OneCare Vermont

2025 Budget Presentation to

Green Mountain Care Board

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November 13, 2024

Budget Executive Summary

- 2025 is the last year of the Vermont All-Payer Model (APM)
  - 2026 represents a pivotal shift in Vermont's healthcare landscape
- Primary budget strategies:
  - Provide consistency for the provider network
  - Comply with GMCB budget targets
  - Manage the cost of ACO infrastructure
- Financial highlights include:
  - $1.1B of healthcare costs in value-based models
  - $27.8M in investments/incentives to providers
  - Reduced operating expenses by $575k
  - Reduced hospital participation fees by $1.2M
- Clinical and Quality highlights include:
  - Continuation of Population Health Model (PHM) and Comprehensive Payment Reform (CPR) initiatives in similar form
  - Continued focus on waiver utilization

Provider Network

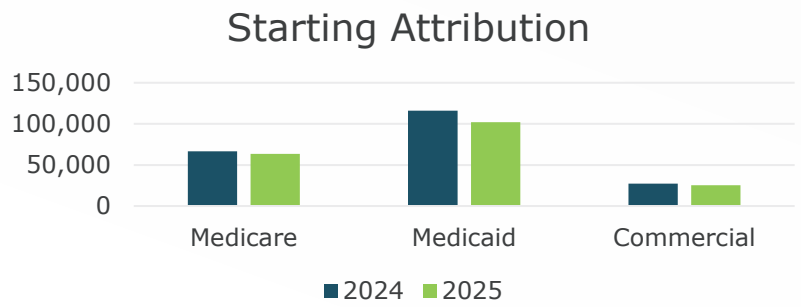
- Largely sustaining the same network in 2025
- Notable changes include:
  - Northwestern Medical Center declined participation in all programs
    - OneCare offered to cover risk for other St. Albans participants to sustain participation in the last year of the APM
  - NOTCH (FQHC) declined participation in the Medicare program
  - Northwestern Counseling & Support Services (Designated Agency) declined participation
- Budgetary impact:
  - Modest expense reduction due to fewer PHM payments
  - NMC participation fees spread to other hospitals

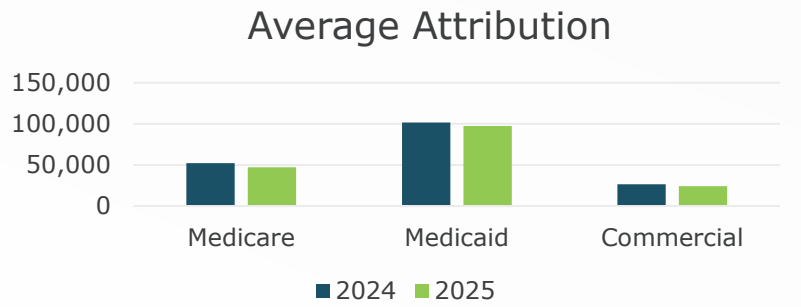
Attribution

Assumptions

- No substantive changes to payer attribution methodology
- Medicaid redetermination ending after 2024
- All attributed lives expected to qualify for scale targets

	Starting Attribution Budget			Average Attribution Budget		
	2024	2025	Change	2024	2025	Change
Medicare	66,736	63,635	(3,101)	52,047	51,354	(693)
Medicaid	116,088	102,001	(14,087)	101,513	97,477	(4,036)
Commercial	27,147	25,198	(1,949)	26,307	24,070	(2,237)
Total	**209,971**	**190,834**	**(19,137)**	**179,867**	**172,901**	**(6,966)**





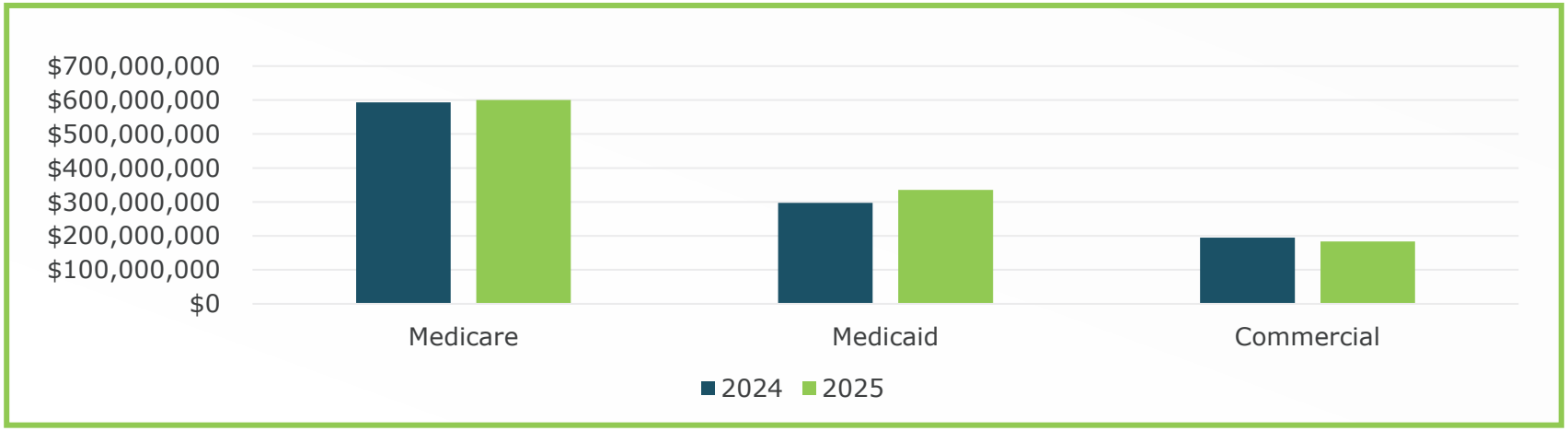
Splits do not include GPP

Program Total Cost of Care (TCOC) Targets Forecast

Assumptions

- Budget assumes Medicare target follows the APM model – 4.0% trend
- Medicaid trend rate modeled from historical analysis
  - Emerging 2024 spend is influencing the 2025 target projection
- Commercial trend based on recent rate filings or plan budgeting

