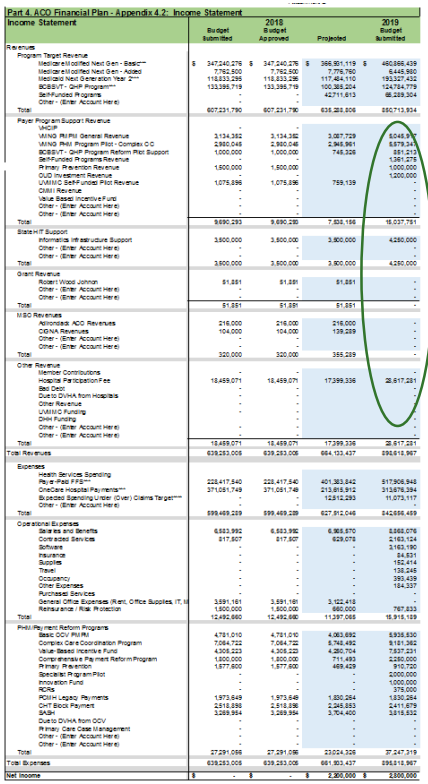
	2017 Base PMPM *	2018 Proj PMPM	2019 Budget PMPM
Blended Budget PMPM	$469.70	$481.70	$490.92
Year 0 w/ 3.5% Trend	$469.70	$486.14	$503.15

This model provides a payer-mix adjusted blended PMPM trend

- 2019 attribution was applied to historical PMPMs to show combined ACO growth

The networks weren't the same each year, which adds noise, but overall the ACO is staying within the 3.5% target expectation set by the All Payer Model

*The 2017 base year PMPMs were updated to reflect the Medicaid and BCBSVT QHP final PMPMs for the shared savings program. The Medicare base came from the 2018 target-setting exercise in last year's budget cycle.



Other Revenues

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement			
Income Statement	**2018**		**2019**
	Budget Approved	**Projected**	**Budget Submitted**
Payer Program Support Revenue			
VMNG PMPM General Revenue	3,134,352	3,087,729	5,045,917
VMNG PHM Program Pilot - Complex CC	2,980,045	2,945,961	5,579,347
BCBSVT - QHP Program Reform Pilot Support	1,000,000	745,326	851,213
Self-Funded Programs Revenue	-		1,361,275
Primary Prevention Revenue	1,500,000		1,000,000
OUD Investment Revenue	-		1,200,000
UVMMC Self-Funded Pilot Revenue	1,075,896	759,139	-
Total	9,690,293	7,538,156	15,037,751
State HIT Support			
Informatics Infrastructure Support	3,500,000	3,500,000	4,250,000
Total	3,500,000	3,500,000	4,250,000
Grant Revenue			
Robert Wood Johnon	51,851	51,851	-
Total	51,851	51,851	-
MSO Revenues			
Adirondack ACO Revenues	216,000	216,000	-
CIGNA Revenues	104,000	139,289	-
Total	320,000	355,289	-
Other Revenue			
Hospital Participation Fee	18,459,071	17,399,336	28,617,281
Total	18,459,071	17,399,336	28,617,281

Other Revenue Sources

The budgeted OneCare funding comes primarily from three sources:

Payer Partners

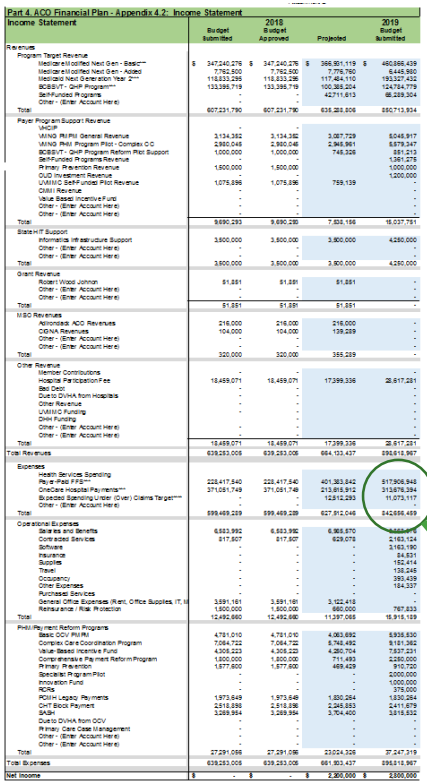
- $6.50 PMPM investment from DVHA
- $3.25 PMPM investment from BCBSVT
- $3.25 PMPM investments from self-funded plans

The State of Vermont

- Advanced Care Coordination program
- HIT informatics capabilities of OneCare
- Primary prevention programs

Hospitals

- Participation Fees (either through fixed payment deduction or invoice)



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Program Target Revenue				
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Medicare Modified Next Gen - Added	7,762,500	7,762,500	7,776,760	6,445,980
Medicaid Next Generation Year 2***	116,833,286	116,833,286	117,464,110	193,327,432
BCBSVT - OHP Program***	133,395,719	133,395,719	100,368,204	124,764,779
Self-Funded Programs	-	-	42,711,613	66,289,304
Other - (Enter Account Here)	-	-		
Total	607,231,790	607,231,790	635,288,806	880,713,934
Payer Program Support Revenue				
UHCIP	-	-		
VMNG PMPM General Revenue	3,134,382	3,134,382	3,087,729	5,048,917
VMNG PMPM Program Pilot - Complex CC	2,860,048	2,860,048	2,946,961	5,879,347
BCBSVT - OHP Program Reform Pilot Support	1,000,000	1,000,000	746,326	551,213
Self-Funded Programs Revenue	-	-		1,361,275
Primary Prevention Revenue	1,500,000	1,500,000		1,000,000
CUD Investment Revenue	-	-		1,200,000
UVMHC Self-Funded Pilot Revenue	1,075,896	1,075,896	759,139	-
CMMI Revenue	-	-		-
Value Based Incentive Fund	-	-		-
Other - (Enter Account Here)	-	-		-
Other - (Enter Account Here)	-	-		-
Total	9,690,293	9,690,293	7,834,156	15,037,751
State HIT Support				
Informatics Infrastructure Support	3,600,000	3,600,000	3,600,000	4,280,000
Other - (Enter Account Here)	-	-		-
Other - (Enter Account Here)	-	-		-
Total	3,600,000	3,600,000	3,600,000	4,280,000
Grant Revenue				
Robert Wood Johnon	51,551	51,551	51,551	-
Other - (Enter Account Here)	-	-		-
Other - (Enter Account Here)	-	-		-
Total	51,551	51,551	51,551	-
MSG Revenues				
Adirondack ACO Revenues	216,000	216,000	216,000	-
OSNA Revenues	104,000	104,000	139,289	-
Other - (Enter Account Here)	-	-		-
Other - (Enter Account Here)	-	-		-
Total	320,000	320,000	355,289	-
Other Revenue				
Member Contributions	-	-		-
Hospital Participation Fee	18,459,071	18,459,071	17,399,336	28,617,231
Bad Debt	-	-		-
Due to DVHA from Hospitals	-	-		-
Other Revenue	-	-		-
UVMHC Funding	-	-		-
DHH Funding	-	-		-
Other - (Enter Account Here)	-	-		-
Other - (Enter Account Here)	-	-		-
Total	18,459,071	18,459,071	17,399,336	28,617,231
Total Revenues	639,253,005	639,253,005	664,133,437	930,618,967
Expenses				
Health Services Spending				
Payer-Paid FFS***	228,417,540	228,417,540	401,383,842	517,906,948
OneCare Hospital Payments***	371,051,749	371,051,749	213,615,912	313,676,394
Expected Spending Under (Over) Claims Target****	-	-	12,512,293	11,073,117
Other - (Enter Account Here)	-	-		-
Total	599,469,289	599,469,289	627,512,046	842,656,459
Operational Expenses				
Salaries and Benefits	6,583,992	6,583,992	6,366,570	9,453,974
Contracted Services	817,507	817,507	629,078	2,163,124
Software	-	-	-	3,163,190
Insurance	-	-	-	84,931
Supplies	-	-	-	152,414
Travel	-	-	-	138,245
Occupancy	-	-	-	393,439
Other Expenses	-	-	-	184,337
Purchased Services	-	-	-	-
General Office Expenses (Rent, Office Supplies, IT, M	3,591,161	3,591,161	3,122,418	-
Reinsurance / Risk Protection	1,500,000	1,500,000	660,000	767,833
Total	12,492,660	12,492,660	11,297,065	16,918,189
PHM-Payment Reform Programs				
Basic OCV PMPM	4,781,010	4,781,010	4,063,692	5,935,530
Complex Care Coordination Program	7,064,722	7,064,722	6,748,492	9,181,362
Value-Based Incentive Fund	4,305,223	4,305,223	4,280,704	7,837,231
Comprehensive Payment Reform Program	1,800,000	1,800,000	711,493	2,280,000
Primary Prevention	1,577,600	1,577,600	469,429	910,720
Specialist Program Pilot	-	-	-	2,000,000
Innovation Fund	-	-	-	1,000,000
RCRs	-	-	-	375,000
PCMH Legacy Payments	1,973,649	1,973,649	1,330,264	1,830,264
CHT Block Payment	2,518,286	2,518,286	2,345,853	2,411,679
SASH	3,269,994	3,269,994	3,704,400	3,818,532
Due to DVHA from OCV	-	-	-	-
Primary Care Case Management	-	-	-	-
Other - (Enter Account Here)	-	-	-	-
Other - (Enter Account Here)	-	-	-	-
Total	27,291,096	27,291,096	23,654,326	37,247,319
Total Expenses	639,253,005	639,253,005	661,803,437	896,819,967
Net Income	$ -	$ -	$ 2,329,999	$ 33,798,999

Health Services Spending

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement			
Income Statement	**2018**		**2019**
	Budget Approved	**Projected**	**Budget Submitted**
Health Services Spending			
Payer-Paid FFS ***	228,417,540	401,383,842	517,906,948
OneCare Hospital Payments ***	371,051,749	213,615,912	313,676,394
Expected Spending Under (Over) Claims Target****	-	12,512,293	11,073,117
Other - (Enter Account Here)	-		-
Total	599,469,289	627,512,046	842,656,459

Approach

- The general philosophy employed in the budget is to project the actual total cost of care (TCOC) spending based on the best data available and actuarial input
  - This is done on a PMPM basis by attributing community to aggregate to a total combined spend

- In cases where the target is negotiated to be the best estimate of actual spending, the estimated spend is the same as the projected benchmark.

