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2019 ACO Financial Results

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December 2, 2020

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2019 Medicare Financial Performance

Medicare Financial Target PY2 (2019)

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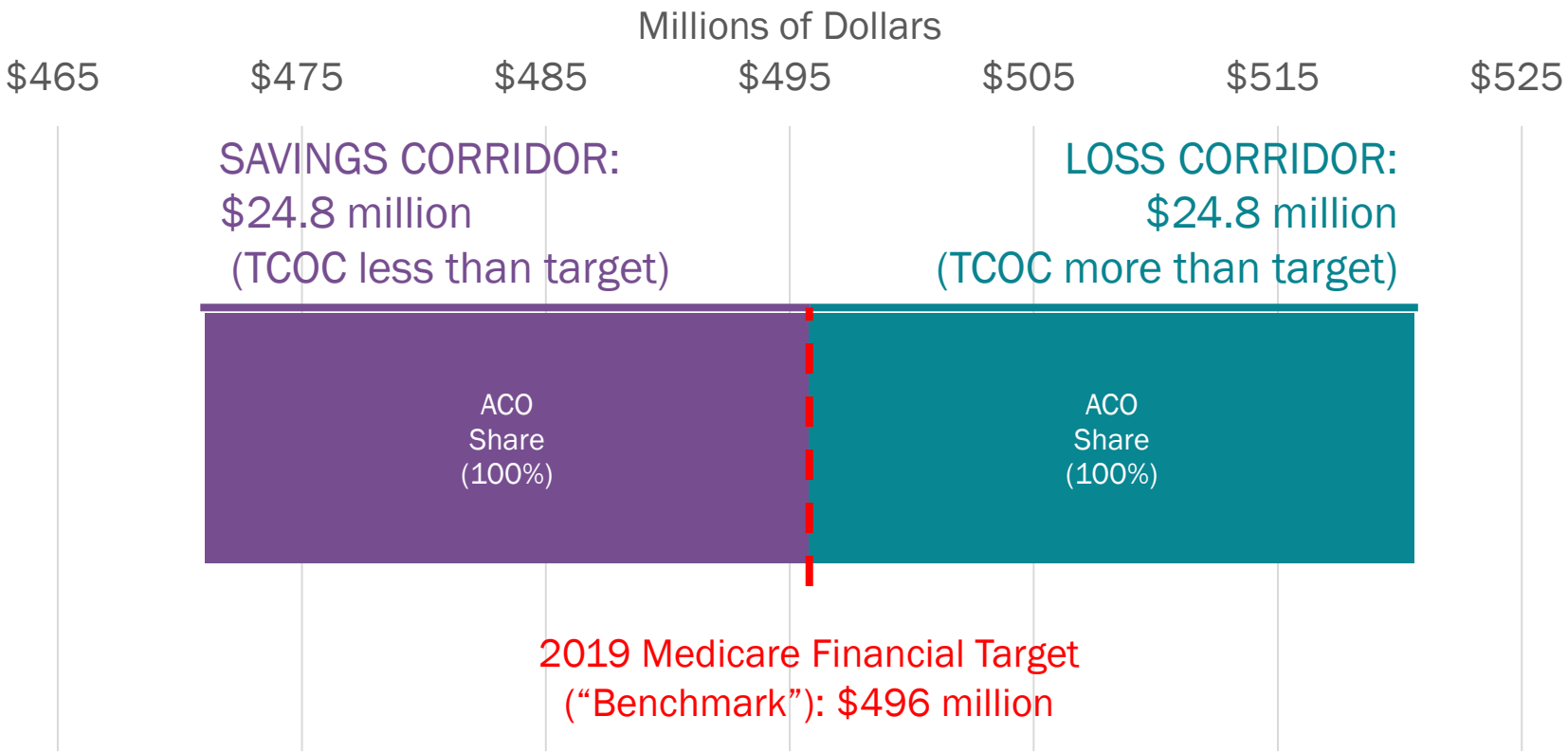

Medicare Financial Target PY2 (2019)