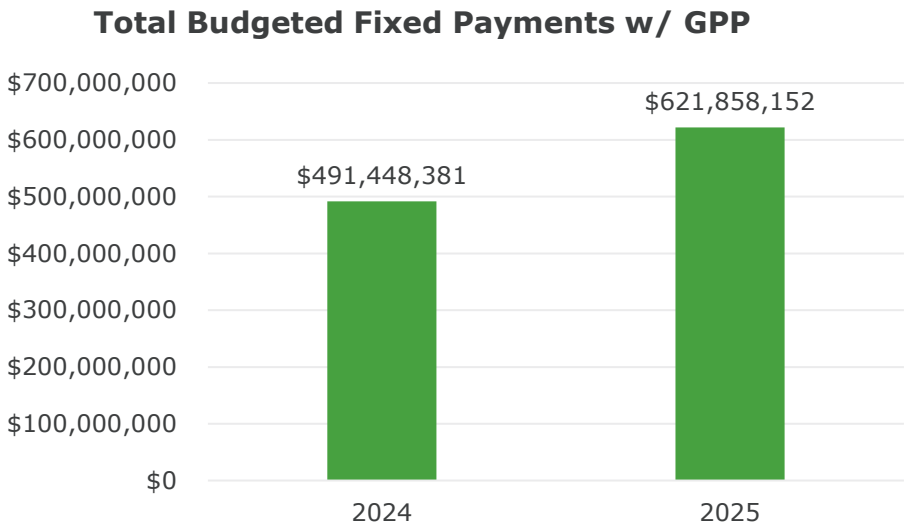
	2024	2025	$ Change
Medicare	$593,514,391	$600,201,206	$6,686,815
Medicaid	$297,663,366	$335,432,994	$37,769,628
Commercial	$195,300,253	$183,839,993	($11,460,261)
Total	**$1,086,478,010**	**$1,119,474,193**	**$32,996,183**



Fixed Payments

Assumptions

- Medicare and Medicaid fixed payments will continue in a similar form
- Medicaid Global Payment Program (GPP) budgeted for 2024 participants
  - Opportunity to expand to other hospitals (not budgeted)
- No commercial fixed payment option expected in 2025



Risk Model

Risk model incorporated into the budget is consistent with the Risk Mitigation Plan approved by the GMCB in June 2024.

Notable sub-arrangements include:

- Continuation of the risk mitigation arrangement for Northeastern Vermont Regional Hospital (NVRH)
  - Limits the St. Johnsbury Health Service Area to a 1% Medicare risk corridor with OneCare as the counterparty
- OneCare holding risk for St. Albans primary care providers beyond the Accountability Pool level
  - Enables continued participation from St. Albans primary care through the end of the Vermont All-Payer Model

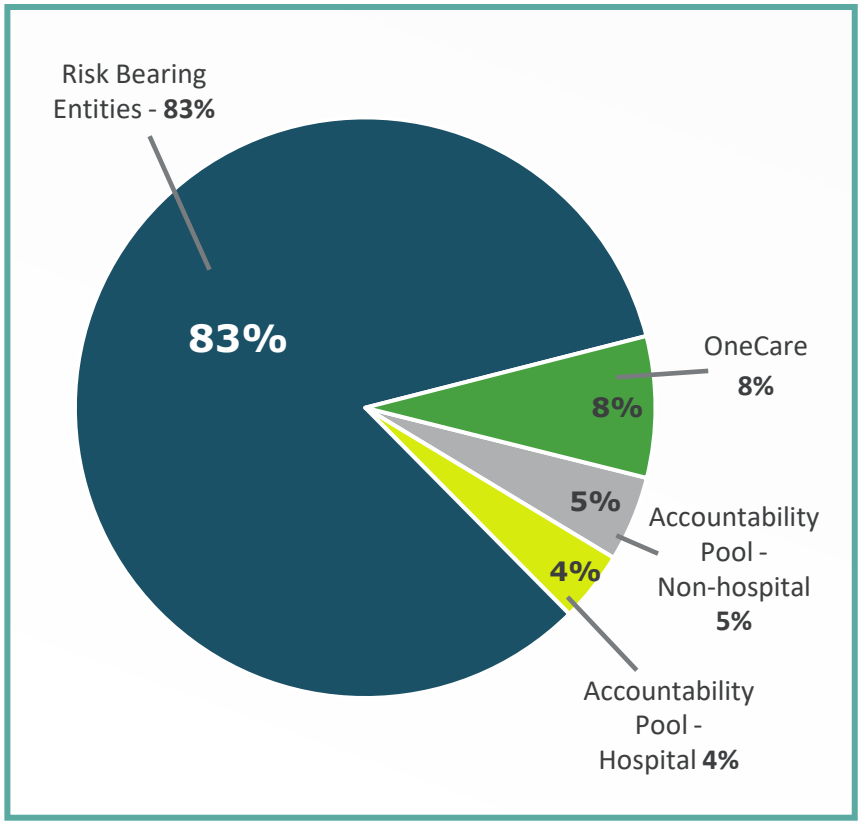
Total Risk

Assumptions

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

Risk	2024	2025	Change
Medicare	$23,740,576	$18,006,036	($5,734,540)
Medicaid	$8,929,901	$10,062,990	$1,133,089
Commercial	$1,419,472	$1,382,608	($36,864)
Total	**$34,089,949**	**$29,451,634**	**($4,638,315)**

Risk	Amount
Accountability Pool - Non-Hospital	$1,401,786
Accountability Pool - Hospital	$1,159,812
Risk Bearing Entities	$24,573,755
OneCare	$2,316,281
Total	**$29,451,634**



* Risk corridor was 4% in 2024

Revenues

Program and Other Revenues

Assumptions

- Medicaid GPP funds included in this category (not part of total cost of care)
- Payer funding levels follow attribution estimates; no other changes assumed
- $2M Value Based Incentive Fund pool expected to continue in 2025

Payer and Other Revenue	2024	2025	$ Change
Medicaid GPP	$1,649,282	$109,532,921	$107,883,639
Medicare	$0	$0	$0
Medicaid	$7,786,241	$7,556,189	($230,052)
Commercial	$1,025,973	$733,161	($292,812)
Fixed Payment Allocation	$2,976,634	$3,354,330	$377,696
Deferred Par Fees	$2,200,202	$1,036,318	($1,163,884)
Interest Income	$1,009,293	$756,970	($252,323)
Total	**$16,647,625**	**$122,969,889**	**$106,322,264**

