VERMONT
GREEN MOUNTAIN CARE BOARD

ACO Oversight
FY 2024 ACO Budget
OneCare Vermont

Budget Modification and Approval
Board Discussion and Potential Vote

December 20, 2023

ACO Budget Review

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GMCB Rule §5.405

5.405 Review Process

(a) The ACO shall have the burden of justifying its proposed budget to the Board.

(b) In deciding whether to approve or modify the proposed budget of an ACO projected to have 10,000 or more attributed lives in Vermont during the next Budget Year, the Board will take into consideration:

1. any benchmarks established under section 5.402 of this Rule;
2. the criteria listed in 18 V.S.A. § 9382(b)(1);
3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and
4. any other issues at the discretion of the Board.

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GMCB Rule §5.402

5.402 Establishing Benchmarks

The Board may establish benchmarks for any indicators to be used by ACOs in developing and preparing their proposed budgets. The Board will meet with ACOs and other interested persons to obtain input prior to establishing benchmarks. The established benchmarks will be included in the annual reporting and budget review manual and will assist the Board in determining whether to approve or modify an ACO's proposed budget.

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18 VSA § 9382(b)(1)

(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;

(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

(E) any reports from professional review organizations;

(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

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18 VSA § 9382(b)(1)

(G) the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;

(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

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18 VSA § 9382(b)(1)

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;

(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(M) information on the ACO's administrative costs, as defined by the Board;

(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;

(O) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and

(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

Public Comment
Themes

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- Value of OneCare's improved health outcomes, higher quality care, lower cost, and enhanced coordination of care
- Value of care coordination and strengthened partnerships with local care organizations
- Concerns about access to care and long wait times to see providers
- Concerns about cost of health care in Vermont
- Concerns about the effectiveness of OneCare, administrative cost relative to demonstrated value, the loss of BlueCross BlueShield and increasing executive salaries

- In total, 14 public comments were received as of 12/20/2023

Targets		Target met?	Notes
1	The FY24 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.	TBD	MVP target met, self-funded TBD
2	ACO must use best efforts to meet or exceed the goals for reconciled and unreconciled FPP and identify and report specific obstacles to achieving the goals; Medicaid 55%, Commercial 24%	Yes	Medicaid FY23 is 57.5%, Commercial is 0%. Best efforts and obstacles reported
3	ACO must hold 100% of the Medicare Advanced Shared Savings dollars at risk at the entity-level and not pass the risk along to the provider networks	No	Holding 8.8% of the risk
4	Increase risk corridors for all payer programs above FY23 levels	No	Risk corridors static
5	Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the 5-year average of 3.25%	Yes	3.13%
6	[Any benchmark or target regarding total executive compensation to be determined and issued]	N/A	
7	[Any benchmark or target regarding the structure of the variable portion of executive compensation to be determined and issued]	N/A	
8	The ratio of population health management funding to number of attributed lives must be at a minimum of the FY23 revised budget amount; specific line items may vary based upon any internal evaluation of the effectiveness of individual PHM programs. The ACO must propose a plan to increase the accountability of its provider network for quality. Examples for increased accountability could include adding in an adjustment to hospital fixed payments for quality or increasing the ratio of the PHM bonus payments to base payments for primary care and community providers.	Yes	Population health management funding per attributed life at $166 per life. Accountability increased through increasing ratio of PHM bonus payments to base payments and the addition of network provider accountabilities to contracts
9	March 2023 Medicare Benchmarking Report: Where OCV ranks below the 10th percentile among the national ACO cohort OR for metrics where the trend has shown a decrease in performance between the years of 2019 and 2021, choose three metrics that the ACO will address through the Quality Evaluation and Improvement plan. The ACO should use metrics on which the ACO's provider network has the most influence on the outcomes and should justify their choice of said metrics.	Yes	Three metrics chosen: ED Utilization Annual Wellness Visits Number of beneficiaries with a primary care visit

