OneCare Vermont

2023 Revised Budget Presentation to

Green Mountain Care Board

Vicki Loner, CEO;
Tom Borys, CFO;
Sara Barry, COO; and
Carrie Wulfman, MD, CMO

May 5, 2023

Presentation Outline

General Budget Updates

- Attribution
- TCOC
- Fixed Payments
- Risk
- Population Health Management (PHM) Expenses
- Operating Expenses
- Hospital Participation Fees

Notable Changes

- No BCBSVT Contract
- New Self-Funded Program
- Comprehensive Payment Reform (CPR) Program
- DVHA $2M Payments
- Evaluation Strategy
- 2% Administrative Cut
- MH Screening and Follow-Up Initiative

General Budget Updates

Attribution Update

Notable Changes

- Medicaid attribution came in higher than estimated
- No BCBSVT attribution in revised budget
- Self-Funded plan restores some lives to the attribution total

Program	Original Budget	Revised Budget	Change
Medicare (Pre MA)	67,558	68,605	1,047
Medicaid Traditional	95,175	105,101	9,926
Medicaid Expanded *	30,563	37,309	6,746
Commercial Programs	103,362	19,925	(83,437)
Total Lives	**296,658**	**230,940**	**(65,718)**
Scale Lives	**267,829**	**230,940**	**(65,718)**
Medicare (Post MA) **	53,763	54,321	558

* Medicaid contract now combines the cohorts; segmentation shown here for comparison

** Excludes those moving to a MA plan after the initial attribution run

Program TCOC Targets Forecast

Notable Changes

- Medicare target estimate updated to reflect treatment of sequestration and a slightly higher attrition rate
- Medicaid targets combined into one; net higher TCOC due to strong attribution
- No BCBSVT healthcare costs included in an ACO program
- MVP target reduced due to lower attribution
- Self-Funded program estimated to restore $63M of healthcare costs back into ACO program

	Original Budget	Revised Budget	Change
Medicare TCOC	$552,916,537	$491,101,380	($61,815,157)
Medicare Shared Savings - Blueprint	$9,545,916	$9,545,916	$0
Medicaid - Traditional TCOC	$264,095,487	$349,847,887	$85,752,400
Medicaid - Expanded TCOC	$41,989,529	$0	($41,989,529)
BCBSVT QHP TCOC	$176,399,528	$0	($176,399,528)
MVP QHP TCOC	$73,483,610	$55,946,415	($17,537,195)
BCBSVT Primary - Risk TCOC	$294,897,695	$0	($294,897,695)
Self-Funded	$0	$62,752,576	$62,752,576
Total	**$1,413,328,302**	**$969,194,174**	**($444,134,128)**

Fixed Payments

- OneCare is required to report on its progress toward "fixed payment targets"
  - These targets were designed to reflect realistic expectations for fixed payment growth over the next few years
- Achievement of targets is dependent on payer willingness to offer attractive fixed payment models

Targets for Contract Revenue in Unreconciled FPPs

Program	Baseline	PY22	PY23	PY24	PY25	PY26
Medicare	0.00%	0.00%	0.00%	0.00%	TBD	TBD
Medicaid	50.40%	50.70%	51.00%	51.30%	51.60%	51.90%
Commercial	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Actual Contract Revenue in Unreconciled FPPs

Program	Baseline	PY22	PY23	PY24	PY25	PY26
Medicare	0.00%	0.00%	0.00%			
Medicaid	55.30%	53.40%	57.50%			
Commercial	0.00%	0.00%	0.00%			

Total Risk

Notable Changes

- Risk reduced due to exclusion of BCBSVT contract
- Small increase due to Self-Funded arrangement
- Other risk changes flow from attribution and TCOC target updates

	Corridor Risk			Blueprint/SASH Risk *		
	Original Budget	Revised Budget	Change	Original Budget	Revised Budget	Change
Medicare	$16,873,874	$15,019,419	($1,854,455)	$9,545,916	$9,545,916	$0
Medicaid - Traditional	$7,922,865	$10,495,437	$2,572,572	$0	$0	$0
Medicaid - Expanded	$839,791	$0	($839,791)	$0	$0	$0
Commercial Programs	$10,895,617	$1,221,228	($9,674,389)	$0	$0	$0
Total	**$36,532,145**	**$26,736,084**	**($9,796,061)**	**$9,545,916**	**$9,545,916**	**$0**

* Risk that the advanced shared savings needs to be refunded to CMMI. OneCare now to hold $3.9M of this risk.

Total Risk, continued

- Notable Changes
  - OneCare responsible for $3.9M of Blueprint/SASH risk, plus risk mitigation for NVRH

	Accountability Pool					
HSA	Non-Hospital PCP	Hospital PCP	Risk Bearing Entity Share	Total Corridor Risk	Blueprint Risk	Total Risk
Bennington	$41,278	$149,562	$1,784,382	$1,975,222	$509,278	$2,484,500
Berlin	$34,323	$257,904	$2,717,461	$3,009,688	$836,671	$3,846,359
Brattleboro	$44,470	$63,558	$1,004,175	$1,112,203	$285,800	$1,398,003
Burlington	$561,644	$370,836	$7,273,781	$8,206,261	$1,974,387	$10,180,648
Lebanon	$37,391	$46,386	$564,714	$648,491	$96,961	$745,452
Middlebury	$66,264	$87,336	$1,264,412	$1,418,012	$319,636	$1,737,648
Morrisville	$90,419	$0	$422,930	$513,349	$0	$513,349
Newport	$521	$103,734	$496,011	$600,266	$0	$600,266
Randolph	$79,222	$0	$377,380	$456,602	$0	$456,602
Rutland	$313,270	$0	$2,689,617	$3,002,887	$699,856	$3,702,743
Springfield	$102,252	$0	$487,892	$590,144	$0	$590,144
St. Albans	$255,356	$0	$2,132,635	$2,387,991	$546,591	$2,934,582
St. Johnsbury	$109,135	$111,708	$1,120,807	$1,341,650	$0	$1,341,650
Townshend	$0	$0	$0	$0	$0	$0
Windsor	$808	$54,144	$562,487	$617,439	$176,268	$793,707
OneCare Vermont	$0	$0	$855,879	$855,879	$4,100,469	$4,956,348
Total	**$1,736,353**	**$1,245,168**	**$23,754,563**	**$26,736,084**	**$9,545,916**	**$36,282,000**

PHM Expenses

- Fewer attributed lives leads to less PHM Program expense
- Incorporation of DVHA funding model
- Incorporation of CPR modification
- New MH Screening and Follow-Up initiative