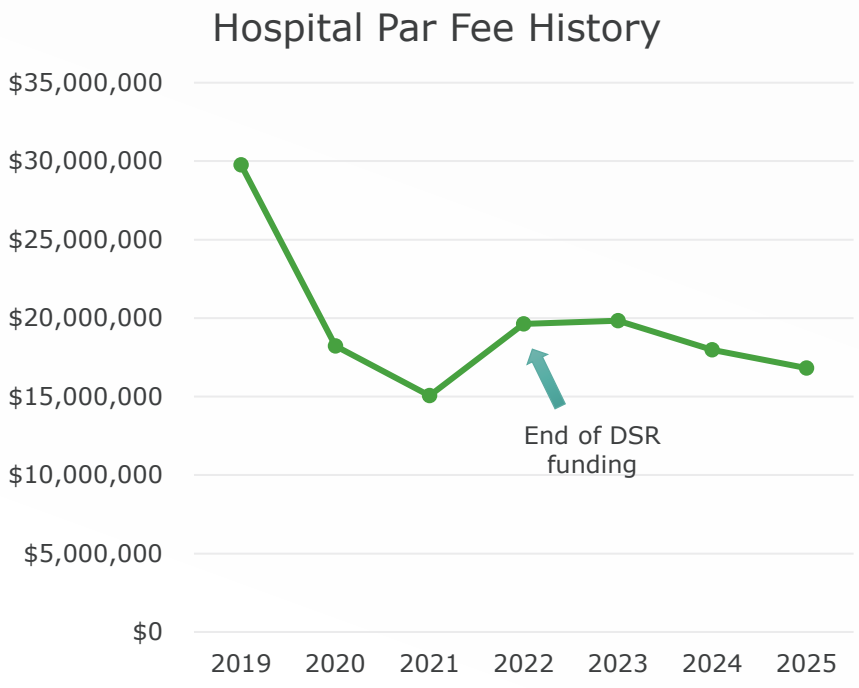
Deferred Revenue

- 2024 deferred revenue is being used in full during the 2024 fiscal year
- The 2025 budget includes assumes ~$1M of 2024 funding for the PHM program will be deferred for use in 2025
  - 2024 budget assumed 60% of the funds would be spent; current estimates are ~45%

Hospital Participation Fees

6.4% reduction to hospital participation fees

	2024	2025	Change
Hospital Participation Fees	$17,969,848	$16,822,322	($1,147,526)



$17,969,848	**2024 Par Fees**
($377,696)	FPP Allocation
$522,864	Payer Revenue
$1,163,884	Deferred Funds
$252,323	Interest Income
($575,753)	Operating Expenses
$100,000	Waiver increase
$50,000	RCRs
($61,022)	DULCE
$3,000	CPR
($1,058,630)	PHM Program Base Pmts.
$941,907	PHM Program Bonus Pmts.
($2,108,403)	MH Screening Initiative
$16,822,321	**2025 Par Fees**
($1,147,526)	**Total Change**

Population Health Expenses

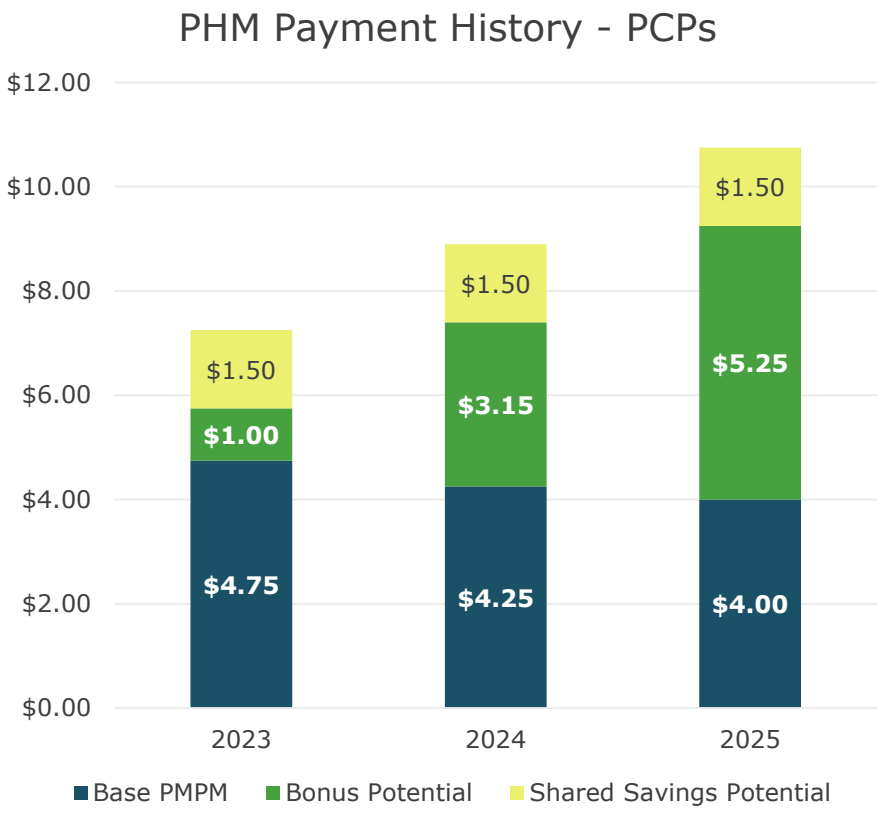
Population Health Expense Overview

- Maintaining core initiatives from 2024
  - Integrating MH Screening & Follow-Up initiative into PHM Program
- Incremental change to PHM Program payments to increase the weight on outcomes
  - Base payments allocated based on attribution moving from $4.25 PMPM to $4.00 PMPM; bonus potential moving from $3.15 PMPM to $5.25 PMPM
  - **Assuming 50% of bonus payments are earned** (was 60% in 2024)
- No significant budgetary changes to CPR model
- RCR budget increased from $250k to $300k
- Waiver implementation finding increased from $200k to $300k
- Blueprint budgeted to increase by the APM trend of 4.0%

Population Health Model Program Evolution

The mix between base payment and bonus potential is again evolving to place more emphasis on outcomes.