ACO Budget Modification Options - Staff Recommendation

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1. Modify the Risk Model
   - OCVT increase the Medicare risk corridor from 3% to 4%
   - OCVT hold the additional risk at the ACO-level (calculated at ~$5.7M)
   - OCVT Settlement Policy to be updated to reflect distribution of the additional risk/reward
2. Modify the Operating Budget and investment in population health/primary care
   - Reduce the operating budget by $957k based on 5-year average ratio of OpEx to attributed lives
   - Reallocate the operating budget cut to population health/primary care program(s)
3. Include reporting, monitoring, and other conditions
   - Revised budget compliant with the GMCB's FY24 Order, including any budget modifications and reporting and monitoring requirements, to be submitted to the GMCB by April 1, 2024

Recommendation to Modify Medicare Risk Model

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Recommendation	Potential Impact	Rationale/Discussion
Increase Medicare Risk Corridor from 3% to 4%	Value of 1% additional risk corridor = $5.7M	- Increases upside/downside risk potential; increases value that can be earned from the cost of operating the ACO - *FY24 Budget Target Not Met*
ACO to hold the additional Medicare risk 1. As submitted: OCV holds **$1.84M** for provider-specific risk mitigation 2. Recommendation: OCV to hold **$7.6M**, the value of the additional 1% of Medicare and the existing provider-specific risk mitigation	$1.84M + $5.7M risk	- Supports hospital participation in the model - Increases accountability at the ACO-level; ACO is accountable for their value as an organization - *FY24 Budget Target Not Met*

Alt. Medicare Risk Models

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	Medicare						
	TCOC	Downside %	Max Downside	OneCareVT Held Risk		Provider Held Risk	
Submitted	573,603,700	3%	17,208,111	961,810	5.6%	16,246,301	94.4%
Alternate	573,603,700	4%	22,944,148	6,697,847	29.2%	16,246,301	70.8%
Change	-	1%	5,736,037	5,736,037		-	

Medicare downside risk is increased by 1% with all additional risk held by OCVT

	Medicare Advanced Shared Savings				
	Max Downside	OneCareVT Held Risk		Provider Held Risk	
Submitted	9,954,481	880,197	8.8%	9,074,284	91.2%
Alternate	9,954,481	9,954,481	100.0%	-	0.0%
Change	-	9,074,284		(9,074,284)	

OCVT holds all the Medicare Advanced Shared Savings risk

Risk Model

Budgeted Risk and Reserves Over Time

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	2019	2020	2021	2022	2023 revised.	2024	2024 Adj.
TCOC (Budgeted)	$823.3M	$1,086.1M	$1,178.3M	$1.278.8M	$950.1M	$963.8	$963.8
Total Risk	$34.8M	$44.1M	$19.0M	$16.2M	$26.7M up; $35.1M down	$26.4M up; $36.4M down	$32.1M up; $42.1M down
Total Risk as % TCOC	4.20%	4.10%	1.60%	1.30%	2.8% up; 3.7% down	2.7% up; 3.8% down	3.7% up; 4.8% down
Provider Held Risk	$30.9M	$40.3M	$18.0M	$16.1M	$25.8M up; $30.7M down	$25.5M up; $34.5M down	SAME
% of Total Risk	*89%*	*91%*	*95%*	*99%*	*96.8% up; 87.4% down*	*96.6% up; 94.8% down*	*79% up; 82% down*
OneCare Held Risk	$3.9M	$3.8M	$1.0M	$125k	$861k up; $4.4M down	$961k up; $1.842M down	$6.7M up; $7.5M down
% of Total Risk	*11%*	*9%*	*5%*	*1%*	*3.2% up; 12.6% down*	*3.6% up; 5.1% down*	*21% up; 18% down*
Net Assets/Equity*	$5.6M	$5.6M	$7.0M	$7.8M	$8.4M	$8.4M	$8.4

SOURCE: OCV FY24 Budget Submission, Appendix 4.1 (TCOC amounts) and 5.1 (FY24 risk amounts); historical OCV budget submissions for total risk; provider-held risk; OCV-held risk.

