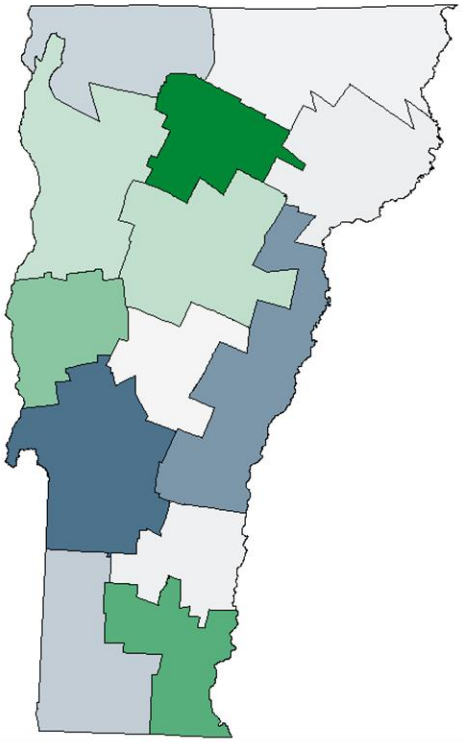

2018 ACO Quality and Financial Results by Payer

Alena Berube, Michele Degree; GMCB
Cory Gustafson, Alicia Cooper; DVHA
Kelly Lange; BCBSVT
Sara Barry; OneCare

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Agenda

1. Overview
2. 2018 Results
    a) Medicare
    b) Medicaid
    c) Commercial (BCBSVT)
3. Board Questions
4. Public Comment

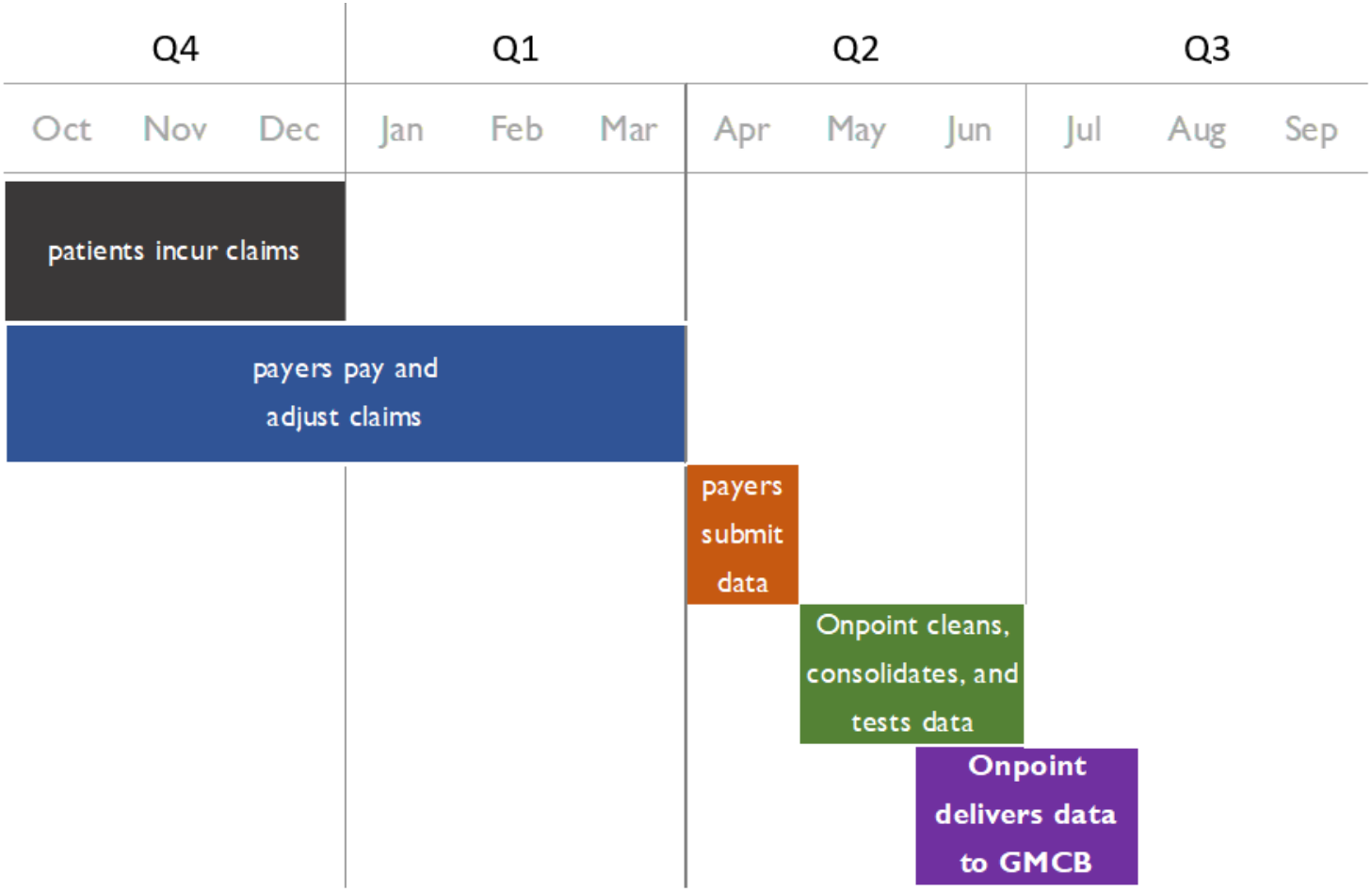
Overview

Overview: Measuring Performance

How do we measure performance of the APM and Vermont's ACO?