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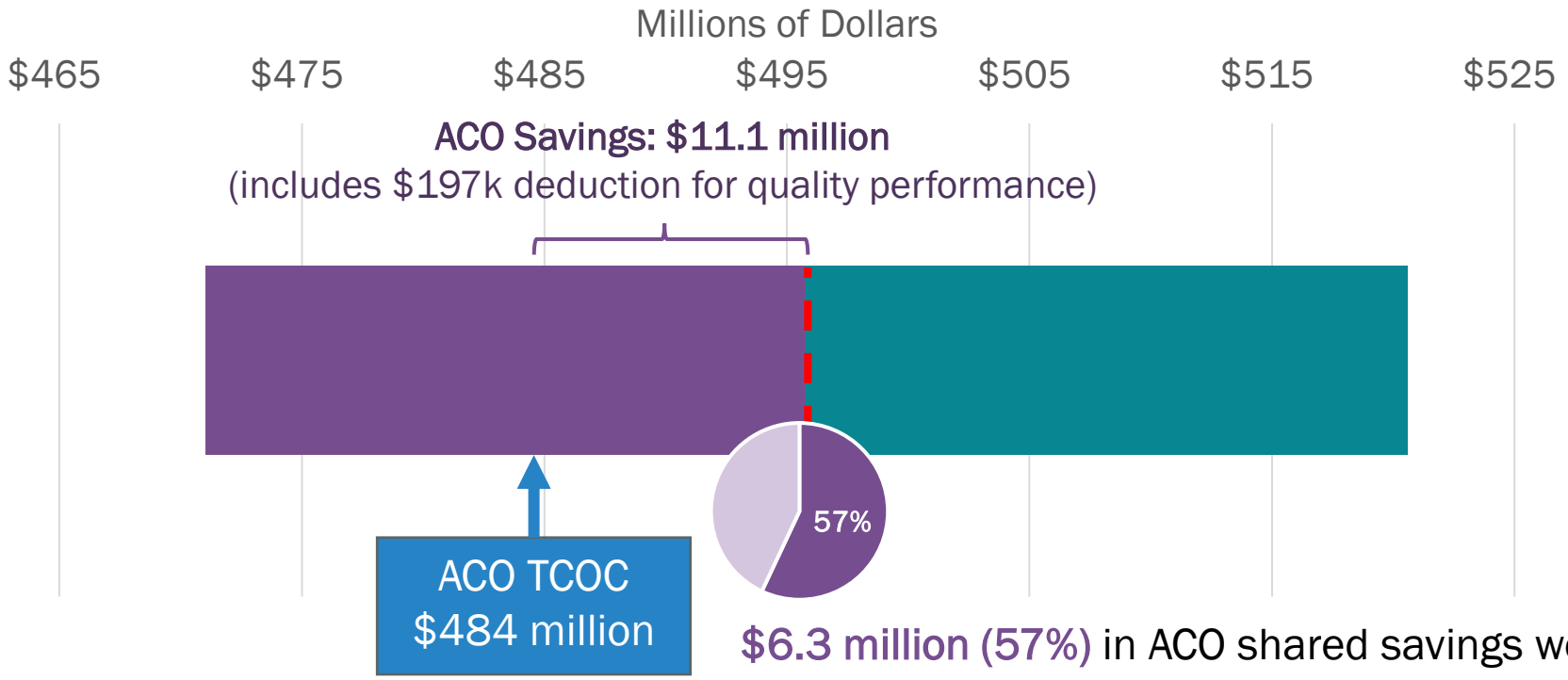

$6.3 million (57%) in ACO shared savings were advanced to help with cash flow to continue Medicare participation in Vermont programs (i.e. Primary Care Medical Homes, Community Health Teams, and SASH).

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Vermont Medicaid Next Generation ACO Program: 2019 Performance

Department of Vermont Health Access

December 2, 2020

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 2019, and 2020, and are in the process of negotiating a final one-year extension for 2021.
- Rates are renegotiated annually and reconciliation may occur more frequently.

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2019 VMNG PROGRAM PERFORMANCE

2019 Results Report

Result 1: 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 modified the attribution methodology to further increase the number of Vermonters connected to the All-Payer ACO Model.

	2017	2018	2019	2020	2021
Health Service Areas	4	10	13	14	14
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000	~4,800
Attributed Medicaid Members	~29,000	~42,000	~79,000	~114,000	~111,000
% Change over Prior Year	--	+45%	+88%	+44%	-3%

Result 2: ACO providers and Medicaid shared financial accountability for health care in 2019

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- DVHA and OneCare agreed on the price of health care upfront, and actual spending was more than expected. Because OneCare shares financial risk with Medicaid, OneCare has to pay for a portion of this spending over the agreed upon price.
- For the third year in a row, providers receiving prospective payments have spent less than expected on services within their control, highlighting the potential of changing financial incentives in this model.

