OneCare Vermont

2022

Budget Presentation to

Green Mountain Care Board

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Tom Borys, Vice President of ACO Finance
November 10, 2021
Budget Section 1

ACO Information and Background
Budget supports continuous advancement towards **value-based care**

- **Growing Statewide Attribution**
  - Increasing number of engaged providers
  - Over 5,000 providers statewide and over 90% of eligible primary care

- **Continuous population health investments**
  - $28.9 million direct payments to providers
  - Growing engagement in independent primary care model

- **Growing conversion from fee-for-service to value-based care**
  - $1.3 billion of existing healthcare dollars (Half of VT’s eligible health care spend in model)
  - 100% in advanced payment model
“CMS wants every Medicare Beneficiary to be in an accountable care relationship by 2030.”

2020 Medicare Beneficiaries in Accountable Care Relationships Vermont vs. National

**Vermont** Traditional Medicare Beneficiaries in an ACO
- 47% (n = 57,842)
- 53% (n = 61,654)

**National** Traditional Medicare Beneficiaries in an ACO
- 42% (n = 13M)
- 58% (n = 17.5M)

Chart source: CMS White Paper on CMS Innovation Center’s Strategy: Driving Health System Transformation - A Strategy for the CMS Innovation Center’s Second Decade; [https://innovation.cms.gov/strategic-direction](https://innovation.cms.gov/strategic-direction); published October 2021
The evaluation of the first two years of the model was conducted by NORC at the University of Chicago, an independent research institution, and assesses the implementation and measures effects of the APM. Report: https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-full-report; https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-report-aag
OneCare’s Core Capabilities

- Network Performance Management
- Data and Analytics
- Payment Reform
 Provider Perspectives

- COVID-19’s impact on care
- ACO as a vehicle to move forward
- Innovation required to do business
- Care coordination evolving
- Abundant opportunities for collaboration
Budget Section 7

ACO Quality, Population Health, Model of Care, and Community Integration
Core Capability: Network Performance Management Quality and Care Model

**Network Contracting**
- 5,060 providers
- 288,000 attributed lives
- Full continuum of care

**Quality**
- Focused quality strategy
- Practice-level quality reporting
- Incentives for high-quality care

**Care Model**
- Population health model
- Prevention
- Care coordination
Core Capability: Network Performance Management Quality

Value-Based Incentive Fund (VBIF)

Quality Focused Areas determined in 2021:
- Hypertension
- Diabetes
- Depression Screening
- Developmental Screening

54 primary care organizations were provided with data to help them understand how they are doing compared to national benchmarks on these quality focus areas. Incentives are tied to providing higher quality of care.

$2.2M of hospital funding allocated twice per year based on performance

<table>
<thead>
<tr>
<th>TIN</th>
<th>Medicaid VBIF Results (2021 Q1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hypertension</td>
</tr>
<tr>
<td>Met Target</td>
<td>49%</td>
</tr>
<tr>
<td>Met Stretch Goal</td>
<td>23%</td>
</tr>
<tr>
<td>Met Target</td>
<td>50%</td>
</tr>
<tr>
<td>Met Stretch Goal</td>
<td>14%</td>
</tr>
</tbody>
</table>

OneCare Aggregate: Below Target 🔴 Met Target 🔴 Met Stretch Goal 🔵 Met Target 🔴
Core Capability: Network Performance Management Quality

VBIF, continued

<table>
<thead>
<tr>
<th>2021 VBIF Q1 - PEDIATRIC MEASURES</th>
<th>DEPRESSION SCREENING</th>
<th>DEVELOPMENTAL SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORGANIZATION</td>
<td>COMMERCIAL</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>Green Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mountain Pediatrics, PC*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pondside Pediatrics</td>
<td></td>
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</tr>
<tr>
<td>Miller Health Partners, Inc.</td>
<td></td>
<td></td>
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<tr>
<td>Hospital and Health Center Inc.</td>
<td></td>
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<tr>
<td>Smith Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABC Pediatrics</td>
<td></td>
<td></td>
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<tr>
<td>Vermont Regional Hospital, Inc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Medical Center Inc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics and Other Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>123 Hospital, Inc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Down the Street Pediatrics</td>
<td></td>
<td></td>
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<tr>
<td>NE Kingdom Pediatrics</td>
<td></td>
<td></td>
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<tr>
<td>Royal Partners Peds</td>
<td></td>
<td></td>
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<tr>
<td>SE Vermont Pediatrics</td>
<td></td>
<td></td>
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<tr>
<td>Medical Center Inc.</td>
<td></td>
<td></td>
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<tr>
<td>Valley Pediatrics</td>
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<tr>
<td><strong>OneCare Aggregate</strong></td>
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<td></td>
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</tbody>
</table>

You are invited to learn more at the upcoming VBIF webinar, scheduled for November 3rd, from 12pm to 1pm. See OneCare Network News for details.