- ACO contractual performance of payers vs. APM agreement performance
- Finance/quality outcomes available on an annual basis
- Trend analysis not available until there is comparable data at two points in time
    - *Two points in time*:
        - Quality performance - 2018 is the first year of the agreement, 2019 data are not final until 2020
        - Financial performance – 2017 is the reference population; however, 2018 is the first year of the agreement
    - *Comparability*: Extent to which data are comparable depend on stability of…
        - Measures
        - Populations
- Another early indicator of ACO performance is the reallocation of resources

Overview: Data Timing



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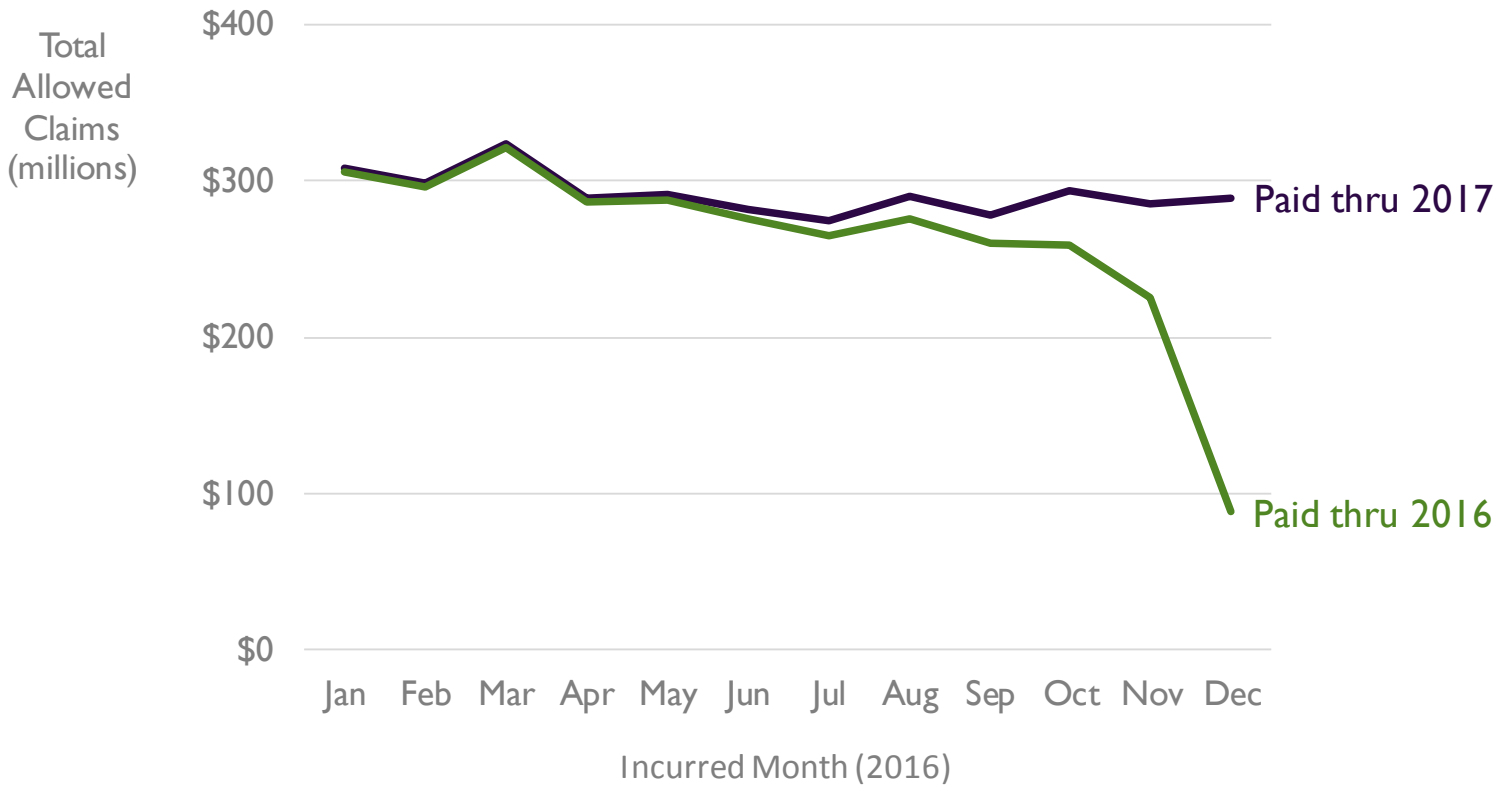
Overview: Data Timing



Source: VHCURES
Allowed amounts are for primary payments from commercial, Medicaid, Medicare

Overview: Payer Program Comparisons

While working toward payer alignment is a primary objective, not all payer programs are equivalent in terms of fiscal and quality requirements:

1. Medicare
2. Medicaid
3. Commercial

Overview: Payer Program Comparison 2018 Fiscal Components

Payer Program	Risk Arrangement	Corridor	FPP	FPP Recon	Attribution
Medicare ACO Initiative	2-side, 5% risk corridor, 80% share (100% also an option), truncation for outliers (top 1%)	95% - 105%	Yes	Yes	NextGen Methodology
Medicaid NextGen ACO	2-side, 3% risk corridor, 100% share, no truncation for outliers	97% - 103%	Yes	No	NextGen Methodology BUT PCP only & larger set of claims than Medicare based on Blueprint & DVHA's 2016 Medicaid Shared Savings E&M codes
BCBS QHP	2-side, 6% risk corridor, 50% share, no truncation for outliers	94% - 106%	No	NA	PCP only

Overview: Payer Program Comparison
2018 Quality Metrics

Similarities can be seen in the quality framework for the Medicaid and the BCBCVT models. Primarily due to the VMNG 2017 experience and ability to closely align quality metrics with those the State is responsible for through the Agreement.