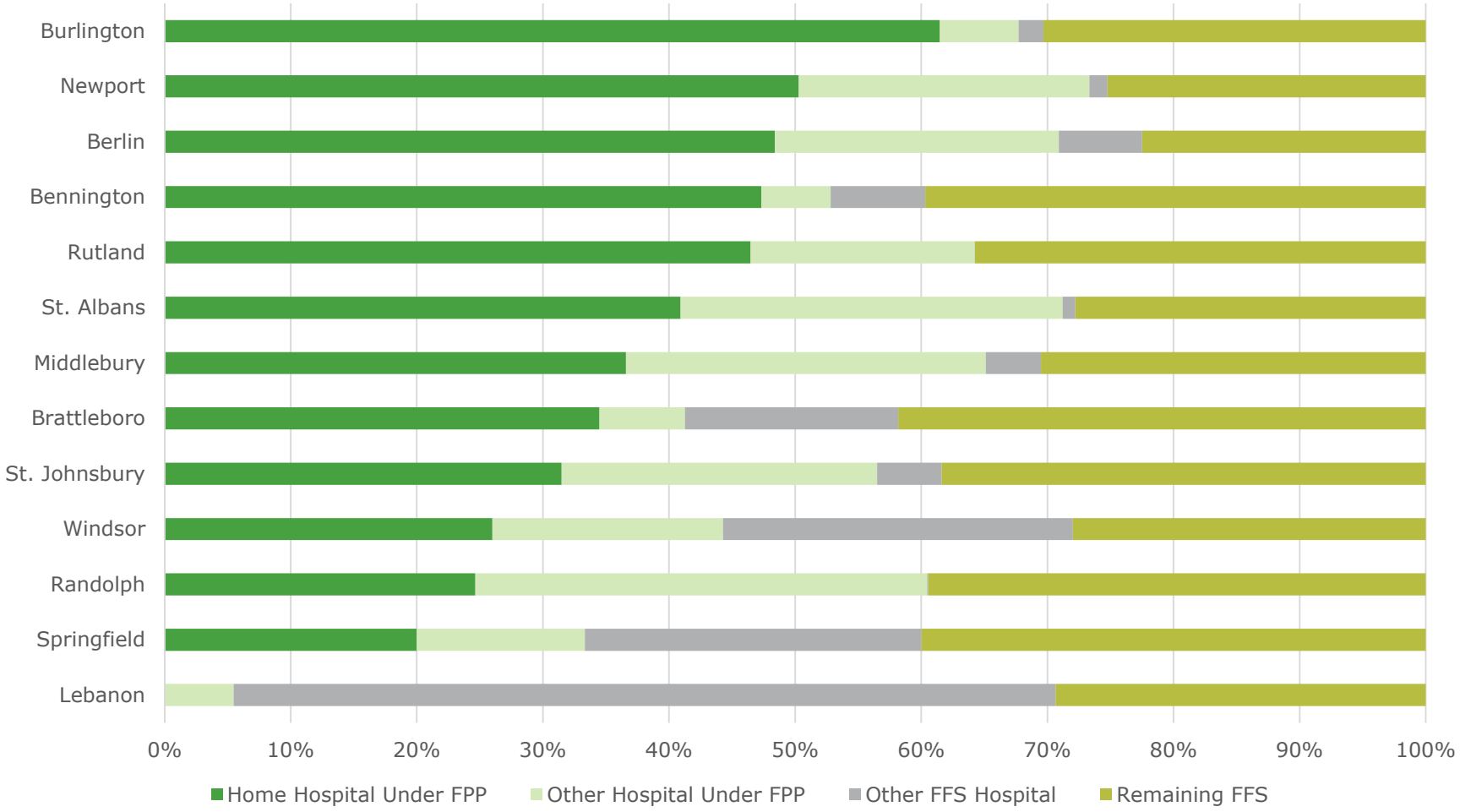
- In cases where contract/other factors contribute to the TCOC target, the estimated spend may not tie to the projected benchmark
  - This results in a program either having projected shared savings or losses

Combined Spending Estimates

- After completing the calculations for each HSA by payer, it is aggregated to the total cost of care estimate for the full ACO

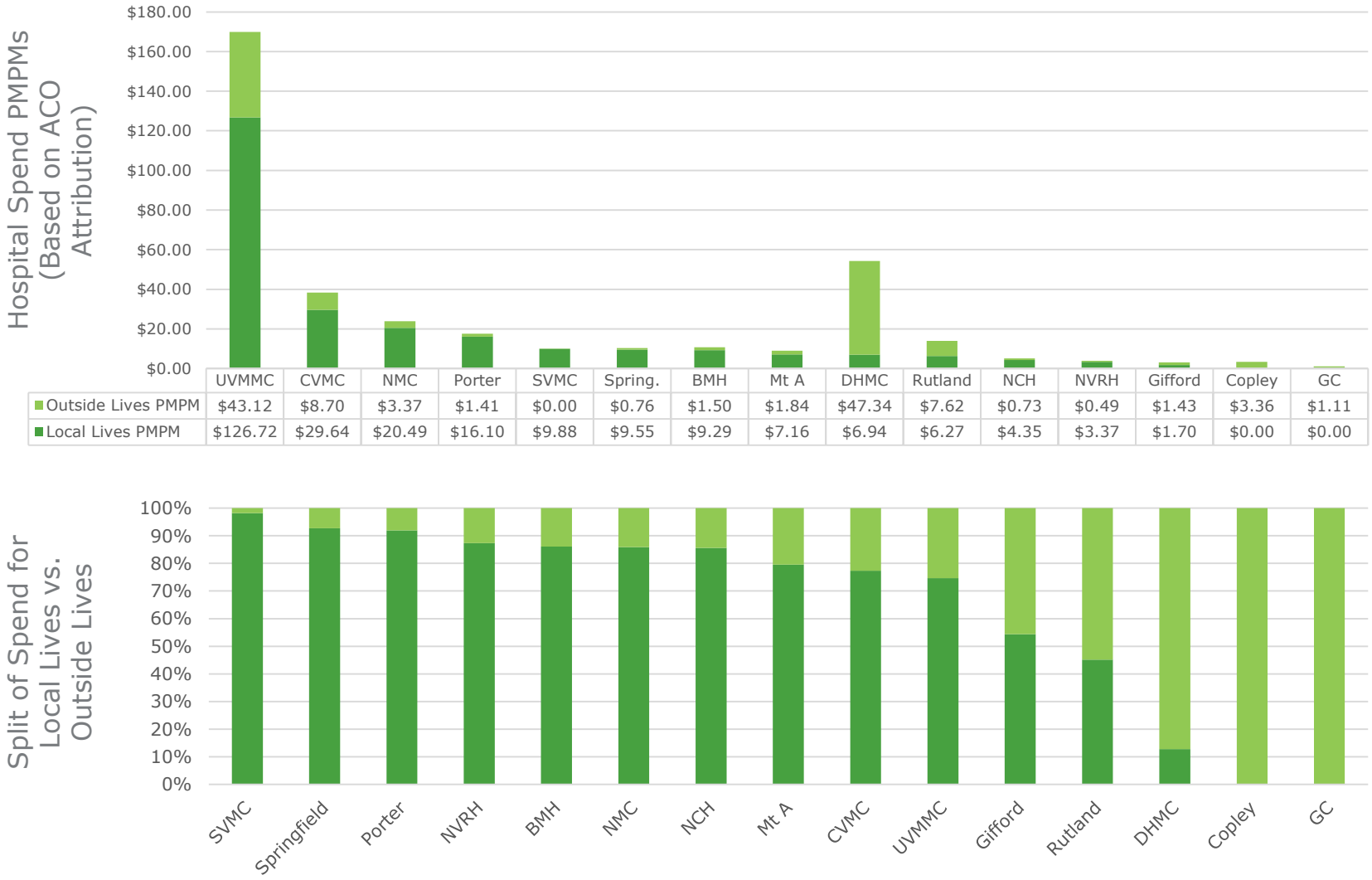
HSA	Medicare	Medicaid	BCBSVT QHP	Self-Funded	Combined Total
Bennington	$62,592,538	$15,439,543	$14,912,956	TBD	$92,945,037
Berlin	$51,043,152	$14,504,814	$14,611,673	TBD	$80,159,639
Brattleboro	$23,289,447	$7,954,575	$4,007,849	TBD	$35,251,872
Burlington	$167,845,599	$52,134,938	$49,911,600	TBD	$269,892,137
Lebanon	$0	$6,055,567	$8,165,121	TBD	$14,220,688
Middlebury	$36,239,560	$12,477,008	$8,870,339	TBD	$57,586,906
Morrisville	$0	$0	$0	TBD	$0
Newport	$0	$11,316,591	$0	TBD	$11,316,591
Randolph	$0	$9,054,839	$0	TBD	$9,054,839
Rutland	$0	$17,663,706	$0	TBD	$17,663,706
Springfield	$46,274,314	$8,155,173	$8,130,913	TBD	$62,560,400
St. Albans	$36,160,160	$21,220,790	$8,180,698	TBD	$65,561,648
St. Johnsbury	$0	$14,018,378	$0	TBD	$14,018,378
Townshend	$0	$0	$0	TBD	$0
Windsor	$24,737,058	$3,331,509	$7,993,630	TBD	$36,062,196
Total	**$448,181,827**	**$193,327,432**	**$124,784,779**	**$65,289,304**	**$831,583,342**
Est. Member Months	532,779	776,295	261,923	161,890	1,732,887
Combined PMPM	**$841.22**	**$249.04**	**$476.42**	**$403.29**	**$479.88**

HSA Spending Breakdown*



*Includes Medicare, Medicaid, BCBS QHP

Hospital Spending Breakdown – Statewide Population



	UVMMC	CVMC	NMC	Porter	SVMC	Spring.	BMH	Mt A	DHMC	Rutland	NCH	NVRH	Gifford	Copley	GC
Outside Lives PMPM	$43.12	$8.70	$3.37	$1.41	$0.00	$0.76	$1.50	$1.84	$47.34	$7.62	$0.73	$0.49	$1.43	$3.36	$1.11
Local Lives PMPM	$126.72	$29.64	$20.49	$16.10	$9.88	$9.55	$9.29	$7.16	$6.94	$6.27	$4.35	$3.37	$1.70	$0.00	$0.00

Fixed Payments

Hospital fixed payments represent an important shift away from FFS.