	Original Budget	Revised Budget	Change	Notes
PHM Base Payments - PCP	$13,156,767	$9,733,548	($3,423,219)	Fewer BCBSVT lives
PHM Base Payments - HH	$882,300	$882,300	$0	
PHM Base Payments - DA	$1,065,050	$640,050	($425,000)	Change in DVHA funding model
PHM Base Payments - AAA	$170,000	$170,000	$0	
PHM Bonus Potential - PCP	$2,030,995	$1,537,459	($493,536)	Fewer BCBSVT lives
PHM Bonus Potential - PCP (DVHA Funding)	$0	($912,514)	($912,514)	Change in DVHA funding model
PHM Bonus Potential - HH	$124,560	$124,560	$0	
PHM Bonus Potential - HH (DVHA Funding)	$0	($8,719)	($8,719)	Change in DVHA funding model
PHM Bonus Potential - DA	$150,360	$590,360	$440,000	Change in DVHA funding model
PHM Bonus Potential - DA (DVHA Funding)	$0	($589,456)	($589,456)	Change in DVHA funding model
PHM Bonus Potential - AAA	$24,000	$24,000	$0	
Longitudinal Care	$399,000	$399,000	$0	
DULCE	$145,366	$145,366	$0	
CPR Program Cost	$1,510,492	$2,106,823	$596,330	MVP transition into CPR
CPR Program Cost (DVHA Funding)	$0	($489,310)	($489,310)	Change in DVHA funding model
Specialist Fund	$150,000	$150,000	$0	
Innovation Fund	$69,667	$69,667	$0	
MH Screening and Follow-Up Program	$0	$1,638,140	$1,638,140	New initiative
SNF Initiative	$201,299	$201,299	$0	
Quality Improvement Initiatives	$296,240	$296,240	$0	
PCMH Payments	$2,163,158	$2,062,850	($100,308)	Updated to reflect info from State
Community Health Team Payments	$2,874,062	$2,974,370	$100,308	Updated to reflect info from State
SASH	$4,508,696	$4,508,696	$0	
Total	**$29,922,012**	**$26,254,729**	**($3,667,284)**	

Operating Costs

- Changes stem from:
  - 2% admin cut
  - Evaluation strategy
  - Deletion of BCBSVT contract
  - Other budgetary updates based on latest information available

	Original Budget	Revised Budget	Change	Primary Driver
Wages & Fringe	$8,704,465	$8,059,973	($644,492)	Positions lost due to 2% admin cut
Purchased Services	$3,369,471	$3,745,930	$376,459	Evaluation strategy; contract updates
Contract & Maintenance	$0	$0	$0	
Software	$1,871,810	$1,734,949	($136,860)	2% admin cut; accounting changes
Insurance	$261,000	$261,000	$0	
Food & Beverage	$18,710	$18,710	$0	
Advertising	$114,000	$50,000	($64,000)	2% admin cut
Travel	$25,975	$25,800	($175)	
Books, Dues, Subscriptions and Licenses	$67,478	$67,478	$0	
Mail & Production	$30,000	$21,750	($8,250)	No contract with BCBSVT
Office Supplies	$35,099	$31,300	($3,799)	
Other Operating Expenses	$508,887	$607,800	$98,913	GMCB billback update
Professional Development	$104,220	$103,349	($871)	
Lease & Rental	$71,455	$50,775	($20,680)	Accounting changes
Utilities	$7,401	$12,901	$5,500	Accounting changes
Risk Protection	$0	$0	$0	
Total	**$15,189,971**	**$14,791,715**	**($398,255)**	

Hospital Participation Fees

- The hospital participation fee amount is used to fund OneCare operations and supplement payer investments to create a uniform PHM financial model
- The amount of the MH Screening and Follow-Up initiative was determined so that **hospital participation fees remain equal to the original budget submission**, despite the changes noted
  - Absent this change hospital participation fees would have been ~$1.6M less

HSA / Hospital	Participation Fees
Bennington / SVMC	$1,576,958
Berlin / CVMC	$2,409,858
Brattleboro / BMH	$822,917
Burlington / UVMMC	$8,466,721
Lebanon / DH	$963,596
Middlebury / Porter	$748,757
Morrisville / Copley	$153,961
Newport / NCH	$793,145
Randolph / Gifford	$249,005
Rutland / RH	$1,412,531
Springfield / Springfield	$207,167
St. Albans / NMC	$719,386
St. Johnsbury / NVRH	$807,913
Townshend / Grace Cottage	$0
Windsor / Mt. Ascutney	$496,528
Updated Budget Total	**$19,828,444**
Original Budget Total	**$19,828,444**
Aggregate Change	**$0**

Notable Changes

Notable Change #1: No BCBSVT Contract

- BCBSVT declined to enter into an ACO contract with OneCare for the 2023 performance year
- This decision has a number of important impacts:
  - Vermont's largest insurer not contributing to Vermont's All-Payer Model
  - Left providers with insufficient time to prepare for the financial fallout
- OneCare promptly engaged with its participants and governance committees – areas of focus included:
  - Communicating financial impact of the BCBSVT decision
  - Providing financial stability for CPR practices
  - Developing a self-funded initiative with UVMHN
  - Creating a mental health screening initiative for primary care

Notable Change #2: Self-Funded Program

- OneCare collaborated with UVMHN to develop an ACO program between the two organizations (as opposed to using a TPA intermediary
  - *Represents a shared commitment to ACO programs and value-based care*
  - *Designed to be viable for other health plans in the future*

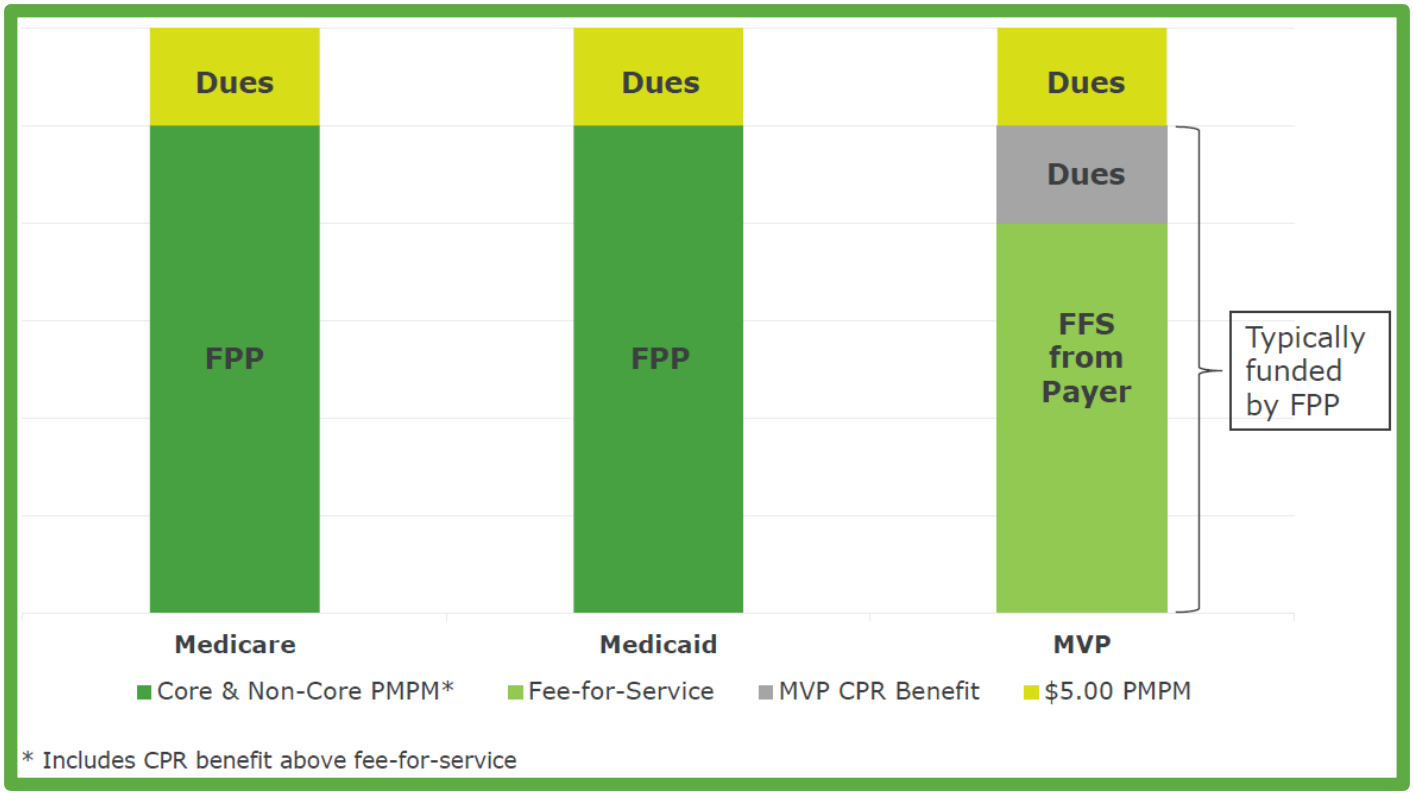
Term	Model
Covered Lives	UVMHN health plan covered lives that attribute to a OneCare provider
Covered Services	Part A- & Part B-like services
Risk Corridor	Meets scale target requirements
ACO Investment	Base PMPM paid by plan to OneCare to be used for provider incentives
ACO Activities	Attributed lives incorporated into OneCare's PHM Program
Quality	Set of quality measures, with emphasis on those relevant to employers
Cost to Hospitals	$296,629