- 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



MH Screening funds have been ported into the PHM Program

Total earning potential on a PMPM basis is 12% higher for a practice meeting all targets

Primary Care PHM & MHSI	2024	2025
PHM Base	$8,274,852	$7,255,152
PHM Bonus - Total Potential	$6,133,126	$9,522,387
MH Screening Payments	$2,108,403	$0
Avg. Attribution	179,867	167,630
Total Potential	**$7.65**	**$8.34**

Population Health Expenses Breakdown

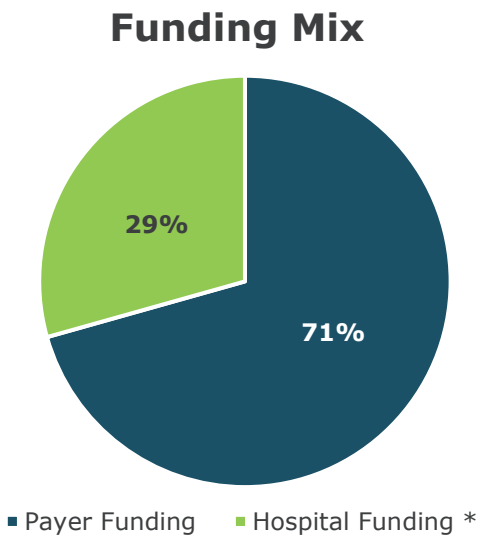
- 2025 GMCB budget guidance included an expectation to keep provider investment/incentive payments at the 2024 level or above.
  - The submitted budget complies with this expectation.

PHM Payments	2024	2025	$ Change
Medicaid GPP - Hospitals	$0	$107,830,463	$107,830,463
Medicaid GPP - CPR	$1,649,282	$1,702,458	$53,175
GPP Subtotal	**$1,649,282**	**$109,532,921**	**$107,883,639**
PHM Base Payments	$9,796,132	$8,737,501	($1,058,630)
PHM Bonus Payments	$4,478,525	$5,420,432	$941,907
Longitudinal Care	$399,000	$399,000	$0
DULCE	$61,022	$0	($61,022)
CPR Program	$2,346,993	$2,349,993	$3,000
MH Screening and Follow-Up	$2,108,403	$0	($2,108,403)
RCRs	$250,000	$300,000	$50,000
Waiver Implementation Funds	$200,000	$300,000	$100,000
PCMH Payments	$2,223,276	$2,312,651	$89,374
Community Health Team	$3,029,537	$3,151,322	$121,786
SASH	$4,701,668	$4,890,672	$189,004
PHM Program Subtotal	**$29,594,556**	**$27,861,573**	**($1,732,984)**
Attribution	179,867	167,630	(12,237)
PHM PMPM	**$13.71**	**$13.85**	**$0.14**

2025 attribution excludes SF lives attributed to UVMHN providers

Population Health Funding Sources

PHM Payments	Budget Total	Payer Funding	Hospital Funding *
PHM Base Payments	$8,737,501	$5,238,637	$3,498,865
PHM Bonus Payments	$5,420,432	$2,586,325	$2,834,108
Longitudinal Care	$399,000	$0	$399,000
CPR Program	$2,349,993	$1,500,706	$849,287
RCRs	$300,000	$0	$300,000
Waiver Implementation Funds	$300,000	$0	$300,000
PCMH Payments	$2,312,651	$2,312,651	$0
Community Health Team	$3,151,322	$3,151,322	$0
SASH	$4,890,672	$4,890,672	$0
PHM Program Subtotal	**$27,861,573**	**$19,680,313**	**$8,181,259**



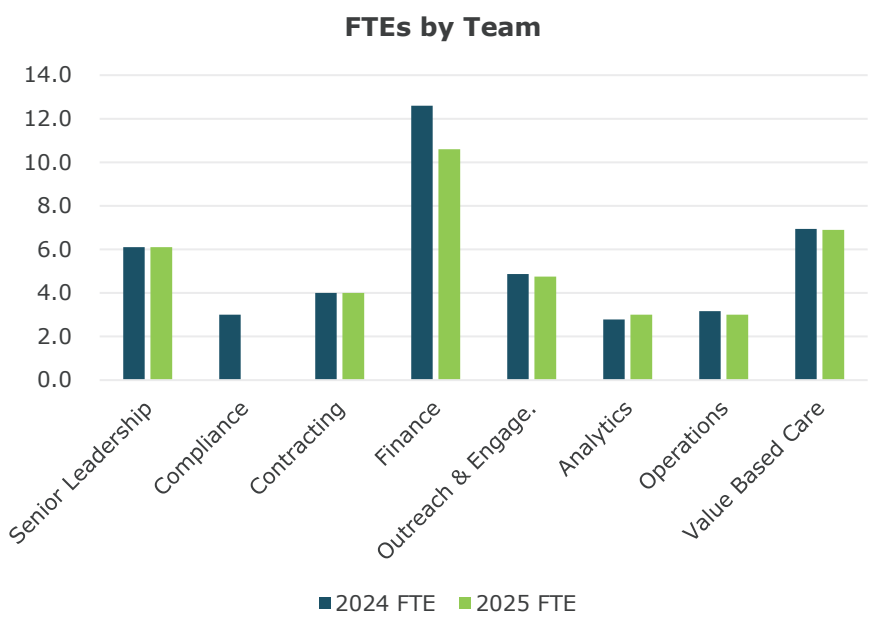
- Funding splits vary based on how much, if any, payer revenues OneCare can collect
- Most of the hospital contributions to PHM relate to the Medicare program

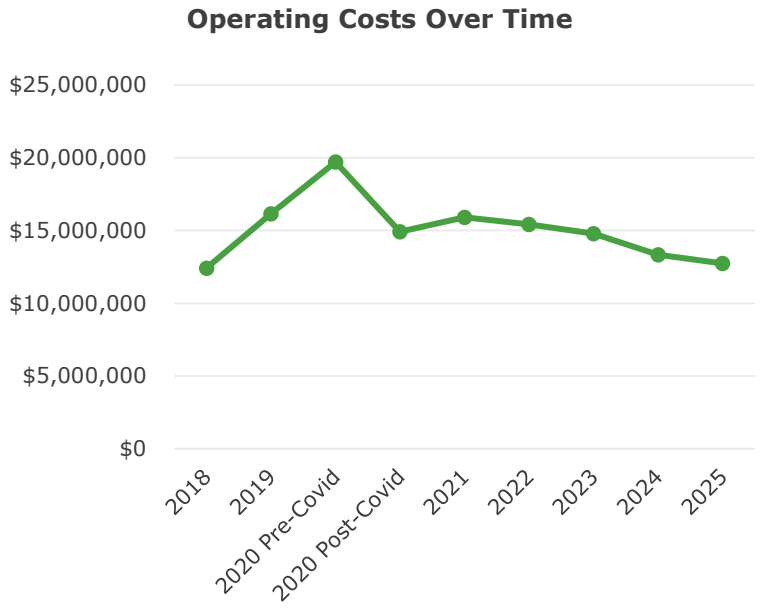
* Hospital funding can be either current year participation fees or from deferred revenue