Differences across payers are primarily seen in the Medicare quality measure set.

Measure	Vermont All-Payer ACO Model	2018 Vermont Medicaid Next Gen	2018 Medicare Next Gen	2018 BCBSVT Next Gen
% of Medicaid adolescents with well-care visits	X	X		X
Initiation of alcohol and other drug dependence treatment	X	X		X*
Engagement of alcohol and other drug dependence treatment	X	X		
30-day follow-up after discharge from emergency department for mental health	X	X		X
30-day follow-up after discharge from emergency department for alcohol or other drug dependence	X	X		X
Screening for clinical depression and follow-up plan (ACO-18)	X	X	X	X
Tobacco use assessment and cessation intervention (ACO-17)	X	X	X	
Hypertension: Controlling high blood pressure		X		X
Diabetes Mellitus: HbA1c poor control	X**	X	X	X
All-Cause unplanned admissions for patients with multiple chronic conditions		X		
Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys***	X	X	X	X
All-cause readmissions (HEDIS measure for commercial plans)				X
Risk-standardized, all-condition readmission (ACO-8)			X	
Skilled nursing facility 30-day all-cause readmission (ACO-35)			X	
All-cause unplanned admissions for patients with Diabetes (ACO-36)			X	
All-cause unplanned admissions for patients with Heart Failure (ACO-37)			X	
Falls: Screening for future fall risk (ACO-13)			X	
Influenza immunization (ACO-14)			X	
Pneumonia vaccination status for older adults (ACO-15)			X	
Body mass index screening and follow-up (ACO-16)			X	
Colorectal cancer screening (ACO-19)			X	
Breast cancer screening (ACO-20)			X	
Statin therapy for prevention and treatment of Cardiovascular Disease (ACO-42)			X	
Depression remission at 12 months (ACO-40)			X	
Diabetes: Eye exam (ACO-41)			X	
Ischemic Vascular Disease: Use of aspirin or another antithrombotic (ACO-30)			X	
Developmental screening in the first 3 years of life		X		X
Follow-up after hospitalization for mental Illness (7-Day Rate)		X		X
Timeliness of prenatal care				
Acute ambulatory care-sensitive condition composite			X	
Medication reconciliation post-discharge (ACO-12)			X	
Use of imaging studies for low back pain (ACO-44)			X	

*BCBSVT Next Gen treats these measures as a single composite measure; All-Payer ACO Model and Vermont Medicaid Next Gen treat them as two separate measures.

**All-Payer ACO Model and Medicare Next Gen treat these measures as a single composite. Medicaid Next Gen and BCBSVT Next Gen treat them as separate measures.

***Surveys vary by program. All-Payer ACO Model includes ACO CAHPS Survey composite of Timely Care, Appointments, and Information for ACO-attributed Medicare beneficiaries. Vermont Medicaid Next Gen includes multiple CAHPS PCMH composites for ACO-attributed Medicaid beneficiaries. Medicare Next Gen includes multiple ACO CAHPS composites for ACO-attributed Medicare beneficiaries. BCBSVT Next Gen includes care coordination composite and tobacco cessation question from CAHPS PCMH for ACO-attributed BCBSVT members.

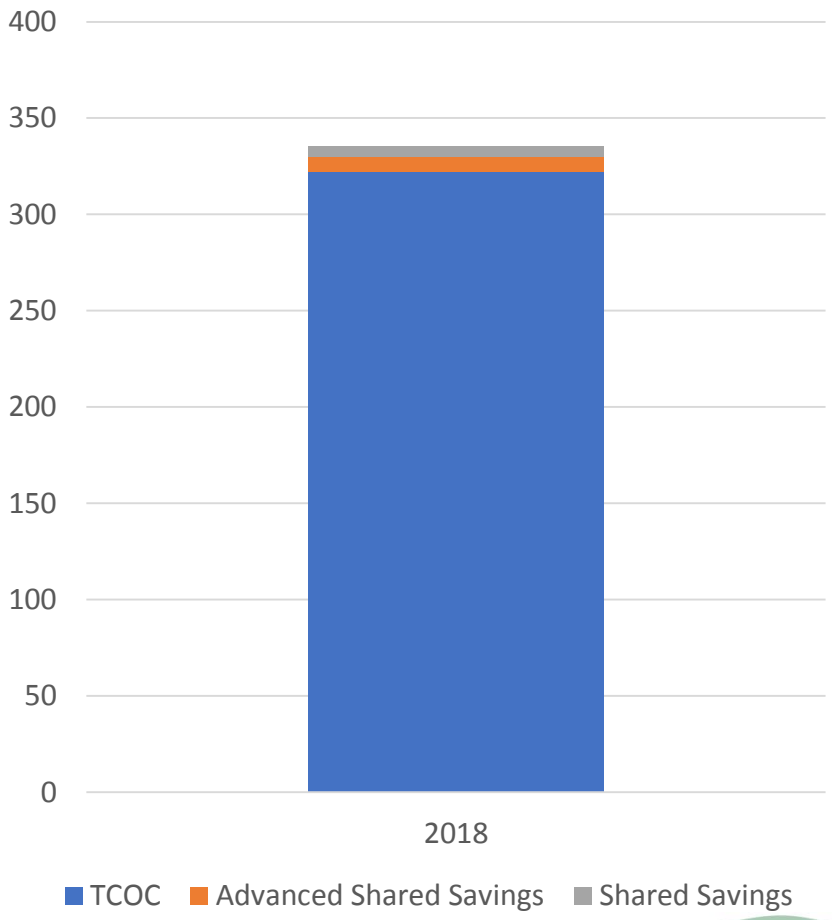
Today's Results Presentation...