The 2019 budget model incorporates a fixed payment approach for the Medicaid and Medicare programs

The Medicaid fixed payment represents the true "cost of care" and is not reconciled at year-end

The Medicare fixed payment is viewed as a cash flow advance and is reconciled with Medicare at year-end to the FFS equivalent. This reconciliation does not affect overall program spending performance, which is measured on a FFS basis (actual FFS plus FFS equivalent)

The amount that any hospital receives includes the cost for all lives attributed to OneCare – not just the lives that attribute to their HSA

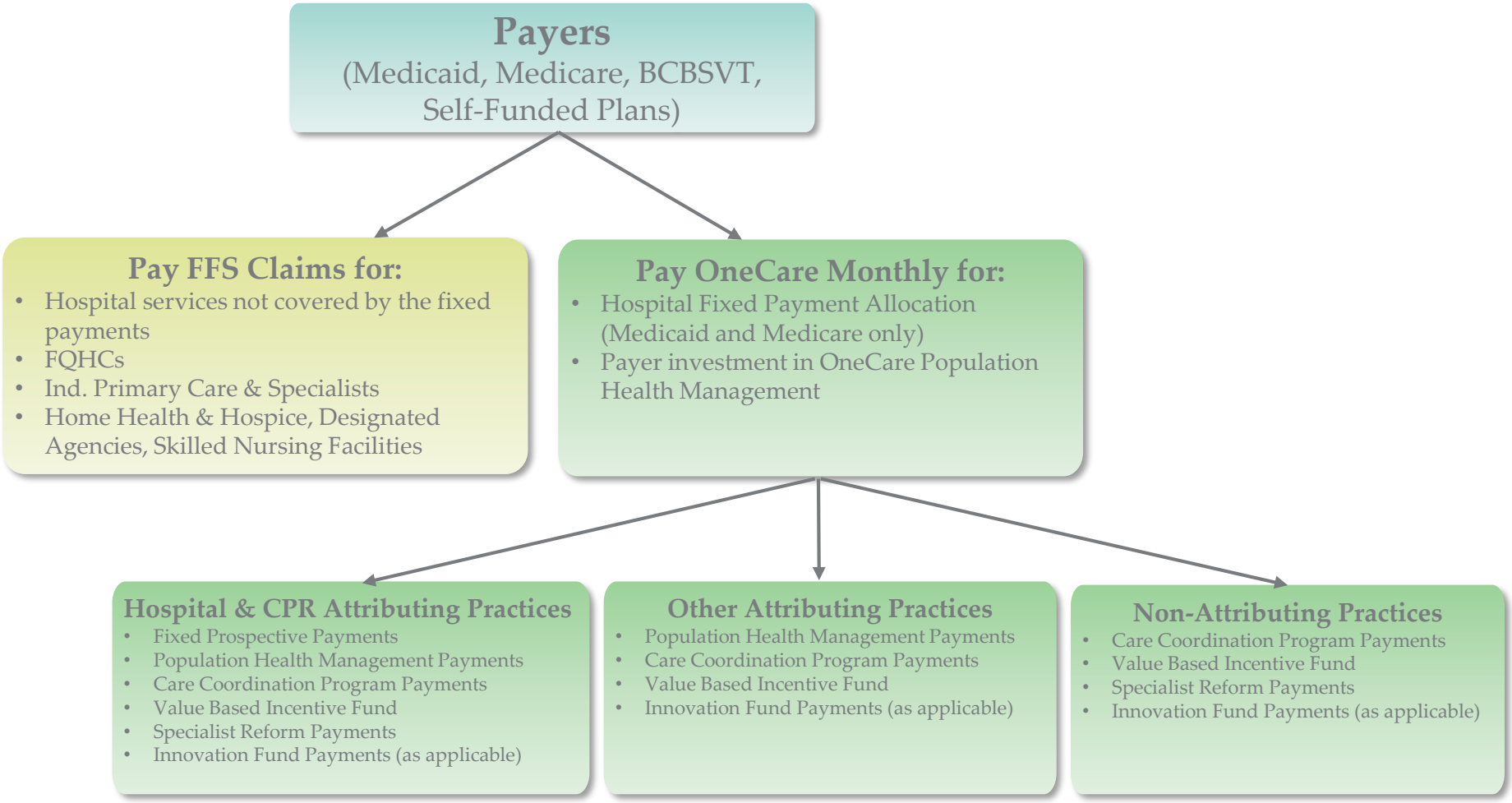
Fixed Payments

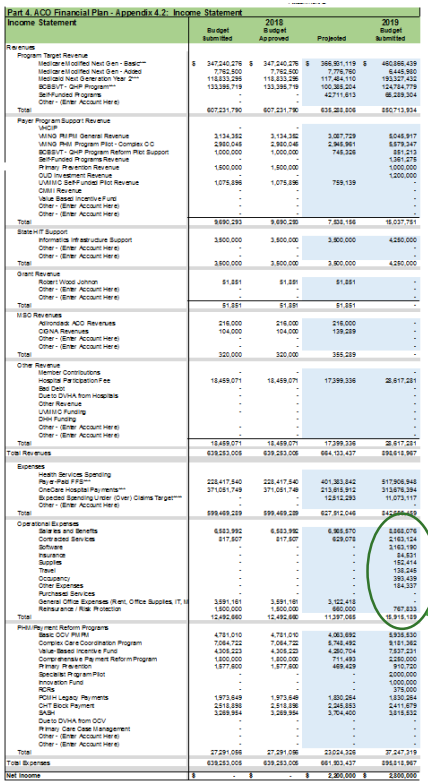
- The fixed payments can be boiled down to PMPMs by either total program attribution or HSA attribution
  - 25% of the total cost of care is distributed to the Network through fixed payments
  - The total program attribution breakdown shows a level volume comparison across the different hospitals
  - The HSA attribution breakdown provides an indication of how much hospital care happens locally

	Medicare			Medicaid		
HSA	Gross FPP	PMPM - Total Attribution	PMPM - HSA Attribution	Gross FPP	PMPM - Total Attribution	PMPM - HSA Attribution
Bennington	$23,030,858	$43.23	$343.51	$8,095,809	$10.43	$124.42
Berlin	$26,360,732	$49.48	$429.96	$10,467,499	$13.48	$162.03
Brattleboro	$7,011,704	$13.16	$236.94	$3,351,716	$4.32	$87.39
Burlington	$109,366,790	$205.28	$529.11	$43,633,310	$56.21	$203.41
Lebanon	$0	$0.00	$0.00	$0	$0.00	$0.00
Middlebury	$11,047,110	$20.73	$232.35	$5,523,075	$7.11	$107.33
Morrisville	$0	$0.00	$0.00	$0	$0.00	$0.00
Newport	$0	$0.00	$0.00	$6,317,365	$8.14	$142.64
Randolph	$0	$0.00	$0.00	$2,661,429	$3.43	$83.36
Rutland	$0	$0.00	$0.00	$10,298,396	$13.27	$181.78
Springfield	$7,440,623	$13.97	$143.42	$2,594,500	$3.34	$97.68
St. Albans	$13,853,074	$26.00	$306.12	$11,283,169	$14.53	$141.39
St. Johnsbury	$0	$0.00	$0.00	$4,812,562	$6.20	$82.64
Townshend	$0	$0.00	$0.00	$0	$0.00	$0.00
Windsor	$7,635,992	$14.33	$325.61	$1,037,443	$1.34	$52.24
Total	**$205,746,884**	**$386.18**	**$386.18**	**$110,076,275**	**$141.80**	**$141.80**

Funds Flow

The funds flow approach remains unchanged for 2019





Population Health Management (PHM) Spending

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement			
Income Statement	**2018**		**2019**
	Budget Approved	**Projected**	**Budget Submitted**
PHM/Payment Reform Programs			
Basic OCV PMPM	4,781,010	4,063,692	5,935,530
Complex Care Coordination Program	7,064,722	5,748,492	9,181,362
Value-Based Incentive Fund	4,305,223	4,250,704	7,537,231
Comprehensive Payment Reform Program	1,800,000	711,493	2,250,000
Primary Prevention	1,577,600	469,429	910,720
Specialist Program Pilot	-	-	2,000,000
Innovation Fund	-	-	1,000,000
RCRs	-	-	375,000
PCMH Legacy Payments	1,973,649	1,830,264	1,830,264
CHT Block Payment	2,518,898	2,245,853	2,411,679
SASH	3,269,954	3,704,400	3,815,532
Total	27,291,056	23,024,326	37,247,319

PHM Programs and Investments

Population Health Management ($3.25 PMPM)

2019 Budget: $5,935,530

Direct financial support to all ACO PCMH to support effective population health management to:

- Maintain core NCQA PCMH concepts
- Conduct patient outreach to promote preventive care and chronic disease management
- Review data and monitor quality measure performance
- Address gaps in care
- Assess and improve coding accuracy

Complex Care Coordination (Base $15 PMPM for high/very high risk plus additional opportunities)

2019 Budget: $9,181,362

Direct financial support to primary care and continuum of care (DA, HH, AAA) to support OneCare's community-based care coordination model

