STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

ONECARE VERMONT 2021 BUDGET HEARING

Hearing held before the Green Mountain Care Board via Microsoft Teams on October 28, 2020 beginning at 9:30 a.m.

BOARD MEMBERS

Kevin Mullin, Chair
Maureen Usifer
Jessica A. Holmes, Ph.D
Robin Lunge, JD, MHCDS
Tom Pelham

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I N D E X

CHAIRMAN MULLIN: Good morning, and welcome to the Green Mountain Care Board. My name is Kevin Mullin, Chair of the Board, and we're about to start the meeting. The first item on the agenda is the Executive Director's report, Susan Barrett.

MS. BARRETT: Good morning, everyone. I have a few scheduling -- so the November board schedule will be up on our website by the end of this week, so take a look at that when you get a chance. In terms of open public comment, we have one current open public comment period for the draft white papers for regulatory alignment. That period ends on, that official period ends on October 30th. So I wanted to remind folks about that.

And then, in terms of the ACO budget, we will be posting an official open public comment here. The parameters are generally going to be that we will open it today, obviously, and then the staff will be presenting to the board on December 9th, and you'll hear all about this from our staff introduction today, but we're looking at likely to have the public comments to be considered by the board and the staff by December 2nd. So we will post that, as I said, on our public comment section of our website. And that is all I have to announce today, Mr. Chair.

CHAIRMAN MULLIN: Thank you. The next item on the agenda are the minutes of Wednesday, October 21st. Is there a motion?

MS. USIFER: So moved.

MR. PELHAM: Second.

CHAIRMAN MULLIN: It's been moved and seconded to approve the minutes of Wednesday, October 21st without any additions, deletions, or corrections. Is there any discussion? Hearing none, all those in favor, signify by saying "aye". Aye. Those opposed signify by saying "nay".

Okay. We're going to move right into the purpose of today's meeting, which is the OneCare Vermont budget hearing, and to kick things off for us will be our staff members, Alena Berube and Marisa Melamed.

MS. BERUBE: Good morning. Can everyone hear me?

CHAIRMAN MULLIN: We can.

MS. BERUBE: Great. So I will share my screen. Let me know when you can see it.

CHAIRMAN MULLIN: We can see it.

MS. BERUBE: Wonderful. So I am Alena Berube, Director of Health Systems Policy, and with me today I have Marisa Melamed, our Associate Director of Health Care Policy, and we're just going to provide an

overview to this year's budget process. So today we'll provide the overview. Then we'll hear OneCare's presentation. There will be time for board questions, Health Care Advocate questions, and public comment. So, Marisa, you want to kick us off here?

MS. MELAMED: Can everyone hear me okay now? Good morning. So this morning, as Alena said, we're going to provide an overview of the ACO oversight process, just to set us up for the hearing today and go over what the board needs to consider as they hear about and review the budget.

So the ACO oversight process is governed by 18 V.S.A. 9382 and Green Mountain Care Board Rule 5.0. There are two parts to the process. There is certification, which is a one-time certification that's done following application, and then there is an eligibility verification that is done annually. So we will review OneCare's continued eligibility for certification as part of the budget process as we have done in past years since they were initially certified in 2018.

The budget review occurs annually during the fall, prior to the start of the program year, which is a calendar year January 1st start date. However, payer contracts and attribution is not finalized until the

spring of the budget year. So it's, they will -- there's a budget review and approval now prior to the end of the year, and then we have the ACO come back in the spring with final contracts and attribution to review and finalize that.

So it's an ongoing process, which you can see in the next slide here. So today, October 28th, we're at the budget hearing. The guidance was issued over the summer in July. We received a response to the certification form September 1st, and we received and have been reviewing the budget since October 1st. We have also submitted an initial round of follow-up questions to the ACO, which we are in the process of reviewing, as well as all monitoring and other reporting that's been submitted to us in preparation for a staff analysis presentation with budget recommendations for FY21, which will be December 9th.

We then have other meetings in December as needed to review those recommendations, discuss them in the public forum, and the board will be scheduled to vote, ideally or tentatively, we have by December 23rd, but it does need to be done by December 31st.

The board then issues a written budget order, which will be finalized in late January or early February, and, as previously noted, in March or April

or in the spring, there is a review of the final attribution budget and contracts, and we do ongoing monitoring and reporting against actual performance throughout ongoing in 2021.