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

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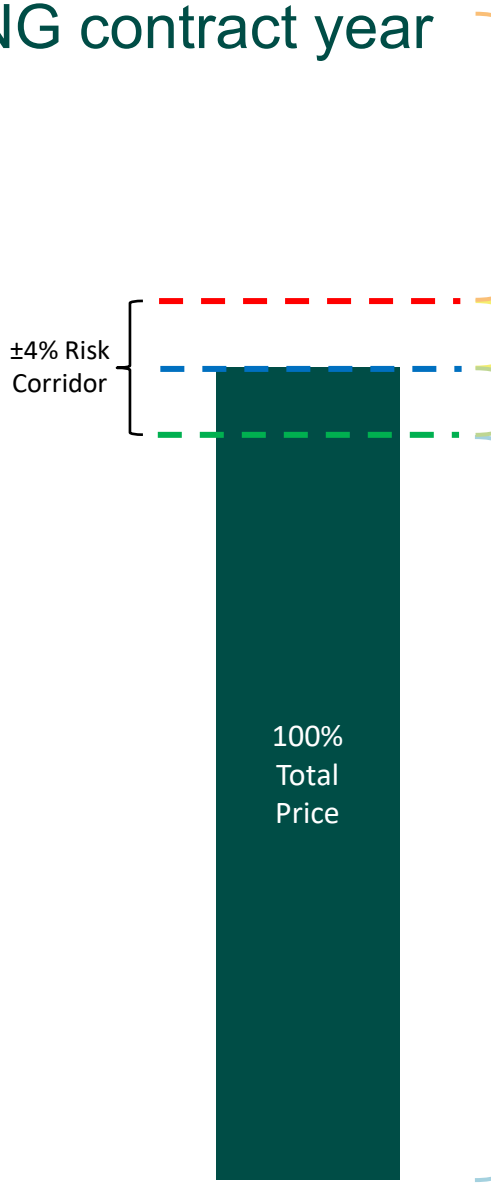

>104%: DVHA bears full accountability for financial performance in excess of the corridor.
This allows providers to change the way they deliver care without facing catastrophic losses.

100%-104%: 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.

96%-100%: ACO network entitled to retain difference between actual performance and 100%.
This creates an incentive to be efficient with resources within the corridor.

<96%: The difference between actual performance and 96% is returned to DVHA.
This creates an incentive to spend money on care and to invest in providers and the community.

Financial Results - Summary

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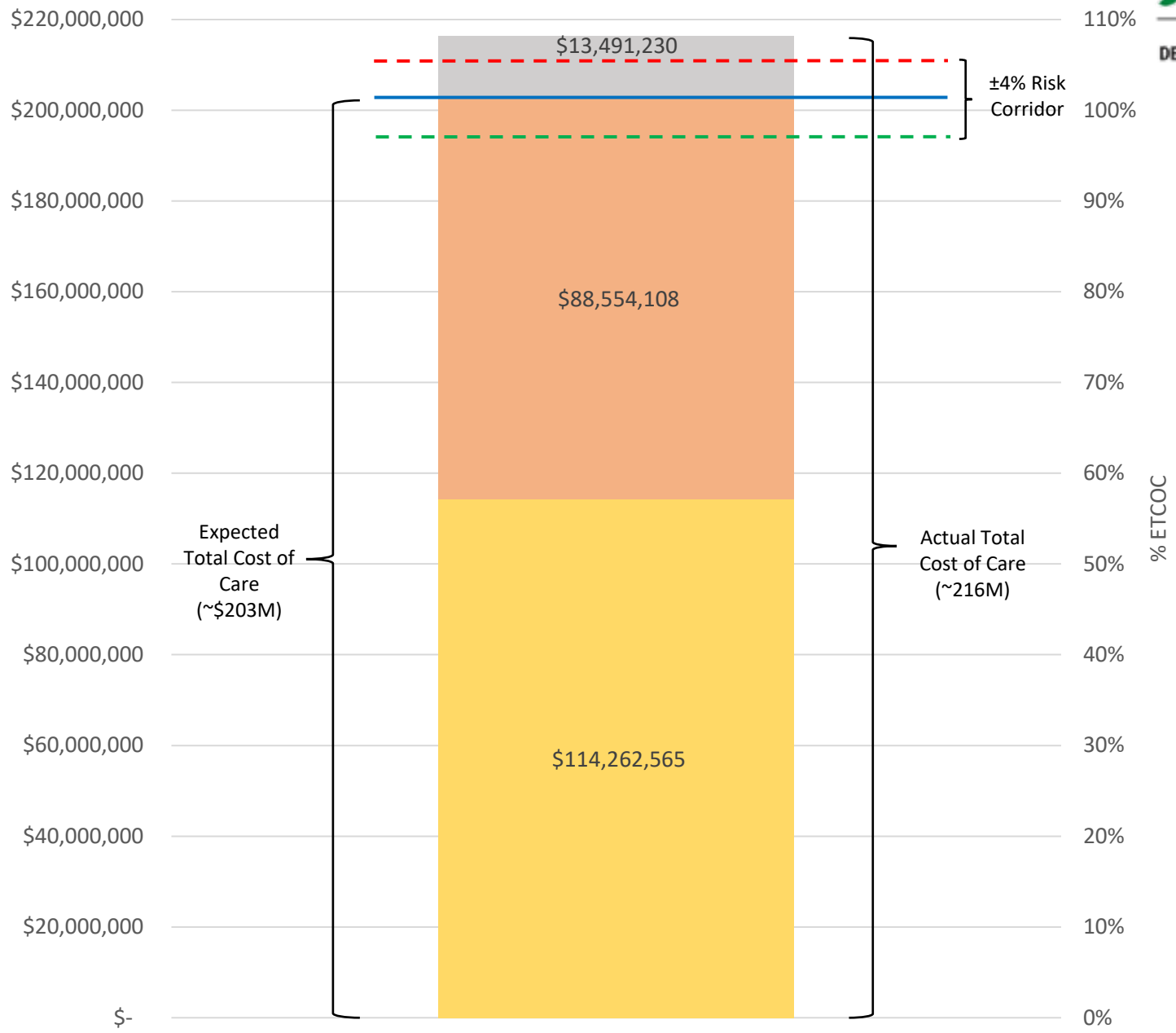
- DVHA and OneCare agreed on the price of health care for attributed Medicaid members up-front, and spending for ACO-attributed members was approximately $13.5 million more than the expected price (approximately $203 million).
- Because financial performance exceeded the agreed-upon price, OneCare is liable for the full amount within the 4% risk corridor—approximately $8.1 million. After application of other necessary adjustments, OneCare Vermont will pay approximately $6.7 million to DVHA.
  - If DVHA and OneCare did not have this risk-sharing arrangement, the Vermont Medicaid program would pay the entirety of the amount in excess of the expected price.