If you have any questions or concerns, please contact your assigned OneCare Quality Improvement Specialist, noted at left.

MOCK DATA
Not for Interpretation
Core Capability: Network Performance Management Care Model

Care Coordination Program

Participant Survey: Care Model
Received 121 responses from Area Agencies on Aging, Designated Agencies, FQHCs, home health and hospice agencies, hospital-owned and independent primary care, SASH, and VCCI.

Actions Taken:
- Re-evaluated Care Navigator
- Conducted two trainings on motivational interviewing
- Developed a 2021 education plan

Affirmed
- Person-Centered Care
- Community Team Based Care
- Shared Care Plans
- Lead Care Coordinator
- Care Conferences
- Shared Communication Platform

2022 Payments:
No Longer Linked to Care Navigator

Payments have two components:
- Base Payment for Network Accountabilities
- Incentive Based on Performance

OneCare Vermont
Core Capability: Network Performance Management Care Model

Care Coordination, continued

Sub-population Areas of Focus

- Frequent use of the emergency department
- High inpatient hospital utilization
- High medical, mental health, and/or social needs

Care Management Rates:
Trending Metric Counts:
Count of Patients Engaged in Care Coordination Activities

Process and Outcome Metrics
Key process and outcomes metrics will still be monitored using a simplified tool. Care Navigator will continue to be available for communication and collaboration.

Next Steps
Support the network in the transition to the 2022 Care Coordination Program
- Educate network on program changes
- Prepare network for simplified reporting requirements
Core Capability: Network Performance Management

2022 Network Accountabilities

- Patient panel management and outreach
- Care coordination
- Bi-annual care managed attestation (NEW)
- Care coordinator professional development
- Cross organizational collaboration and communication
- Process improvement
Core Capability: Data and Analytics

Actionable Data & Insights for Providers

Participant Survey: Data & Analytics

Respondents use:
- static reports
- self-service analytic tools
- direct support

Improvement opportunities:
- data availability
- ease of use
- customized support

78% of network survey respondents said they currently use OneCare data for organizational decision-making:
- inform financial decisions
- quality improvement work
- workflow refinement
- coordinating within and across HSAs
- identify variations in care or quality

OneCare analysts are:
- identifying opportunities for changes in workflow or improvement in quality of care
- interacting with participants to determine where data could support improvement efforts

Featured OneCare tools and apps:
- OneCare Performance Dashboard
- Performance Dashboard Companion Application
- Inpatient Care Location Insights
- Influenza Vaccine Quality Improvement Initiative
- Hypertension and Diabetes Management
Core Capability: Data and Analytics

Financial Performance Report

- Designed to communicate total program savings/loss outcomes to participants
  - Current month
  - Year-to-date
  - Year-end forecast
- Cascades from aggregate results down to HSA and practice level financial outcomes
- Aggregates all program elements into one financial summary

**Mock Data Not for Interpretation**
Designed to consolidate multiple data elements into one quarterly report

- Practice panel composition
- Total cost of care
- Utilization
- Quality

Performance benchmarked against a peer group of similar practices

Further research and analysis facilitated through:

- WorkbenchOne
- Direct OneCare support

Not for Interpretation
OneCare Vermont: Data and Analytics
https://youtu.be/t1uJzyhtGqQ

Find more videos about OneCare in our video center: www.onecarevt.org/videos
Core Capability: Payment Reform

Fixed Payment Transformation

Participant Survey: Payment Reform

Highlights:

- Requests for additional supports
- Customize support to promote understanding of offerings and underlying models
- Technical and formatting enhancements to existing reports

OneCare facilitates fixed payment conversions on behalf of its participants:

- Stabilizes provider revenue
- Stabilizes healthcare costs
- Shifts away from volume-based incentives

Fixed Payment Progression

- FPP Non-Reconciled
- FPP Reconciled
Core Capability: Payment Reform
Fixed Payment Transformation

Program to transition independent primary care practices to stable monthly fixed payments