Notable Change #3: CPR Program Adjustments

- OneCare's Comprehensive Payment Reform (CPR) Program is a payer-blended fixed payment initiative for independent primary care
  - Historically included a BCBSVT fixed payment component
- OneCare engaged with CPR participants in late December to discuss ways to stabilize their financials and adjust the CPR program in light of no contract with BCBSVT
- In response, this budget includes migration of **MVP attribution into the CPR financial model**, even absent a fixed payment option
  - Lessens the financial drop-off for participating practices
  - Restores some program scope and alignment

Notable Change #3: CPR Program Adjustments cont.

- Because there is no fixed payment option from MVP, some of the program costs now need to be funded through hospital participation fees
  - Historically managed through fixed payment allocations



Notable Change #4: DVHA $2M Direct Payments

- The budget submitted last October included a $2M “unsecured revenue” line related to the DVHA contract
  - It was unclear at the time if those funds would flow through OneCare, or be processed as payments directly from DVHA to OneCare participants
- DVHA will make the payments directly to providers
  - Providers will receive some funds from OneCare and some funds from DVHA for the same initiative
  - Payments linked to outcomes-based components
- The revised budget reflects this change
  - Deleted $2M “unsecured revenue”
  - Inserted expense offsets to the initiatives/components DVHA will be funding
- This change **does not affect overall program design or provider payment amounts**; just from whom the payment comes

Notable Change #5: 2% Admin Budget Cut

- The GMCB budget orders require a 2% cut to the administrative budget to generate savings for Vermonters – approximately $304,000
  - Due to the nature of OneCare funding, the cut flows to participating hospitals through reduced participation fees
- This cut results in fewer resources to support ACO activities and the participating providers
- Budget includes other estimate revisions netting ~$8k

2% Admin Cuts

Staffing Changes	Amount
Eliminated Position - Compliance Analyst	
Eliminated Position - Evaluation Manager	
Eliminated Position - VBC Coordinator	
Eliminated Position - ACO Data Collection Specialist	
Eliminated Position - Network Operations Specialist	
Total Salary Decrease	**($419,447)**
Fringe	($126,673)
Total Salary & Fringe Decrease	**($546,120)**
Other Cuts	**Amount**
Software and Consulting	$220,000
Public Relations	($64,540)
GMCB Billback Update	$86,413
Combined Impact	**($304,247)**
Target	$303,799
Variance from Order	**($448)**

Notable Change #6: Evaluation Strategy

Purpose:

- **Evaluate the effectiveness of key OneCare programmatic initiatives**
- **Inform strategic decision-making about future investments and programmatic adaptations**

Scope:

- **Design, conduct, and report on four focused studies:**
  - Comprehensive Payment Reform Program
  - Complex Community Care Coordination Program
  - Value Based Incentive Fund (2022)
  - GMCB's Budget Order to examine the ROI for OneCare's activities during the Vermont All-Payer Model
- **Plan the design of evaluation activities for OneCare's 2023 PHM program**

Evaluation Strategies

- **Mixed methods approach:**
  - **Quantitative:** regression-adjusted trend, benchmarking, and subgroup analyses to understand the extent to which costs, utilization, and quality outcomes change over time
  - **Qualitative:** focus groups and interviews with key stakeholders in each program
- **Leverage existing data and collect new information as needed**
- **Integrated data collection timelines and methods**
- **Timelines:**
  - Programmatic study findings anticipated September 2023
  - ROI study findings anticipated November 2023

Benchmarking

Background

- **Updated reports per GMCB's latest specifications:**
  - Added a comparator to all Medicare ACOs combined ("National All ACO Cohort"); risk and cost adjusted per prior methodology
  - Incorporated 10th, 50th, and 90th percentiles for the National All ACO Cohort for each metric independently
- **Updated the report with CMS data through Q2 of 2022, increased attribution to ACOs nationally by 10%**
- **Reports are for performance years 2019-2021**

Selecting Comparison Groups

Possible Comparison Groups	Key Features
Vendor Off-the-shelf product	All Medicare beneficiaries nationally • In and outside ACOs • Fee-for-service claims
National All ACO Cohort (GMCB Required)	All Medicare beneficiaries associated with 513 ACOs nationally • Any ACO track (e.g. shared savings only, bundled payments, two-sided risk) • Any ACO structure (e.g. large integrated, rural, SNF or PCP-only)
National ACO Peer Cohort (Vendor Recommended)	All Medicare beneficiaries associated with 20 ACOs nationally, selected for similarities to OneCare based on: • ACO two-sided risk model • High revenue category ACO (i.e. not only primary care) • An urban/rural beneficiary mix • Large representation of specialist providers in ACO network (> 40%) • <15% of attributed beneficiaries are also enrolled in Medicaid (Duals)

General Population

ACOs similar to OneCare

2021 OneCare vs National ACO Peer Cohort Comparison

Areas of Strength

- Lower total cost of care[a] (OneCare KPI)
- Low ambulatory care sensitive admissions for diabetes composite, hypertension, uncontrolled diabetes, amputation for patients with diabetes, and asthma in younger adults[b]
- Low preference sensitive or outpatient sensitive preventable admissions (15/15 measures)[b]
- High post acute care (combined inpatient facility rehabilitation, SNF facility, and home health care) spend* and a high percentage of inpatient admissions discharged to home health[b] (OneCare KPI)
- Low inpatient facility (medical and surgical) utilization and spend[b] (OneCare KPI)
- Despite high outpatient facility surgery volume, the spend is low[b]
- Low outpatient professional surgery visits and spend[a]
- Low Part B pharmacy (combined outpatient and professional) spend[b]

Areas of Opportunity

- High emergency department utilization and cost[b] (OneCare KPI)
- Low primary care utilization and rate of primary care and annual wellness visits[b] (OneCare KPI)
- High prevention quality indicator composite (overall, acute, chronic) admissions[a] (possible future OneCare KPI)
- High ambulatory care sensitive admissions for congestive heart failure, community-acquired pneumonia, COPD, and diabetes long-term complications[a]