*NOTES: Includes $3.9M in reserves (required by GMCB's OCV FY19 Budget Order) plus net assets. OCV also holds a $10M line of credit to support its Medicare risk, as required by Medicare. SOURCE: Audited financials (through 2022, latest available) and OCV provided balance sheets.

Risk Model
Budgeted Risk Over Time

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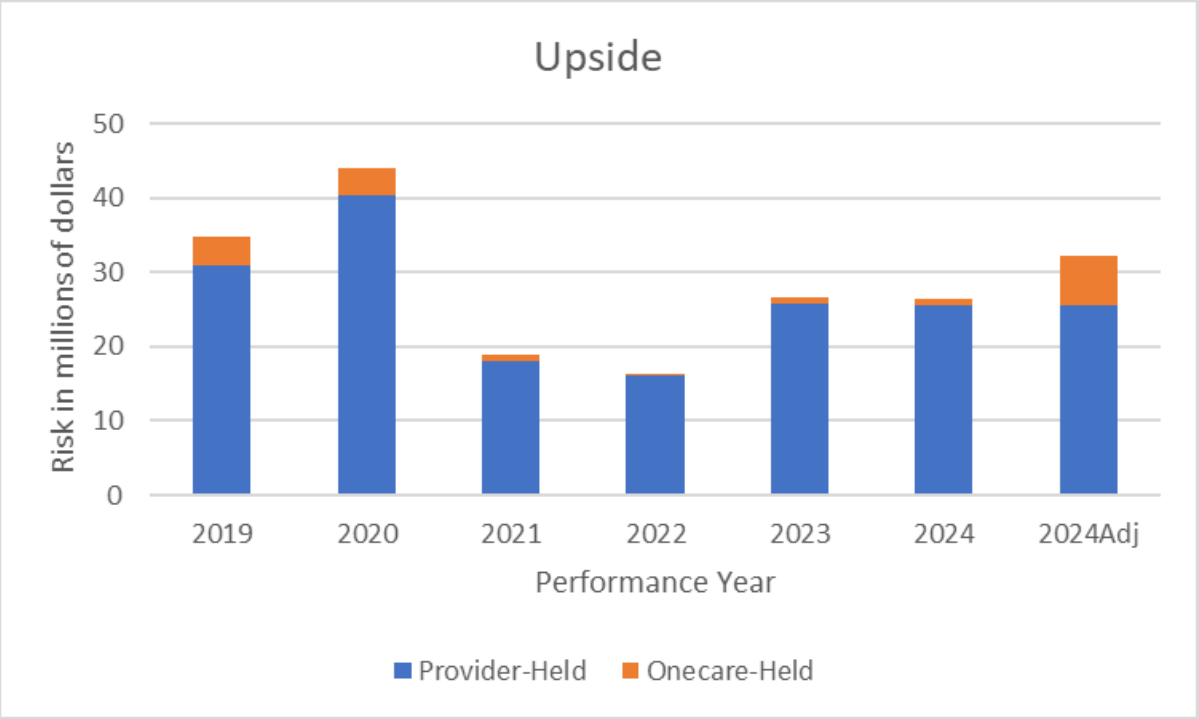