Operating Budget

- 4.3% overall decrease
- 5.1 fewer full-time equivalent FTEs
- Compliance work moved to contract model
- Scrutiny of all other expenses

	2024	2025	Change
Wages & Fringe	$7,234,410	$7,202,258	($32,153)
Purchased Services	$4,327,955	$4,039,925	($288,030)
Software	$494,951	$239,192	($255,760)
Insurance	$274,050	$243,038	($31,012)
Supplies	$36,560	$34,544	($2,016)
Travel	$38,071	$35,862	($2,209)
Occupancy	$53,064	$57,301	$4,237
Other	$869,055	$900,243	$31,188
Total	**$13,328,116**	**$12,752,362**	**($575,753)**





Budget Target Analysis

#	Target Summary*	Analysis
1	Commercial trends consistent with approved rate filings.	Actuarial process underway, but no concerns with compliance based on latest discussions.
2	Maintain risk corridors for all public-payer programs at a minimum of FY23 levels or elect the new asymmetric risk corridor offered by Medicare.	Budget, and negotiation intent, complies with the guidance.
3	No new programs in 2025; Admin budget support access, quality, affordability and/or provider benefit	No new initiatives included in 2025; Administrative costs relate to operating ACO programs, which are in spirit of, and financially incentivize, appropriate access, quality, and affordability. OneCare arrangements with providers (ex. PHM and CPR) are designed to benefit providers by supplying funding, data, collaboration opportunities, and general support.
4	Operating expense to PHM/payment reform payments must not exceed 2024 revised budget amount.	Budget complies with target, both with GPP included and excluded in the calculation. 2024 w/ GPP: $13,328,116 / $521,042,938 = 0.02558 2025 w/ GPP: $12,752,362 / $649,719,726 = 0.01963 2024 w/o GPP: $13,328,116 / $519,393,655 = 0.02566 2025 w/o GPP: $12,752,362 / $540,186,805 = 0.02361
5	Ratio of population health management funding to number of attributed lives must be at a minimum of the FY24 revised budget amount.	FY24 PMPM: $13.71 FY25 PMPM: $13.85 Please see Population Health Expenses Breakdown slide for calculation detail.
6	Continue efforts around the three metrics in response to the March 2023 Medicare ACO Performance Benchmarking report.	The PHM program will continue to incentivize population health activities that aim to reduce ED utilization, increase primary care utilization, and increase utilization of Medicare Annual Wellness Visits.
7	Revise budget if OneCare transitions to MSSP.	OneCare intends to remain in the Vermont Medicare ACO Initiative in 2025.
8	Submit administrative budget by function.	Included in submitted budget workbook.

Major Investments and Initiatives

Investment #1—Population Health Model (PHM) Program

2024 Observations and Outcomes:

- Three of the aggregate targets have been met year-to-date
- Performance remains strong on preventative care visit rates (ex. well-visits)
- There is opportunity to improve initiation and engagement measures (new measures in 2024)

PHM Measure	Performance Rate*	Target
1. Developmental Screening	**74.2**	57.4
2. Child & Adolescent Well Care	**67.2**	61.15
3. Medicare Annual Wellness Visits	46.2	51.8
4. 7 Day Follow Up after ED Visit (FMC)	50.8	56.5
5. Hypertension: Controlling High Blood Pressure	**67.9**	67.27
6. IET Initiation	36.2	44.32
7. IET Engagement	15.7	18.87

*Data Source: October 2024 Release OneCare Executive Summary Performance Periods:
Claims Measures 1-4: August 1, 2023 to July 31, 2024
Practice-Reported Measure 5: September 1, 2023 to August 31, 2024
DVHA-Reported Measures 6-7: April 1, 2023 – March 31, 2024

Cells shaded in dark blue indicate that the target was met

QUALITY PROGRESS - THRU JUL 2024

MEASURE	PERFORMANCE		PRIOR PERIOD	TREND	TARGET
Developmental Screening: 0-3y	✓ 74.2%	3,428 / 4,618	74%		57%
ED Follow-Up: Chronics	✗ 50.8%	3,300 / 6,496	51%		56%
Medicare Annual Wellness Visit	✗ 46.2%	16,645 / 35,990	46%		52%
Well-Care Visits: ages 3-21	✓ 67.2%	29,424 / 43,781	66%		61%