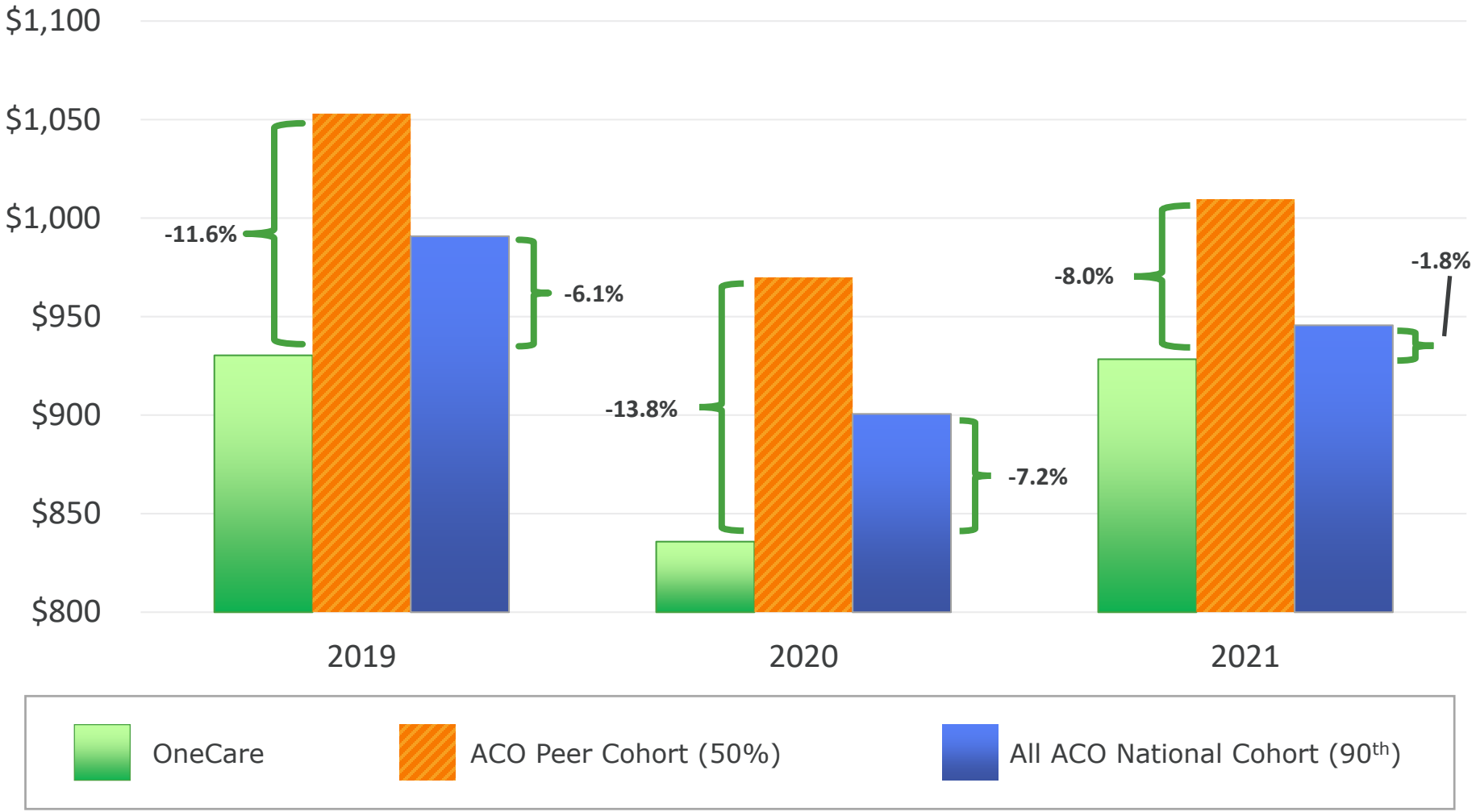
Inconclusive report observations:

- Explore reasons for low specialty care visits and spend[b]
- Explore reasons for high utilization, LOS, and costs in skilled nursing facilities[b]

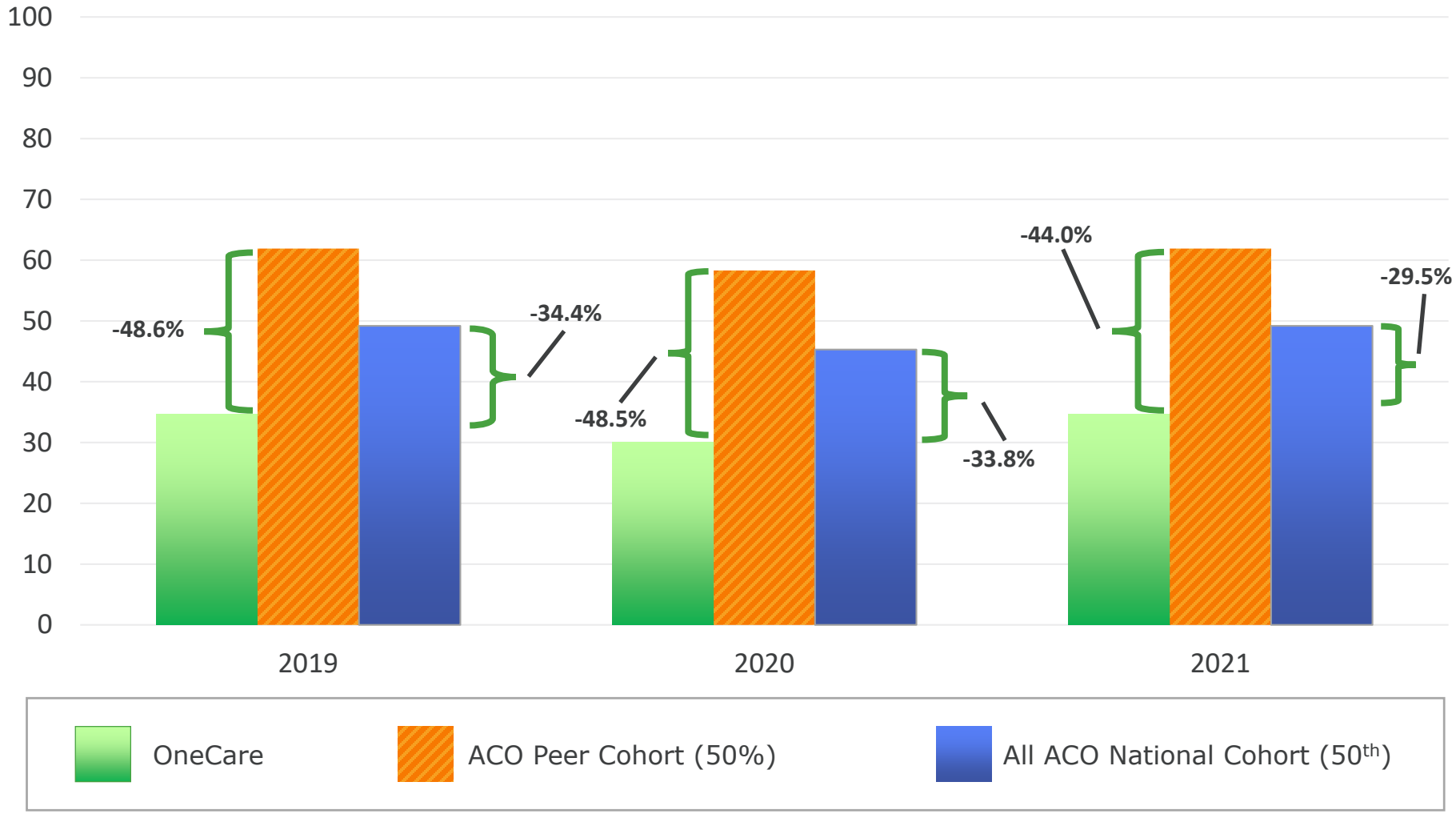
[a] Comparison to National All ACO Cohort 90th %ile. | [b] Comparison to National All ACO Cohort 50th %ile

* Note OneCare believes that higher post acute spend is better if it is part of a system of care keeping people in the most appropriate setting of care