- Monthly PMPM payments for “core” primary care services
- FFS+ reimbursement for other services offered within the primary care setting like:
  - Behavioral health
  - Procedures
  - Lab
- Supplemental PMPM to support care delivery evolution

Hosted a series of focus groups in the summer of 2021

- Opportunity to collect feedback and ideas
- Provided input into 2022 program adjustments
Lessons Learned

- Network engagement takes time and dedication
- Participants deeply engaged in programmatic evolutions
- Commitment to care coordination affirmed
- Clinical prevention warrants more focus
- COVID-19 reinforced the importance of value-based care
  - Team-based care,
  - Coordination of care,
  - Payment reforms,
  - Use of data,
  - Alternate visit types/telehealth
- Providers recognize value in progressive capitated payment model
Budget Section 2

ACO Provider Community
2022 ACO Map and Participants

- 14 Hospitals
- 121 Primary Care Practices*
- 262 Specialty Practices**
- 5060 Individual Providers
- 9 Federally Qualified Health Centers
- 22 Skilled Nursing Facilities
- 10 Home Health Agencies
- 5 Area Agencies on Aging
- 21 Regional Housing Authorities (SASH)
- 10 Designated Agencies for Mental Health & Substance Abuse

~288,000 people
cumulatively covered by payers

The number of attributed people has grown nearly tenfold from 29,100 in 2017

* Including independent primary care practices and hospital primary care practices
** Including hospital and independents
Budget Section 3

ACO Payer Programs
Value-Based Care Programs

Budget includes continuation of all payer programs offered in 2021

COVID continues to create challenges, but also reinforces the need for value-based care

Medicare
- Budget anticipates similar program design
- Trend rate budgeted per CMS forecast

Medicaid
- No substantial changes incorporated into budget

BCBSVT QHP & Primary
- Contracts merged into one
- No substantial changes incorporated into budget

MVP QHP
- No substantial changes incorporated into budget
Attribution by Program

Budget Includes 288k lives; 257k expected to qualify for scale

- Modest increase to Medicaid attribution expected
- Additional participation in BCBSVT programs expected in increase commercial attribution

* Does not qualify for All-Payer Model scale
Budget Section 4

Total Cost of Care
$1.33B of Health Care Costs in Value-Based Contracts

- 2022 represents another year with significant healthcare costs included in a value-based model
- Impacts of the COVID pandemic make forecasting payer targets challenging
- Accountability growth follows attribution increases, insurance rate increases, COVID rebound, and other payer reimbursement modifications
Program Trend Rates

Best available data are used to develop the total cost of care estimates

- In 2022 this is complicated by the fact that 2020 would typically be the “base year” for some programs
  - Conversations are ongoing as to how each payer will work around this unusual year

- Current healthcare patterns continue to evolve

Unique Medicare program factors:

- End Stage Renal Disease (ESRD) and Non-ESRD components budgeted at the United States Per Capita Cost (USPCC) trend forecast
  - Supports providers and reform efforts
  - Potential to affect cost shift

- Multi-Payer Advanced Primary Care Practice (MAPCP) component budgeted conservatively at 3.5%

- Despite these assumptions, the Medicare trend rates will ultimately be established by the GIMCB
Budget Section 5

Risk Management
Total cost of care forecasts are prepared for the purpose of estimating risk/reward opportunity.

While program terms are being actively negotiated, the budget assumes continuation of reduced risk levels in 2022 as the pandemic continues to disrupt healthcare patterns.

*Figures approximate the budgeted/estimated risk levels entering the performance year. The figures do not factor in COVID-related adjustments such as proration for the duration of the public health emergency.*
The risk model changed to a pooled approach in 2020 in response to COVID, actuarial concerns, and resource constraints.

In concert, PHM investments are evolving to include performance-based components.

Working together, these two elements spread accountability down to the individual practice level without overloading community providers with untenable risk.

- Largely remains with hospitals
- Opportunity to offset participation fees
- Pooled by HSA, with HSA-level performance factors
- Accountability Pool incorporates primary care into the risk model

- Many OneCare investments now have specific performance-based components
- Providers meeting/exceeding targets have the opportunity to earn more relative to their peers
- Enables financial accountability to align with the size of investments
Underneath total cost of care (TCOC) accountability programs, OneCare is able to facilitate payment reforms for its providers.