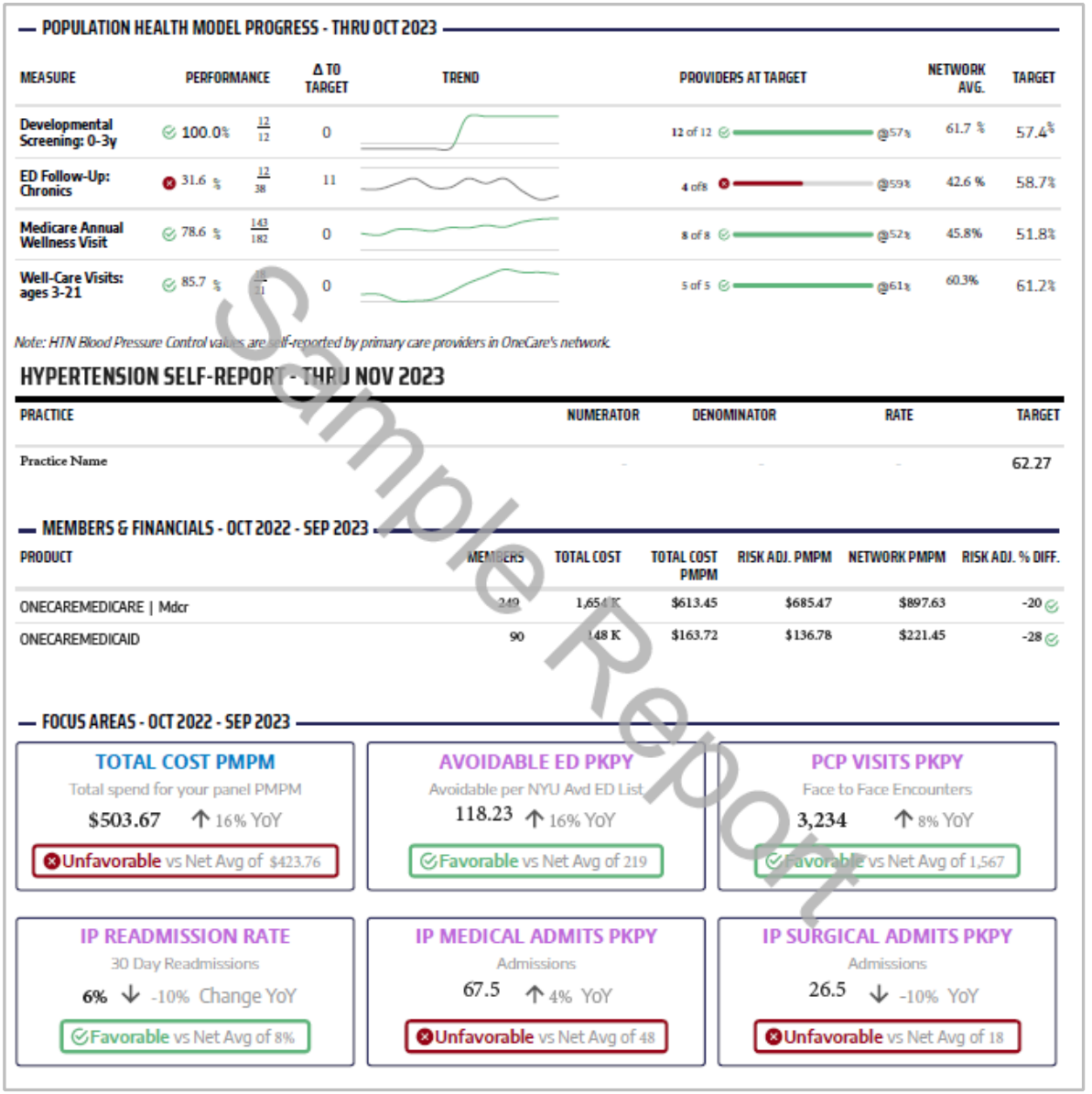
- Data are showing positive trends in many of the continuing claims-based measures
- Note: Prior period represents the previous month, trend line represents the last 12 months

Example Quarterly PHM Practice Performance Report

The value-based care team reviews practice-level reports with RCRs and participants

Used to develop Performance Improvement Plans (PIPs) for focus

Provides insight beyond the PHM measures



POPULATION HEALTH MODEL PROGRESS - THRU OCT 2023

MEASURE	PERFORMANCE	Δ TO TARGET	TREND	PROVIDERS AT TARGET	NETWORK AVG.	TARGET
Developmental Screening: 0-3y	100.0% 12/12	0		12 of 12 @57%	61.7 %	57.4%
ED Follow-Up: Chronics	31.6 % 12/38	11		4 of 8 @59%	42.6 %	58.7%
Medicare Annual Wellness Visit	78.6 % 143/182	0		8 of 8 @52%	45.8%	51.8%
Well-Care Visits: ages 3-21	85.7 % 18/21	0		5 of 5 @61%	60.3%	61.2%

Note: HTN Blood Pressure Control values are self-reported by primary care providers in OneCare's network.

HYPERTENSION SELF-REPORT - THRU NOV 2023

PRACTICE	NUMERATOR	DENOMINATOR	RATE	TARGET
Practice Name	-	-	-	62.27

MEMBERS & FINANCIALS - OCT 2022 - SEP 2023

PRODUCT	MEMBERS	TOTAL COST	TOTAL COST PMPM	RISK ADJ. PMPM	NETWORK PMPM	RISK ADJ. % DIFF.
ONECAREMEDICARE | Mdcr	249	1,654 K	$613.45	$685.47	$897.63	-20
ONECAREMEDICAID	90	148 K	$163.72	$136.78	$221.45	-28

FOCUS AREAS - OCT 2022 - SEP 2023

TOTAL COST PMPM
Total spend for your panel PMPM
$503.67 ↑ 16% YoY
Unfavorable vs Net Avg of $423.76

AVOIDABLE ED PKPY
Avoidable per NYU Avd ED List
118.23 ↑ 16% YoY
Favorable vs Net Avg of 219

PCP VISITS PKPY
Face to Face Encounters
3,234 ↑ 8% YoY
Favorable vs Net Avg of 1,567

IP READMISSION RATE
30 Day Readmissions
6% ↓ -10% Change YoY
Favorable vs Net Avg of 8%

IP MEDICAL ADMITS PKPY
Admissions
67.5 ↑ 4% YoY
Unfavorable vs Net Avg of 48

IP SURGICAL ADMITS PKPY
Admissions
26.5 ↓ -10% YoY
Unfavorable vs Net Avg of 18

Investment #2—Regional Clinical Representatives

- Re-established in 2024 to help drive PHM performance at ground level
- MDs, NPs, PAs in local clinical practice, leaders
- Nine engaged to date, June-September on-boarding
- Twelve needed to cover all primary care 2025
- Partner with OneCare Value-Based Care team members to review practice data, develop Performance Improvement Plans (PIPs), support and oversee implementation of PIPs
- Collaboration with local Blueprint Quality Improvement Facilitators—accountability in 2025

Investment #3—Comprehensive Payment Reform Program

2024 Observations and Outcomes:

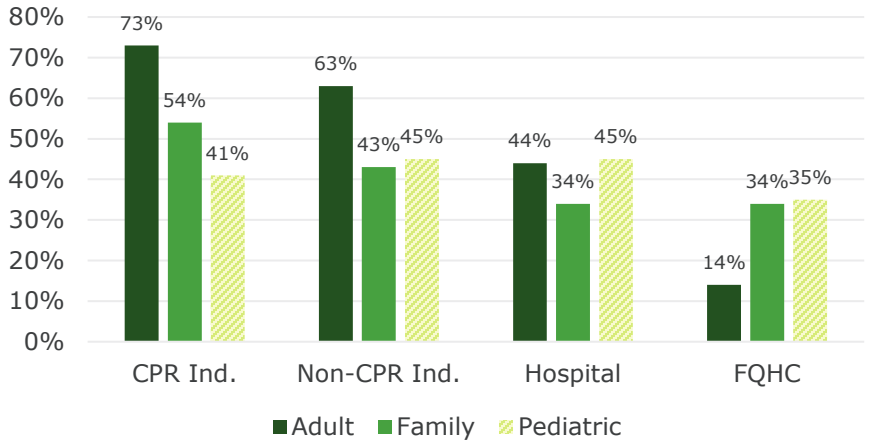
- Practices are being paid at 9.5% or 10.0% of the total cost of care
  - On average practices receive ~145% of FFS
- All but two of the CPR practices committed to the staffed/partnership model for mental health follow-up (Tier 3)
- In 2024 OneCare included Medicaid Global Payment Program (GPP) payments
  - Now all Medicaid membership is included in the CPR program model

