OneCare Vermont

2024

Budget Presentation to

Green Mountain Care Board

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November 8, 2023

Macro Overview

2024 Budget Largely Consistent with 2023

- Similar network configuration
- Similar payer program terms
- Continuation of most programs with only modest adjustments

DVHA $2M Flowing through OneCare

- No financial impact to OneCare or participations, but significant operational efficiencies

Capturing Savings from the Analytics Transition

- Phase-out of expenses related to Health Catalyst
- Similar contracted expense model with UVMHN Data Management Office

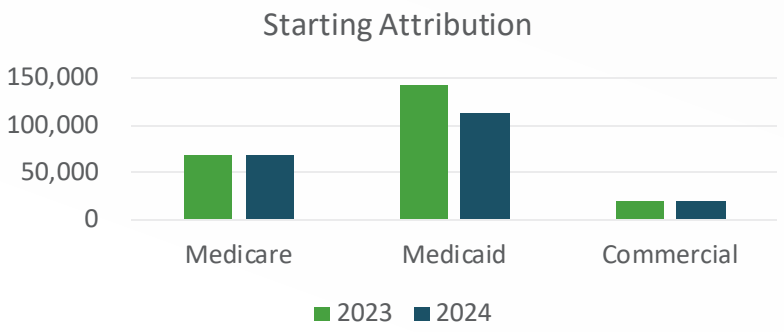
~$2M in hospital participation fee relief

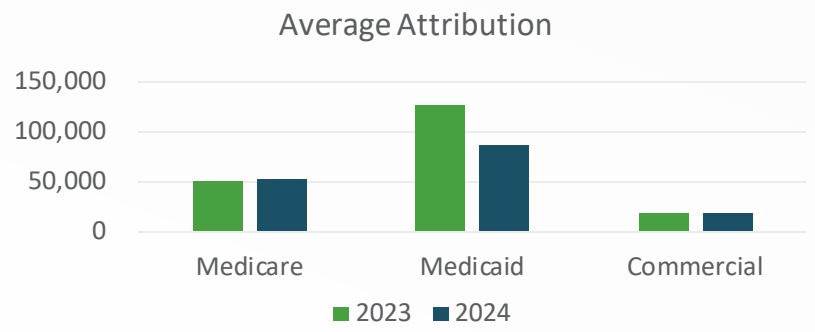
Attribution

Assumptions

- Slowing of the Medicare Advantage migration
- Medicaid redetermination continuing into 2024
- No material changes budgeted under commercial contracts
- All attributed lives expected to qualify for scale targets

	Starting Attribution			Average Attribution		
	2023	2024	Change	2023	2024	Change
Medicare	68,605	67,870	(735)	51,159	53,145	1,986
Medicaid	142,410	113,575	(28,835)	126,880	86,129	(40,751)
Commercial	19,925	19,833	(92)	18,253	18,986	733
Total	**230,940**	**201,278**	**(29,662)**	**196,292**	**158,260**	**(38,032)**



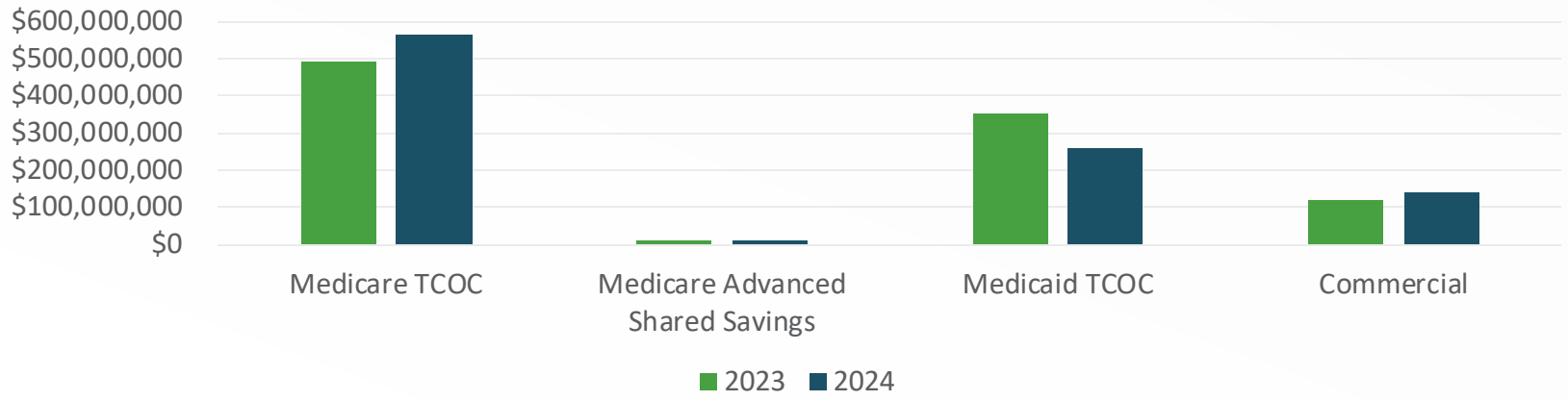


Program Total Cost of Care (TCOC) Targets Forecast

Assumptions

- Budget assumes Medicare target follows the APM model – 4.28% trend
- Medicaid trend rate modeled from historical analysis
  - Projected redetermination lowers TCOC estimate
- Commercial trend based on recent rate filings or plan budgeting

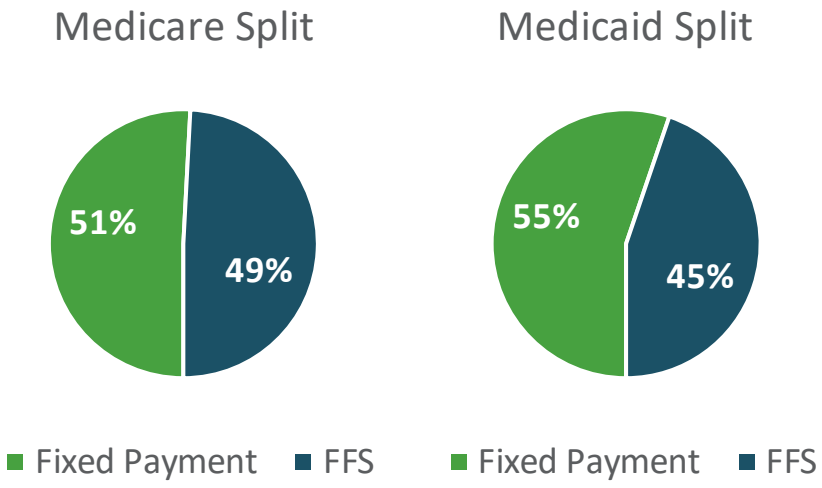
	2023	2024	Change
Medicare TCOC	$491,101,380	$563,649,234	$72,547,854
Medicare Advanced Shared Savings	$9,545,916	$9,954,481	$408,565
Medicaid TCOC	$349,847,887	$259,971,659	($89,876,228)
Commercial	$118,698,991	$140,209,382	$21,510,391
Total	**$969,194,174**	**$973,784,755**	**$4,590,581**

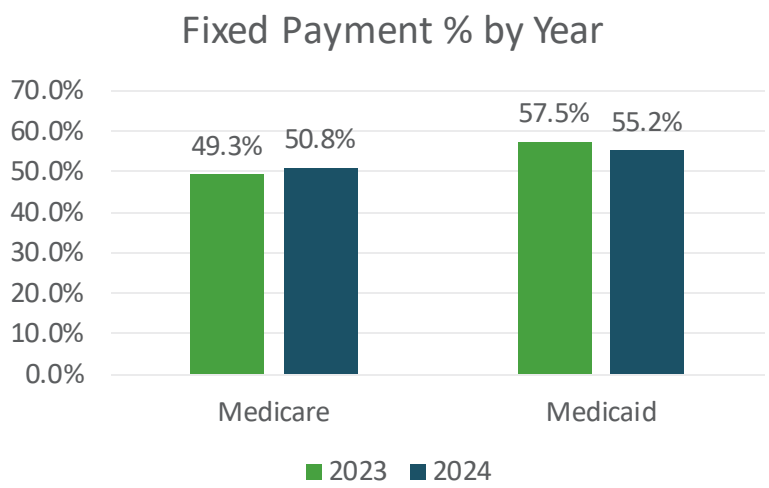


Fixed Payments

Assumptions

- Medicare and Medicaid fixed payments will continue in a similar form
- No commercial fixed payment option expected in 2024





Advances in Development

- Actively working on a Medicaid Global Payment Program (GPP) to cover hospital care for unattributed lives
- In discussion with FQHCs regarding a Medicaid fixed payment pilot, building on concepts from the Comprehensive Payment Reform (CPR) program