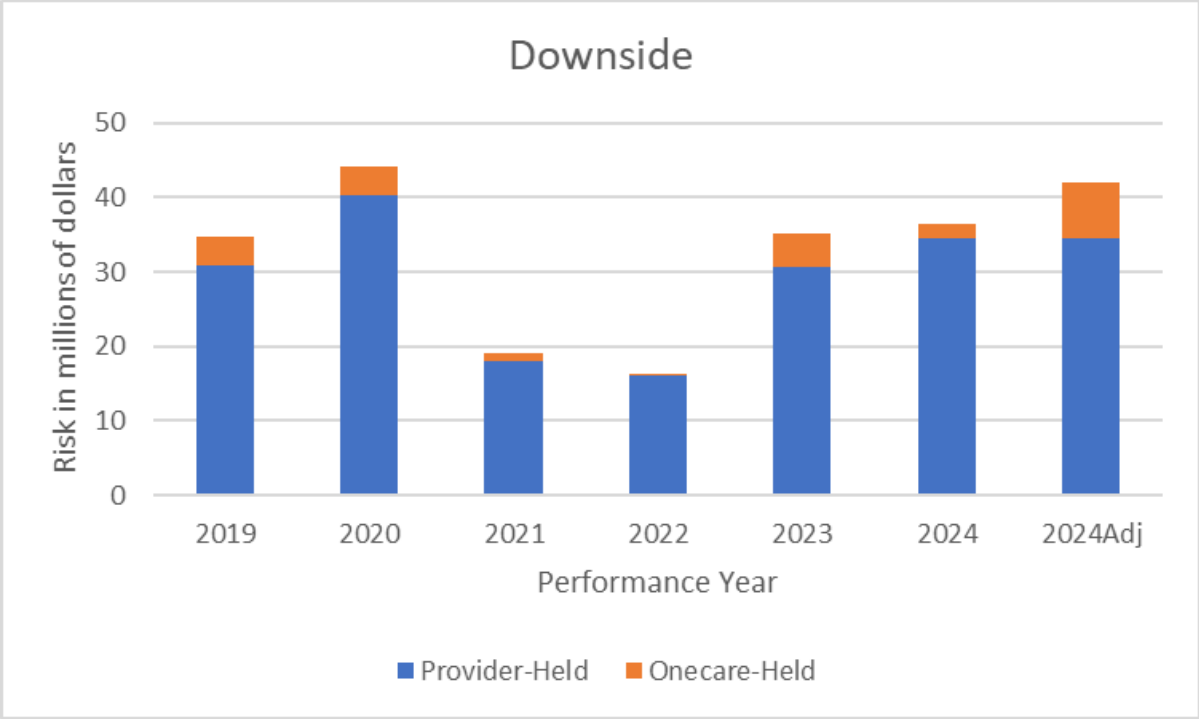

Board Ordered Restrictions on Reserves (FY2023)

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1. Additional funding for population health investments;
2. Financial backing for risk incurred by participating providers;
3. Maintaining ACO-wide risk on behalf of participating providers;
4. Temporary cash flow issues associated with payer revenue delays; and
5. Other uses pre-approved by the GMCB.

Options to Modify Operating Budget

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Options to reduce operating budget based on ratio of operating budget to attributed lives, adjusted for inflation[1]

Option	Ratio	Budget Impact $	Budget Impact %
(1) Keep as proposed (FY24)	$89.07	$0	0%
(2) 5-year average (FY19-FY23 projected)	$83.50	-$957,245	-6.7%
(3) average FY24 budget with FY23 projected.	$81.82	-$1,190,574	-8.3%
(4) Hold to FY23 projected.	$74.58	-$2,381,147	-16.7%
(5) Highest scale year (FY22).[2]	$63.66	-$4,124,657	-28.9%

Notes:
1) Inflation calculated using CPI-U figures, adjusted to 2023 dollars.
2) "Highest scale year" refers to the fiscal year (FY22) with the lowest Operating Expense to Attributed Lives ratio.

Review of Aspects of Operating Budget

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- Executive Compensation
  - Unclear how bonuses are tied to organizational performance ($410K)
  - Unclear if executive compensation is set relative to an appropriate benchmark (Base Salaries $2.59M)
- Unclear if/ how program performance (or ROI) are measured
- Historic overestimation of OpEx (budget vs actual)
  - Average of $1.25M from FY19-FY23 (FY23 uses projections)
- Areas for fiscal responsibility (budgeted amounts not well supported):
  - Marketing expense ("Public Affairs" $661k FY24 budget, $757k FY23 projected)
  - Purchased services ($4.3M)
  - Supplies/occupancy/travel expenses ($123K)