OneCare’s payment reform offerings are affected by:

- The contracted payer programs and the health care costs included within those contracts
- Whether or not the payer program offers a fixed payment option
- The size of the attributed population
- Proportion of care in-network vs. out-of-network
- Provider readiness

OneCare’s fixed payment evolution can be determined by comparing the fixed payments to the in-network TCOC included in program contracts.

**Public Payer Programs**

- Fixed Payments: 61%
- In-Network Fee-for-Service

**All Programs w/ Fixed Pmts.**

- Fixed Payments: 55%
- In-Network Fee-for-Service

**All Programs**

- Fixed Payments: 41%
- In-Network Fee-for-Service

*Note: 2021 data used to develop the pie charts*
Budget Section 6

ACO Budget
Overview: **$44.1M Budget**

**Balanced Budget**
- No profit or loss
- No additional contributions to OneCare reserves

**Key Strategies**
- Accommodate the end of Delivery System Reform and Health Information Technology revenue
- Continue focus on care coordination
- Sustain investments that have become reliable revenue streams for participating health care providers
- Maintain capacity to support the provider network

**$28.9M in Population Health Management program investments**

**$15.3M in OneCare shared infrastructure**
Revenue Highlights

Landscape:

- The main challenge in the 2022 budget was accommodating the loss of Delivery System Reform (DSR) and Health Information Technology (HIT) funding
  - $3.9M revenue loss

- Budget includes consistent reform investments through payer contracts
  - Revenue levels float with attribution

- Deferred funds accumulated through the pandemic largely consumed in 2021
  - Some remains for programs continuing into 2022

- $3.6M increase in hospital participation fees needed to balance the budget
## Revenue Highlights

<table>
<thead>
<tr>
<th>Area</th>
<th>2021 Revised</th>
<th>2022</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer Program Support</td>
<td>$10,923,620</td>
<td>$11,988,969</td>
<td>$1,065,349</td>
</tr>
<tr>
<td>Blueprint</td>
<td>$8,767,133</td>
<td>$9,073,983</td>
<td>$306,850</td>
</tr>
<tr>
<td>DSR Funding</td>
<td>$2,900,000</td>
<td>$0</td>
<td>($2,900,000)</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>$1,000,000</td>
<td>$0</td>
<td>($1,000,000)</td>
</tr>
<tr>
<td>Fixed Payment Allocation</td>
<td>$3,354,110</td>
<td>$3,360,439</td>
<td>$6,329</td>
</tr>
<tr>
<td>Other Revenues</td>
<td>$3,993,990</td>
<td>$1,062,121</td>
<td>($2,931,869)</td>
</tr>
<tr>
<td>Hospital Participation Fees</td>
<td>$15,056,520</td>
<td>$18,696,155</td>
<td>$3,639,635</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$45,995,373</strong></td>
<td><strong>$44,181,667</strong></td>
<td><strong>($1,813,706)</strong></td>
</tr>
</tbody>
</table>
Expense Highlights: Population Health Management

**Landscape:**

- In light of the revenue loss, the budget aims to protect as much of the population health investments as possible

- Investments in care coordination were specifically identified as an area to sustain funding
  - Care coordination is at the epicenter of many ACO models
  - Requires hospital investment to sustain

- Despite some necessary changes to certain programs, OneCare is able to sustain $28.9M of funding to participating providers
**Expense Highlights: Population Health Management**

### Care Coordination
- Significant effort to maintain this program; some reductions required
- Funding model moving off of Care Navigator
- Each payment stream has a component for outcomes/performance
- Continuation of the Longitudinal Care Program
- Reduced DULCE expense for OneCare
  - Program maintained in full through additional support from VDH

### PCP Engagement Payments
- The revenue that historically supported these payments will be reallocated to help sustain the care coordination program

### Value-Based Incentive Fund (VBIF)
- Continuing to move toward a payer-blended approach that enables OneCare to reward providers for high-quality care
  - Timely payments
  - Practice-specific quality scores
Expense Highlights: Population Health Management

**Prevention**
- Budget includes six months of RiseVT funding in the same form
- Work beginning to determine the next iteration of clinical prevention and health equity

**Blueprint**
- Aggregate 3.5% inflation

**Payment Reform Programs**
- CPR program expansion anticipated in 2022: two additional practices
- Working on pilot with FQHCs for anticipated 2023 launch