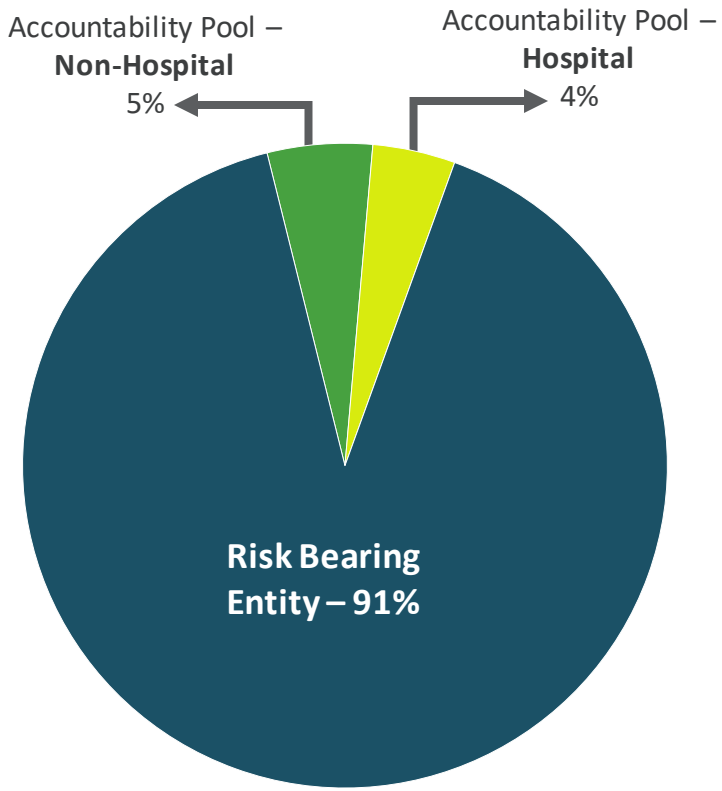
Total Risk

Assumptions

- Medicare: 3% Corridor w/ 100% Sharing
- Medicaid: 3% Corridor w/ 100% Sharing
- Budget assumes similar risk sharing terms with commercial plans

	2023	2024	Change
Medicare	$15,019,419	$17,208,111	$2,188,692
Medicaid	$10,495,437	$7,799,150	($2,696,287)
Commercial	$1,221,228	$1,433,905	$212,677
Total	**$26,736,084**	**$26,441,166**	**($294,918)**

	Amount
Accountability Pool - Non-Hospital	$1,393,956
Accountability Pool - Hospital	$1,095,876
Risk Bearing Entities	$23,951,334
Total	**$26,441,166**



Risk Model

Risk model incorporated into the budget is unchanged since 2021

- Savings/Losses pooled and allocated to Health Service Areas (HSAs)
- Performance Incentive Pool component if shared savings are earned
- Primary care organizations eligible for the first $1.50 PMPM through the Accountability Pool

Budget incorporates OneCare Board of Managers' strategy to delegate risk to the provider network

- Avoids creating a new financial layer to shield providers from financial accountability for health care cost outcomes

The budget includes continuation of the risk mitigation arrangement for Northeastern Vermont Regional Hospital (NVRH)

- Limits the St. Johnsbury HSA to a 1% Medicare risk corridor with OneCare as the counterparty

Revenues

Program Funding

Payer Contributions

- Funding levels follow attribution estimates; no other changes assumed
- $2M Value Based Incentive Fund pool will flow through OneCare in 2024
  - No change to financial opportunity, but payments will be from a single source

Payer Revenue	2023	2024	Change
Medicare	$0	$0	$0
Medicaid	$7,232,160	$4,909,353	($2,322,807)
Commercial	$711,867	$740,454	$28,587
DVHA VBIF	$0	$2,000,000	$2,000,000
Total	**$7,944,027**	**$7,649,807**	**($294,220)**

Other Revenue

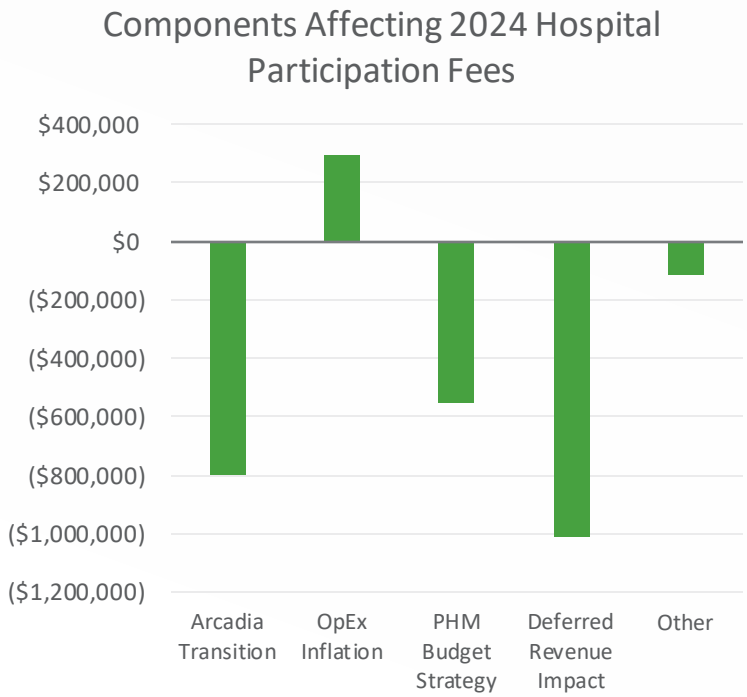
- Deferred revenue pool now includes reinvestment funds obligated from the 2021 performance year
- Budgeting interest income (offsets participation fees)

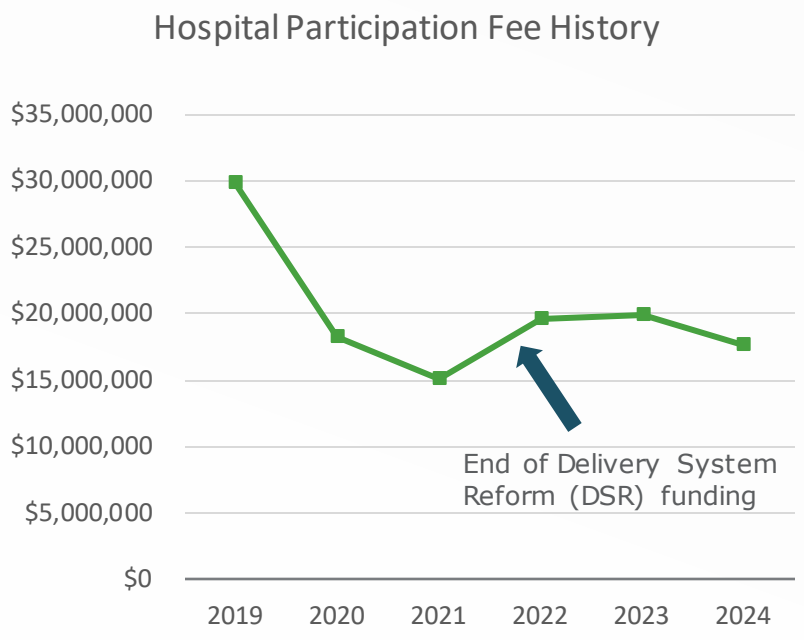
Other Revenue	2023	2024	Change
Fixed Payment Allocation - Hospitals	$3,060,850	$2,599,717	($461,134)
Deferred Revenue	$567,206	$1,821,788	$1,254,582
Interest Income	$100,000	$317,662	$217,662
Total	**$3,728,056**	**$4,739,166**	**$1,011,110**

Hospital Participation Fees

11.0% reduction to hospital participation fees

	2023	2024	Change
Hospital Participation Fees	$19,828,444	$17,643,487	($2,184,957)





Population Health Expenses

Population Health Expense Overview

Maintaining core initiatives from 2023

Incremental change to the Population Health Model (PHM) Program to increase the weight on outcomes

- Base payments allocated based on attribution moving from $4.75 PMPM to $4.25 PMPM; bonus potential moving from $1.00 PMPM to $2.50 PMPM
- Non-attribution-based payments updated with a similar shift to more weight on outcome
- Assuming 60% of bonus payments are earned

Sustaining the 2023 Mental Health Screening Initiative

- Intended to be a one-time program, but budget utilizes deferred funding to continue in 2024

Blueprint budgeted to increase by the APM trend of 4.28%

- The decision on trend ultimately lies with the GMCB

$200k allocated to support increased use of waivers

Population Health Expenses Breakdown

	2023 *	2024	Change
PHM Bonus Payments **	$2,276,379	$3,353,192	$1,076,813
PHM Base Payments	$11,425,898	$8,731,119	($2,694,779)
Longitudinal Care	$399,000	$399,000	$0
DULCE	$145,366	$68,162	($77,204)
CPR Program	$2,106,823	$1,323,900	($782,923)
Specialist/Innovation	$515,907	$0	($515,907)
MH Screening and Follow-Up	$1,638,140	$1,671,727	$33,587
SNF Support	$201,299	$0	($201,299)
Waiver Implementation Funds	$0	$200,000	$200,000
PCMH Payments	$2,062,850	$2,223,276	$160,426
Community Health Team	$2,974,370	$3,029,537	$55,167
SASH	$4,508,696	$4,701,668	$192,972
Total	**$28,254,727**	**$25,701,580**	**($2,553,147)**