- ACO-Payer performance in 2018 based on contractual obligations.

- Today is **not** an evaluation of the All-Payer Model.
  - GMCB annual reports on finance and quality
  - External evaluator hired by CMMI

Medicare

Medicare: Financial Results



In 2018, OneCare Vermont Accountable Care Organization, LLC earned ***$5.6 million in shared savings*** *and received an additional $7.7 million in money designated for population health investments through its Vermont Modified Next Generation ACO participation agreement as part of the Vermont All-Payer ACO Model with Centers for Medicare and Medicaid Services (CMS). The All-Payer Model Agreement earmarked approximately* ***$7.7 million to continue Vermont's Blueprint for Health program and support the Support And Services at Home*** *(SASH) and* ***Community Health Team*** *(CHT) programs in 2018. Though it received a large portion of those earmarked funds up front, OneCare remained responsible for that money as part of the risk it assumed under its agreement with CMS. OneCare will distribute the remaining $5.6 million of shared savings to its network using a previously outlined methodology.*

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Medicare: Quality Results

Background: Quality measurement alignment was done prior to the start of the 2019 performance year. Per Agreement language; Measures for 2019 will be different from 2018 in an effort to better align with other ACO-payer programs in operation.

As outlined in the Vermont All-Payer ACO Model Agreement, CMS and the State of Vermont are expected to identify a quality strategy for the Vermont Medicare ACO Initiative for Performance Years 2-5, beginning in January 2019. The specific language in the Agreement states that:

> *CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019, and its performance period will align with Performance Years 2 through 5 of this Agreement. CMS shall require Vermont ACOs participating in the Initiative (VMA ACOs) to accept beneficiary alignment methodology, ACO quality measures, payment mechanisms, and risk arrangements for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the ACO. The GMCB may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-Insured Plans. CMS may accept such proposals at its sole discretion.*[1]

[1] Vermont All-Payer Accountable Care Organization Model Agreement, section 8.

Medicare: 2018 Quality Results

		Measure	PY 2018	Scoring Based on Benchmarks from Reporting Year							2018 Rates	Num	Den	Quality Points
				30th	40th	50th	60th	70th	80th	90th				
				1.10	*1.25*	*1.40*	*1.55*	*1.70*	*1.85*	*2.00*				
Patient Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	84.62	—	269	2.00
	2	How Well Your Providers Communicate	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	93.59	—	309	2.00
	3	Patient's Rating of Provider	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	92.14	—	304	2.00
	4	Access to Specialists	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	73.55	—	191	2.00
	5	Health Promotion and Education	R	54.18	55.48	56.72	**57.95**	59.39	60.99	63.44	59.05	—	334	2.00
	6	Shared Decision Making	R	54.75	**55.97**	57.05	58.10	59.27	60.58	62.76	56.95	—	297	2.00
	7	Health Status/Functional Status	R	-	-	-	-	-	-	-	76.93	—	340	2.00
	34	Stewardship of Patient Resources	R	24.25	25.57	26.74	28.12	29.43	31.08	33.43	23.80	—	307	2.00
Care Coordination Patient Safety	8	Risk Standardized, All Condition Readmissions	R	15.18	15.04	14.91	14.79	**14.65**	14.50	14.27	14.62	—	—	2.00
	35	Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM)	R	19.22	18.81	18.47	18.15	**17.80**	17.41	16.85	17.54	—	—	2.00
	36	All-Cause Unplanned Admissions for Patients with Diabetes	R	39.00	35.81	33.20	30.86	28.48	26.05	23.12	40.75	—	—	2.00
	37	All-Cause Unplanned Admissions for Patients with Heart Failure	R	**82.32**	76.20	71.24	66.71	61.91	57.13	50.99	79.91	—	—	2.00
	38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	R	**65.99**	61.21	57.25	53.51	50.00	46.16	41.39	63.84	—	—	2.00
	43	Ambulatory Sensitive Condition Acute Composite (AHRQ* Prevention Quality Indicator (PQI #91))	R	-	-	-	-	-	-	-	1.59	—	—	2.00
	12	Medication Reconciliation	R	-	-	-	-	-	-	-	94.48	582	616	2.00
	13	Falls: Screening for Fall Risk	R	43.42	50.42	58.45	66.00	**73.39**	81.79	90.73	79.85	210	263	2.00
	44	Imaging Studies for Low Back Bain	R	-	-	-	-	-	-	-	73.98	—	—	2.00
Preventive Health	14	Preventive Care & Screening: Influenza Immunization	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	70.20	172	245	2.00
	15	Pneumococcal Vaccination Status for Older Adults	R	30.00	40.00	50.00	60.00	70.00	**80.00**	90.00	84.32	500	593	2.00
	16	Preventive Care & Screening: Adult Weight Screening and Follow-Up	R	30.00	40.00	50.00	**60.00**	70.00	80.00	90.00	65.65	193	294	2.00
	17	Tobacco Use Screening and Cessation Intervention	R	-	-	-	-	-	-	-	81.82	18	22	2.00
	18	Depression Screening	R	30.00	40.00	**50.00**	60.00	70.00	80.00	90.00	57.55	141	245	2.00
	19	Colorectal Cancer Screening	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	75.00	186	248	2.00
	20	Mammography Screening	R	30.00	40.00	50.00	60.00	**70.00**	80.00	90.00	72.09	439	609	2.00
	42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	R	-	-	-	-	-	-	-	82.39	468	568	2.00
At-Risk Populations	40	Depression Remission at Twelve Months	R	-	-	-	-	-	-	-	1.33	1	75	2.00
	DM*	ACO #27: Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) **and** ACO #41: Diabetes - Eye Exam	R	29.90	34.33	38.81	43.32	48.21	**53.64**	60.37	58.02	152	262	2.00
	28	Hypertension (HTN): Controlling High Blood Pressure	R	30.00	40.00	50.00	**60.00**	70.00	80.00	90.00	68.12	250	367	2.00
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	30.00	40.00	50.00	60.00	70.00	80.00	**90.00**	96.68	378	391	2.00
													Total:	58.00