Net assets have accumulated

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FY	Increase to Net Assets (*millions*)	Key Drivers
2018	$1.0 (Base)	NA
2019	$4.69*	Overbudgeted OpEx $0.6M
2020	$0.00	Overbudgeted OpEx $0.9M
2021	$1.29	Overbudgeted OpEx $2.3M
2022	$0.90	Overbudgeted OpEx $1.8M
2023	$0.59	Projected Overbudgeting of OpEx $0.7M
Total	**$8.48**	

**Board ordered OneCare to hold at least $3.9 million in reserves by the end of 2019.*

Difficult to identify key sources of variance between budget and actual because reporting is not consistent by line item over time; recommend Board to require OCV to submit accumulated net asset statement from 2018 to 2023 actuals and update annually; or to adapt sources and uses table for this purpose.

Increase Investment in Population Health/Primary Care

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- Reallocate the operating budget reduction to population health/primary care program(s)
- OCVT present reallocation in FY24 Revised Budget

Potential Conditions

Consistent with previous years

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- OneCare must submit reports and information in accordance with the GMCB Reporting Manual, to be developed by GMCB staff.
- Notify GMCB of any material changes to their budget and explain variance.
- OneCare's administrative expenses must not exceed the amount ordered by the GMCB.
- OneCare's administrative expenses must be less than the health care savings.
- Submit a revised budget by April 1, 2024, and present on the revised budget in April 2024, including final payer contracts, attribution by payer, a revised budget, hospital dues and risk, any changes to the risk model, source of funds for population health programs.
- Notify GMCB of any use of reserves or line of credit or any adjustment to participation fees.

Potential Conditions
Consistent with previous years

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- Notify GMCB of any use of reserves or line of credit or any adjustment to participation fees. The use of reserves, additional participation fees, or funds drawn from OneCare's line of credit shall be limited to:
  - Additional funding for population health investments;
  - Financial backing for risk incurred by participating providers;
  - Maintaining ACO-wide risk on behalf of participating providers;
  - Temporary cash flow issues associated with payer revenue delays; and
  - Other uses pre-approved by the GMCB.
- OneCare must implement the risk model as modified by the Board, with requirement for OneCare to submit copies of contracts and a requirement to notify and seek approval from the GMCB as early as possible of any proposed changes to the risk model

Potential Conditions
Consistent with previous years

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- Implement benchmark trend rates for payer contracts in alignment with the GMCB's decision on the Medicare ACO benchmark (Presentation 12/13, vote 12/20); the GMCB's Medicaid Advisory Rate Case; and, for commercial payer contracts, in alignment with ACO-attributed population and the GMCB approved rate filings.
- Engage in payer programs that qualify for APM Scale to the greatest extent possible and align payer programs in key areas to the extent reasonable; explain non-Scale qualifying programs and areas of misalignment. Require continued reporting on payer programs.

Potential Conditions
Consistent with Previous Years

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- Fund population health management and payment reform programs as detailed in the FY24 submission or ordered by the Board, and to notify GMCB of any changes, including funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.
- Report evaluation results and evaluation focus areas for 2024 to GMCB
- Fund the Support and Services at Home (SASH) program and Blueprint for Health payments to primary care practices and community health teams consistent with the amount approved by the GMCB in the Medicare ACO Benchmark process (vote scheduled 12/20).

Potential Conditions
Updated/New Deliverables

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- Work with Medicare Advantage plans operating in Vermont ~~over the next two years~~ – with a particular focus on Vermont-based plans offered by BCBSVT and UVMMC-MVP – to develop Scale-qualifying programs.
- Report FPP data and progress toward the goals as specified in the ACO Reporting Manual and FY24 Guidance
- Report on the CPR program
- Make improvements to benchmarking report
  - Statistical significance analysis (NEW)
  - Risk of all cohorts for each year (NEW)
- OCV to submit accumulated net asset statement from 2018 to 2023 actuals and update annually; or to adapt sources and uses table for this purpose
- Reconcile PHM payments after year end (Year End Sources and Uses Q4 reporting or in guidance)
- OCV to verify to the GMBC that payments for primary care are used to support primary care consistent with 18 V.S.A. § 9382(b)(1)(G)