** 2023 figures include DVHA direct payments*

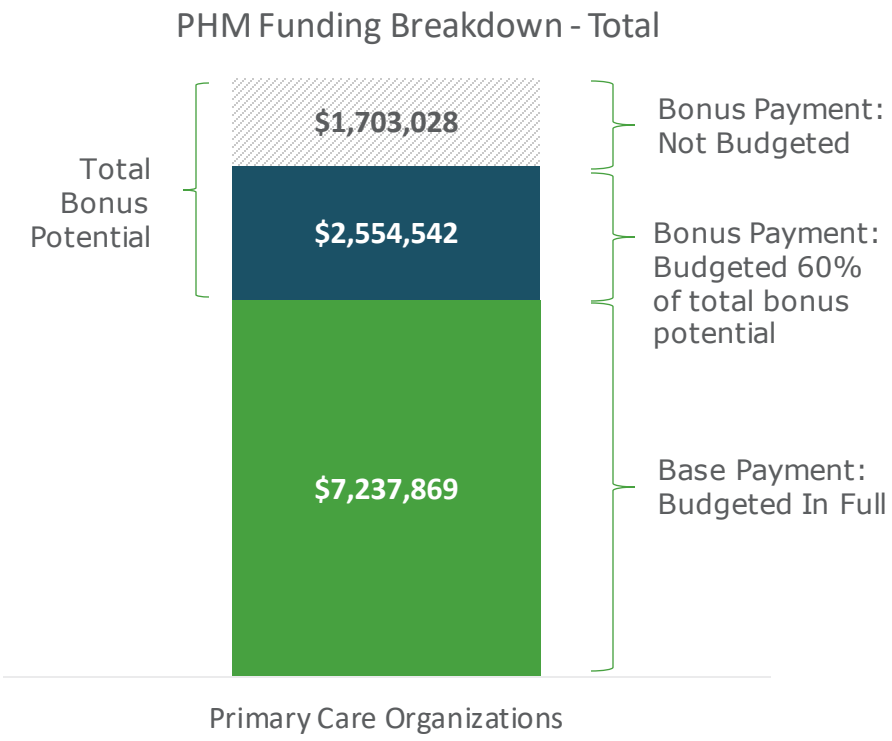
*** Budgeted at 60% earned rate*

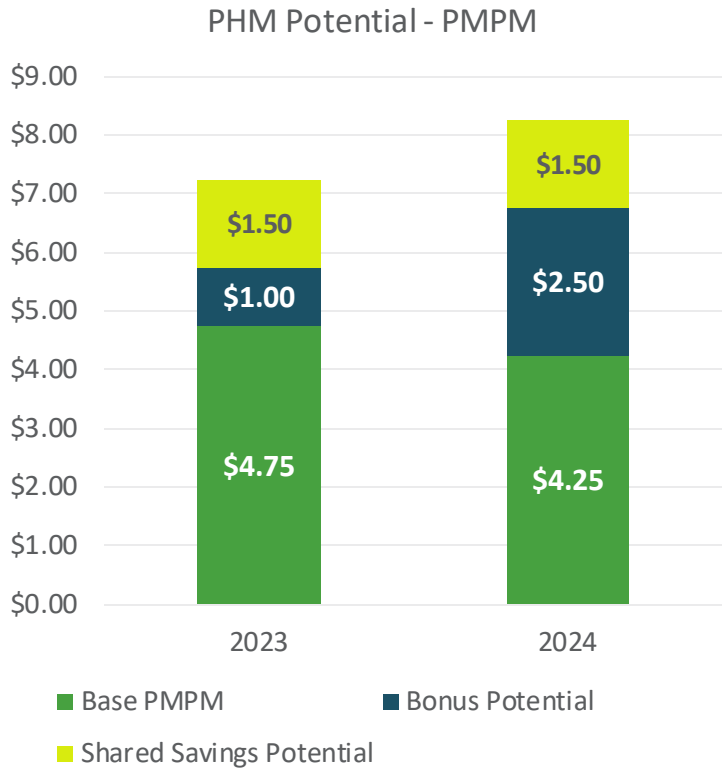
- Change in PHM payment mix between base and bonus
- Planned transition of DULCE funding
- CPR amount lowered due to redetermination
- New funding for waiver implementation support
- Blueprint payments based on 2023 data from Blueprint plus APM trend

PHM Program Budget vs. Potential

As the program strategy evolves, there is a growing differentiation between the amount "pre-funded" through participation fees vs. funding potential for providers

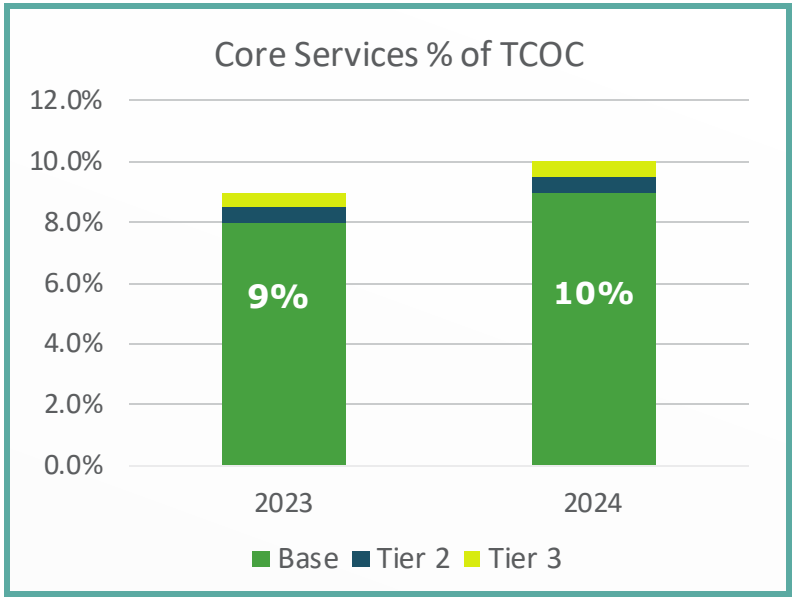
- While the budget pre-funds an estimate of what will be earned based on outcomes, OneCare is obligated through contract/policy to pay up to the full potential

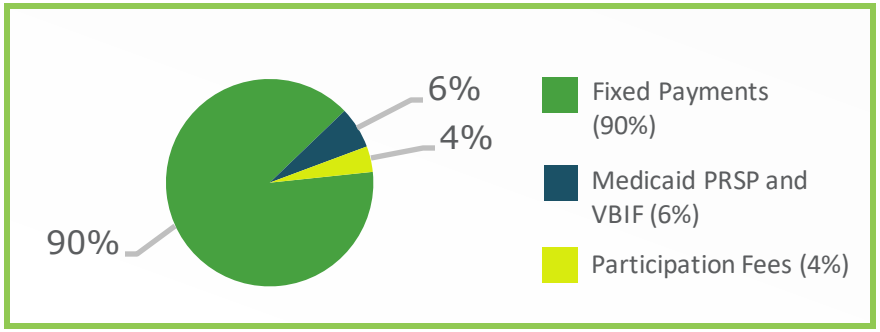




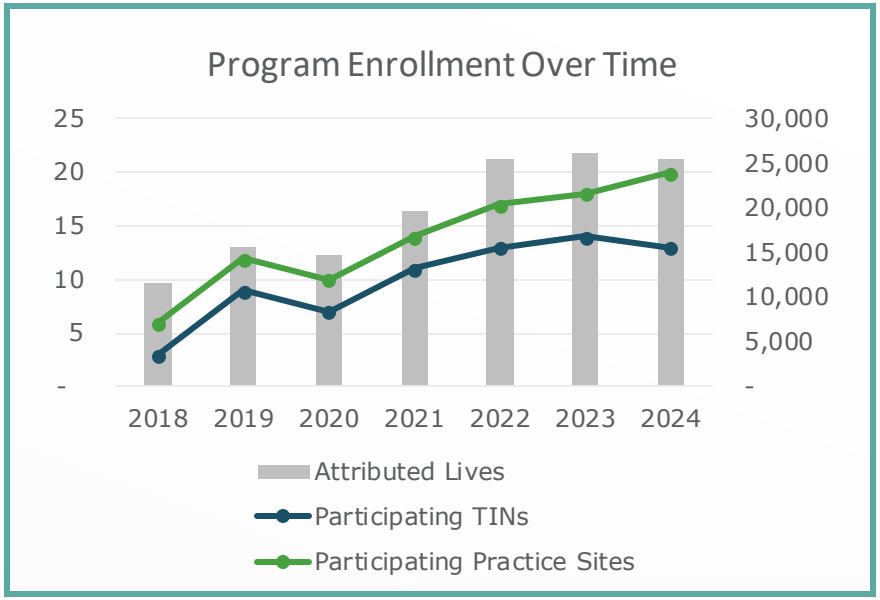
Comprehensive Payment Reform (CPR) Program

- Program developed by OneCare Vermont to offer a payer-blended fixed payment option to independent primary care organizations
- Starting in 2023 the program incorporated a payment linkage to total health care costs