2019 VMNG Financial Performance relative to Expected Total Cost of Care



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Financial Results – Additional Analysis

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- ACO-participating providers who were paid prospectively (instead of fee-for-service) spent $8.2M *less than* expected on the services within their control. Conversely, providers who were paid fee-for-service (both within and outside of OneCare's network) spent $13.5M *more than* expected. This highlights how two different changing financial incentives might impact the delivery and cost of health care.
- The ACO-attributed population nearly doubled from 2018 to 2019. This significant change introduced relatively more uncertainty into the rate setting process than in prior years.
- Overall utilization trends increased for the entire Medicaid-enrolled population between 2017 (the base year that was used for rate development) and 2019 (the performance year). 2019 utilization was more similar to 2018 utilization, but the agreed-upon price was based on lower 2017 utilization.

VMNG ACO Program: 2017, 2018, & 2019 Financial Performance

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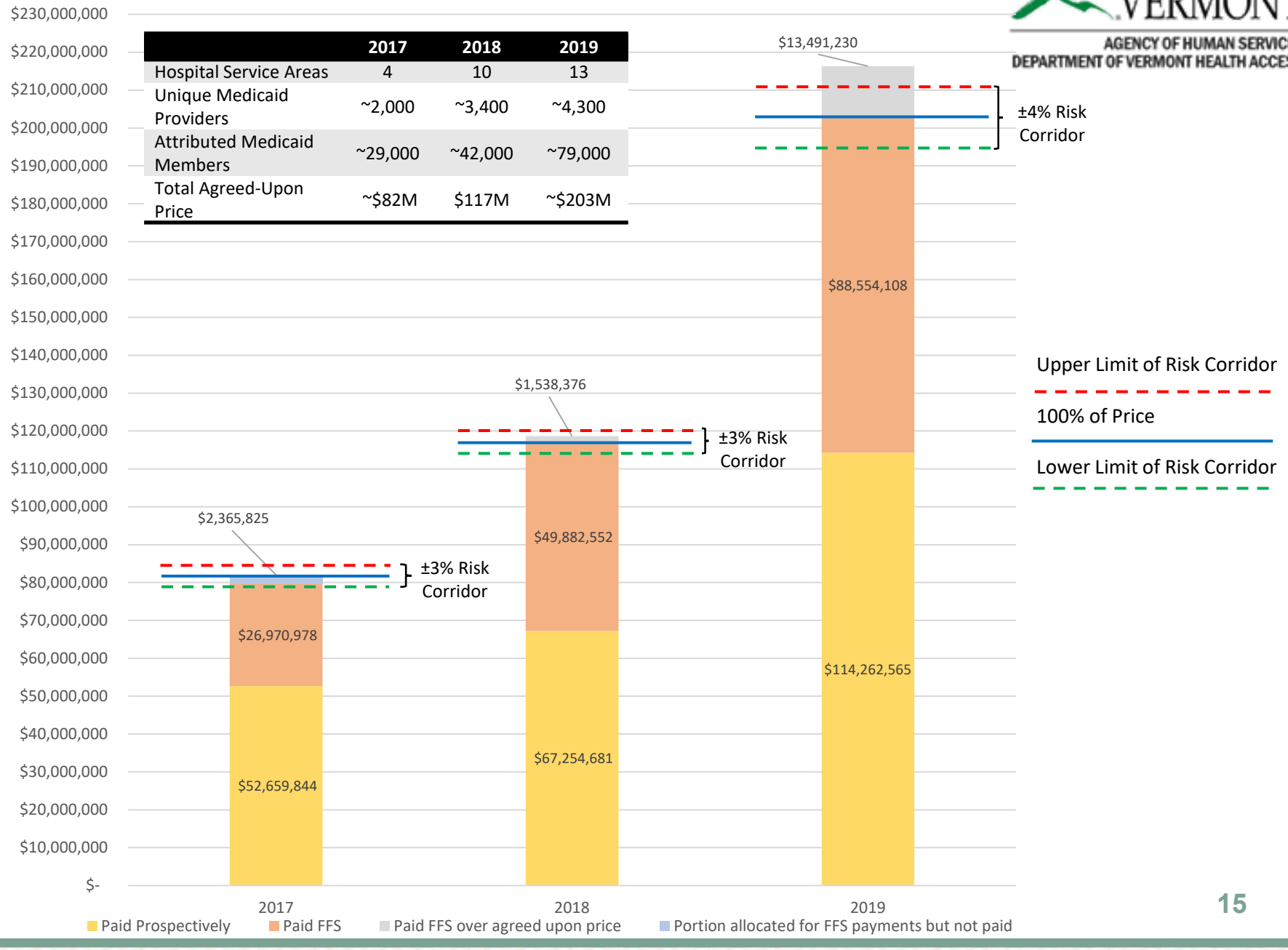
	2017	2018	2019
Hospital Service Areas	4	10	13
Unique Medicaid Providers	~2,000	~3,400	~4,300
Attributed Medicaid Members	~29,000	~42,000	~79,000
Total Agreed-Upon Price	~$82M	$117M	~$203M