Potential Motion Language

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Potential Motion language – modification of Medicare risk corridor and requirement for OCV to hold additional risk:

> *Move to modify OneCare Vermont's FY24 budget by requiring OneCare to increase its Medicare risk corridor from 3% to 4%, with OneCare Vermont holding the additional risk of shared losses using its net assets as risk mitigation, and for OneCare to update its Settlement Policy to reflect additional potential upside, consistent with the Board's discussion today.*

Potential Motion language – modification of the operating budget:

> *Move to modify OneCare Vermont's FY24 budget by reducing Operating Expenses by $[xxxx] (xxxx%) and requiring OneCare to instead reallocate that amount to population health and primary care programs that will achieve the best return on investment, consistent with the Board's discussion today.*

Potential Motion Language

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Potential Motion Language – approval of modified budget with reporting, monitoring, and other conditions:

> *Move to approve the OneCare Vermont FY24 budget as modified today by the GMCB and subject to the conditions presented today by GMCB staff [with the additions and modifications discussed today by the GMCB].*

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APPENDIX

Target 5: OpEx to PHM Payment Ratio

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- Ratio of operating expenses to PHM/payment reform payments (including FPP and budgeted bonus payments) must not exceed the 5-year average of 3.25%
  - Target Met? Yes. 3.1%

	FY2018A	FY2019A	FY2020A	FY2021A	FY2022A	FY2023P	FY2024B
Total PHM/Payment Reform Program less Settlement Expenses	260,027,734	375,802,982	435,107,902	436,367,075	473,336,001	499,317,118	455,781,789
Total Operating Expenses	13,739,102	15,341,451	14,044,262	13,608,546	13,613,662	14,108,861	14,285,361
	5.28%	4.08%	3.23%	3.12%	2.88%	2.83%	3.13%

5-year AVG	**3.23%**

ACO Budget & Financials

Spending per Life

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	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop Health Spending ($M)	$22.64	$29.46	$32.70	$28.21	$28.42	$25.30	$25.70
Pop Health Expenditures per Attributed Life	$247	$215	$160	$132	$126	$134	$166
Operating Expenses ($M)	$13.74	$15.34	$14.04	$13.61	$13.61	$14.11	$14.29
Operating per Attributed Life	$150	$112	$69	$64	$61	$75	$92

HCA Letter Follow-Up -Spending per Life

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As Presented 12/06	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop. Health Spending ($M)	$22.64	$29.46	$32.70	$28.21	$28.42	$25.30	$25.70
Pop. Health Spend / Attributed Life	$246.99	$215.03	$160.46	$131.80	$126.45	$133.73	$166.18
Operating Expenses ($M)	$13.74	$15.34	$14.04	$13.61	$13.61	$14.11	$14.29
Operating per Attributed Life	$149.91	$111.97	$68.91	$63.58	$60.57	$74.58	$92.36

- Includes Blueprint
- Nominal dollars
- Average attribution
- Actuals/projected (FY18-23)

Actuals (Including Blueprint)	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop. Health Spending ($M)	$26.50	$33.87	$37.15	$32.05	$29.87	$25.30	$24.78
Pop. Health Spend / Attributed Life	$289.10	$247.23	$182.30	$149.74	$132.90	$133.73	$160.25
Operating Expenses ($M)	$16.08	$17.64	$15.96	$15.46	$14.31	$14.11	$13.78
Operating per Attributed Life	$175.46	$128.74	$78.30	$72.23	$63.66	$74.58	$89.07

- Includes Blueprint
- 2023 dollars
- Average attribution
- Actuals/projected (FY18-23)