*DM = Diabetes Composite

Notes:

- Green and bold indicates the 2018 percentile
- P: Performance Measure and R: Reporting Measure - Medicare awards full points for reporting measures and points for performance measures based upon benchmarks
- CMS did not perform significance testing from prior years to deterime quality improvement points due to this being the first year in the Next Generation ACO Model program.

2018 Final Score
100.00%

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Medicare: 2018 Quality Results

Earned Score: 100%

- 2018 was a reporting-only year, as is standard practice for year 1 of program implementation

Score Based on Benchmarks from Reporting Year: 82.4%

- 29 measures (2pt maximum each = 58pts)
- 9 measures (18pts) with no benchmark or score available
- Total of 40 points available

$$\frac{32.95\ earned\ points}{40\ possible\ points} = 82.4\%$$

Medicare: Quality & Fiscal Considerations

Exogenous Factors:

- Attribution
  - Growing provider network
  - Payer churn
  - Attribution methodology
- Vermont Population Demographics
  - Aging
  - Acuity
- Policy Changes
  - Delivery system changes
  - Changing payment systems/payment reform
  - Waivers

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Vermont Medicaid Next Generation ACO Program: 2018 Performance

Department of Vermont Health Access

November 20, 2019

The VMNG program is reinforced by DVHA's priorities

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01 Value-Based Payments

02 Information Technology Projects

03 Performance

- Medicaid as predictable and reliable payer partner
- A focus on continual, incremental programmatic and performance improvements
- Opportunities to align with other payer programs; opportunities to be an innovative leader

VMNG ACO Contract Term

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- The original contract was a one-year agreement (2017) with four optional one-year extensions.
- DVHA and OneCare triggered one-year extensions for each 2018 and 2019, and are in the process of negotiating a third one-year extension for 2020. The parties will have the option of one additional one-year extension thereafter.
- Rates are renegotiated annually and reconciliation may occur more frequently.

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2018 VMNG PROGRAM PERFORMANCE

2018 Results Report

Result 1: DVHA and OneCare made incremental program improvements

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- DVHA and OneCare continued program operations and identified opportunities for incremental improvement.
  - Expansion of prior authorization waiver to all providers in the Vermont Medicaid network.
  - Further decreasing administrative burden for providers; relying on their clinical expertise when caring for patients.

Result 2: The program continues to grow

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- Additional providers and communities have joined the ACO network to participate in the program for the 2019 and 2020 performance years.
- In 2020, DVHA and OneCare are planning to modify the attribution methodology, which would further increase the number of Vermonters connected to the All-Payer ACO Model.

	2017 Performance Year	2018 Performance Year	2019 Performance Year	2020 Performance Year
Health Service Areas	4	10	13	14
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs			
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000
Attributed Medicaid Members	~29,000	~42,000	~79,000	~86,000 + Geographically Attributed Members

The VMNG has taken an incremental approach to changes in attribution

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2017

- Consistent with the Medicare Next Generation ACO beneficiary alignment methodology.

2018

- Altered the VMNG attribution methodology to consider only primary care specialties as eligible to attribute.

2019

- Further refined the Medicaid definition of attribution-eligible primary care specialties; increased look-back period to 2.5 years; introduced geographic attribution pilot in St. Johnsbury HSA.

2020

- Exploring statewide implementation of the geographic attribution approach.

Result 3: ACO providers and Medicaid shared financial accountability for health care in 2018

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- DVHA and the ACO agreed on the price of health care upfront, and the ACO provided approximately $1.5 million in care above the expected price. Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members paid this amount to DVHA.