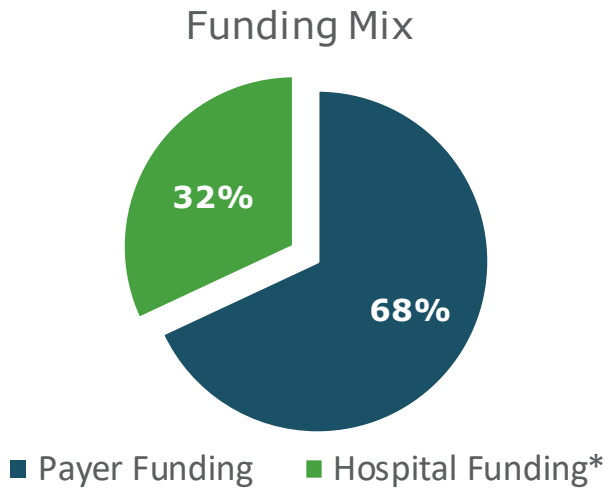


Year	$ Benefit Above FFS	% Benefit Above FFS
2022	$2,579,761	136%
2023	$3,891,658	152%
2024 (Projected)	$4,725,257	160%



Population Health Funding Sources

	Budget Total	Payer Funding	Hospital Funding*
PHM Program - Base Payments	$8,731,119	$4,946,233	$3,784,886
PHM Program - Bonus Payments	$3,353,192	$1,885,502	$1,467,690
Longitudinal Care	$399,000	$0	$399,000
DULCE	$68,162	$0	$68,162
CPR Program Cost	$1,323,900	$818,071	$505,829
MH Screening and Follow-Up Program	$1,671,727	$0	$1,671,727
Waiver Implementation Fund	$200,000	$0	$200,000
PCMH Legacy Payments**	$2,223,276	$2,223,276	$0
CHT Block Payment**	$3,029,537	$3,029,537	$0
SASH**	$4,701,668	$4,701,668	$0
Total	**$25,701,580**	**$17,604,287**	**$8,097,294**



Hospital participation fees enable OneCare to offer payments and incentives that are aligned across payer programs

* Hospital funding can be either current year participation fees or from deferred revenue

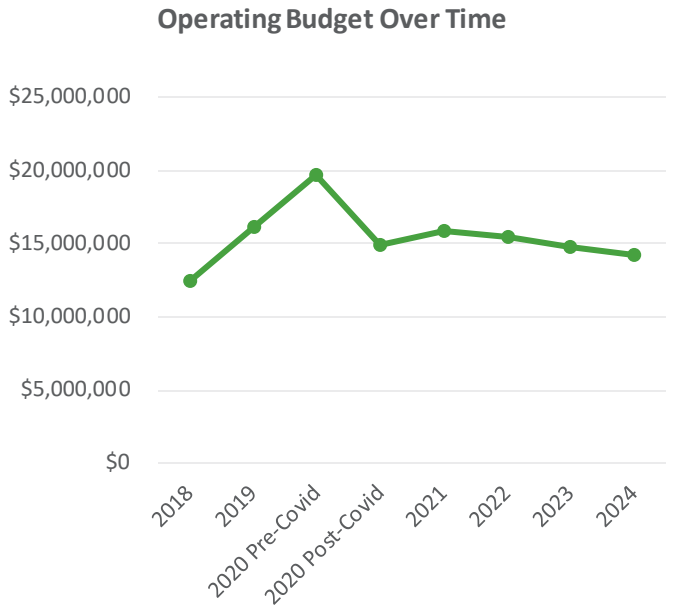
** Blueprint funding can flip to hospitals if Medicaid TCOC performance is poor

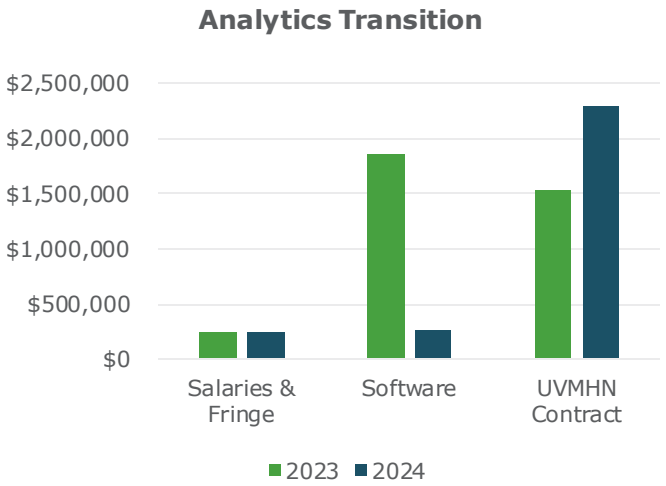
Operating Budget

- 3.4% decrease
- Operating costs fully funded by hospitals
- No significant staffing changes
- Significant reduction in software expenses no longer needed with Arcadia
- Ordinary scrutiny of all other expenses

Operating Budget	2023	2024	Change
Salaries & Benefits	$8,059,973	$8,191,655	$131,682
Purchased Services	$3,745,930	$4,327,955	$582,025
Software	$1,734,949	$494,951	($1,239,998)
Insurance	$261,000	$274,050	$13,050
Supplies	$31,300	$32,060	$760
Travel	$25,800	$38,071	$12,271
Occupancy	$50,775	$53,064	$2,289
Other Expenses	$881,988	$873,555	($8,433)
	$14,791,715	**$14,285,361**	**($506,354)**

Analytics Expenses	2023	2024	Change
Salaries & Fringe	$242,392	$251,197	$8,806
Software	$1,851,865	$276,000	($1,575,865)
UVMHN Contract	$1,524,312	$2,291,214	$766,902
Total	**$3,618,569**	**$2,818,412**	**($800,157)**





Major Investments and Initiatives

Investment #1—Population Health Model (PHM) Program

Goal

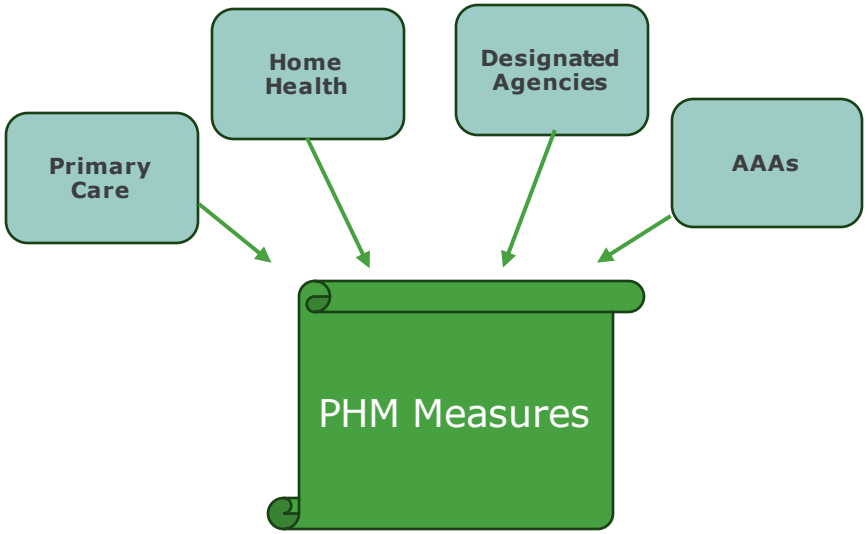
- Improve **population health outcomes** and quality scores

2024 Approach

- Align focus across the provider spectrum on key population health outcomes included in OneCare's payer contracts
- Provide base payments, and bonus payments to organizations meeting targets
- Provide data and reporting on current performance, and analyses to help organizations improve outcomes

Organizations

- Primary care organizations
- Home Health Agencies (HH)
- Designated Agencies (DA)
- Area Agencies on Aging (AAA)



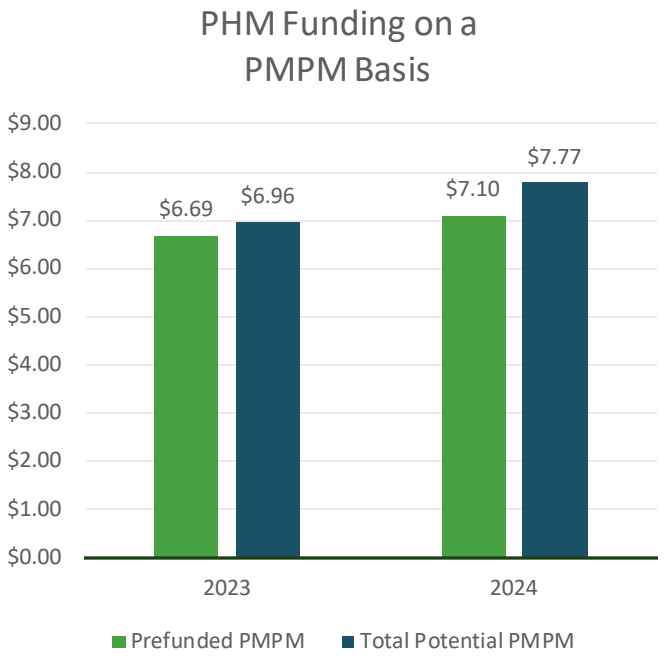
Investment #1—Population Health Model (PHM) Program