- Outreach to engage/maintain individuals in care coordination
- Partner across organizations to form person-centered care teams
- Create shared care plans; participate in shared care planning and care conferences to facilitate the individual's goals of care
- Support effective transitions of care (e.g. ED follow-up calls, post hospital discharge visits)
- Anticipated partnership with VDH and the Developmental Understanding and Legal Collaboration for Everyone (DULCE) Program to address social determinants of health and promote healthy development for infants from 0-6 months and their caregivers

Value Based Incentive Fund

2019 Budget: $7,537,231

Financial incentive for quality measure performance

- 70% to primary care based on attribution; testing new model for variable payments
- 30% to rest of Network; refining model in 2019

PHM Programs and Investments

Comprehensive Payment Reform (CPR)

2019 Budget: $2,250,000

Payment and system delivery reform program for independent primary care practices to facilitate transition to a value based payment model

- Requires participation in three core programs (Medicare, Medicaid, and Commercial)
- Expanding from three to nine organizations in 2019

Specialist Payment Reform (SPR)

2019 Budget: $2,000,000

Support for specialists to increase access and decrease lower acuity visits with alternative access models

- Align with OneCare's population health management approach and the Triple Aim
- Improve access to specialists
- Improve quality of care
- Facilitate person-centered care through enhanced coordination among primary and specialty care providers
- Overseen by Population Health Strategy Committee
- Payment elements and alternate access models under development
- Phased implementation approach beginning in 2019

Primary Prevention

2019 Budget: $910,720

Programs support Quadrant 1 of OneCare's Care Model

- RiseVT aims to improve population health and reduce the long-term social and economic burden of chronic disease
- Matching funds to support local program coordinators; amplify grants to support local programming

PHM Programs and Investments

Regional Clinician Representatives

2019 Budget: $375,000

Financial support to 13 local providers + one statewide pediatrician to facilitate peer-to-peer engagement in ACO activities

- Promote utilization of ACO data to identify variation and drive change and improvement
- Disseminate local success stories and lessons learned across local health service areas

Innovation Fund

2019 Budget: $1,000,000

Direct funding to test new innovative pilot programs

- Rapidly test and evaluate innovative programs to facilitate progress towards achieving the Triple Aim (cost, quality, experience of care)
- Support transformation to a value-based healthcare delivery system
- Align with OneCare priority funding areas and Care Model
- Sustainable and scalable
- Promotes partnerships and collaboration to develop/advance integrated systems of care
- Overseen by Population Health Strategy Committee

PHM Programs and Investments

PCMH Payments

2019 Budget: $1,830,264

- Refresh Medicare attribution and include new PCMH practices
- Hold current PCMH PMPM stable pending available funds
- Distribute funds to both ACO and Non-ACO primary care participants

CHT Block Payments

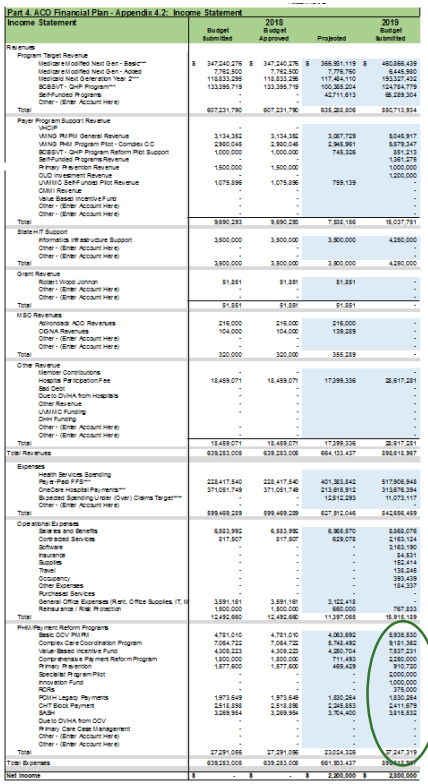
2019 Budget: $2,411,679

- Refresh Medicare attribution and adjust CHT attribution accordingly
- Allow for trend increases pending available funds
- Distribute funds to both ACO and Non-ACO primary care participants

SASH Payments

2019 Budget: $3,815,532

- Fund all existing SASH panels
- Allow for trend increases pending available funds
- Direct contract between OneCare and SASH to assure alignment with the Care Model



Operating Costs

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement			
Income Statement	**2018**		**2019**
	Budget Approved	**Projected**	**Budget Submitted**
Operational Expenses			
Salaries and Benefits	6,583,992	6,985,570	8,868,076
Contracted Services	817,507	629,078	2,163,124
Software	-	-	3,163,190
Insurance	-	-	84,531
Supplies	-	-	152,414
Travel	-	-	138,245
Occupancy	-	-	393,439
Other Expenses	-	-	184,337
General Office Expenses (Rent, Office Supplies, IT, Mainte	3,591,161	3,122,418	-
Reinsurance / Risk Protection	1,500,000	660,000	767,833
Total	12,492,660	11,397,065	15,915,189

Operating Cost Breakdown

Category	2018 Budget	2019 Budget	$ Change	% Change
Salaries and Benefits	$6,583,992	$8,868,076	$2,284,084	35%
Contracted Services	$817,507	$2,163,124	$1,345,617	165%
Software	$2,953,726	$3,163,190	$209,464	7%
Insurance	$79,891	$84,531	$4,640	6%
Supplies	$112,142	$152,414	$40,272	36%
Travel	$78,680	$138,245	$59,565	76%
Occupancy	$321,051	$393,439	$72,388	23%
Other Expenses	$45,671	$184,337	$138,666	304%
Reinsurance / Risk Protection	$1,500,000	$767,833	-$732,167	-49%
Total	**$12,492,660**	**$15,915,189**	**$3,422,529**	**27%**

	2018 FTE	2019 FTE	Change
Senior Leadership	4.5	4.6	0.1
Compliance	0.5	0.9	0.4
Finance and Strategy	5.8	6.5	0.7
Outreach and Engagement	1.5	3.0	1.5
Clinical and Quality	17.4	18.2	0.8
Informatics and Analytics	8.9	10.5	1.6
Operations	10.9	13.0	2.1
Base Subtotal	**49.5**	**56.6**	**7.1**
Rise Vermont	0.0	4.0	4.0
MH/OUD Program Mgmt	0.0	2.0	2.0
New Initiative Subtotal	**0.0**	**6.0**	**6.0**
Total	**49.5**	**62.6**	**13.1**

The 2019 budget includes thoughtful growth to operations in order to accommodate an expanded network and increased regulatory effort required

FTE growth is generally spread across the OneCare teams and reflects minor restructuring and reacting to the needs of the network

The increase in contracted expenses is largely related to the integration of RiseVT into OneCare operations

Reserves

The 2019 budget model results in a $2.8M operating gain

This, combined with the $2.2 M in reserves ordered by end of 2018, will result in $5M of reserves at the end of the year

These reserves are an important asset for OneCare

- Allows for flexibility to help smaller hospitals join and minimize risk
- Provides protection against default risk
- Serves as a cash-flow resource to help transition between plan years or protect against unexpected business timing events
- Must scale proportionately with Network growth

These reserves should be considered alongside the reserves required by Medicare and any other risk protections when evaluating appropriate reserve amount

Network's Commitment to Accountable Care

Network Commitment

OneCare is a network of providers coming together to further the components of the Triple Aim

Achieving the Triple Aim goals takes both clinical reforms and financial payment reforms that are coordinated, align incentives, and are applicable across a health system

Furthering this objective requires two critical commitments: acceptance of downside risk and funding to operationalize OneCare programs.

- Accepting downside risk reverses the overall spending incentive: a healthier population that needs fewer acute services will result in financial benefit to the network
- To improve overall population health takes investment in initiatives that target opportunities to prevent or better manage conditions that drive healthcare spending

The OneCare model asks the hospitals to take on these financial commitments on behalf of their HSA

Risk Overview

Taking financial accountability for the attributed population requires downside risk for the ACO. In 2019, the delegated risk model continues with the hospitals bearing the risk (or receiving the reward) for the lives attributed to their HSA.

Each hospital will again be supplied with a Maximum Risk Limit (MRL) that applies the program risk corridor/sharing terms to the spend for their local attributed lives.

Final decisions on risk/reward specifics are determined through either negotiation with the payer/third party, or a selection within certain criteria and must be approved by the OneCare Board of Managers – all figures subject to change.

Program	Gross Risk/ Reward Corridor	Sharing Rate Within Corridor	Effective Risk/ Reward Corridor
Medicare	5%	100%	5%
Medicaid	4%	100%	4%
BCBS QHP	6%	50%	3%
Self-Funded*	6%	30%	1.8%

* Best current estimate – still in negotiations

Hospital Risk

HSA / Hospital	Medicare	Medicaid	BCBSVT QHP	Total
Bennington / SVMC	$3,207,210	$617,582	$447,389	$4,272,180
Berlin / CVMC	$2,675,188	$580,193	$438,350	$3,693,731
Brattleboro / BMH	$1,221,777	$318,183	$120,235	$1,660,196
Burlington / UVMMC	$8,794,030	$2,085,398	$1,497,348	$12,376,776
Lebanon / DH	$0	$242,223	$244,954	$487,176
Middlebury / Porter	$1,898,569	$499,080	$266,110	$2,663,760
Morrisville / Copley	$0	$0	$0	$0
Newport / NCH	$0	$452,664	$0	$452,664
Randolph / Gifford	$0	$362,194	$0	$362,194
Rutland / RH	$0	$706,548	$0	$706,548
Springfield / Springfield	$2,422,080	$326,207	$243,927	$2,992,214
St. Albans / NMC	$1,879,252	$848,832	$245,421	$2,973,505
St. Johnsbury / NVRH	$0	$560,735	$0	$560,735
Townshend / Grace Cottage	$0	$0	$0	$0
Windsor / Mt. Ascutney	$1,267,514	$133,260	$239,809	$1,640,583
Total Risk/Reward	**$23,365,621**	**$7,733,097**	**$3,743,543**	**$34,842,262**

These risk estimates reflect the amount of upside or downside for each hospital

The OneCare risk model dictates the way in which any risk owed/due outside of the MRLs is treated. This includes the possibility of third party risk protection, cross HSA pooling or OneCare reserves being applied.