DVHA and OneCare set an agreed-upon price for each VMNG contract year

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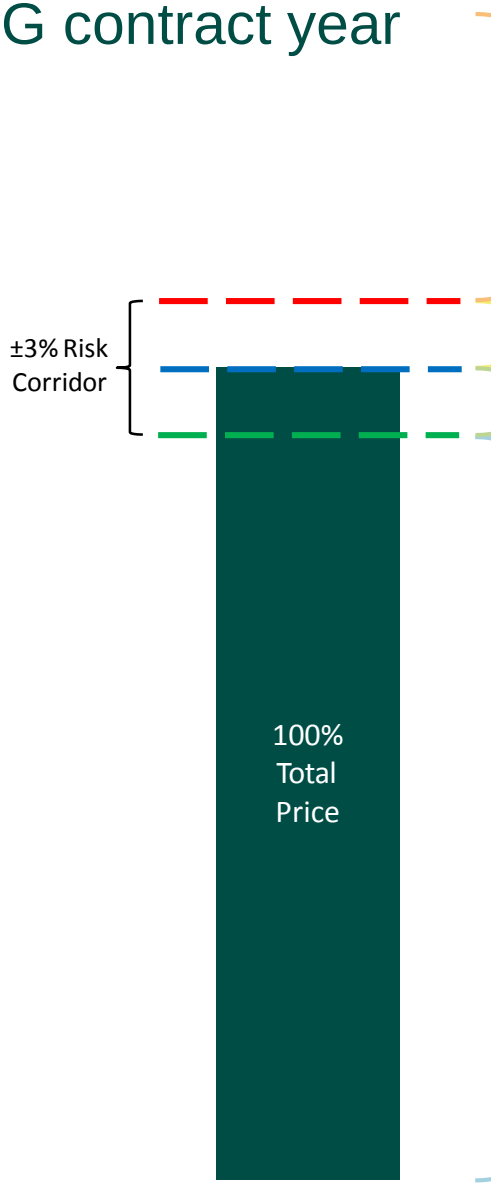


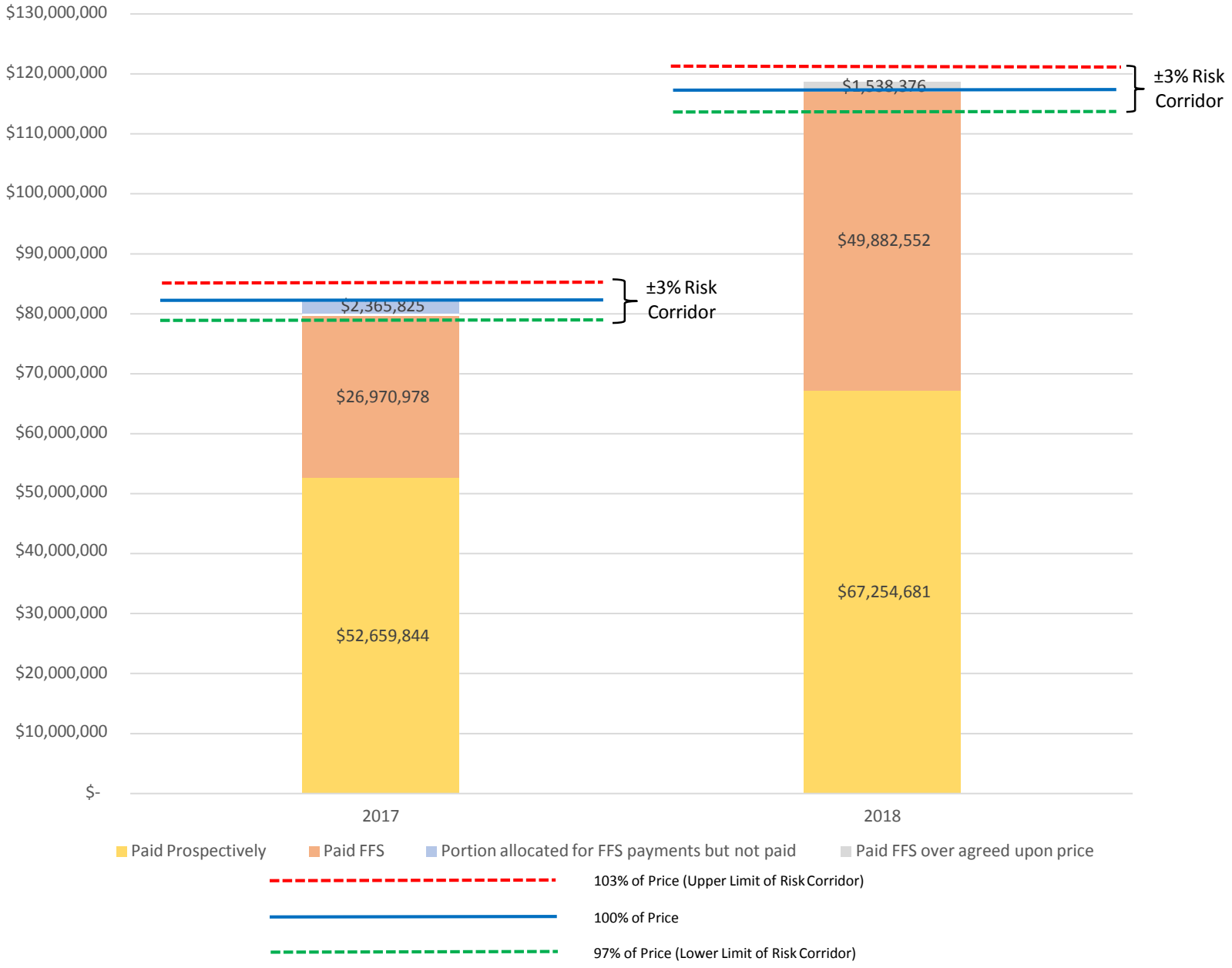
>103%: DVHA bears full accountability for financial performance in excess of the corridor.
This allows providers to change the way they deliver care without facing catastrophic losses.