Funds Available

- $13,986,435 potential for provider organizations
  - $12,084,311 pre-funded in budget

Allocation Model

- Primary Care Organizations
  - $4.25 PMPM base; up to $2.50 PMPM bonus
- Non-Attributing Organizations
  - Aggregate pools established through budget process
  - 75% allocated based on proportion of spend
    - AAA allocation based on HSA attribution proportion
  - 25% bonus component



Provider Accountabilities

- Actively pursue meeting Population Health Model (PHM) measure targets
- Fulfill care coordination obligations
- Engage with OneCare on improvement activities

Investment #1—Population Health Model (PHM)

Results Indicators

- Increased PHM measure results by practice
- Increased PHM measure results by measure
- Increased PHM outcomes by HSA
- Increase in relevant quality scores in payer contracts

Opportunities

- Continue advancing the partnership and alignment with the Blueprint
- Leveraging Arcadia to deliver advanced data and insights
- Maintaining focus on challenging areas over multiple years

Investment #1—Population Health Model (PHM) Program

Measure Selection

- Considerations include:
  - Availability of data
  - Inclusion in payer contracts
  - Performance levels
  - Ability to influence results
  - Provider burden
  - Standard measure (ex. HEDIS) vs. custom
  - Applicability across populations, payers, and continuum of care
  - Feedback from providers
- Percentile targets based on national benchmarks and set relative to current performance levels
- Selections corroborated by benchmarking and evaluation report outcomes
- Met with 3 similar ACOs for peer-to-peer learning—ED and primary care strategies

PHM Measure Evolution

2023 PHM Measure	2024 PHM Measure	Adult Primary Care	Pediatric Primary Care	Family Medicine Primary Care	Designated Agencies	AAA/HHH
Diabetes Poor Control	Retired					
Follow Up after Hypertension New or Routine Diagnosis	Hypertension: Controlling High Blood Pressure (HEDIS CBP)	X		X		
Potentially Avoidable ED Revisits by Those with Two ED Visits in Last 90 Days	Follow Up After Emergency Department Visits for Patients with Multiple Chronic Conditions (HEDIS FMC)	X	X	X	X	X
Age 40+ All-Payer Annual Wellness Visit	Medicare Annual Wellness Visits	X		X		
Child and Adolescent Well-Care Visits	Child and Adolescent Well-Care Visits (HEDIS WCV)		X	X		
Developmental Screening in the First 3 Years of Life	Developmental Screening in the First 3 Years of Life (CMS Child Core CDEV)		X	X		
Primary Care Engagement for Individuals in Care Management (DA/AAA)	Retired					
Inpatient Admissions within 60 days Following Home Health Visit (HHH)	Retired					
	Initiation of Substance Use Disorder Treatment (HEDIS IET)	X	X	X		
	Engagement of Substance Use Disorder Treatment (HEDIS IET)	X	X	X		
30 Day Follow-Up After ED Visit for Substance Use (HEDIS FUA)	30 Day Follow-Up After ED Visit for Substance Use (HEDIS FUA)				X	
30 Day Follow Up After Emergency Department Visit for Mental Illness (HEDIS FUM)	30 Day Follow Up After Emergency Department Visit for Mental Illness (HEDIS FUM)				X	
7 Day Follow Up After Hospitalization for Mental Illness (HEDIS FUH)	7 Day Follow Up After Hospitalization for Mental Illness (HEDIS FUH)				X	

- Claims based
- Standardized
- Targeting national benchmarks
- Maintaining focus on key areas (wellness, prevention, chronic disease management, ED utilization, mental health)
- Sunset inverse measures

Engagement

HSA Executive Consultations

- **Description:** The purpose of these consultations is to share performance insights and provide an opportunity for discussion to create connection with leaders in your health service area.
- **Audience:** Health care leaders in your community.

Quarterly Value-Based Care Webinars

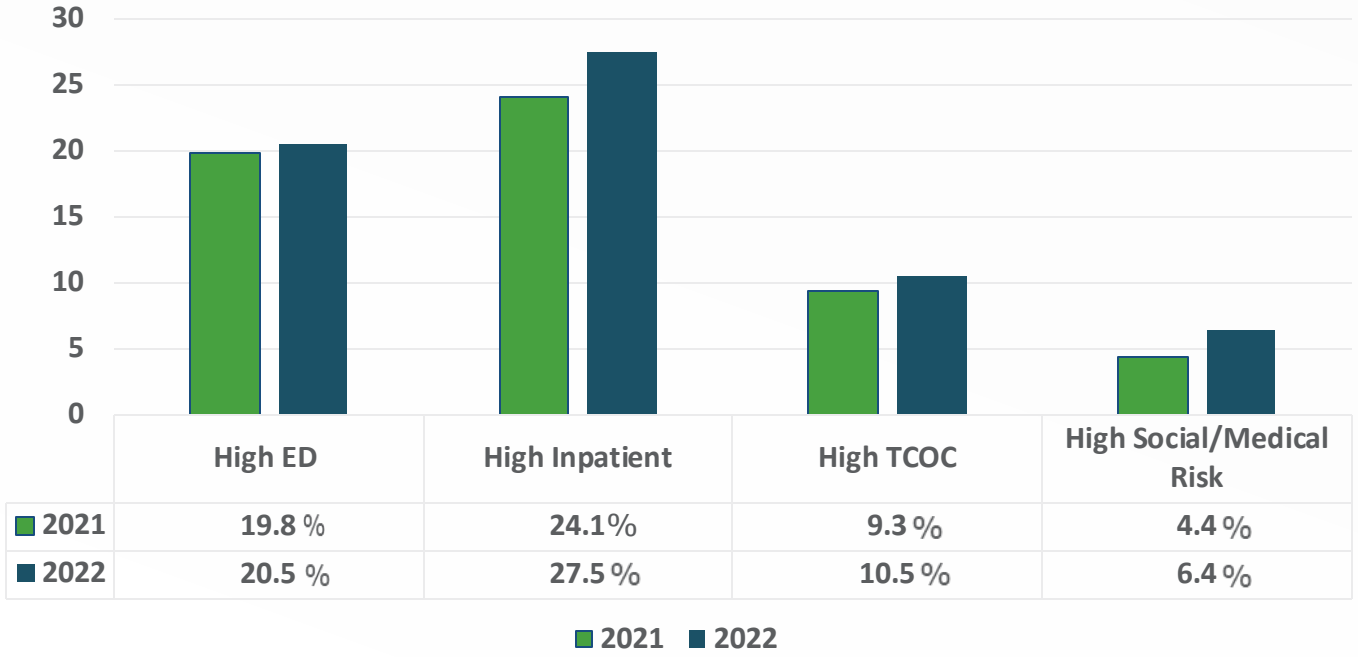
- **Description:** These webinars feature providers who are excelling in PHM performance. OneCare provides a forum for sharing of lessons learned and best practices with the goal of creating a space for peer-to-peer learning.
- **Audience:** Quality and care coordination team members, practice managers, and providers from across OneCare's network.

Quarterly PHM Performance Improvement

- **Description:** Each quarter OneCare will share performance data on the PHM quality measures at each health service area. Performance data are available at the practice level for both primary care practices and continuum of care partners. The intent of this data review is to provide insights on performance and initiate conversation about potential quality improvement collaborations.
- **Audience:** Quality and care coordination team members, practice managers, partner organizations, and providers from across OneCare's network.

Care Coordination

Care Managed Rates by Populations of Focus



	High ED	High Inpatient	High TCOC	High Social/Medical Risk
2021	19.8 %	24.1%	9.3 %	4.4 %
2022	20.5 %	27.5 %	10.5 %	6.4 %

- Strong partnership with Blueprint and other collaborators is necessary
- Evaluation confirms interoperable communication tool essential for improved program and provider satisfaction