Hospital Participation Costs

Hospital	Gross Deduction	Exp. PHM Receipts	Net Cost	Breakdown of Net Cost: Community Investment	Breakdown of Net Cost: Contribution to Reserves	Breakdown of Net Cost: Contribution to OCV Operations
SVMC	$2,620,824	$1,339,696	$1,281,128	$349,949	$244,749	$686,430
CVMC	$3,802,970	$2,375,250	$1,427,720	$389,992	$272,754	$764,974
BMH	$1,371,953	$786,263	$585,691	$159,985	$111,891	$313,814
UVMMC	$12,493,314	$4,677,840	$7,815,474	$2,134,851	$1,493,083	$4,187,539
DHMC	$710,262	$316,008	$394,254	$107,693	$75,319	$211,242
Porter	$1,528,005	$1,112,428	$415,577	$113,518	$79,393	$222,667
Copley	$0	$0	$0	$0	$0	$0
NCH	$891,519	$702,518	$189,000	$51,627	$36,107	$101,266
Gifford	$333,051	$190,804	$142,247	$38,856	$27,175	$76,216
RH	$835,638	$129,090	$706,548	$192,999	$134,980	$378,569
Springfield	$561,012	$129,999	$431,013	$117,734	$82,342	$230,937
NMC	$1,852,950	$1,044,425	$808,524	$220,854	$154,462	$433,208
NVRH	$676,618	$488,231	$188,387	$51,459	$35,990	$100,938
Grace Cottage	$0	$0	$0	$0	$0	$0
MT.A	$939,165	$668,263	$270,902	$73,999	$51,754	$145,150
Total	**$28,617,281**	**$13,960,814**	**$14,656,467**	**$4,003,516**	**$2,800,000**	**$7,852,951**

- The 2019 budget model still relies on hospital funding
- These dues are collected either through fixed payment deductions when applicable, or via separate quarterly invoice

Quality & Outcomes

2019 Anticipated Quality Measures

Measure	Medicare	Medicaid	BCBS QHP	UVMMC SF	Data Source
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	X	X	X	X	Claims
30 Day Follow-Up after Discharge from the ED for Mental Health	X	X	X	X	Claims
Adolescent Well-Care Visit		X	X	X	Claims
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	X	X			Claims
Developmental Screening in the First Three Years of Life		X	X	X	Claims
Initiation of Alcohol and Other Drug Dependence Treatment	X	X			Claims
Engagement of Alcohol and Other Drug Dependence Treatment	X	X			Claims
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite)			X	X	Claims
ACO All-Cause Readmissions (using most recent HEDIS Methodology)	X		X	X	Claims
Follow-Up After Hospitalization for Mental Illness (7-Day Rate)		X	X	X	Claims
Influenza Immunization	X				Clinical
Colorectal Cancer Screening	X				Clinical
Tobacco Use Assessment and Cessation Intervention	X	X			Clinical
Screening for Clinical Depression and Follow-Up Plan	X	X	X	X	Clinical
Diabetes HbA1c Poor Control (>9.0%)	X	X	X		Clinical
Hypertension: Controlling High Blood Pressure	X	X	X	X	Clinical
CAHPS Patient Experience Survey	X	X	X		Survey

2017 Quality Measure Performance

85% Vermont Medicaid Next Generation (pilot in 4 HSAs)

- First year of the two-sided risk based program
- New quality measure set
- Plan to reinvest in quality through local Community Collaboratives/Accountable Communities for Health

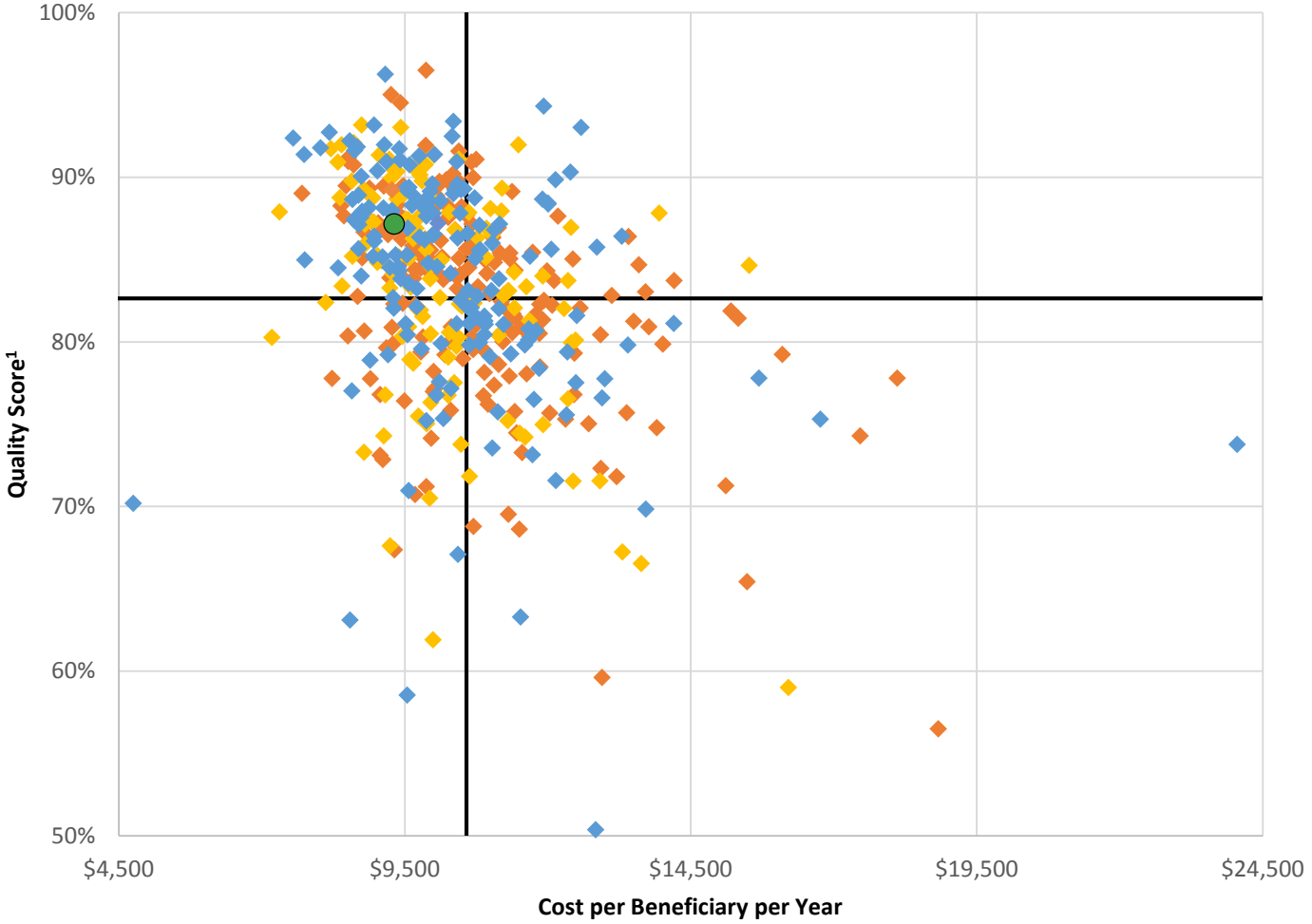
73% BCBS Qualified Health Plan (Shared Savings Program)

- Improved in 2 measures; remained steady for 3 measures; declined in 3 measures

88% Medicare Shared Savings Program

- 6 quality measures changed from reporting to payment

MSSP ACO Cost vs. Quality 2017 Results



- ACOs receiving shared savings distribution
- ACOs beat target but did not earn shared savings
- ACOs that did not beat target
- OneCare Vermont (did not beat target)

ACOs receiving shared savings distributions	159
ACOs beat target but did not earn shared savings	125
ACOs that did not beat target	188
TOTAL	**472**

211 ACOs were above OCV's cost per beneficiary and beat their targets or generated Shared Savings

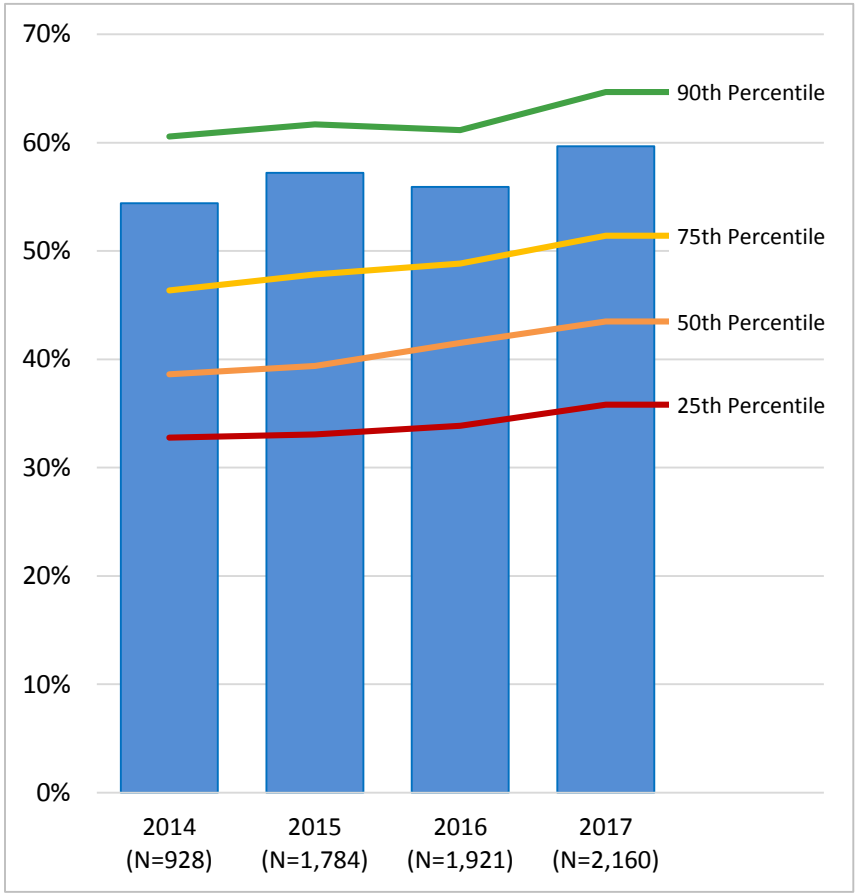
Footnotes

[1] This figure is calculated internally as if all measures were performance scored rather than any pay-for-reporting; this calculation will more closely match the CMS-Calculated figure over time as CMS decreases the pay-for-reporting component (score does not include quality improvement points).