Result 3: The ACO performed well against quality targets

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- OneCare's quality score was 95% on preselected performance measures, and OneCare demonstrated statistically significant year-over-year improvement on five measures.
- 2019 VMNG quality results were presented in detail during the October 7, 2020 GMCB meeting

Result 4: The ACO extended care coordination to more communities and people

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- There has been a steady increase in the percentage of high-risk and very high-risk attributed Medicaid members who received care coordination interventions under OneCare's Advanced Community Care Coordination model.

Result 5: DVHA and OneCare made incremental program improvements

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- DVHA and OneCare continued program operations and identified opportunities for incremental improvement.
- Tested an expanded attribution methodology in the St. Johnsbury community based on a Medicaid member's residence rather than their primary care utilization.
  - Foundation for broader VMNG attribution changes implemented in 2020.

VMNG Benefits & Opportunities

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- The VMNG program has given the Vermont Medicaid program more certainty in budgeting than it would have had absent this arrangement.
- The VMNG program allows for more revenue predictability for the providers participating in OneCare's network.
- The risk corridor ensures there are both incentives to control costs and protections (for providers and the Medicaid program) for when actual spending is different than expected. Payment predictability and risk-sharing work together to build system stability over time.
- Prospective and FFS spending patterns in the first three years, while not conclusive, signal the potential of changing financial incentives.
- Throughout VMNG implementation there have been incremental improvements in quality performance and changes in the delivery and coordination of care.
- Opportunity to continue testing this model, and to continue improving to the rate setting methodology to allow for additional year-over-year predictability in future.

FINANCIAL OUTCOMES OF 2019 BCBSVT VISG MEMBERS ATTRIBUTED TO ONECARE VERMONT

December 2, 2020

BCBSVT'S Vision and Mission Aligned With All Payer Model

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.

Our Mission

We are committed to the health of Vermonters, outstanding member experiences and responsible cost management for all of the people whose lives we touch.

Progress and Challenges in 2019

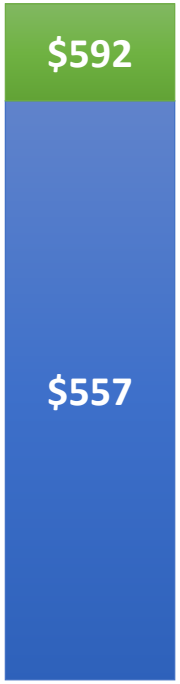
Bright Spots

- BCBSVT Clinical, Quality Improvement, Analytics, and Client teams ready to support OneCare
- Collaborative approach of both organizations fosters responsiveness to external challenges
- Worked together to successfully implement commercial perspective payment system

Challenges

- Difficulty connecting current quality metrics/methodology to the impact of the OCV on BCBSVT members
- OCV and BCBSVT are already working to include monitoring of an annual quality improvement work plan as a solution to this recurring issue
- Not yet able to clearly demonstrate that attributed members are outperforming unattributed populations
- COVID-19 disrupted both quality measurement and provider's ability to engage in any new QI initiatives