So the other thing to mention is that, this process, we're still ongoing for 2020. So, at the same time that we're reviewing 2021 information that's come in for the upcoming budget, we're still reviewing information that is coming through 2020, which, of course, because of the public health emergency, some of that has been extended as well. So everything ends up rolling into each other.

Also, to note, as Susan said, there's a public comment period, which we accept public comment throughout this process. However, it's important to note the dates that Susan mentioned. If you want a comment that can be included in our remarks or considered in time for our remarks on the 9th, you need to submit that to the board by December 2nd, and, again, if you have an additional comment or a comment at a later date to be considered in the board's final decision, that should be submitted by December 21st, and that will be posted on our website as well.

All the materials are posted on the Green Mountain Care Board website at the link that you see on the

slide, and, of course, if you have any questions about materials or need help finding things, please contact board staff, because there's a lot of things that are submitted, and we want to make sure people can find what they're looking for.

Next slide, so, just as an overview and a reminder since we've been through this process a few times already, the board, in deciding whether to approve or modify the proposed budget of the ACO, needs to consider the following under Rule 5, any benchmarks established under Section 5.402 of the rule. There are 16 criteria listed in the statute, which I'm going to do a brief, but not extensive, overview of, and as well as any, you know, elements that need to be considered under Vermont's All-payer Accountable Care Organization Model Agreement between the State of Vermont and CMS, as well as any other issues at the discretion of the board.

In addition, the board considers all public comment at this hearing or any other meetings to collect information with OneCare as well. The Office of the Health Care Advocate has a role in this hearing. We will hear questions from them today, and they have submitted written questions as well. The board takes their input into consideration.

And then you can go to the next slide. So the statutory criteria, again, the 16 listed, they're extensive, and they are not simple or straightforward to evaluate. So just some examples from last year of conditions that are tied to that criteria. These are the -- as the board is considering the criteria, the conditions that end up in the budget order are the things that the board has asked us to monitor in order to allow us to evaluate whether that criteria is being met.

So here are some examples of some things that we had in last year's budget order. There are network development strategies, scale target initiatives. We have them report on program alignment, the effectiveness of their population health investments, how to make decisions about scaling up projects or sunsetting projects. We're in the process of working on an ACO performance dashboard. The ACO has submitted a prototype to us, which is under review, and we are also seeking comment or input on to look at variations in cost and quality, trends and impact of the care model on utilization to help make some of these metrics more visible and available.

Other aspects of the budget order have been measuring the value of the ACO investments over the

term of the agreement that there -- there's a budget order condition that has one, asks OneCare to fund the staff in Blueprint for Health at a certain dollar amount, and, again, there are others. There are 22 in total in the FY20 budget order, and some of these things will probably persist and live on year or over year or can be incorporated into our guidance. Some of them are one-time things that the board may ask us to look at.

You can go to the next slide. So the, the duties and obligations of the ACO are also in the Rule 5.403. There are 22 reporting criteria as part of the annual guidance to help us collect everything. At each year the board issues guidance. This year's guidance included the following elements that you see on this slide. So we have both narratives and data tables that are submitted and also available on our website, and this is the information that we have reviewed or need to review to check against the criteria.

And I think the next slide is to you, Alena.

MS. BERUBE: Yeah. So thank you, Marisa. So it is a very extensive process, and, as you mentioned, the all-payer model is one of those considerations. So, just as a reminder, you know, some of the key goals of, and requirements of the all-payer model agreement,

the first is total cost of care, the five-year growth target. So this is really about trying to get health care cost growth to align with the growth of the Vermont economy, which, at the time, was around 3.5 percent, but no higher than 4.3 percent. So this was for the period of time of 2018 through 2022. So there are certainly fluctuations in how we performed over the last couple of years, especially now with Covid. So this is something that we will continue to monitor and report on.

The second is quality and population health outcomes. So, to reiterate at a high level, you know, there's a very detailed quality framework behind it, but the population health outcomes that we chose as a state were to increase access to primary care, reduce deaths due to suicide and drug overdose, and lower the prevalence of chronic disease. So these three criteria kind of are the basis for, you know, the quality framework behind it.