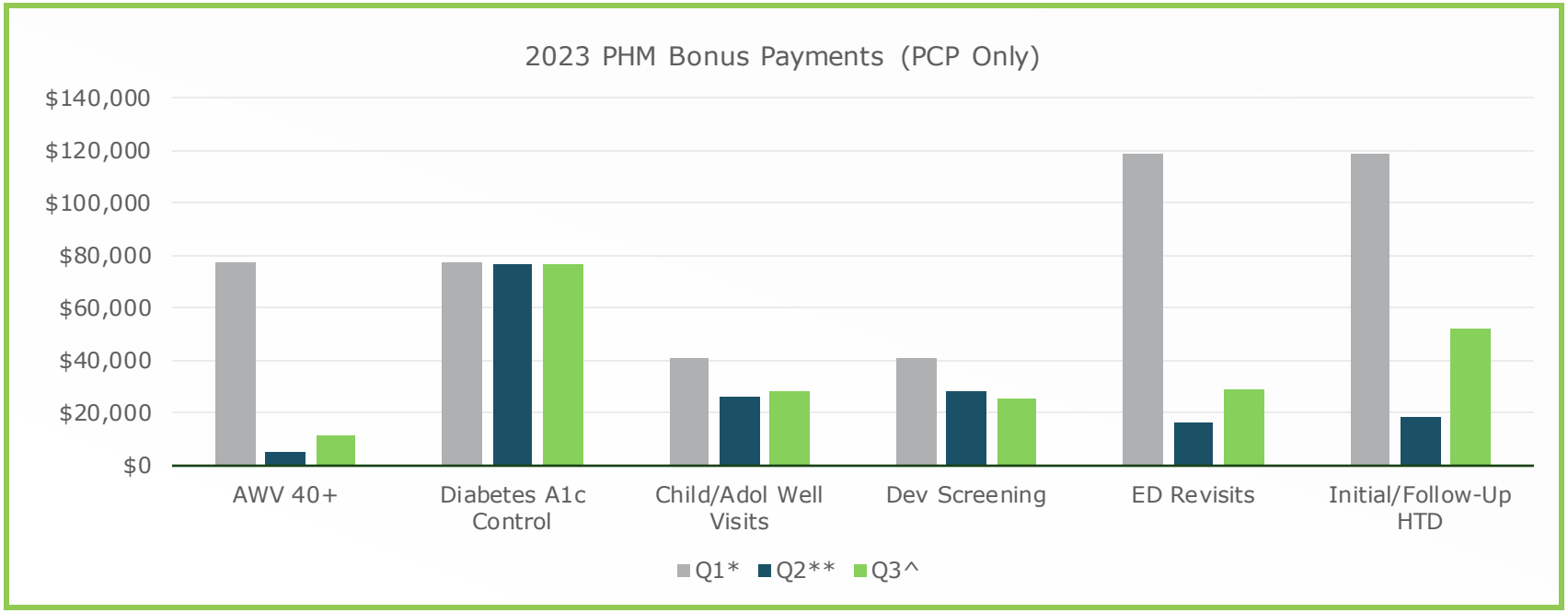
Data Source: 2021: Care Navigator | 2022: Triannual Reporting

Care Coordination Evaluation

Annual Patient Experience Survey

Survey Question	2021 - % of respondents answering "Always"	2022 - % of respondents answering "Always"
The people involved in my care communicated about my needs and goals.	55.98%	72.25%
The people involved in my care ask me what I think about things related to my health and support.	55.80%	70.16%
I am invited to meetings where my needs and health are talked about.	29.58%	51.57%
I have one person on my care team identified as my primary contact (often referred to as Lead Care Coordinator.)	91.55%	92.93%

Investment #1—Population Health Model (PHM) Program



Early 2023 PHM Results and Signals

- Initial data shows some positive signals while also indicating there is significant opportunity for improvement
- Of five claims-based measures, four showed improvement between the Q2 and Q3 data runs
  - Q1 was a reporting only quarter and shows full funding potential for the participants
- Significant opportunity remains in Annual Wellness Visit, ED Revisit, and Hypertension measures

* Q1 PHM Bonus payments for reporting only | ** Q2 PHM Bonus payments based on cohort 2022 performance | ^ Q3 PHM Bonus payments based on cohort 2023 performance

Example Quarterly PHM Practice Performance Report

2023 Mid-Year Estimated Attribution	
Pediatric - 194	Adult - 393

	PHM Measure			Target	Performance: Practice	Performance: HSA	Monthly PHM Bonus: Earned	Monthly PHM Bonus: Unearned
	Child and Adolescent Well Visits		*(n=174)*	>57.54%	60.3%		$48.50	$0.00
	Developmental Screening		*(n=39)*	> 57.4%	53.8%		$0.00	$48.50
INVERSE MEASURES [1]	Diabetes Poor Control (A1c>9)		*(n=49)*	< 39.9%	16.3%		$98.25	$0.00
INVERSE MEASURES [1]	Annual Wellness Visit 40+ Incomplete		*(n=978)*	< 38.0%		43.5%	$0.00	$98.25
INVERSE MEASURES [1]	Emergency Department Revisits		*(n=664)*	< 26.7%		26.4%	$146.75	$0.00
INVERSE MEASURES [1]	Hypertension Follow Up Incomplete *(compound measure)*	Initial Dx	*(n=172)*	< 58.7%		57.6%	$146.75	$0.00
INVERSE MEASURES [1]		Routine Dx	*(n=207)*	< 28.8%		24.2%		
						Total [2]	$440.25	$146.75

1 Inverse Measure - rates lower than target succeed
2 Total does not include potential bonus from Diabetes A1c

Investment #2—Comprehensive Payment Reform (CPR) Program

Goal

- Support independent primary care practices to advance primary care delivery and remain financially viable

2024 Approach

- Replace fee-for-service (FFS) with a payer-blended monthly fixed payment
- Connect reimbursement to the total cost of care (TCOC) and increase the amount allocated to independent primary care practices
- Offer financial incentives to expand services offered by independent primary care practices
  - Increase reimbursement for mental health integration
  - 5% premium on non-core service reimbursement

Organizations

- Independent primary care practices participating in the Medicaid and Medicare programs
  - Medicare exemption for pediatric-only practices

Investment #2—Comprehensive Payment Reform (CPR) Program

Funds Available

- 9% of total cost of care (TCOC) base for core services
  - 0.5% advancement for Tier 2
  - Additional 0.5% advancement for Tier 3
- 105% of fee-for-service for non-core services

Tier 2: Commit to MH screening

Tier 3: Commit to MH screening and develop a staffed or partnership model to support patients

Allocation Model

- Each practice receives a payment derived from the targeted percentage of total cost of care (TCOC) and based on:
  - Attribution
  - Risk scores (adults); age/gender matrix (pediatrics)

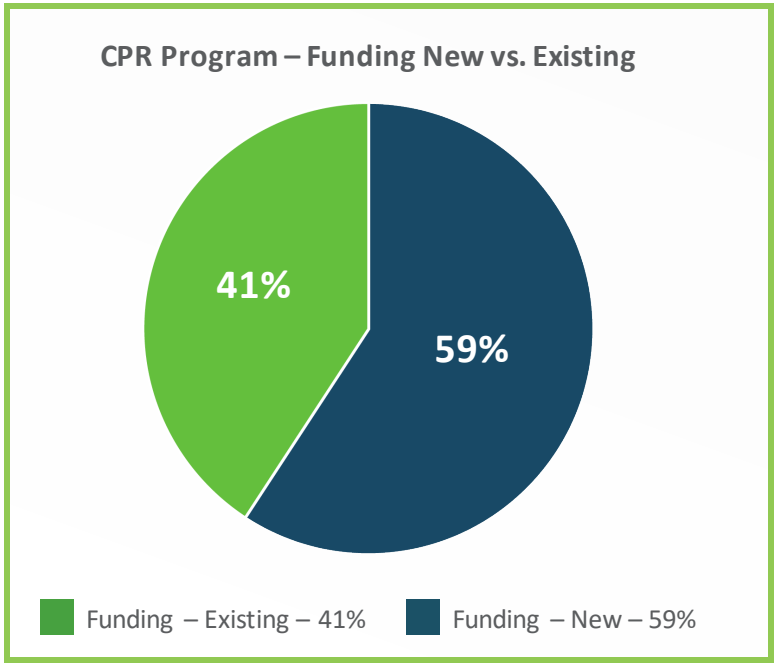
Provider Accountabilities

- All Population Health Model (PHM) accountabilities apply
- For practices receiving advanced tier payments, fulfill mental health integration expectations
- Participate in CPR Clinical Advisory Group meetings
- Engage with OneCare to help advance the program design each year

Investment #2—Comprehensive Payment Reform (CPR) Program

Financial Results

- All participating practices benefited financially from the CPR program in 2022, and the same result is projected in 2023
- Practices reported that ~59% of CPR funding is used to support new activities, with the remainder sustaining existing activities



Participant-Reported Uses Include:

- Funding helped keep existing mental health initiatives in place (NP retention)
- Practice is using additional funding to do more outreach to patients (e.g. care coordination staffing)
- Practice purchased a spirometer with funds to help manage asthma patients. Funding for provider CBT coursework. Funding for additional hours of BP coordinator time.
- All new activities are mental health-related (new MH FTE beginning with practice soon)
- New mental health initiatives (note: before 2023, % new was quite a bit lower)
- Still too early in program to start new projects
- No new programs implemented solely because of CPR program enrollment
- Stayed afloat because of CPR payments during COVID
- New provider joined to help with practice data
- Increased Care Coordination FTE from 2.5 days to 4 days; Increased Licensed MH Counselor from 4 days to 5 days; Increased Front Desk Staff from 1 day to 1.5 days

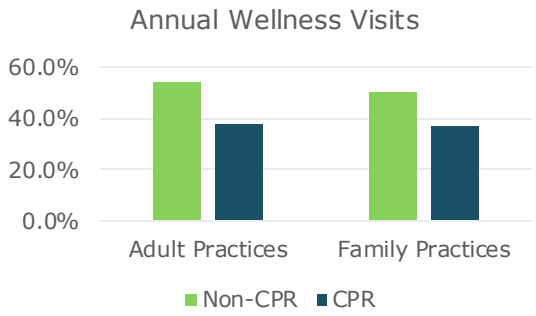
Investment #2—Comprehensive Payment Reform (CPR) Program