2019 RESULTS FOR ATTRIBUTED SMALL GROUP AND INDIVIDUAL MEMBERS



Actual – $592 PMPM

Target – $557 PMPM

Actual Spend Exceeded Target*

- Costs exceeded target by about $6.5 million, net of member cost share
- In 50%/50% risk share, OneCare Vermont would owe BCBSVT $3.25 million
- Because of data challenges in 2019, BCBSVT agreed to shift shared savings only

*Include Medical and MHSUD Claims—Retail Pharmacy is excluded

Summary of Performance Against Target

- After normalizing results against the rest of the BCBSVT QHP population, the attributed population results are 6.6% above target
- 2.3% of the overage is directly related to GMCB adjustments to filed QHP premiums
- The remaining ~4% of excess expenses are unique to OneCare Vermont attributed members
- BCBSVT identified Professional utilization patterns unique to OneCare
- The data challenges, resolved in mid 3rd quarter, don't appear to have affected the outcomes

Details of Utilization Differences

Three Dynamics Driving Most of Overage

- Significantly more E&M and Professional MHSUD Visits
- Higher use of Urgent Care Visits
- More costly and/or intense PT services

Downstream Effects

- OneCare Adolescents receive well care at a much higher rate
- Otherwise, additional office visits are not yet translating into reduced Gaps in Care
- Urgent care use not reducing ER utilization in attributed pool