**Specialist / Innovation**
- No new expenses; all expenditures represent continuation of previously funded initiatives
<table>
<thead>
<tr>
<th>Investment Area</th>
<th>Amount</th>
<th>Focus &amp; Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Services</td>
<td>$10,789,077</td>
<td>Payments to primary care intended to supply resources to focus on population health initiatives</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>$6,753,948</td>
<td>Payments designed to encourage enhanced coordination and communication of patient care; Longitudinal Care; DULCE</td>
</tr>
<tr>
<td>Quality</td>
<td>$1,527,247</td>
<td>Programs and payments designed to incentivize high-quality care</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>$215,000</td>
<td>Investments in prevention programs</td>
</tr>
<tr>
<td>Specialty / Innovation</td>
<td>$534,873</td>
<td>Investments for innovative program pilots with the opportunity to improve care and drive success under program goals</td>
</tr>
<tr>
<td>Blueprint Programs</td>
<td>$9,073,983</td>
<td>Supports and Services at Home (SASH), Community Health Team (CHT), and Patient Centered Medical Home (PCMH) payments</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$28,894,128</strong></td>
<td><strong>Total funding opportunity</strong></td>
</tr>
</tbody>
</table>
## PHM Investment Recipients

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Amount</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital / Hospital PCP</td>
<td>$9,921,295</td>
<td>Population Health Mgmt. Program, Complex Care Coordination Program, Value-Based Incentive Fund, Primary Prevention, Specialist Program, Innovation Fund, PCMH Payments, Community Health Team Payments, Reinvested VBIF Quality Initiatives</td>
</tr>
<tr>
<td>Independent PCP</td>
<td>$6,263,893</td>
<td>Population Health Mgmt. Program, Complex Care Coordination Program, Value-Based Incentive Fund, Comprehensive Payment Reform Program, PCMH Payments</td>
</tr>
<tr>
<td>FQHC</td>
<td>$4,867,996</td>
<td>Population Health Mgmt. Program, Complex Care Coordination Program, Value-Based Incentive Fund, Primary Prevention, PCMH Payments, Community Health Team Payments</td>
</tr>
<tr>
<td>Specialist</td>
<td>$120,000</td>
<td>Value-Based Incentive Fund</td>
</tr>
<tr>
<td>Designated Agency</td>
<td>$1,029,452</td>
<td>Complex Care Coordination Program, Value-Based Incentive Fund, Specialist Program, Innovation Fund</td>
</tr>
<tr>
<td>Home Health</td>
<td>$1,459,000</td>
<td>Complex Care Coordination Program, Value-Based Incentive Fund, Longitudinal Care</td>
</tr>
<tr>
<td>Area Agency on Aging</td>
<td>$258,301</td>
<td>Complex Care Coordination Program, Value-Based Incentive Fund</td>
</tr>
<tr>
<td>SASH</td>
<td>$4,285,795</td>
<td>SASH</td>
</tr>
<tr>
<td>Community</td>
<td>$50,000</td>
<td>Community entities</td>
</tr>
<tr>
<td>Other / TBD</td>
<td>$638,395</td>
<td>Parent Child Centers, TBD</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$28,894,128</strong></td>
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</tbody>
</table>
Expense Highlights: Operations

Landscape:

The resource demands from the provider network are higher than ever – **and this is a good thing.**

- **Participants are asking for additional data, insights, and direct support**
- **OneCare continues to operate a complex suite of value-based ACO programs**
- **Participants need support in understanding their roles and implementing their accountabilities**
- **This is a learning organization, and incorporating new findings and insights in a way that includes network input and feedback takes resources**

In addition, staff needs time to meet demands outside of provider support, which limits the time that can be dedicated to participating providers and ACO activities.

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The operating budget aims to sustain the capacity to continue supporting participating providers, and also being mindful of the costs charged to hospitals.
## Expense Highlights: Operations

<table>
<thead>
<tr>
<th>Category</th>
<th>2021</th>
<th>2022</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>Salaries, Payroll taxes &amp; Fringe</td>
<td>$9,646,062</td>
<td>$9,651,315</td>
<td>$5,253</td>
</tr>
<tr>
<td>Software/Informatics Tools</td>
<td>$3,604,919</td>
<td>$2,516,505</td>
<td>($1,088,414)</td>
</tr>
<tr>
<td>Consulting, legal and purchased services</td>
<td>$1,147,448</td>
<td>$1,193,249</td>
<td>$45,801</td>
</tr>
<tr>
<td>Supplies, Travel, and Other</td>
<td>$1,507,230</td>
<td>$1,926,469</td>
<td>$419,239</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$15,907,679</strong></td>
<td><strong>$15,289,560</strong></td>
<td><strong>($618,120)</strong></td>
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</tbody>
</table>

- $618k expense reduction
- Supplies, Travel, Other category includes reclass of software professional services
- Salaries: Comparable staffing model
- Software: Restructuring of VITL contract; reclass of software professional services

![Expense Breakdown Chart](chart.png)
Expense Highlights: Operations

Staffing remains the single largest operational investment. Operations continue with 16.35 fewer FTEs than planned in the 2020 Pre-COVID budget.