And then, finally, while, you know, a requirement and kind of a theory of change is that scale is important. So, if we're really going to affect total cost of care and quality population health outcomes, we really have to have as many providers involved as possible and touch as many lives as we can in Vermont.

So we recently received a warning letter from CMMI for not meeting our scale targets for two years in a row and also, you know, for 2020, it's, which is kind of, already kind of finalized in that sense, and we're probably not -- you know, it's unlikely that we will hit our scale targets again.

There's, you know, we understand the scale targets were aggressive to begin with, but we believe that there's some opportunity to continue to work here together, and so we're working with our co-signatories and getting stakeholder feedback to draft a response in to send back in early December outlining some of these strategies. So that might kind of be an element that we see through this year's process.

The other thing to keep in mind is AHS is going to issue a report on how we can improve our performance on the all-payer model, and so looking really internally and externally about all the theories of strategy, you know, bigger than scale for how we can really move forward together as a state. So we look forward to that report and working with them to really kind of, you know, usher us in the right direction.

Another thing to keep in mind is the proposal for a subsequent agreement, which is required back to CMMI by the end of 2021. So, if there is additional kind of

learning that we need to have before then to affect that proposal, you know, I think that needs to happen in the next couple of months, and we need to continue engaging with our ACO and with providers to really learn as much as we can about what's working or not working or where there may be additional barriers remaining that we can address as a state.

So I think that brings us to next steps. So today we'll hear, as was mentioned, from the ACO, you know, we're expecting a second round of questions for any kind of loose ends to go out in December as soon as we can compile those. You know, we're looking forward to AHS's and the administration's all-payer model improvement plan. And then, as Susan mentioned and Marisa mentioned, our staff presentation on preliminary recommendations is scheduled for December 9th.

The two remaining pieces that will also be, you know, part of, maybe part of that presentation or perhaps after -- it depends on timing -- is the 2021 benchmarks. So, given Covid and, you know, exogenous factors, we're working to kind of come up with a method that makes sense for this year. And then the Medicaid Advisory Rate Case, we're looking for input from our partners at DVHA, and then the tentative board vote we

expect by the end of December, as Marisa discussed before.

So, with that, we will turn it over. There's some reference slides if you should wish, but, if there are no questions, Kevin, we can turn it over to OneCare.

CHAIRMAN MULLIN: Before we get started with the budget presentation, does any member of the board have any questions for staff? Hearing none, at this point, we're going to move to the budget presentation. Before we do that, we'll need to have Sunnie, the court reporter, swear in the witnesses. Vicki, who plans on testifying on your behalf today?

MS. LONER: I do.

CHAIRMAN MULLIN: Anyone else, though?

MS. LONER: Oh, Sara Barry and Tom Borys.

CHAIRMAN MULLIN: Okay. If you could all be sworn in together, that would be great.

MS. LONER: Sure.

VICTORIA LONER, SARA BARRY, and TOM BORYS, SR.
having been duly sworn to tell the truth,
testify as follows:

CHAIRMAN MULLIN: Thank you. So, Vicki, whenever you are ready, you can take it away. Will you be presenting through the screen?

MS. LONER: Yes. Tom Borys, our Vice

President of Finance, will be putting up the screen. So just give him a minute to do that, and I'll be kicking this off, Vicki Loner, CEO of OneCare Vermont.

CHAIRMAN MULLIN: Okay, great. We see the screen.

MS. LONER: I love it when technology works for us.

CHAIRMAN MULLIN: Don't jinx it.

MS. LONER: I know, I know. I'm just waiting for my screen to shut down any minute now. So thank you very much for the opportunity to testify before you today. I just want to take a minute to recognize that 2020 has, and continues to be, a very unprecedented year for us all and as a nation, and I'm just so proud of the work that Vermont has done during these really hard times to come together and persevere.

You know, early on in the pandemic, many speculated that we would lose a lot of ground in health care reform just due to the tremendous operational and financial strain and the uncertainty facing the provider communities and front-line health care providers. You know, strangely though, making lemonade out of lemons, during the first three months when the health care provider revenues were the most strained and most depressed because patients were staying home

and staying safe, we recognized that the value-based payments offered through OneCare allowed many health care providers to actually persevere and keep their doors open.