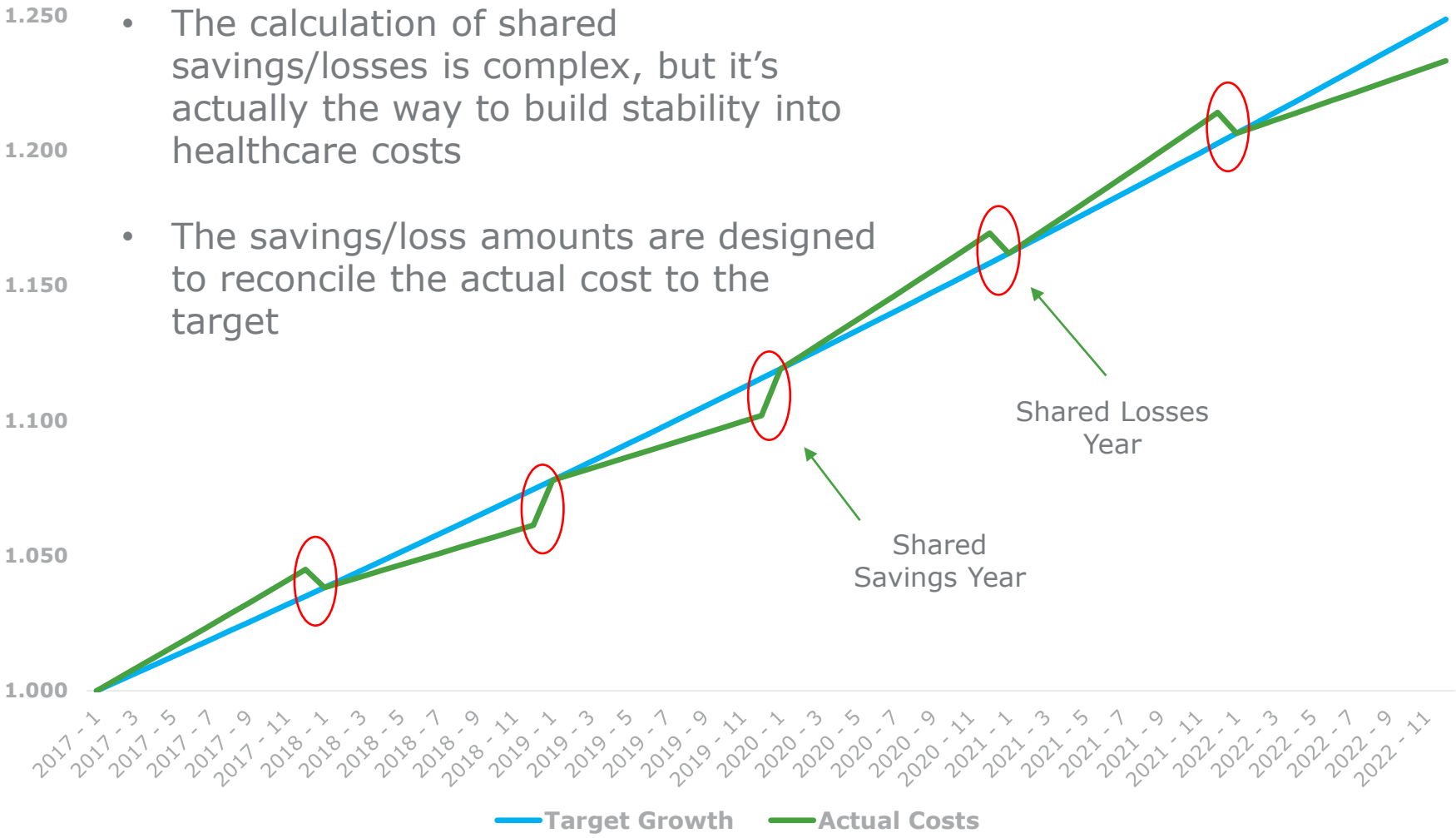
Next Steps

BCBSVT and OneCare Working Together to Dig Deeper

- How much of the additional office-based care was proactive and preventive?
- How does Urgent Care use differ across regions?
- Is increased PT expense tied to unit cost or to intense services tied to specific procedures?

Value-Based Care at Work

- The calculation of shared savings/losses is complex, but it's actually the way to build stability into healthcare costs
- The savings/loss amounts are designed to reconcile the actual cost to the target



* Illustrative Example *

Distribution of Savings and Losses

- Through contracts with participating providers, savings or losses are distributed out to the OneCare network

- The savings or losses are broken down by HSA
  - In 2019, this was done based on specific HSA-level performance
  - In 2020 and beyond, this will be done through a proration

- The HSA amount is then due to/from the HSA
  - Through 2020, the hospital in each HSA was assigned as the risk bearing entity
  - Beginning in 2021, accountability is more broadly shared and now include all attributing providers

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Questions?

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Resource Slides

Medicare Financial Target PY1 (2018)

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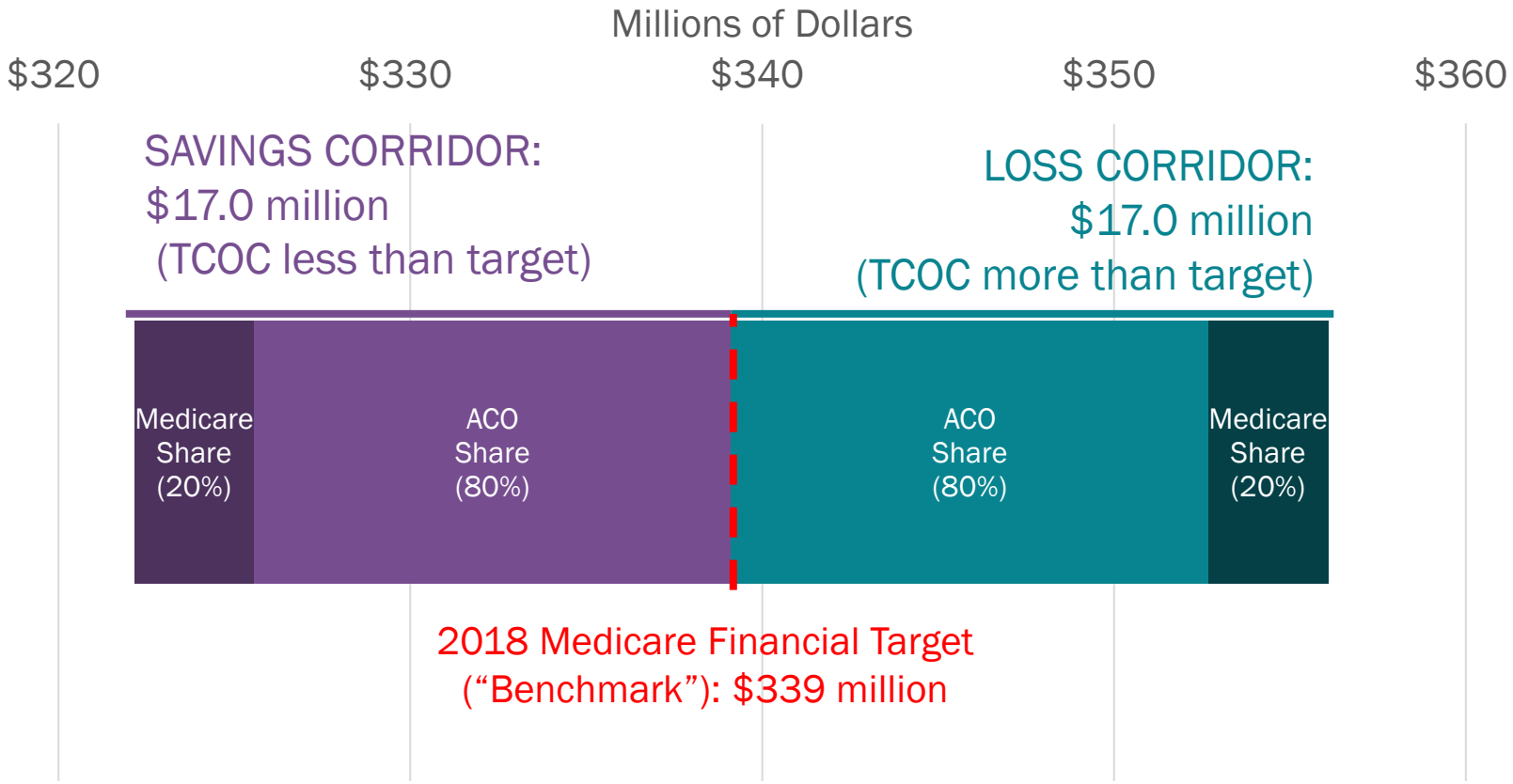