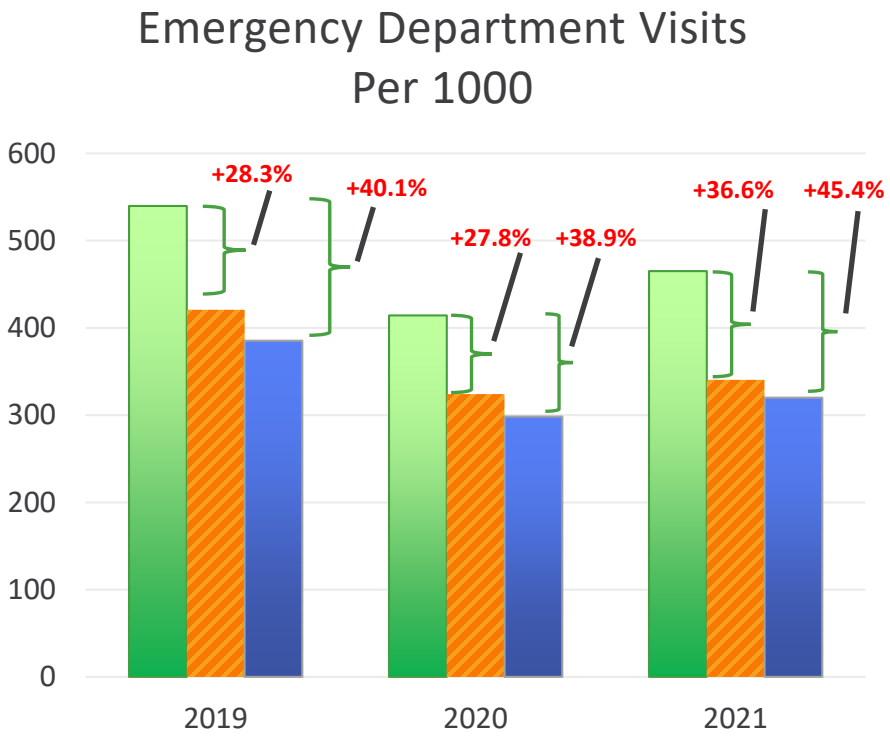
OneCare Medicare PMPM Costs are Consistently Lower than Among Comparison Groups

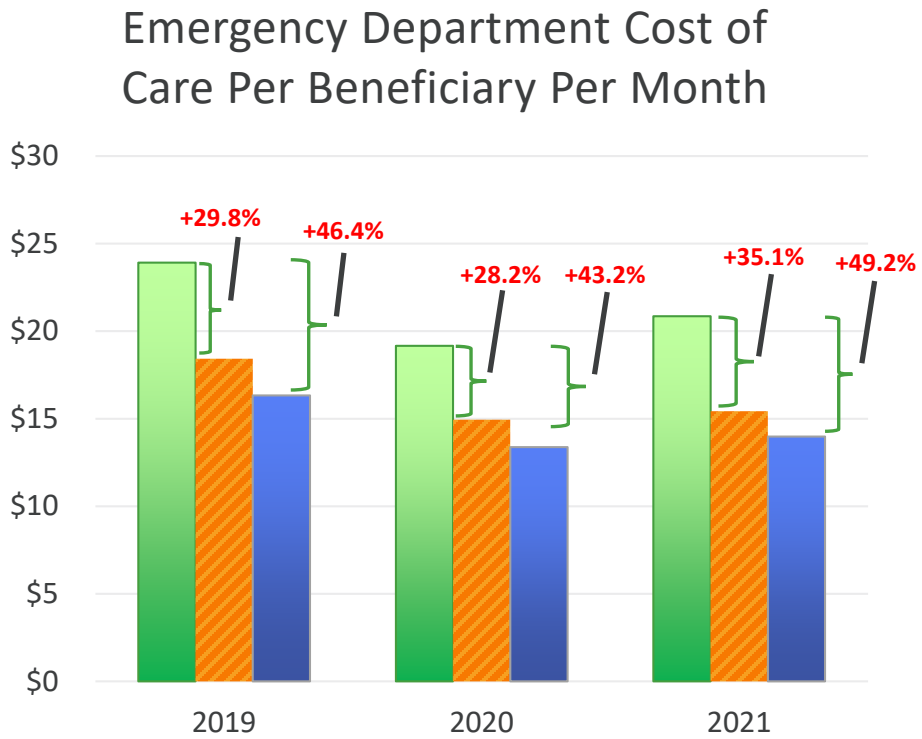


OneCare Medicare Preference Sensitive or Outpatient Sensitive Preventable Admissions/1000 Composite is Consistently Lower than Among Comparison Groups



OneCare Medicare Emergency Department Visits and Costs are Higher than Among Comparison Groups