### Staffing

<table>
<thead>
<tr>
<th></th>
<th>2020 Pre-COVID</th>
<th>2020 Post-COVID</th>
<th>2021 Initial</th>
<th>2021 Update</th>
<th>2022</th>
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</thead>
<tbody>
<tr>
<td>Full Workforce FTEs</td>
<td>77.75</td>
<td>67.26</td>
<td>64.65</td>
<td>67.50</td>
<td>61.40</td>
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<tr>
<td>Budgeted Paid FTEs *</td>
<td>77.75</td>
<td>59.03</td>
<td>64.65</td>
<td>61.37</td>
<td>61.40</td>
</tr>
</tbody>
</table>

* Incorporates timing estimates for filling any vacant positions
Expense Highlights: Operations

OneCare reduced its operating expenses significantly to support the providers who fund ACO programs and activities.

The operating expense budget remains at this lower level through 2022.

Maintaining this level limits OneCare’s ability to take on new initiatives.
### Summary Income Statement

<table>
<thead>
<tr>
<th>Description</th>
<th>2022 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCOC Targets</td>
<td>$1,330,238,159</td>
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<tr>
<td>Payer Contract Rev.</td>
<td>$11,988,969</td>
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<td>Other Revenues</td>
<td>$4,422,559</td>
</tr>
<tr>
<td>Hospital Dues</td>
<td>$18,696,155</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$1,365,345,842</td>
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<tr>
<td>Health Services</td>
<td>$1,321,164,176</td>
</tr>
<tr>
<td>PHM Investments</td>
<td>$28,894,128</td>
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<tr>
<td>Operating Costs</td>
<td>$15,287,538</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$1,365,345,842</td>
</tr>
<tr>
<td>Gain (Loss)</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Health Services Spending Total**: 96.8%

**PHM Investments**: 2.1%

**Operations**: 1.1%
### Income Statement

**2022 Budget**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare TCOC</td>
<td>$524,136,820</td>
</tr>
<tr>
<td>Medicare - Blueprint Obligation</td>
<td>$9,073,983</td>
</tr>
<tr>
<td>Medicaid - Traditional TCOC</td>
<td>$245,245,465</td>
</tr>
<tr>
<td>Medicaid - Expanded TCOC</td>
<td>$47,558,217</td>
</tr>
<tr>
<td>BCBSVT QHP TCOC</td>
<td>$159,654,505</td>
</tr>
<tr>
<td>MVP QHP TCOC</td>
<td>$66,924,423</td>
</tr>
<tr>
<td>BCBSVT Primary - Risk</td>
<td>$277,644,746</td>
</tr>
<tr>
<td><strong>Total Cash, Investments, &amp; Reserves</strong></td>
<td><strong>$1,330,238,159</strong></td>
</tr>
<tr>
<td>Payer Program Support</td>
<td>$11,988,969</td>
</tr>
<tr>
<td>DSR Funding</td>
<td>$0</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>$0</td>
</tr>
<tr>
<td>Fixed Payment Allocation</td>
<td>$3,360,439</td>
</tr>
<tr>
<td>Other Revenues</td>
<td>$1,062,121</td>
</tr>
<tr>
<td>Hospital Dues</td>
<td>$18,696,155</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$1,365,345,843</strong></td>
</tr>
<tr>
<td>FFS Spend</td>
<td>$875,282,023</td>
</tr>
<tr>
<td>Fixed Payment Spend</td>
<td>$445,882,154</td>
</tr>
<tr>
<td><strong>Health Services Spending Total</strong></td>
<td><strong>$1,321,164,176</strong></td>
</tr>
<tr>
<td>Population Health Management Payment</td>
<td>$9,457,821</td>
</tr>
<tr>
<td>Complex Care Coordination Program</td>
<td>$6,549,463</td>
</tr>
<tr>
<td>Value-Based Incentive Fund</td>
<td>$1,527,247</td>
</tr>
<tr>
<td>DULCE</td>
<td>$204,485</td>
</tr>
<tr>
<td>CPR Program</td>
<td>$1,331,256</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>$215,000</td>
</tr>
<tr>
<td>Specialist and Innovation</td>
<td>$534,873</td>
</tr>
<tr>
<td>PCP Engagement</td>
<td>$0</td>
</tr>
<tr>
<td>SASH</td>
<td>$4,285,795</td>
</tr>
<tr>
<td>Blueprint PCMH</td>
<td>$1,993,092</td>
</tr>
<tr>
<td>Blueprint CHT</td>
<td>$2,795,095</td>
</tr>
<tr>
<td><strong>Total PHM Investments</strong></td>
<td><strong>$28,894,128</strong></td>
</tr>
<tr>
<td>General Operations</td>
<td>$15,287,538</td>
</tr>
<tr>
<td>Risk Protection</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Infrastructure</strong></td>
<td><strong>$15,287,538</strong></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$1,365,345,843</strong></td>
</tr>
<tr>
<td><strong>Gain (Loss)</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