Actuals	2018A	2019A	2020A	2021A	2022A	2023P	2024B
Average Attributed Lives	91,651	137,012	203,794	214,040	224,763	189,175	154,665
Pop. Health Spending ($M)	$17.39	$28.40	$27.61	$22.09	$20.33	$18.66	$15.19
Pop. Health Spend / Attributed Life	$189.73	$207.31	$135.47	$103.21	$90.45	$98.63	$98.18
Operating Expenses ($M)	$16.08	$17.64	$15.96	$15.46	$14.31	$14.11	$13.78
Operating per Attributed Life	$175.46	$128.74	$78.30	$72.23	$63.66	$74.58	$89.07

- Excludes Blueprint
- 2023 dollars
- Average Attribution
- Actuals/projected (FY18-23)

Budget	2018B	2019B	2020B	2021B	2022B	2023B	2024B
Average Attributed Lives	109,728	159,916	215,809	224,259	236,537	203,534	201,278
Pop. Health Spending ($M)	$23.92	$36.33	$31.37	$27.22	$21.06	$16.71	$15.19
Pop. Health Spend / Attributed Life	$217.97	$227.21	$145.38	$121.36	$89.05	$82.09	$75.44
Operating Expenses ($M)	$14.62	$18.30	$16.95	$18.07	$16.22	$14.79	$13.78
Operating per Attributed Life	$133.26	$114.43	$78.53	$80.58	$68.59	$72.67	$68.44

- Excludes Blueprint
- 2023 dollars
- Starting Attribution
- Budgeted (FY18-23)

Budget Indicators

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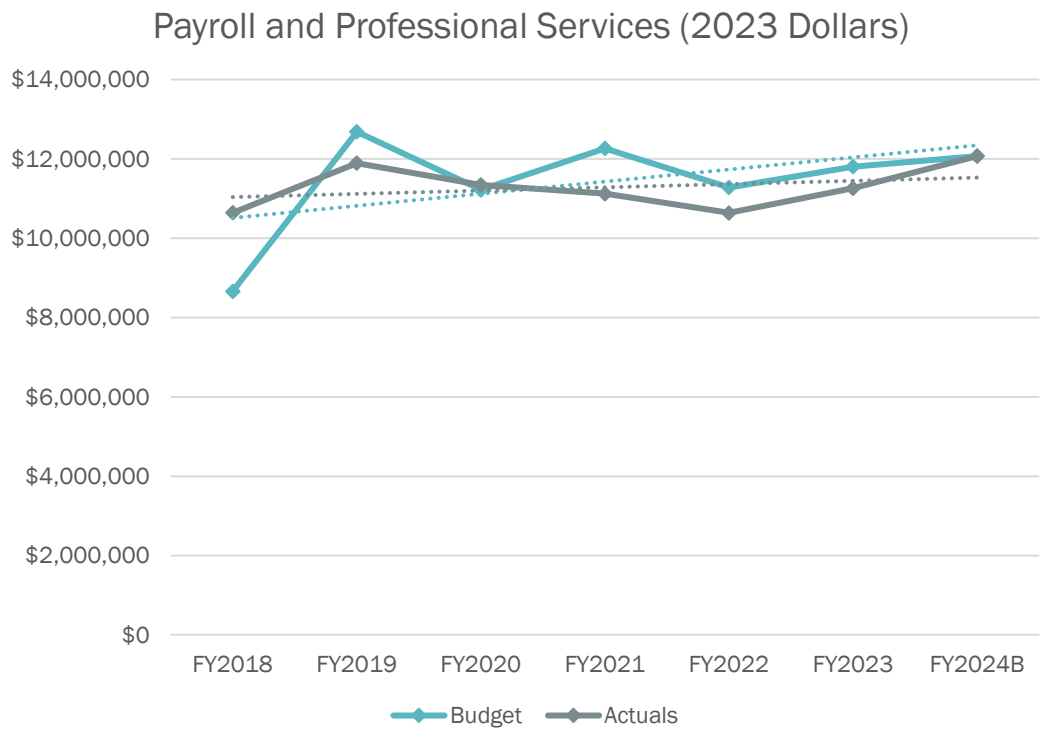