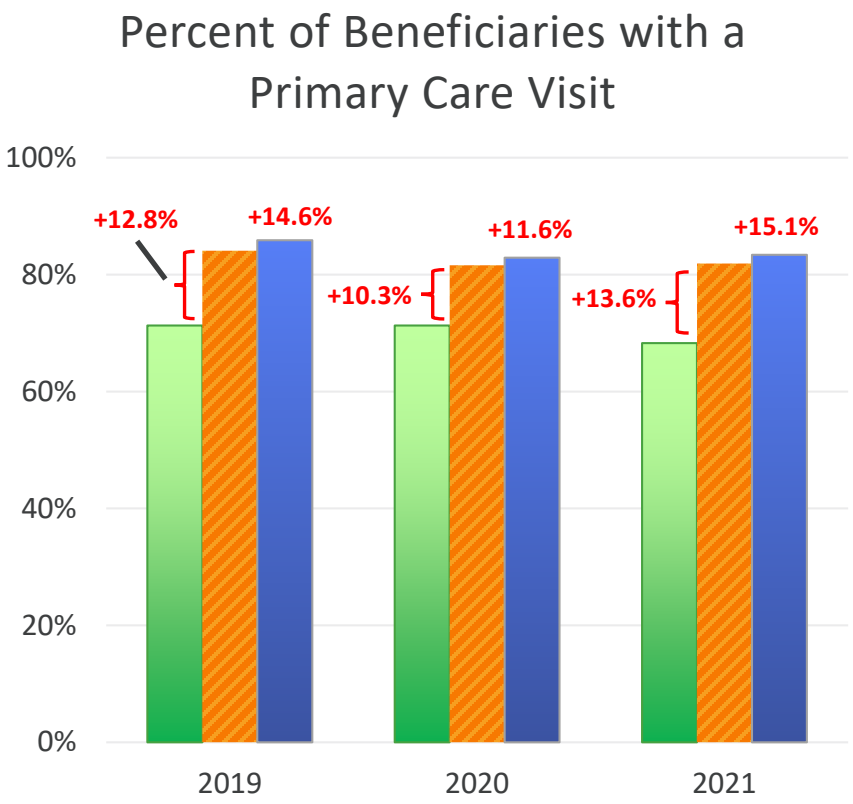


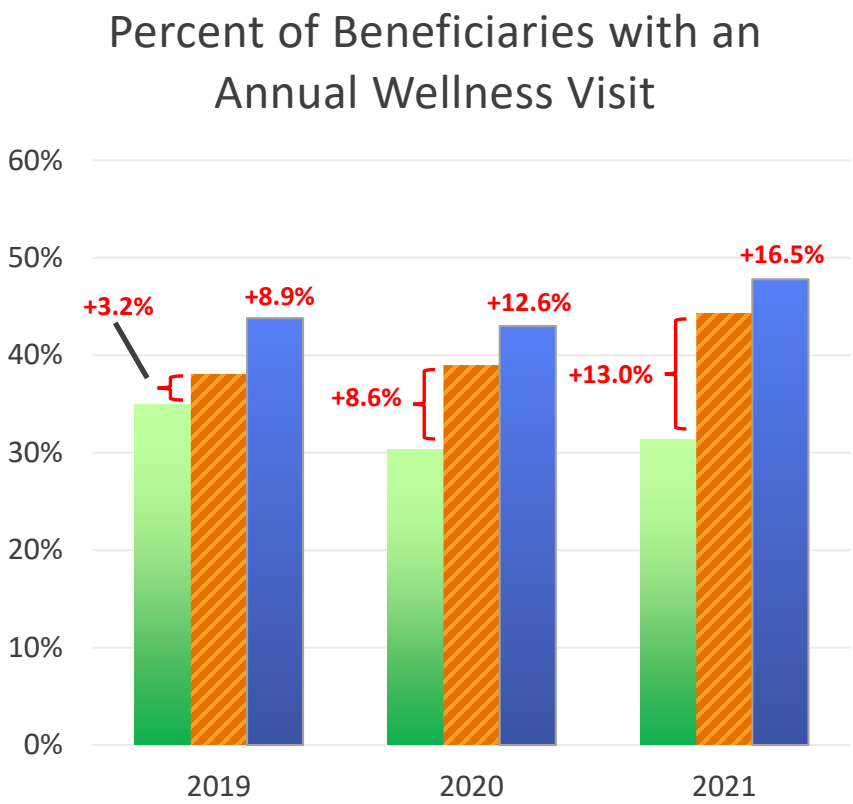
OneCare

ACO Peer Cohort (50%)

All ACO National Cohort (50th)

OneCare Medicare Beneficiaries are Less Likely to Have a Visit with their Primary Care Provider or Participate in an Annual Wellness Visit than Among Comparison Groups





OneCare

ACO Peer Cohort (50%)

All ACO National Cohort (50th)

Key Strategies to Address these Opportunities

- **2023 PHM specifically targets ED utilization and wellness visits as high priority areas:**
  - Set performance targets
  - Gather data quarterly to identify high/low performers; provide patient activation lists
  - Share performance against targets transparently across provider organizations
  - Disseminate strengths and opportunities via HSA Consultations, learning about success/best practices in the network
- **OneCare is creating opportunities to learn from top performers and amplify successes:**
  - With our providers: HSA consultations, value-based care quarterly webinars, peer-to-peer learning, and ongoing quality improvement collaborations
  - With other ACOs: ongoing outreach with other top performing peer ACOs to discuss best practices in context of their local systems of care

EXAMPLE - March Peer-to-Peer learning featured three high-performing organizations discussing their strategies to maximize wellness visits. Strategies included:

- Take every opportunity to do wellness visit check-in with patients (including connections with pharmacy, sick/acute visits, phone calls)
- Establish and prioritize a culture of wellness
- Patient outreach reminders - automated reminders for staff in EMR/Maximizing EMR are helpful
- Understand patient population who haven't been seen in 2-3 years

OneCare Surveys

Qualitative Provider Survey
Presented at STFM Conference, September 2022

Survey Title	Survey Date	Purpose of Survey
Patient Experience of Care Coordination Survey ('21)	2021	
Finance Survey	2021	
Data & Analytics Survey	7/2021	Request for feedback around types of reporting OneCare offers, the data needs of the network, confirmation of the right contacts at each organization, etc.
Patient Experience of Care Coordination Survey ('22)	2022	
Narrative Embedded in Triannual Reporting	2022	Asked for a description of how OneCare Care Coordination Funding is used.
UVM COM Provider Survey	Late 2022	SEE NEXT SLIDE FOR DETAILS
Provider Qualitative Interview/Focus Group (Alicia Jacobs)	2022	
CPR Informal/Qualitative Meeting Survey	2022	
Health Service Area Consultation Survey	2023	Requested feedback around the Spring 2023 HSA Consultation sessions to engage the network in if this forum supports their work.

Drs. Jacobs, Wulfman, and Cangiano

- **Study question:** How well do family medicine physicians understand value-based care and its impact on their work?
- **Target Population:** Academic Family Medicine MDs
- **Methods:** Qualitative, recorded virtual interviews, transcribed in entirety
- **Findings -** Academic Family Medicine Doctors
  - Understand value-based care (VBC)
  - See VBC as the hope for the future of the primary care workforce
  - Are looking forward to further evolving their care teams
  - Younger faculty learned VBC and have only practiced in this model
  - Do not really understand ACOs

Quantitative Survey of Providers - Larner College of Medicine, Survey Tool Development

2022 UVM College of Medicine Survey

- Literature Review – no existing provider survey measures
- Build survey based on Technology Acceptance Model
  - Survey Theme #1: "Ease of Use"
  - Survey Theme #2: "Perceived Usefulness"
- Very low response rate – difficult to interpret
  - ~7.6% completion rate
- Most common response: "Neither Agree Nor Disagree"
  - Suggests a lack of understanding ACO?
  - Perhaps poor question choice?

2022 UVM CoM Survey Key Findings

- For 'Usefulness' theme, highest correlations: rewarded for good outcomes, ACO membership by choice and percent of patients in ACO
- For Ease of Use, the opposite pattern was observed
- "Valid" results are minimally actionable
- Independent practice respondents more than twice as likely to report they understand OneCare

Key Takeaways and Next Steps

- **Respondents often lack understanding of OneCare**
- **OneCare remains dedicated to surveying a broad group of stakeholders to improve its work**
- **Survey mechanics are challenging**
- **Balancing qualitative and quantitative analyses is optimal**
- **OneCare can better centralize and coordinate survey approach**

Population Health Model (PHM)

2023 Progress update

PHM Defined-
(Evolution from prior programs, not new)

- Promotes clarity, simplification, efficiencies
- Blends base, care coordination, and bonus funding streams
- Marries care coordination and quality improvement activities
- Rewards teamwork in practices and across the care continuum at local level
- Drives work on identified priority areas for both quality improvement and cost reduction