* The income statement is displayed in a non-GAAP manner in order to transparently display the scope of 2022 operations.

### Balance Sheet

**2022 Budget**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>20,350,000</td>
</tr>
<tr>
<td>Restricted Cash</td>
<td>3,900,000</td>
</tr>
<tr>
<td><strong>Total Cash, Investments, &amp; Reserves</strong></td>
<td><strong>$24,250,000</strong></td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>2,200,000</td>
</tr>
<tr>
<td>Accounts Receivable from Participants - Contract Risk Settlement</td>
<td>-</td>
</tr>
<tr>
<td>Accounts Receivable from Payers - Contract Risk Settlement</td>
<td>-</td>
</tr>
<tr>
<td>Prepaid Expenses and other current assets</td>
<td>275,000</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>$26,725,000</strong></td>
</tr>
<tr>
<td>Board Designated Assets</td>
<td>-</td>
</tr>
<tr>
<td>Property, Plant And Equipment, net</td>
<td>30,000</td>
</tr>
<tr>
<td>Other Long-Term Assets</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$26,755,000</strong></td>
</tr>
<tr>
<td>Accrued Expenses/NW Payable</td>
<td>15,718,574</td>
</tr>
<tr>
<td>Accounts Payable to Participants, Contract Risk Settlement</td>
<td>-</td>
</tr>
<tr>
<td>Accounts Payable to Payers, Contract Risk Settlement</td>
<td>-</td>
</tr>
<tr>
<td>Due to UVMMC</td>
<td>4,100,000</td>
</tr>
<tr>
<td>Due to DHH</td>
<td>-</td>
</tr>
<tr>
<td>Deferred Revenue</td>
<td>1,250,000</td>
</tr>
<tr>
<td>Debt</td>
<td>-</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>-</td>
</tr>
<tr>
<td>Designated Risk Reserve Fund Balance</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>$21,068,574</strong></td>
</tr>
<tr>
<td>Long Term Liabilities - Deferred Revenue</td>
<td>-</td>
</tr>
<tr>
<td>Long Term Liabilities - Other</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>$21,068,574</strong></td>
</tr>
<tr>
<td>Capital Contributions</td>
<td>-</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>-</td>
</tr>
<tr>
<td>OneCare Net Assets</td>
<td>5,686,426</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td><strong>5,686,426</strong></td>
</tr>
<tr>
<td><strong>Liabilities and Equities</strong></td>
<td><strong>$26,755,000</strong></td>
</tr>
</tbody>
</table>

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OneCare's work towards making steady advancements in value-based care adoption

**Successes**

1. **Growing engagement**
   - Broad accountability and engagement across 162 independent organizations
   - Increasing attribution

2. Continual commitments to population investments and approach in support of delivery reform

3. Advancing innovative payments models linked to outcomes and quality

4. Delivering on fixed predictable payments for payers and providers

**Top Three Facilitators for Maximum Success***

- Provider Interest
- Health Plan Interest/Readiness
- Government Influence

*HCP-LAN survey

**Future Opportunities**

- Move away from fee-for-service lookback as the basis for target setting
- Maximizing risk/reward in alternative advanced payment models
- Models that support rural high value/low-cost providers