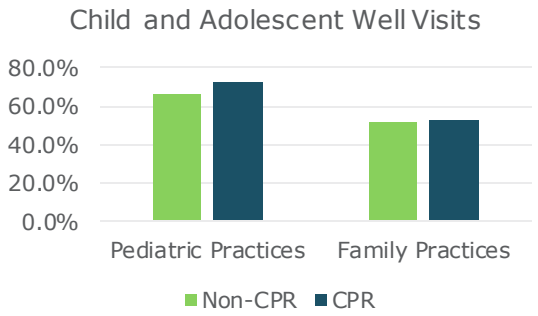
2023 Practice-Level PHM Results Relative to Non-CPR Practices

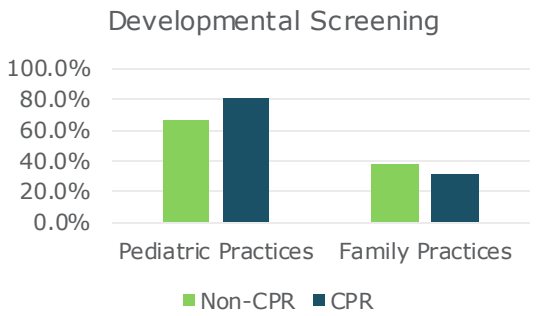
- Annual Wellness Visits
  - Both Adult and Family Med CPR practices do not perform as well
- Child and Adolescent Well Visits
  - Pediatric CPR practices perform better
  - Family Med CPR practices generate similar results
- Developmental Screening
  - Pediatric CPR practices perform better
  - Family Med CPR practices generate similar results

Data reflect averaged quarterly PHM results to date

Results hold when comparing to just other independent primary care practices or all primary care







Action Steps

- Leverage the CPR Clinical Advisory Group to understand barriers to Annual Wellness Visits results
- Explore differences between family medicine and pediatric practices related to Child and Adolescent Well Visits and Developmental Screening protocols
- Based on findings, explore incentive model in future program design

Investment #2—Comprehensive Payment Reform (CPR) Program

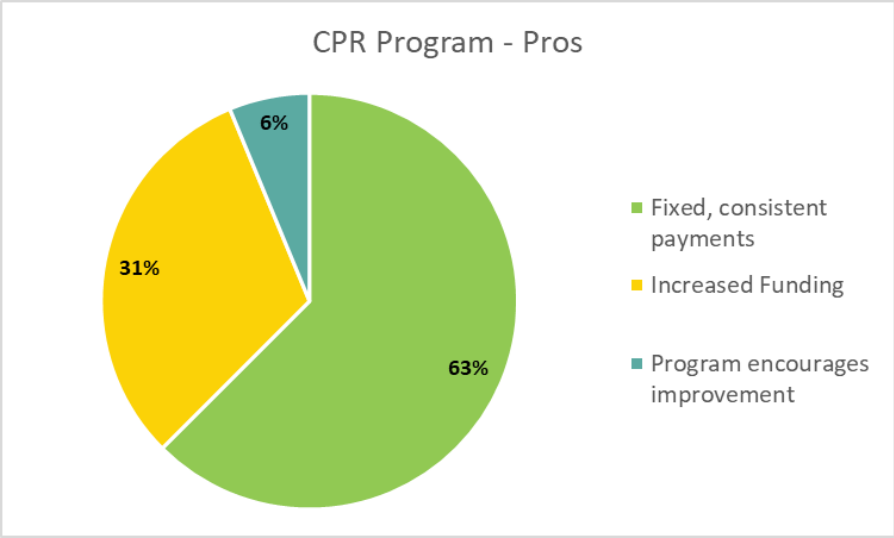
Participant Feedback

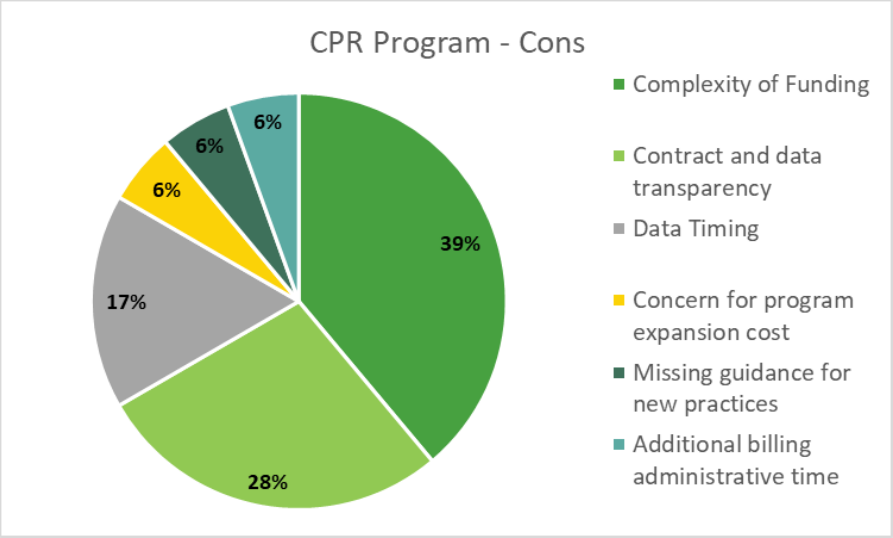
Pros

Fixed, consistent payments and increased funding available to practices

Cons

Complexity of funding model, contract and data transparency, and data timing





OneCare Response Actions

- Periodic meetings with each participating practice to review financial and clinical results
- Development of a CPR Clinical Advisory Group to discuss clinical outcomes
- Development of Arcadia to enhance data delivery

Investment #2—Comprehensive Payment Reform (CPR) Program

Results Indicators

- CPR program payments greater than fee-for-service
- Improved PHM performance
- Strong engagement in OneCare meetings and initiatives
- Provider satisfaction with the program design
- Practices remain financially viable

Opportunities

- Continue advancing the financial model relative to the total cost of care
- Reintegrate commercial fixed payments into the model (if a commercial fixed payment is available)
- Evaluate and evolve the mental health integration model implemented in 2023

Investment #3--Mental Health Screening Initiative (MHSI)

Goal

- **Standardize mental health screening** and **data-collection protocols** across primary care organizations

2024 Approach

- Align with Blueprint expansion project on screening processes
- Provide financial incentives
- Collect screening rate data to help inform opportunities for further mental health integration efforts
- Structure in a payer- and attribution-agnostic way

Organizations

- All primary care organizations within the OneCare network

Funds Available

- $1,671,727

Investment #3--Mental Health Screening Initiative (MHSI)

Allocation Model

- Standard Per Member Per Month (PMPM) (~$1.00) paid in two installments

Provider Accountabilities

- Integrate eligible mental health screenings into workflows across all patients
- Report on screening and referral rates

Results Indicators

- Increase percentage of eligible primary care organizations committing to standardized mental health screening
- Increase screening rates across the provider network

Opportunities

- Standardize data reporting
- Set screening rate targets
- Develop protocols and pathways for positive screening results

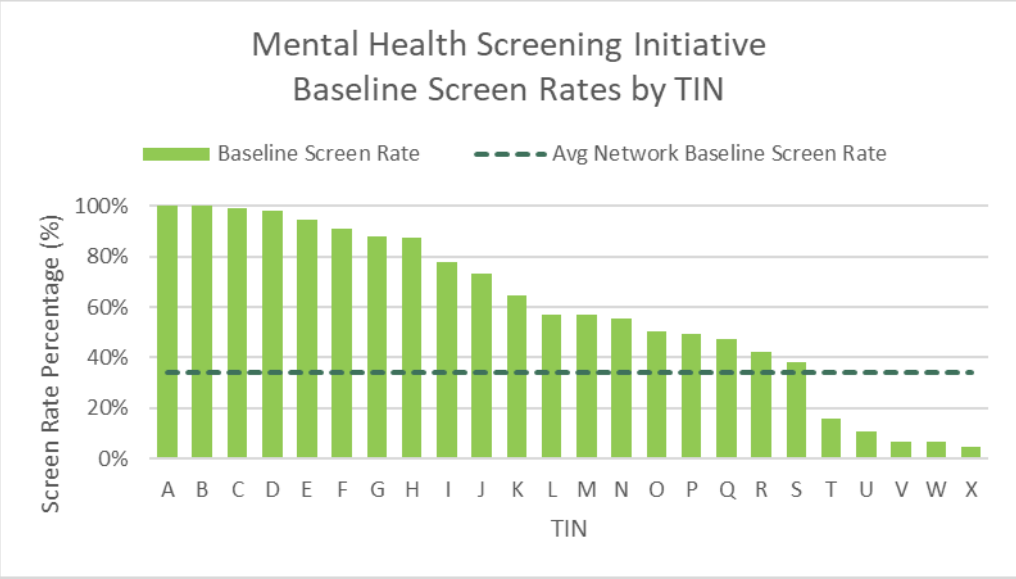
Investment #3--Mental Health Screening Initiative (MHSI)

2023 Baseline Data - Participation

- Of 117 eligible practices, 92 (79%) attested to participating in MHSI program
- 92 attesting practices attribute 127,239 (80%) of total eligible lives (158,151)