I'd like to point to Dr. Joe Hagan, who is a pediatrician, independent pediatrician, who has been very vocal to say that the PMPM money that their practice has received really helped to keep them alive when the patients weren't there. You know, we, in Vermont and as a nation, I would say, cannot afford practices to, to close. We need a more predictable model that supports people in good times and in bad, and the Covid epidemic has really shown the many flaws and fault lines in fee-for-service payments, and it will never allow providers to really be resilient when we face any sort of uncertainty moving forward. So, if practices were on the verge of closing their doors because of our flawed system, how can we not move to a more sensible payment system such as value-based care?

I also want to point out that our current system of fee-for-service care does not support providers working together. It doesn't support investments in wellness. What it does support is management of sickness and illness, and that's the only thing that it pays for. The reasons why ACOs were created was to

provide an avenue for providers to be able to invest and work in new and different ways that they weren't able to under a fee-for-service construct, and so that's why they are the federal government's preferred vehicle for really shepherding forward both health care and delivery system reform, because they understand that, if providers aren't changing their focus and changing the way that they work together, we're really not going to reform anything.

And I'd like to just point to a quote on this slide that I found really powerful, and you can obviously read the slide, but Steve Gordon from Brattleboro Memorial Hospital kind of put it best that said, when all providers are working together towards a common goal, everybody wins. So it's a victory for all.

Tom, next slide, please. ACOs like OneCare really do offer the best opportunity for all provider types to be able to participate in value-based care. You know, having a shared infrastructure to be able to support providers, because, as we know, this is the way that the federal government is moving, and so providers really have to have the tools and resources needed to be able to operate under a value-based care system.

And, when Rutland was thinking about entering into

the Medicare contract for next year, really, this was one of the things that you have to look at is, Do you have the resources and tools that you need as a community to be able to operate under these value-based programs and share financial risk with payers?

And the providers that are part and form OneCare have really decided that having the shared infrastructure, having one single ACO provides them the best opportunity to really achieve that meaningful health care payment and delivery reform in Vermont. We have a lot of conversations about what OneCare is and what it isn't, but, at its core, OneCare really is the sum of all of its parts, Vermont health care providers coming together to invest in a better future for Vermonters.

Tom, next slide, please. So, in terms of provider commitment, I would encourage you to really look at the numbers for next year. We did not decline. We did not fall back. Providers are very committed to the reform efforts in Vermont. We're anticipating, and, of course, as you know, the numbers won't be solid until the first quarter of next, next year, that we'll have about 288,000 Vermonters cumulatively covered under ACO value-based programs with about 28,000 new Vermonters coming in that would meet those scale target eligible

markers for the state. Now, of course, we do have other programs, but they do not operate under the all-payer model to be able to meet those scale targets.

So, as you can see, providers are continuing to form under OneCare. They're continuing to expand their participation, and, really, the providers who make up OneCare are working very hard to do their part in helping the state to meet the reform goals and their scale target goals.

Thanks, Tom. So this is one of my busier slides. I had a lot of information I was trying to show here, but, really, at its core, what I want to say is that reforming decades of payment systems that reward volume over value and changing the way that care is delivered is a big job, and it requires all parts of the system to play a role, and that is why the all-payer model really requires a strong public-private partnership, and it requires all stakeholders to really lean into the health care reform efforts.

So I'm not going to spend a lot of time on all of the important stakeholders that are part of this model, because our conversation here is about what OneCare's role is in the model, but I just want to briefly touch on them. There is the agreement, and we have talked about this extensively. Really, the agreement is

between the State and the federal government, CMS, and an arm of CMS, which is CMMI, and the State has the ultimate responsibility to administer, regulate, evaluate the model, as well as design and finance the public insurance programs such as Medicare and Medicaid.

Then you have the payers, and the payers have a really important role, too, in Vermont in that they are the ones that are offering health insurance coverage to Vermonters. They also, if they choose to, can create opportunities for ACOs to work with them to really move away from the fee-for-service and offer value-based programs where payers and providers can share both clinical and financial risk and be able to be rewarded if they do a really good job in meeting both their quality and cost targets.

And, currently, in Vermont the two major commercial insurers who have agreed to create such opportunities and work with the State and the ACO are MVP Health Care and Blue Cross Blue Shield of Vermont, and, of course, the public payers, Medicaid or DVHA and the Medicare program.