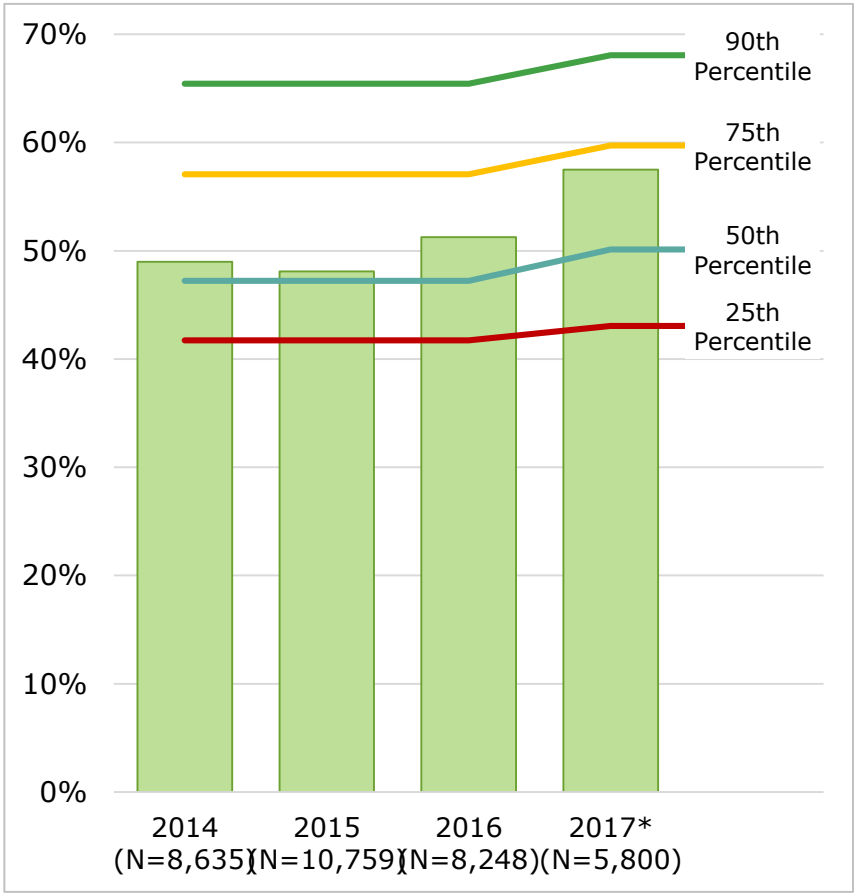
[2] Genesis Healthcare ACO, LLC; SEMAC; Accountable Care Coalition of Western Georgia, LLC; AmpliPHY of Texas ACO LLC; Sandhills Accountable Care Alliance, LLC; and KCMPA-ACO, LLC are not shown on the graph due to outlier status in cost or quality.

Adolescent Well-Care Visits

BCBS QHP



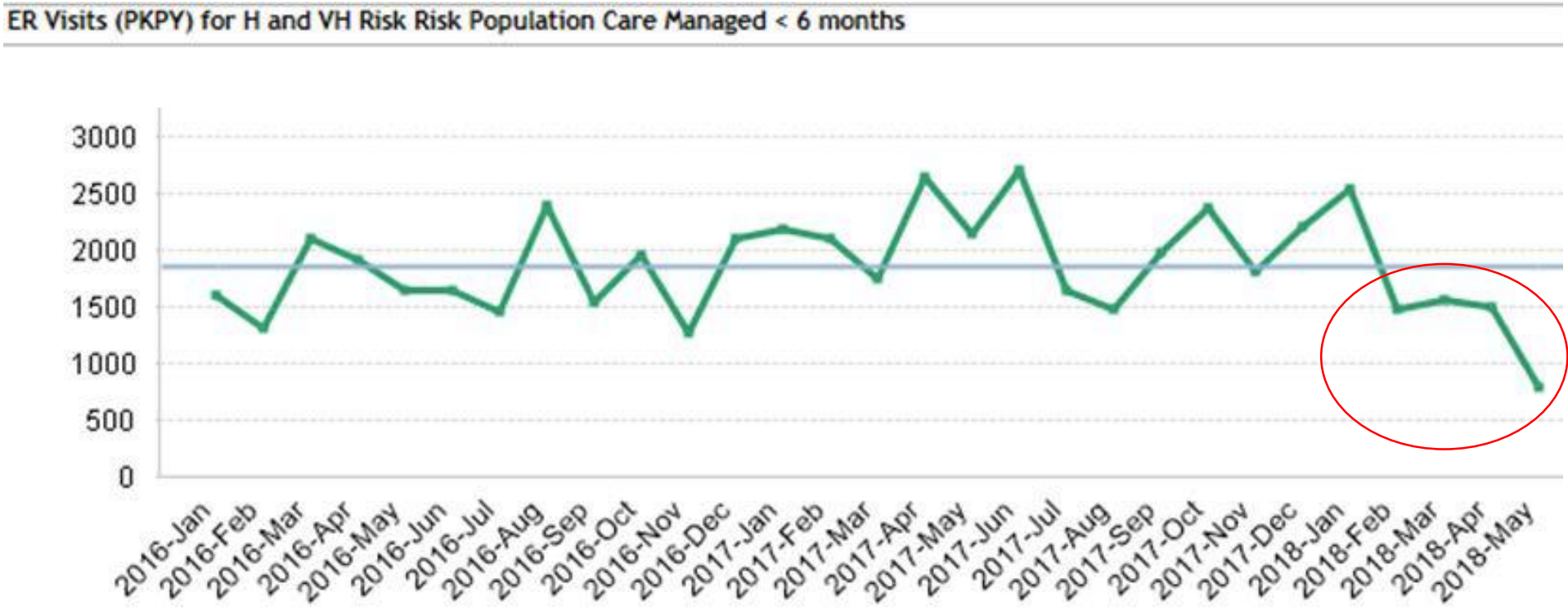
Medicaid



* 2017 only represents the 4 communities participating in the VMNG program.

Care Coordination Progress

There is a noticeable decrease in ER visits among high/very high risk patients across payers engaged in care coordination for <6 months



Patient Benefit Enhancements *Waivers*

Three-Day Skilled Nursing Facility *Waiver*

Waives the requirement of a 3-day inpatient and/or previous SNF stay prior to a SNF admission. SNF must have 3 star minimum rating to be eligible.

Status:

- Currently 11 eligible SNFs
- Middlebury Pilot → 18 patients utilized waiver since May 1st; expanding access to admit directly from ED
- Brattleboro → First patient admitted
- Berlin, St. Albans, Rutland → completed training and ready to admit patients
- Newport, Springfield, St. Johnsbury → scheduled trainings

Post-Acute Home Discharge *Waiver*

Allows for a physician to contract with, and bill for, a licensed clinician to provide up to nine patient home visits post-acute discharge with "general supervision" by the patient's physician.

Status:

- Clinical criteria for eligibility for visits determined for pilot project
- Finalizing legal requirements
- Preparing to pilot between UVMHN HHH and UVMMC Colchester Family Practice

Telehealth *Waiver*

Eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and allows use of asynchronous telehealth services for dermatology and ophthalmology.

Status:

- Pilot project launched in September with SASH/Cathedral Square/ UVMMC Adult Primary Care – Essex
- Connects 90 eligible SASH residents to primary care via video visits
- Open to all ACO participants through completion of a Telehealth OneCare Attestation

Population Health Management Platform

Attributed Beneficiary/ Claims Feeds

Blueprint Clinical Registry Data

HIE Clinical Data Feeds Direct EMR Feeds

ADT Feeds (HIE, PatientPing)

Internal Warehouse & Tools

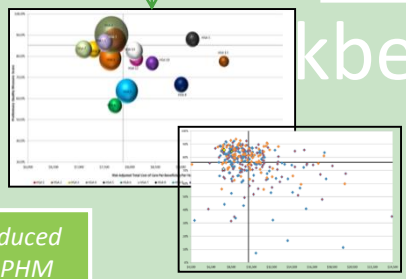
3M · acg · SAS · Microsoft SQL Server · Qlik

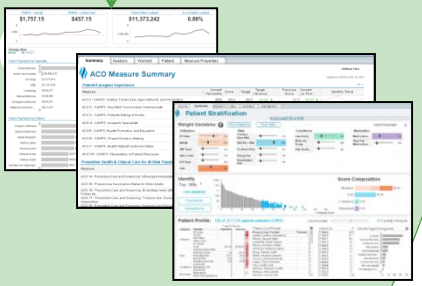
HealthCatalyst ignite change

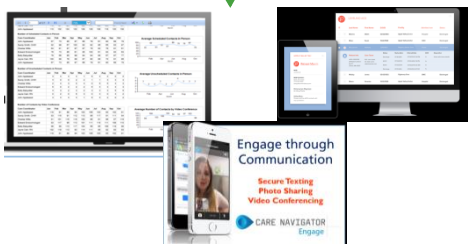
2-way data flow

CARE NAVIGATOR An Intraprise Health Business

Maintained by Data Architect team







Produced by PHM Analytics team

Deep Dive Analytics
Financial Modeling
Predictive Modeling
Outcomes Analysis
QI Project Support