2023 Baseline Data – Preliminary Screening Rates

- Based on data submissions through September, the average baseline screening rate was 34%
- Screening rate percentages ranged from 4% - 100%



OneCare Response Actions

- Partner with Blueprint to align initiatives
- Engage with practices not participating to understand barriers
- Standardize data collection
  - There may be some variation in the way these data are being reported

Additional Contributions to Health Care Transformation

Cynosure Impact Evaluation—Strategic Considerations

As stated by our independent evaluator:

Develop a multi-modal communications strategy that continually emphasizes goals, approaches, and progress

Bolster relationships with statewide stakeholders (such as the Blueprint and Department of Mental Health) and explore new ways to influence state-wide policy and planning

Develop explicit transformation targets and hold practices accountable

Special Funding: Fraud and Abuse Waivers

- Waivers are powerful tools to fuel innovation and allow us to share risk, money/savings, and data
- Allow flexibility and efficiency in the delivery of care to our patients
- Waivers designed by OneCare and our participants to meet specific needs of a community
  - Ambulance transport project: partnership between Hospitals, Brattleboro Retreat, and Rescue Inc.
    - 204 people transported, positively impacting emergency department wait time
  - Payment by discharging hospital for IV drugs for SNF patients, medical nutrition therapy, personal care assistance
- Waivers designed by Medicare:
  - SNF 3-day waiver: 61 people admitted since May
- $200,000 budgeted for future waiver implementation

Social Determinants of Health (SDOH) Screening Alignment for Vermont: *Uncovering and Addressing Health Disparities*

- First meeting hosted by OneCare
- Invited key partners including payers, provider organizations, state government, and practicing providers.
- 25 attended (hybrid meeting)
- Screening tools and requirements shared and compared
- Discussed the shared goal of standardized tool, digital entry, and data governance
- Agreement that data is needed to design solutions
- Flexibility and desire to work together
- Planning next meeting for January 2024

Health Equity

Quintuple Aim

- Equity and access are integral to all population health efforts and initiatives at OneCare.
- HSA consultations include HSA-specific disparities data.
- Assessing health equity is a requirement in provider accountabilities.
- For 2024, our new data platform will improve data integrity and scope in this area.

CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes

Image credit: Neuroflow

Income Statement and Summary

- Budget thoughtfully balances sustainability of reform efforts relative to cost
- $970M of Total Cost of Care accountability
- Sustains core PHM initiatives
- Incorporates analytics transition
- 3.4% operating cost decrease
- 11% participation fee decrease
- Break-even model with no additional contribution to reserves

Revenue Category	2023 Budget	2024 Budget	Change
Medicare TCOC	$491,101,380	$563,649,234	$72,547,854
Medicare - Blueprint Obligation	$9,545,916	$9,954,481	$408,565
Medicaid - Traditional TCOC	$349,847,887	$259,971,659	($89,876,228)
Medicaid - Expanded TCOC	$0	$0	$0
BCBSVT QHP TCOC	$0	$0	$0
MVP QHP TCOC	$55,946,415	$67,482,473	$11,536,058
BCBSVT Primary - Risk	$0	$0	$0
Self-Funded Program TCOC	$62,752,576	$72,726,909	$9,974,333
TCOC Targets Total	**$969,194,174**	**$973,784,755**	**$4,590,582**
Payer Program Support	$7,944,027	$7,649,807	($294,220)
Fixed Payment Allocation	$3,060,850	$2,599,717	($461,134)
Other Revenues	$667,206	$2,139,449	$1,472,244
Hospital Participation Fees	$19,828,444	$17,643,487	($2,184,957)
Total Revenue	**$1,000,694,701**	**$1,003,817,215**	**$3,122,515**
FFS Spend	$516,458,769	$533,750,067	$17,291,298
Fixed Payment Spend	$443,189,489	$430,080,208	($13,109,282)
Health Services Spending Total	**$959,648,258**	**$963,830,274**	**$4,182,016**
PHM Base Payments	$11,425,898	$8,731,119	($2,694,779)
PHM Bonus Potential	$765,689	$3,353,192	$2,587,503
Longitudinal Care	$399,000	$399,000	$0
DULCE	$145,366	$68,162	($77,204)
CPR Program-PCP	$1,617,513	$1,323,900	($293,613)
MH Screening and Follow-Up Program	$1,638,140	$1,671,727	$33,587
Waiver Implementation Funding	$0	$200,000	$200,000
Specialist and Quality Reinvest.	$717,206	$0	($717,206)
SASH	$4,508,696	$4,701,668	$192,972
Blueprint PCMH	$2,062,850	$2,223,276	$160,426
Blueprint CHT	$2,974,370	$3,029,537	$55,167
Total PHM Investments	**$26,254,728**	**$25,701,580**	**($553,147)**
General Operations	$14,791,715	$14,285,361	($506,354)
Risk Protection	$0	$0	$0
Total Infrastructure	**$14,791,715**	**$14,285,361**	**($506,354)**
Total Expenses	**$1,000,694,701**	**$1,003,817,215**	**$3,122,515**
Gain (Loss)	**$0**	**$0**	**$0**

Appendix

Budget Guidance Breakdown

FY 2024 Budget Targets	OneCare Analysis
The FY24 commercial benchmark trend rates must be consistent with the ACO-attributed population and the GMCB approved rate filings.	The 2024 budget complies with this target. While target development is not yet final, OneCare expects full compliance with this expectation.

The ACO must use best efforts to meet or exceed the goals for reconciled and unreconciled FPP as adopted by the GMCB as seen below and identify and report specific obstacles to achieving the goals and action steps required (by OCV or others) to overcome those obstacles:
• Medicaid 55%
• Commercial 24%
	The 2024 budget complies with this target.
	OneCare has and continues to use best efforts to advocate and negotiate for unreconciled fixed payments. The 2024 budget includes a 55% allocation mix in the Medicaid program. Based on the current status of commercial negotiations, it is not likely that an unreconciled option will be available to OneCare in 2024. Barriers include:
	• QHP
	  ○ Preference for the insurer's own payment reform models
	  ○ Small attribution
	• Self-Funded
	  ○ Role of the Third-Party Administrator

The ACO must hold 100% of the Medicare Advanced Shared Savings dollars as risk at the entity-level and not pass this risk along to the provider network.	The 2024 budget incorporates the directive of the OneCare Board of Managers, through the exercise of its oversight and strategic direction authorities, .to delegate risk/reward to the provider network in full.
Increase risk corridors for all payer programs above FY23 levels.	The 2024 budget incorporates the directive of the OneCare Board of Managers, through the exercise of its oversight and strategic direction authorities, to establish appropriate risk corridors.
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%.	The 2024 budget complies with this target. $14,285,361 / ($25,701,580 + $286,528,147 + $143,552,061) = 3.13%
[Any benchmark or target regarding total executive compensation to be determined and issued]	TBD

Budget Guidance Breakdown, continued

FY 2024 Budget Targets	OneCare Analysis
[Any benchmark or target regarding the structure of the variable portion of executive compensation to be determined and issued]	TBD
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.	The 2024 budget complies with this target. FY23: $26,254,728 / (196,292 * 12) = $11.15 PMPM FY24: $25,701,580 / (158,260 * 12) = $13.53 PMPM (Note the mid-year attribution estimates were used to align with the way in which PHM projections are calculated.) The budget also increases increase the accountability of its provider network for quality by adjusting the mix between base PHM payments and bonus potential for all eligible provider types.
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.	The 2024 budget complies with this target. There are four measures incorporated into the PHM Program where provider performance is below the 10th percentile and showing declining performance: • ED visits/1000 • ED Cost of Care • % of Members with a Primary Care Visit • Primary Care Visits / 1,000 The PHM Program incentivizes providers to follow-up after an ED visit for people with multiple chronic conditions (HEDIS FMC) as a strategy to prevent future ED visits and increase child and adolescent wellness visits and Medicare annual wellness visits.

2023 Q3 PHM Measure Performance Rankings

Performance Period: April 1, 2022 to March 31, 2023

	Inverse Measures							
	Practice Level Measures				HSA Level Measures			
Health Service Area by Rank	Child and Adolescent Visits	Developmental Screening	Age 40+ Annual Well Visits	Diabetes A1c Control	Emergency Department Re-Visits	Initial Hypertension Follow-Up	Routine Hypertension Follow-Up	Cumulative Rank
Lebanon	3	14	1	10	3	1	1	33
Middlebury	4	7	3	3	9	5	2	33
Randolph	1	1	4	11	4	4	10	35
Bennington	1	5	2	9	11	7	4	39
Brattleboro	12	4	8	4	5	11	5	49
Burlington	7	2	5	8	13	8	6	49
St. Albans	10	9	11	5	10	2	3	50
Windsor	8	10	14	6	2	5	9	54
Berlin	9	8	7	1	8	12	12	57
St. Johnsbury	5	5	12	2	7	14	13	58
Morrisville	13	13	9	12	1	9	7	64
Springfield	14	3	10	14	14	3	8	66
Newport	6	11	6	13	6	13	14	69
Rutland	11	12	13	6	12	10	11	75

Blue highlight indicates HSA met HSA target
Practice Level measures do not have an HSA target