100%-103%: ACO network bears full accountability for financial performance within the corridor.
This creates incentives to moderate costs and keep them close to the agreed-upon price.

97%-100%: ACO network entitled to retain difference between actual performance and 100%.
This creates an incentive to be efficient with resources within the corridor.

<97%: The difference between actual performance and 97% is returned to DVHA.
This creates an incentive to spend money on care and to invest in providers and the community.

Vermont Medicaid Next Generation ACO Program: 2017 & 2018 Financial Performance



Result 4: The ACO met most of its quality targets

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- The ACO's quality score was 85% on 10 pre-selected measures.
- OneCare's performance exceeded the national 75th percentile on measures relating to developmental screening in the first three years of life and 30-day follow-up after discharge from Emergency Departments for mental health, alcohol, and other drug abuse or dependence.
- Examining quality results over time will be important in order to understand the effect of changing provider payment on quality of care.

Overview of VMNG Quality Performance, 2018

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Measure Description	NQF #	Numerator	Denominator	Rate	Quality Compass 2018 Benchmarks (CY 2017) National Medicaid Percentiles				Points awarded
					25th	50th	75th	90th	
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	2605	72	247	29.15%	10.07	16.26	24.48	32.15	2
30 Day Follow-Up after Discharge from the ED for Mental Health	2605	282	345	81.74%	45.58	52.79	66.25	74.47	2
Adolescent Well Care Visits	N/A	4903	8693	56.40%	45.74	54.57	61.99	66.80	1.5
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	CMS ACO #38	11	1078	1.02%	N/A	N/A	N/A	N/A	2
Developmental Screening in the First 3 Years of Life‡	1448	1861	3140	59.27%	17.80	39.80	53.90	N/A	2
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	0059	122	366	33.33%	46.96	38.20	33.09	29.68	1.5
Hypertension: Controlling High Blood Pressure	0018	223	349	63.90%	49.27	58.68	65.75	71.04	1.5
Initiation of Alcohol and Other Drug Dependence Treatment	0004	494	1271	38.87%	38.62	42.22	46.40	50.20	1
Engagement of Alcohol and Other Drug Dependence Treatment	0004	206	1271	16.21%	9.11	13.69	17.74	21.40	1.5
Screening for Clinical Depression and Follow-Up Plan	418	142	327	43.43%	N/A	N/A	N/A	N/A	2
								Total Points Earned	**17**

** denotes measures for which a lower rate indicates higher performance*
‡ denotes measure with multi-state benchmarks: 26 states reporting (FFY 2016)

Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (1 point)
Above 50th percentile (1.5 points)
Above 75th percentile (2 points)
Above 90th percentile (2 points)

Result 5: The ACO expanded implementation of the Advanced Community Care Coordination (A3C) model to all participating communities

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- OneCare distributed approximately $2.7 million in A3C payments to 65 community partner organizations (including primary care practices, Designated Mental Health Agencies, Area Agencies on Aging, and Visiting Nurse Associations).
- Key performance indicators showed incremental increases in care team activity in OneCare's care coordination software, Care Navigator.
- OneCare trained nearly 700 community care team members in care coordination skills and core competencies, including the use of Care Navigator.
- Care Coordination Core Teams were active in all ten participating communities, tasked with expanding upon best practices, sharing learnings, and implementing team-based care quality improvement projects using Care Navigator.

VMNG Opportunities

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- Reviewing and modifying DVHA's requirements for prior authorizations and service limitations
- Restructuring utilization reporting to better understand patterns over time

Blue Cross & OneCare 2018 Performance

Green Mountain Care Board Meeting

November 20, 2019

Introduction

- Program term overview
- Population demographics
- Quality results
- Clinical results
- Financial results
- Overall ACO value review and summary

Our vision

Together we can build a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care.

Program term overview

- Covering attributed Qualified Health Plan lives with relationship with a OneCare Participating Primary Care Provider.
- 50/50 Shared Risk/Shared Savings Financial Arrangement within 6% of Expected Medical Spend based on GMCB QHP approved rates.
- Quality metrics aligned with the All Payer Model
- Performance on Quality impacting ACO value based incentive fund amounting to 0.5% of total cost of care
- Collaboration requirements on quality, care coordination and analytics activity

Quality results

QHP attributed lives | Improvement in follow-up measures | condition-specific programs

Measures	2017 Rate	2018 Rate	Change	National Percentile Band Performance	Full Quality Points Earned
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	15.0%	19.4%	↑ 4.4%	75th Percentile	✓
30 Day Follow-Up after Discharge from the ED for Mental Health	76.9%	83.3%	↑ 6.4%	90th Percentile	✓
Adolescent Well Care Visits	59.7%	62.6%	↑ 2.9%	75th Percentile	✓
ACO All-Cause Readmission Ratio **INV**	0.93%	.085%	↓ .08%	25th Percentile	
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) **INV**	20.0%	23.1%	↑ 3.2%	90th Percentile	✓
Hypertension: Controlling High Blood Pressure	68.8%	61.1%	↓ 7.7%	50th Percentile	
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (Composite)	23.7%	23.9%	↑ .2%	50th Percentile	
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	54.6%	69.2%	↑ 14.7%	90th Percentile	✓

***INV** = Inverted measure. A lower score is better* ✓ *= OCV earned 2 out of 2 available quality points for this measure*

Clinical results

Demographics demonstrate increasing risk score within the population.