Investment #3—Comprehensive Payment Reform Program

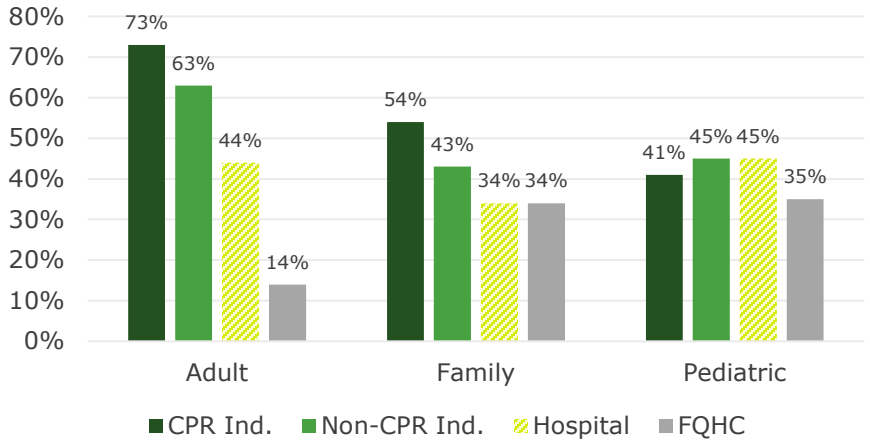
2024 Observations and Outcomes cont.

- Overall, CPR practices earned 51% of available bonus dollars through October
  - This is roughly level with non-CPR independent, better than hospital-affiliated practices (40%), and FQHCs (32%)
- The **adult** CPR practices earned 73% of available bonus dollars through October
  - This is better than non-CPR independent (63%), hospital-affiliated (44%) and FQHCs (14%)
- The **family** CPR practices earned 54% of available bonus dollars through October
  - This is better than non-CPR independent (43%), hospital-affiliated (34%) and FQHCs (34%)
- The **pediatric** CPR practices earned 41% of available bonus dollars through October
  - This is slightly lower than non-CPR independent (45%) and hospital-affiliated (45%), and higher than FQHCs (35%)

PHM Bonus % by Practice Type



PHM Bonus % by Practice Focus



Investment #4—Waiver Support Investments

Fraud and Abuse Waivers

Provider designed flexibility for meeting patient needs

Regularly available to support discharges

2024 Special Funding of $343,000 awarded to 17 diverse projects after competitive applications:

- Preventative Care – Annual Wellness Visit
- SUD Care – Peer Counselors
- Mental Health – support groups, Brightside
- Home Care – longitudinal care
- EMS Response –COPD follow up, payment for in field services

Benefit Enhancement Waivers

Medicare designed Payments

3 Day SNF – served 228 patients through Q3 2024

New for 2025:
Hospice Concurrent Care – focus on dialysis
Home Health Homebound
Expanded Telehealth

Over 1000 Vermonters Benefited

Additional Contributions and Outcomes— Impacting Population Health for Vermonters

2023 PHM Evaluation

A comprehensive, qualitative and quantitative independent evaluation of 2023 PHM was performed in 2024. Key results shown below.

Network Engagement

OneCare's efforts to streamline their incentive programs and enhance communication have led to increased awareness of and engagement in the PHM, as compared to previous programs.

Network participants consistently understood the goals of the PHM and described multiple activities to improve performance on the PHM metrics.

Aligning with National Trends

Overall, from 2022 to 2023, average rates of primary care visits, annual wellness visits, and developmental screening increased across OneCare participating TINs mostly consistent with national trends.

Exceeding National Trends

Primary care visit rates for patients 65 years or older increased more dramatically in Vermont than nationally.

*A small number of practices with especially large increases in primary care also saw decreases in measures of Acute Care Reliance.**

Increase in primary care visit rates may reflect efforts toward increasing follow-up after acute inpatient, emergency department, and mental health visits.

* Acute Care Reliance is defined as the ratio of urgent care and emergency department (i.e., acute care) visits to all outpatient visits. This directly measures the extent to which OneCare patients are seeking acute care versus more cost-effective care.

Network 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.

Value-Based Care Engagement

- Webinars to highlight providers excelling in PHM performance, participants can share lessons learned and best practices
- Quarterly PHM performance improvement meetings are held to review performance data and identify areas of improvement.

Regional Clinical Representatives

- Clinical representatives supporting primary care practices
- Partnership with VBC team member to support access to data to develop performance improvement plans
- Focused on improvement of PHM measures

Statewide Collaborative Sessions (Topics: Controlling Hypertension – four sessions, Social Determinant of Health Screening – four sessions)

- Broad participation across Vermont, co-led by Blueprint, UVMHN PHSO, Vermont Department of Health
- Focused on alignment, best practice, broad participation and collaboration, IT standardizations

Statewide Stakeholder Series #2: Controlling Hypertension in Vermont

- Co-led by Vermont Department of Health, Blueprint, and OneCare
- Collaborative forum for sharing of information and goals
- Promotion of aligned clinical care pathway/best practices
- Exploration of necessary IT enhancements related to digital capture and reporting of hypertension data and creating IT connections to the Health Information Exchange (HIE)

ATTENDEE ORGANIZATIONS

- Age Well/ Home Health Agencies
- Agency of Human Services (AHS)
- Bi-State Primary Care Association (FQHCs)
- Blue Cross Blue Shield VT
- Department Vermont Health Access (DVHA)
- MVP
- Primary Care Health Partners (independent practitioners)
- Support and Services at Home (SASH)
- The University of Vermont Health Network (UVMHN)
- Vermont Agency of Digital Services
- Vermont Information Technology Leader (VITL)
- Vermont Medical Society (VMS)
- Vermont Program for Quality in Health Care, Inc
- Vermont Retaining Employment After Injury/Illness Network (RETAIN)

2023 Quality and Financial Results

2023 Medicare Quality Result

OneCare Overall		
PY2021	**PY2022**	**PY2023**
100%	**65.63%**	**73.13%**

Measure Improvement

Depression Screening and Follow-Up Plan (60th to 70th percentile)

Depression Screening & Follow-Up Plan (70th to 80th percentile)