Population Health Model Metrics - 2023

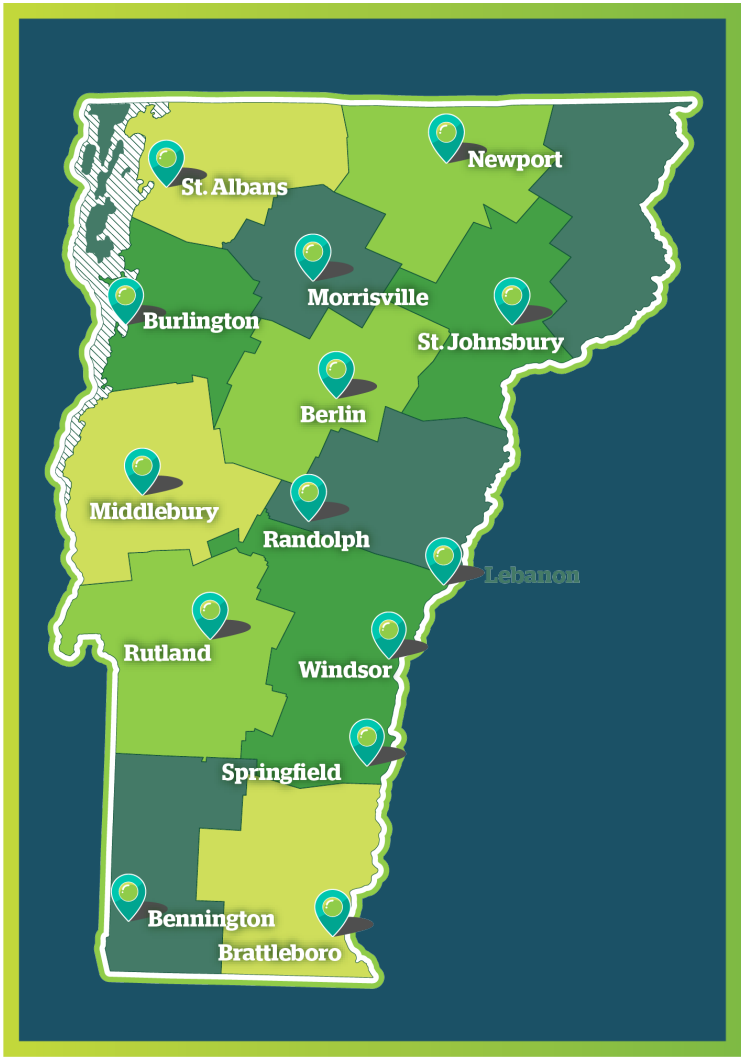
Metric	Population	Baseline Performance	Comparison Performance	Target
Child & Adolescent Well Visits (Claims)	2022 OneCare Cohort (Excl. BCBS)	58.0%	57.74%	57.54%
Developmental Screening	2022 OneCare Cohort (Excl. BCBS)	63.6%	62.02%	57.40%
Age 40+ Annual Wellness Visit	2022 OneCare Cohort (Excl. BCBS)	53.5%	52.96%	48.19%
ED Re-Visits	2022 OneCare Cohort (Excl. BCBS)	34.6%	32.64%	31.14%
Initial HTN Follow-up	2022 OneCare Cohort (Excl. BCBS)	62.1%	63.27%	55.88%
Routine HTN Follow-up	2022 OneCare Cohort (Excl. BCBS)	22.8%	22.87%	20.48%
Diabetes: HbA1c Poor Control (>9%)	MVP QHP	21.4%	16.33%	Payer Blended 39.9%
Diabetes: HbA1c Poor Control (>9%)	Medicaid	39.0%	31.99%	Payer Blended 39.9%
Diabetes: HbA1c Poor Control (>9%)	Medicare	13.7%	9.98%	Payer Blended 39.9%

Target met Target not met

Includes claims received by OneCare as of 4/17/2023

HSA Consultations, Spring 2023

- Value-Based Care Team met with all 14 HSAs (March-April)
- OneCare expanded invitee list: Primary Care, AAAs, HHH, DAs, Blueprint, Hospitals, etc.
- The audience includes key executive, operational and clinical contacts
- Average attendance rate: 11 leaders per consultation
- Survey to analyze content and purpose of HSA Consultation and 94% of respondents found the consultations to be somewhat insightful/insightful/very insightful



Trending Highlights 2023

- Randolph-meeting HSA level target for initial HTN follow up
- Rutland-increasing Medicaid Expanded PCP engagement and lowering spend rate in same
- Springfield-increasing PCP engagement, reducing ED utilization, increasing well visits
- Bennington-reducing readmissions, increasing team-based care, increasing colorectal cancer screening
- Newport- established daily care coordination rounding in primary care and improved diabetes control
- St. Johnsbury-reducing avoidable ED visits, meeting stretch goals for diabetes control

PHM Accountabilities - Primary Care 2023

- Required tri-annual care coordination reporting
- Timely response to audits
- Must meet Care Coordination accountabilities to unlock any PHM funds
  - High medical and social risk
  - High ED utilizers
  - High total cost of care
  - High inpatient utilizers
- Must engage in ongoing process improvement plan if not meeting ED and HTN targets

PHM Performance Update (Sample)

Table 1: Population Health Model Measure Performance by Practice

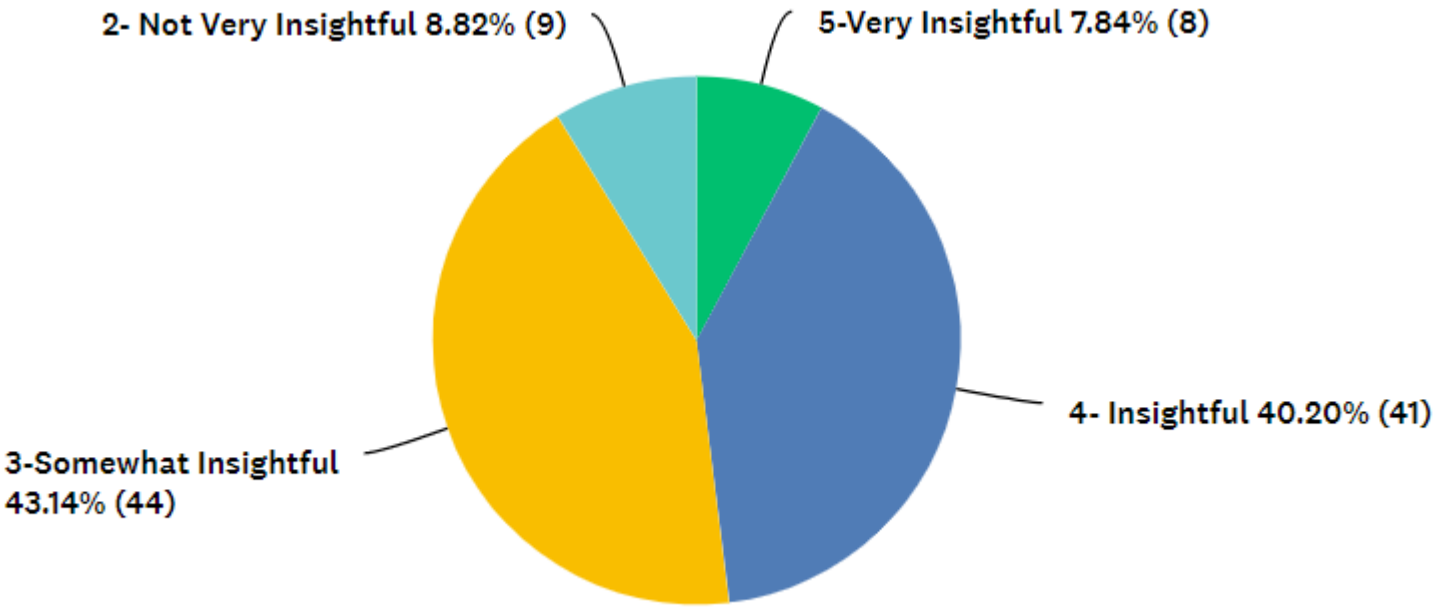
Table Color Key: =Meeting Target

		Population		Estimated Mid-Year Assignment		Practice-Level Measures			HSA-Level Measures			Q3 VBIF Results (TIN level)
								Inverse Measures				
Organization	Practice Type	Practice		Pediatric	Adult	Child & Adolescent Well Visits	Developmental Screening	Age 40+ Annual Wellness Visit*	Emergency Department Re-visits*	Initial Hypertension Follow-Up*	Routine Hypertension Follow-Up*	Diabetes A1c Control
	Family			42	232	**62.0%**	0.0%	**15.2%**	**5.3%**	**56.8%**	**14.1%**	**16.0%**
	Family			59	215	**58.9%**	50.0%	**24.2%**	38.7%	73.8%	31.8%	**12.5%**
	Adult			<11	306			3.9%	33.3%	72.1%	31.2%	**9.4%**
	Pediatric			292	<11	**82.4%**	**97.6%**		47.6%	**0.0%**	**0.0%**	
	Adult			35	1,060			39.2%	33.9%	**30.6%**	**9.1%**	**23.3%**
	Family			204	1,236	44.2%	15.4%	39.8%	**18.9%**	75.0%	34.9%	**30.7%**
	Adult			<11	1,599			14.1%	48.3%	74.9%	30.4%	**30.7%**
	Family			601	1,593	52.5%	**59.1%**	45.7%	**27.1%**	62.8%	25.6%	**30.7%**
	Pediatric			2,045	93	**66.1%**	**65.7%**		**22.0%**	**33.3%**	**0.0%**	
	Adult			64	1,192			41.5%	46.5%	67.8%	31.1%	**30.7%**
HSA Total				3,342	7,535	**58.6%**	**63.9%**	38.5%	34.4%	63.6%	25.8%	**23.2%**
OneCare Total		**OneCare Total**				**59.0%**	**64.3%**	**48.1%**	**32.5%**	**64.0%**	**25.4%**	**21.0%**
HSA Rank (out of 14)						6th	7th	2nd	8th	4th	9th	10th