Population-level Dashboards
Self-Service Analytics
Quality Measure Scorecards

Care Coordination Population Dashboards
Risk Stratification for Focused Population Reviews
Integrated Patient Records
Shared Care Plans
Transition of Care Support
Real-time Event Notification

Regulatory Reporting

CMS · VERMONT · DHVA · GMCB · BlueCross BlueShield

Board of Managers
Population Health Strategy Committee
Clinical & Quality Advisory Committee
Pediatric and Lab Subcommittees
Patient & Family Centered Care Committee

Facilitated by Clinical and Network Ops teams

Community Collaboratives

Providers

Care Coordinators

Thoughts on Ensuring Success in 2020+

- Focus on affordability using the All Payer Model targeted growth rate as "True North"
  - Understand ACO-attributed population as subset
  - Set appropriate expectations for success as delivering under the APM growth rate while improving the health system
- Alignment of regulatory oversight levers
  - Collaboratively understand the direct and indirect relationships among Insurance Rate Review, Hospital Budgets, and ACO Regulation
- Committed, flexible and responsive payer partners
  - Continued Government program innovation and ACO support
  - Commercial payer partners willing to work with OneCare on ACO support, common models and incentives, and inclusion of self-funded populations
- For hospitals, appropriate incentives to participate/continue in APM
  - Recognition of hospital-contributed transformation investments
  - Addressing need to move hospitals to participation in all risk programs to approach scale targets overall and for Medicare
  - As scale increases, addressing need for more substantial reserves at hospitals and/or OneCare (hospital maximum risk close to saturation point under existing approaches)

Questions

Supplemental Slides

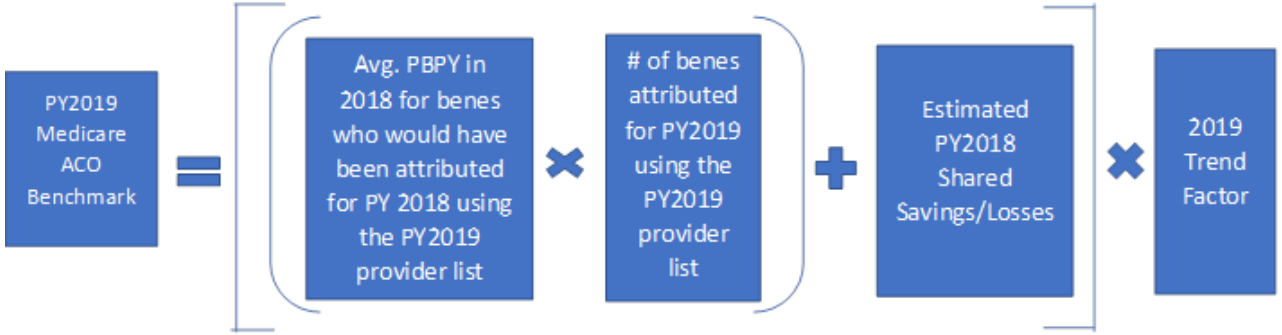
Medicare TCOC

Medicare economics are largely determined by the Vermont All-Payer Model agreement with specific components subject to approval by the Green Mountain Care Board (GMCB)

Target set based upon 2018 FFS-equivalent spend for the assumed 2019 network and trended forward using the national Medicare Advantage United States Per Capita Cost (USPCC) rate of increase as determined by CMS and subject to GMCB approval

- The CMS projections resulted in a 4.0% blended trend rate
- After applying the 0.2% discount per the Vermont All-Payer Model, we are **seeking approval for a 3.8% trend rate** on the Medicare spend

The 2019 target will also include any shared savings earned in 2018 trended forward at the same approved rate. This is the means by which the target stays connected to the base year of the All Payer Model.



Medicare Spending Estimates

HSA	2018 Base Spend PMPM	Inflated Spend PMPM	Est. Member Months	Est. Total Spending
Bennington	$910.82	$933.59	67,045	$62,592,538
Berlin	$812.25	$832.56	61,309	$51,043,152
Brattleboro	$767.79	$786.99	29,593	$23,289,447
Burlington	$792.22	$812.02	206,701	$167,845,599
Lebanon	*$0.00*	*$0.00*	*0*	*$0*
Middlebury	$743.62	$762.21	47,546	$36,239,560
Morrisville	*$803.36*	*$823.45*	*0*	*$0*
Newport	*$1,058.64*	*$1,085.11*	*0*	*$0*
Randolph	*$863.90*	*$885.50*	*0*	*$0*
Rutland	*$1,007.96*	*$1,033.16*	*0*	*$0*
Springfield	$870.17	$891.93	51,881	$46,274,314
St. Albans	$779.57	$799.06	45,254	$36,160,160
St. Johnsbury	*$779.96*	*$799.46*	*0*	*$0*
Townshend	*$1,014.89*	*$1,040.26*	*0*	*$0*
Windsor	$1,029.11	$1,054.84	23,451	$24,737,058
Total			**532,779**	**$448,181,827**

Data are gathered from a mix current year participation data feeds, past data from participation in OneCare shared savings programs, data procured by CHAC, and in some cases estimates.

Once the 2019 program year begins, OneCare will receive historical data for the attributed lives and these data will be used to reset each HSA target.

Medicaid Spending Estimates

HSA	Base Spend PMPM	Inflated Spend PMPM	Est. Member Months	Est. Total Spending
Bennington	$236.10	$237.28	65,068	$15,439,543
Berlin	$223.41	$224.53	64,602	$14,504,814
Brattleboro	$206.37	$207.40	38,354	$7,954,575
Burlington	$241.83	$243.04	214,514	$52,134,938
Lebanon	$241.33	$242.54	24,968	$6,055,567
Middlebury	$241.25	$242.46	51,460	$12,477,008
Morrisville	*$236.04*	*$237.22*	*0*	*$0*
Newport	$254.24	$255.51	44,290	$11,316,591
Randolph	$282.19	$283.60	31,929	$9,054,839
Rutland	$310.24	$311.79	56,652	$17,663,706
Springfield	$305.49	$307.02	26,562	$8,155,173
St. Albans	$264.59	$265.91	79,804	$21,220,790
St. Johnsbury	$239.52	$240.72	58,235	$14,018,378
Townshend	*$207.47*	*$208.51*	*0*	*$0*
Windsor	$166.93	$167.77	19,858	$3,331,509
Total			**776,295**	**$193,327,432**

Data are gathered from a mix current year participation data feeds and a modeling dataset provided by DVHA. Editorial note: having historical data for HSAs that have been participating for multiple years makes the modeling much more stable.

Once the 2019 program year begins, OneCare will receive historical data for the attributed lives and these data will be used to reset each HSA target.

BCBSVT QHP Spending Estimates

HSA	Base Spend PMPM	Inflated Spend PMPM	Est. Member Months	Est. Total Spending
Bennington	$543.85	$573.49	26,004	$14,912,956
Berlin	$375.05	$395.49	36,945	$14,611,673
Brattleboro	$333.87	$352.06	11,384	$4,007,849
Burlington	$469.39	$494.97	100,837	$49,911,600
Lebanon	$561.84	$592.46	13,782	$8,165,121
Middlebury	$365.91	$385.85	22,989	$8,870,339
Morrisville	*$417.36*	*$440.11*	*0*	*$0*
Newport	*$590.70*	*$622.90*	*0*	*$0*
Randolph	*$634.98*	*$669.58*	*0*	*$0*
Rutland	*$433.90*	*$457.55*	*0*	*$0*
Springfield	$462.27	$487.46	16,680	$8,130,913
St. Albans	$434.76	$458.45	17,844	$8,180,698
St. Johnsbury	$506.04	$533.61	0	$0
Townshend	*$465.43*	*$490.79*	*0*	*$0*
Windsor	$490.40	$517.12	15,458	$7,993,630
Total			**261,923**	**$124,784,779**

Data are gathered from a mix current year participation data feeds and a modeling dataset provided by BCBSVT. Editorial note: having historical data for HSAs that have been participating for multiple years makes the modeling much more stable.

Once the 2019 program year begins, OneCare will receive historical data for the attributed lives and these data will be used to reset each HSA target.

Self-Funded Spending Estimates

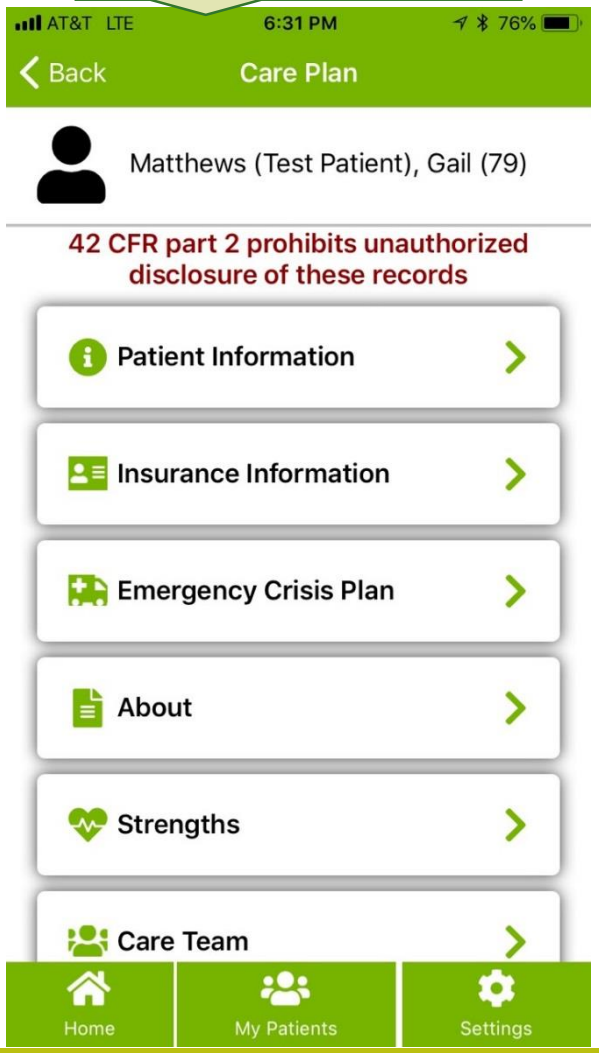
HSA	Base Spend PMPM	Inflated Spend PMPM	Est. Member Months	Est. Total Spending
Bennington	TBD	TBD	TBD	TBD
Berlin	TBD	TBD	TBD	TBD
Brattleboro	TBD	TBD	TBD	TBD
Burlington	TBD	TBD	TBD	TBD
Lebanon	TBD	TBD	TBD	TBD
Middlebury	TBD	TBD	TBD	TBD
Morrisville	TBD	TBD	TBD	TBD
Newport	TBD	TBD	TBD	TBD
Randolph	TBD	TBD	TBD	TBD
Rutland	TBD	TBD	TBD	TBD
Springfield	TBD	TBD	TBD	TBD
St. Albans	TBD	TBD	TBD	TBD
St. Johnsbury	TBD	TBD	TBD	TBD
Townshend	TBD	TBD	TBD	TBD
Windsor	TBD	TBD	TBD	TBD
Total			**161,889**	**$65,289,304**

In regard to spend, only high-level data are available at this time. So that the OneCare budget contains self-funded components, both a target estimate and spending estimate are included in aggregate.