Demographics	OneCare Population			Non OneCare QHP Population		
	Case Weight	Age	Gender (Female/Male)	Case Weight	Age	Gender (Female/Male)
January 2017	1.08	42	52%/48%	0.94	45	50%/50%
December 2017	1.22			1.02		
January 2018	1.23	42	52%/48%	1.05	45	49%/51%
December 2018	1.27			1.14		

Higher case weight = higher risk population

Clinical results

- Steady Primary Care Engagement
- Decreased Emergency Department and Inpatient Use

Utilization Metric	2018	2019 (through 10/31)
ED Utilization per 1000	231	195
IP Utilization per 1000	45.9	38.5
PCP Visits	77% full year 72% through 10/31/18	70%

Financials Results

Calendar year 2017

- Included a minimum savings rate of 2.45%, making the target $481.11
- One-sided arrangement with no downside risk

Calendar year 2018

- No minimum savings rate, making the target equal to expected
- Two-sided arrangement

Utilization Metric	Calendar Year 2017	Calendar Year 2018	Illustrative – Calendar Year 2018 without reduction in Utilization Trend
Expected Spend PMPM	$493.18	$530.91	$541.37
Actual Spend PMPM	$494.80	$537.74	$537.74
Actual to Expected	100.3%	101.3%	99.3%
Total Member Months	303,061	227,175	227,175
Total Shared Savings/Risk	$0	$(645,574)	$343,853

- GMCB reduced utilization trend from 2% to 1%, which reduced the expected spend.

Review of early indicators

Bright spots—what's working

- Early indicators of positive impact based on utilization and quality metrics
- ACO performance consistent or better than non ACO QHP population
- Jointly developed programs and analytics targeting readmissions outreach and gaps in care

What will impede progress

- Disregard for small numbers and change in demographics in year-over-year comparison
- GMCB-approved QHP premiums directly affect ACO target and ability to achieve savings

Measuring clinical programs in the future

- **Use condition-specific measurements**, not broad-based population metrics
  - **Example**: maintaining healthy BMI, ED visit linked to asthma event, adherence to medication
- **Use a comprehensive clinical health assessment**
  - Patient satisfaction and engagement data
  - Health confidence measure, a way to gauge member empowerment
- **Connect clinical measurements to financial impact**
- **Evaluate annually** (or more frequently when appropriate) current measures, the need for new programs, new measurements and appropriateness of benchmarks
- **Learn from others**—track national programs related to evolving research on social determinates of health and outcome metrics

All-payer model achievements

- Moving to risk contracting after four years of shared savings
- Collaborating on clinical opportunities—more than a payment program
- Expanding analytics capabilities through shared expertise
- Developing long term goals and process for improvement
- Aligning quality and processes with Medicaid Program

All-payer model challenges

- Data mapping and managing claims and clinical data sharing
- Expanding the Provider Network for Blue Cross Agreement
- Complexity with Fixed Prospective Payment
- Expansion of risk model while ensuring access and stability of the health care system
- Aligning premium setting with ACO expected spend target

Success cannot be measured in one year

- Impact of programs will develop over time
- Programs will take three to five years to mature
- Adopt continual assessment and improvement strategy

Understanding the value the all-payer model

- Did we impact total cost of care?
- Did member and client satisfaction increase?
- Did provider satisfaction increase?
- Did we close gaps in care?
- Did transitions in care lead to reduced inpatient stays?
- Did member health improve year over year?
- Did we support Vermont's overall population health goals?

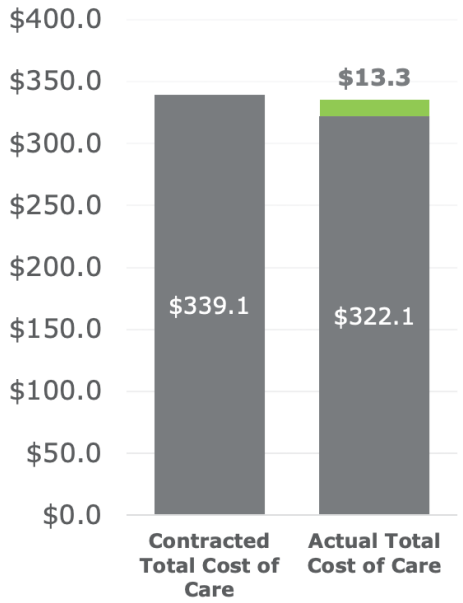
Thank you

Questions?

2018 Value-Based Financial Results

* All chart numbers in millions

MEDICARE



Reconciling Payment	$13,345,337
% of TCOC	3.9%
Fixed Payment Performance	$0
Combined Result	**$13,345,337**

MEDICAID

Reconciling Payment	($1,540,534)
% of TCOC	(1.3%)
Fixed Payment Performance	$7,663,309
Combined Result	**$6,122,776**

BCBSVT QHP

Reconciling Paymenta	($645,574)
% of TCOC	(0.5%)
Fixed Payment Performance	$0
Combined Result	**($645,574)**

**Note: Medicare's $13.3 M results is $7.7 M in Advanced Shared Savings and $5.6 in Shared Savings*