- Rank is based on a comparison of age, payer, and hospital-proximity adjusted HSA rates, except for Diabetes A1c Control (VBIF samples)
- Lower ranks = better performance (i.e. ascending order for inverse measures, ascending order for others)

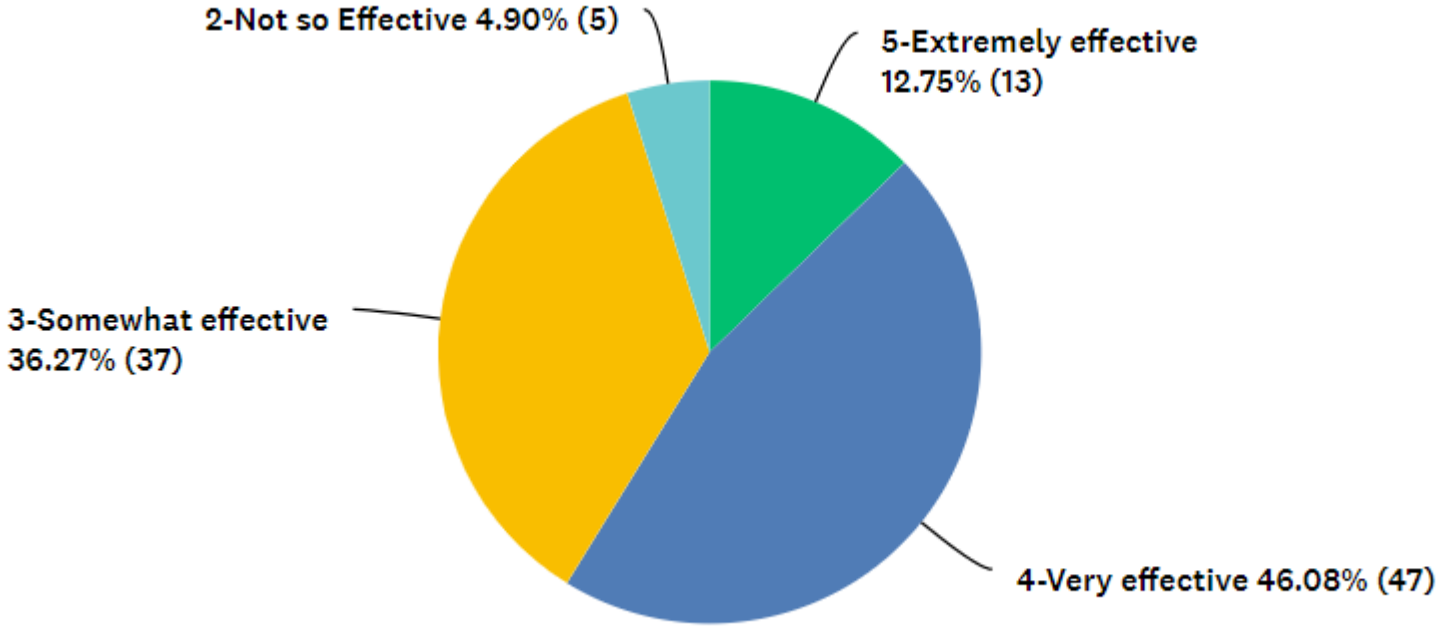
Engagement

How insightful was the data presented related to health disparities?



Engagement

How effective was the OneCare team at achieving our goal of creating a space for collaboration?



Related Work & Next Steps:

- Value-Based Care Team local meetings: monthly to quarterly
- Quarterly Quality Webinars
- Outreach to low-performing participants
- Best practices identification and information sharing
- 2024 Metrics and Policy Development, added accountabilities
- Fall rounding Sept-Oct

Notable Change #7: Mental Health Screening Initiative

- OneCare is offering a one-time mental health screening initiative in 2023 of $1.6 Million total –two payment installments
- Payment #1: May 2023 to those practices who implement or already have a protocol to administer depression and suicide screening for patients aged twelve and older and report results electronically
- Participants already screening must report 2022 year-end baseline electronically
- Participants must document and track screening and follow-up electronically and submit data to OneCare
- Qualifying primary care practices must report progress back to OneCare in latter half of the year
- Payment #2: December 2023 to those practices who met Payment #1 requirements and who electronically report results.

Questions?

Medicaid Attribution

- Attribution levels are specific to a point in time

Type	Explanation
Starting Attribution	• Attribution generated in the October/November timeframe leading up to a performance year • Maximum number of lives eligible for participation • Used to determine program terms (e.g. total cost of care target)
Monthly Attribution	• Refresh of the Starting Attribution list to evaluate member eligibility • Not all lives on the Starting Attribution list will be eligible in each month
Average Attribution	• Projected average of Monthly Attribution throughout the full year (i.e. member months / 12) • Used to PHM revenue and payments estimates
Final/Settlement Attribution	• Attribution used for purposes of final settlement and shared savings/losses calculations

- The difference between Starting Attribution of 142,409 and January attribution of 130,882 reflects lives on the Starting Attribution roster who are no longer eligible as of January
  - Common reasons for lost eligibility include change to a different insurer, change in Medicaid coverage type, and the member has passed

PHM Payments Comparison

- The following table provides a comparison of PHM payment estimates in the original budget vs. the revised budget
  - Incorporated the DVHA funds paid directly to providers
  - Incorporated estimated BCBSVT payments paid directly to providers

- The overall increase in funding potential to primary care is driven by higher-than-estimated Medicaid attribution and addition of the self-funded program

	Original	Revised				
PHM Program	**OneCare Pmts.**	**OneCare Pmts.**	**Plus DVHA Pmts. ***	**Plus BCBSVT Pmts. ****	**Total**	**Change**
Hospital/Hospital PCP	$10,250,510	$8,667,414	$383,118	$1,500,000	$10,550,532	$300,022
Independent PCP	$5,618,833	$5,062,679	$709,963	$800,000	$6,572,642	$953,809
FQHC	$6,143,165	$5,198,308	$308,743	$1,100,000	$6,607,051	$463,886
Specialist	$185,549	$185,549	$0	$0	$185,549	$0
Designated Agency	$1,297,404	$722,947	$589,456	$0	$1,312,403	$14,999
Home Health	$1,423,634	$1,414,915	$8,719	$0	$1,423,634	$0
Area Agency on Aging	$211,774	$211,774	$0	$0	$211,774	$0
SASH	$4,508,696	$4,508,696	$0	$0	$4,508,696	$0
Other / TBD	$282,445	$282,445	$0	$0	$282,445	$0
	$29,922,010	**$26,254,726**	**$2,000,000**	**$3,400,000**	**$31,654,726**	**$1,732,716**

* Paid directly to providers in alignment with OneCare initiatives

** Rounded estimate of the amount BCBSVT has committed to providers through 2023 (rounded for confidentiality protections)