If you go down to -- this is what we're really going to talk about. The all-payer model requires that there be an ACO and that, or ACOs -- you could have

more than one ACOs, and, really, they are the ones that the federal government has kind of sanctioned to allow providers to come together in new and different ways to be able to deliver on the metrics that are in the all-payer model. In Vermont, OneCare Vermont is the single ACO that has stepped forward to be part of Vermont's one, reform efforts. So our discussion today, of course, is to talk about OneCare Vermont. There are many more people in the room that are more qualified than me to talk about the role of the State and the payers.

So what we're going to talk about today is our budget, how it was created to really support providers in operating under value-based care contracts and to do the hard work that is necessary to really make those investments and change the way that health, health care is delivered and paid for in Vermont.

Tom, next slide, please. So I think we had this slide last year, but it's a really important slide, and I just want to take a minute to, to really break it down. Whenever our budget is talked about, it's really this big number at the top of the screen, which is the $1.45 billion, and, really, that's not OneCare's budget. That's OneCare's accountability. It's our accountability, plus our investments, plus our shared

infrastructure costs in that.

If you go down to the next line, the $1.4 billion, or 97 percent of that total accountability, is really what is projected to be spent in health care in 2021 for the lives that are attributed to OneCare Vermont, and, if we're doing well and providers are still excited about health care reform and participating, this number will grow. So you want this number to grow over time, because that means that more providers are participating in value-based care opportunities that are offered through the, through the payers.

If you go back down one more line, OneCare Vermont's budget, this $46 million, and so that's really broken down into two components that we're going to spend a lot of time talking about today. The first is the network investments. So that's about 2 percent of our overall accountability or $30 million. And these are really the dollars that hospitals and insurers are investing in health care programs to support better patient health outcomes in order to meet those goals, both under the all-payer model and the goals that are very specific to the ACO and the payer programs underneath them.

OneCare is accountable for really looking at this, the money that comes in, how it's disbursed, for what

programs it is disbursed, evaluating the programs to make sure that they're successful, and then working with its provider network to make some decisions around whether or not programs will continue on because we've seen the value proposition in them or whether or not they will sunset for the next year.

The next number is operating costs. So this is probably more true to what you think about when you see a budget, and this is really the cost of that shared infrastructure to be able to support providers who would like to participate in value-based care contracts. So this is about 1 percent of our total accountability for the ACO, and, if you think about it, this operating cost really is supporting a statewide infrastructure.

The federal government, as we have said, this is the way that they're moving. They're going to be expecting providers to participate in value-based care contracts. So, rather than every community setting up their own system and infrastructure, they've decided to come together to form OneCare to really be able to work together as a state to be successful moving into health care reform efforts.

And so the very last line here is a really important one, because there's always a question about

our for-profit versus not-for-profit status. OneCare operates as a non-for-profit organization in support of the mission of our founders, because they're both nonprofit organizations. So, at the end of the year, it's always a break-even budget, no profits, no loss.

Next slide, Tom. So I just want to really emphasize that the ratio of the OneCare operating expenses, when you look at it as a total of our overall health care accountability, has really declined significantly as we've increased scale in the program, and this is a really important indicator of why you want to have a shared infrastructure and why you don't want every community setting up their own individual infrastructure to be able to support that, because then you'd be up here at the higher number, 11.7 percent, when we started off this initiative and only had about four communities participating.

Next slide, Tom. So I think Alena really teed up for us at the beginning that the all-payer model has some pretty lofty goals, and the providers also need the tools to be able to be successful in that, and they need to be able to make the right investments. So, really, our budget supports two things, those investments in population health management so that Vermonters can do better and have better outcomes, as

well as that shared infrastructure, which is the data and the tools, the risk mitigations that's necessary to be successful under this model.

Next slide, Tom. I want to take a second to really focus on population health investments. So, as we said, pretty lofty goals over a five-year period, and then really important to understand is the all-payer model has goals that the State, remember, in that agreement is responsible for, and then the ACO has specific goals and measures that really tie up to those overall goals of the all-payer model.

And so, you know, they're in things like prevention and chronic disease management and mental health and substance use, but they're not the same as the ones under the all-payer model, but, really, what we need to do as an ACO and as a provider group is look at what those measures are, how we're doing, and then make some decisions about the programs and investments that the providers need in order to be successful under the metrics that are defined for them.