Medicare Financial Target PY1 (2018)

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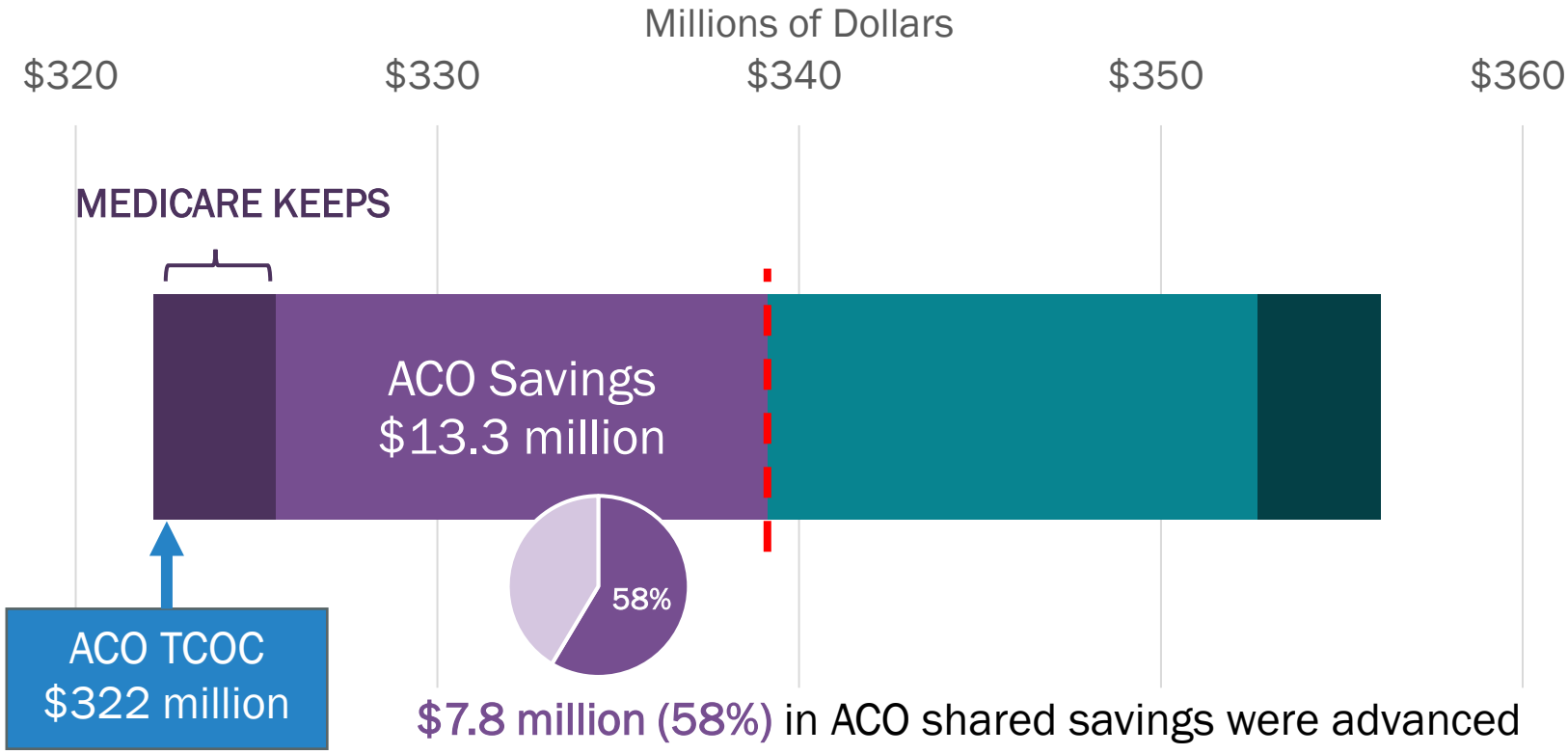

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