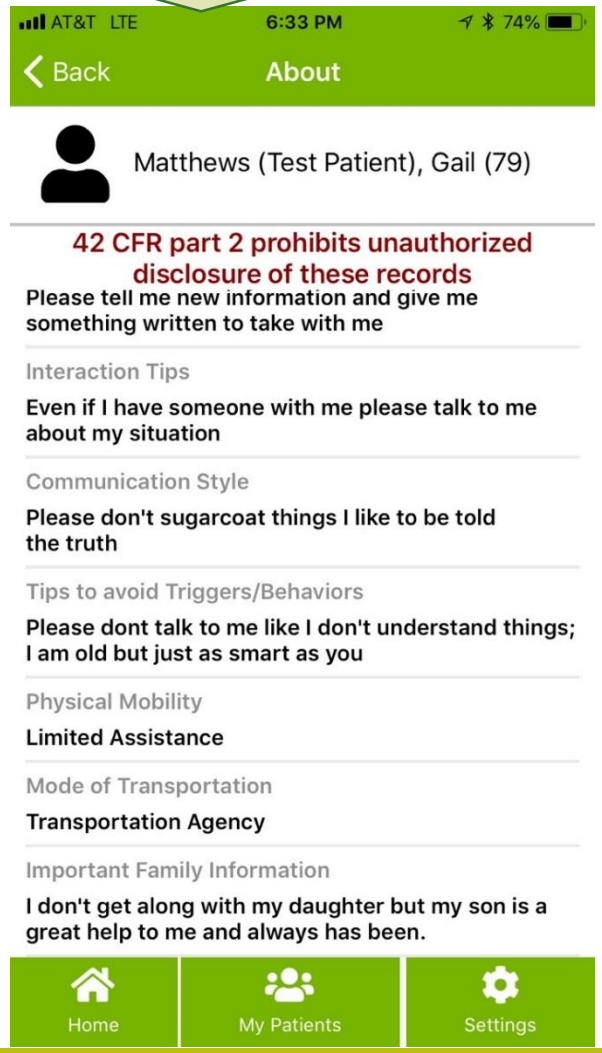
It is assumed that the agreed target will equal the actuarial spend projection in the budget.

Care Navigator Mobile Application

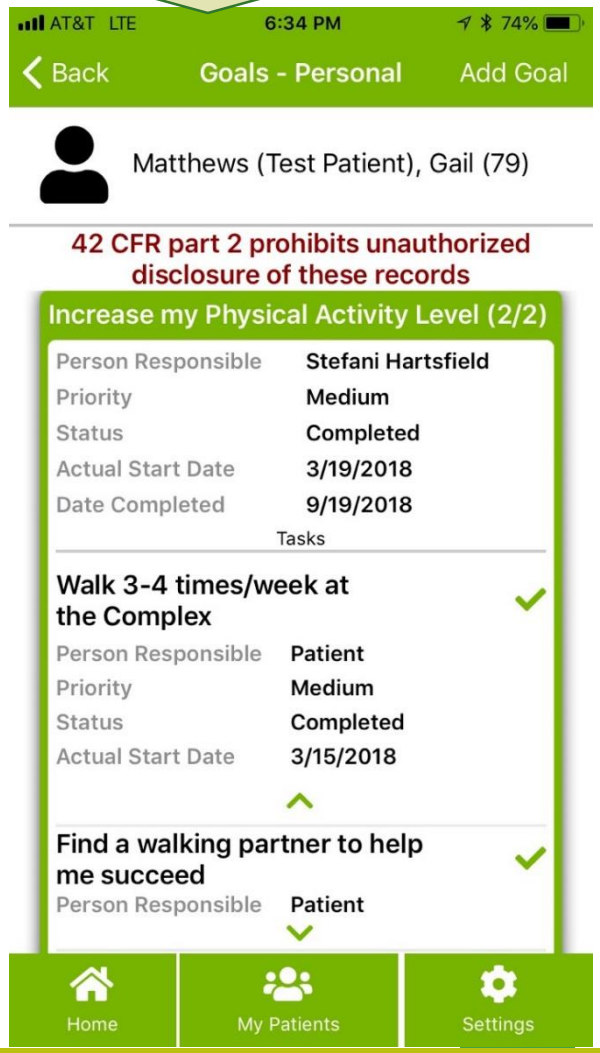
Care Plan Sections



About Me

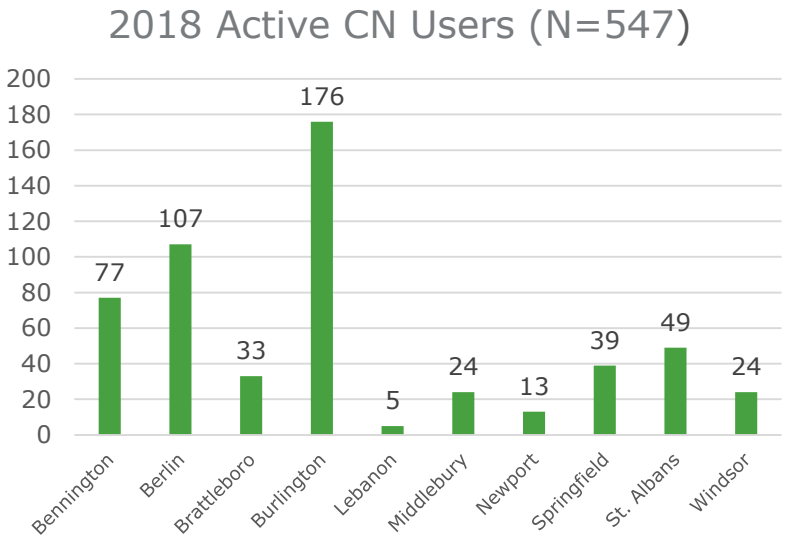


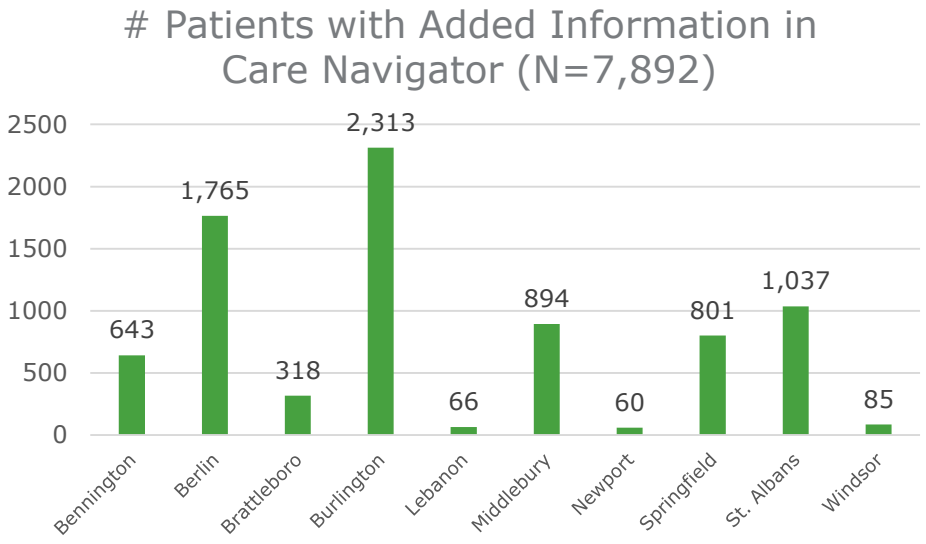
Personal Goals



Care Navigator & Patient Engagement

- OneCare has hosted 31 unique Care Navigator trainings in 2018
- There are 17,541 individuals identified as high or very high risk using the Johns Hopkins ACG algorithm, of those:
  - 7,982 individuals (46%) have added information entered into Care Navigator by care team members
  - 3,303 individuals, regardless of care coordination level, have a lead care coordinator identified
  - As of September, 936 have a shared care plan initiated (range 1-479 per HSA)





Care Coordination Training

- Strategies:
  - Trains all levels of care coordination workforce, regardless of ACO participation
  - Provides clear, conceptual framework focused on practical applications
  - Promotes professional development and team building

- Training Workshops:
  - Core Skills - focused on core skills for effective care coordination (e.g. Share Care Plans, Ecomaps)
  - Care Conferences – guidance on how to successfully facilitate a person-centered care conference
  - Leader and Staff Teams Training - enhance knowledge base and build workflows within the organization
  - Senior Leader Training - engage in cross-community and cross-organizational networking, information sharing and learning
  - Putting Care Coordination Tools into Practice - advancing skills knowledge and practice by developing multidisciplinary workflows, patient engagement strategies and integrating Care Navigator into daily work