Measure Opportunity

Engagement of Alcohol and Other Drug Abuse Dependence

CAHPS Patient Experience

Performance improvement (in five domains)

Access to Specialists and Stewardship of Patient Resources (opportunities exist in two domains)

2023 Medicare Financial Result

Performance vs. Total Cost of Care (TCOC) Target[1]		$13,700,910
Quality Adjustment	+	($702,411)
Net Settlement		**$12,998,498**
Obligated Blueprint/SASH Payments[2]	+	($9,614,968)
Final ACO Settlement		**$3,383,531**
Fixed Prospective Payment (FPP) Benefit/(loss)[3]		$0
Payer Funding for Population Health Efforts[4]	+	$9,545,916
Total Funds Generated for Population Health		**$12,929,447**

Notes
[1] A positive number indicates positive TCOC performance (spend below target)
[2] Payments made for Community Health Teams, Primary Care, and SASH
[3] AIPBP (Medicare fixed payment) reconciles to fee-for-service
[4] Blueprint payments to the network

2023 Medicaid Quality Result

OneCare Overall		
PY2021	**PY2022**	**PY2023**
68.75%	**65.00%**	**81.25%**

Measure Improvement

Child and Adolescent Well-Care Visits

Developmental Screening in the First Three Years of Life

Initiation of Alcohol and Other Drug Dependence

Engagement of Alcohol and Other Drug Dependence Treatment

Bonus Point Opportunities

Achieved: Child and Adolescent Well Care, Developmental Screening in First Three Years of Life & Engagement of Alcohol and Other Drug Dependence Treatment

Lost: Follow-Up After Hospitalization for Mental Illness

Measure Opportunity

Hypertension: Controlling High Blood Pressure

2023 Medicaid Financial Result

Performance vs. Total Cost of Care (TCOC) Target[1]		$194,809
Quality Adjustment	+	($659,567)
Net TCOC settlement		**($464,758)**
Other Adjustments		+ $0
Final ACO Settlement		**($464,758)**
Fixed Prospective Payment (FPP) benefit/(loss)[2]		$5,758,001
Payer-funded payments[3]	+	$8,936,097
Total Funds Generated for Population Health		**$14,229,340**

Notes
[1] A positive number indicates positive TCOC performance (spend below target)
[2] The difference between the total FPP to OneCare and shadow (i.e. FFS) spend
[3] Includes PMPMs and lump sum VBIF funding

2023 MVP Quality Result

OneCare Overall		
PY2021	**PY2022**	**PY2023**
85.00%	**45.00%**	**62.63%**

Measure Improvement

ACO All-Cause Readmissions (PCR)

Child and Adolescent Well-Care Visits

Measure Opportunity

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Additional Notes

Measures with fewer than 30 patients in denominator, points redistributed (FUA, FUM, FUH) consistent with prior years

Diabetes benchmark significant change in PY2023 - Performance rate met 75th (2023) percentile vs. 90th (2022)

2023 MVP Financial Result

Performance vs. Total Cost of Care (TCOC) Target[1]		$397,982
Quality Adjustment		$0
Net TCOC Settlement[2]		**$0**
Payer-funded payments[3]	+	$274,934
Total Funds Generated for Population Health		**$274,934**

Notes

[1] A positive number indicates positive TCOC performance (spend below target)
[2] No shared savings earned; minimum shared savings of 3% TCOC (achieved 0.72%)
[3] Population health management funding

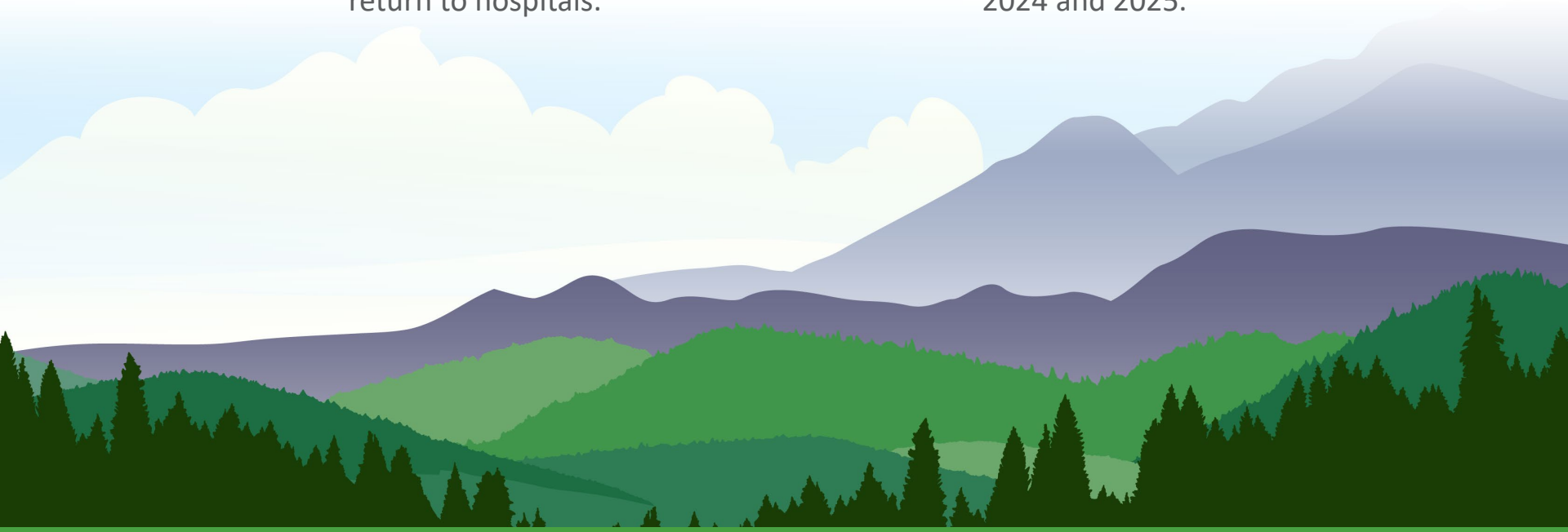
Wrap Up

Pleased with 2023 results – but want to continue building on the momentum through 2024 and 2025

Committed to providing consistency to the provider network through 2025 and aiding future transitions.

With change on the horizon, generating savings while keeping operations strong means funds return to hospitals.

Energized by provider commitment and eager to deliver the best patient care outcomes in 2024 and 2025.




End of
Presentation