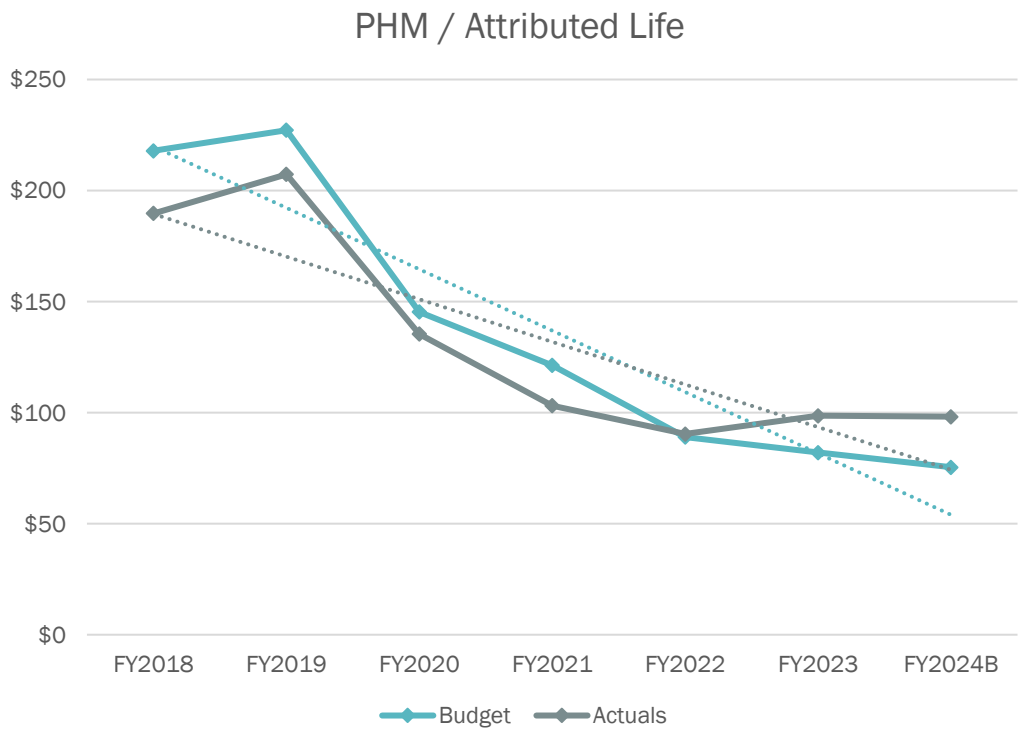

- **Actuals**
  - Excludes Blueprint
  - 2023 dollars
  - Average Attribution
  - Actuals/projected (FY18-23)
- "**Budget**"
  - Excludes Blueprint
  - 2023 dollars
  - Starting Attribution
  - Budgeted (FY18-23)

Settlements

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	2018	2019	2020	2021	2022
Gross Savings / (Losses)	$ 17,845,450	$ 11,285,496	$ 27,002,622	$ 22,318,060	$20,378,944
Cap on Savings / (Losses)	$ 20,634,180	$ 24,790,486	$ 20,391,839	$ 10,026,241	$ 9,574,335
Capped Savings / (Losses)	$ 17,845,450	$ 11,285,496	$ 20,391,839	$ 10,026,241	$ 9,574,335
Quality Adjustment	$ -	$ (196,758)	$ -	$ -	$ (786,302)
ACO Risk Arrangement	80%	100%	80%	100%	100%
Adjusted capped savings / (Losses)	$13,990,833*	$11,285,496*	$ 16,313,471	$10,024,813*	$9,564,328*
Advanced Shared Savings	$ 7,776,760	$ 6,342,236	$ 8,401,660	$ 8,767,133	$ 9,073,982
Net Settlement Adjusted for Advanced Shared Savings	$ 6,214,073	$ 4,943,260	$ 7,911,811	$ 1,233,926	$ 490,346

* Includes deduction for sequestration