And so, when we look at that and we also look at, you know, we're all under some pretty hard economic times right now, and so we have to be really thoughtful about the programs, because, you know, providers who are investing in these programs have less and less

revenues, and so they have to make sure that the investments that they're making are really going to help drive better outcomes on those metrics.

So for 2021 we really think about it in two overall buckets: primary care investments, because we know that primary care is foundational to help us both lower the cost of care as well as meet some of those quality indicators, and we also need community health and the providers in the community health such as home health designated agencies, skilled nursing facilities to be, really be working in tandem with primary care providers to meet the needs of the patients.

So, overall, in totality still a pretty nice number for next year. We're anticipating about $30 million in investments in population health programs. 19 of it is projected to support primary care. You know, we've talked a lot about the programs specific to independent primary care, and I believe we've presented to this board really looking at what those opportunities are in addition to the fee-for-service revenue that they receive from the payers, and really independent who are fully participating in value-based care programs through OneCare Vermont can earn up to 49 percent more revenue than what they receive currently from the payers.

So that's significant for those providers, and you can see, back to the first slide, why physician practices like Joe Hagan really think that this type of payment is more sensible for them as they move forward. It also means, though, that they have to take some risk and accountability in it, and so providers of OneCare who are signing up understand that risk and accountability that is really tied to changing the way that health care is delivered.

We have population-based payments that help us to meet overall goals under the model, as well as the total cost of care target, because, if we're not meeting those targets, then we cease to exist as an organization and as health care providers under value-based care. So they're important to be able to meet those targets.

We're also providing some payments to make sure that individuals are connected with primary care providers to make sure that they have a medical home. Not all Vermonters are readily connected with a primary care provider, and we think that's really important. Care coordination, which I'm really excited, we're going to show you a video if technology holds later on in the presentation about an individual who has really benefited from the care coordination programs that are

designed by OneCare's providers and carried out by the providers who make up OneCare Vermont. So that's some pretty exciting stuff. We hope you'll enjoy the video.

There's also the continued financial support for state-led programs. So these are not OneCare programs. These are state-led reform programs through the Blueprint for Health, and Blueprint for Health has been in Vermont for a very long time and is very important to support primary care and care coordination out in the community.

As we move over, community health investments, again, care coordination, because it's important for the team to be working together, as Steve Gordon noted previously, to stop working in silos and everybody come together around the patients to ask them what they need. Longitudinal care programs offered through home health that have really shown some nice outcomes in terms of managing chronic illness for people. We have some programs for our, our moms and new babies to make sure that they have the opportunity to get good prevention and get all the care that they need to be healthy adults.

Work in primary care prevention and thinking about doing some new work with the Blueprint along the self-management programs, and, of course, still testing

some pilots around mental health. Mental health is really important, has really shown that mental health conditions are really on the rise, especially during the pandemic. So want to make sure that we continue support, supporting both SASH and the DAs that are doing some good work around these programs and then, again, continuing the financial support of these state-led programs, such as the Community Health Team and SASH.

Next slide, Tom. So I think this is my last slide, and this is really looking at our overall operations budget and what it supports. So our operations budget, again, is supporting a state-shared infrastructure so that providers can participate in value-based care, and not every community has to do that on their own. I don't think that we'd be better off if everybody decided to go at it on their own and set up their own infrastructure, not to mention the fact that it would probably be rather costly to be able to do that.

So the two ways that we are really looking at supporting providers is to make sure that they have the tools that they need to be able to deliver on those delivery reform goals and also be able to participate in payment reform programs with the payers, which means

that providers have risk, financial risk, as well as some -- they've always had the clinical risk, but the financial risk that transfers over to them.

So, in terms of what are the tools, the tangible things that OneCare is providing in the delivery care reform space, that's really the data and analysis, so taking the clinical and claims data that would not otherwise be available to them unless they participated through an ACO and really combining those data sets to show providers where there's opportunity or where there's variances in care, a lot of the quality reports to show how we're doing in terms of overall quality measurement.

We also are responsible as the central ACO for looking at the benefit and payment waivers that are available to ACOs only to be able to provide better flexibility and a better patient experience, such as the three-day stay waiver, and then, of course, really being, housing those best practices and care coordination programs that will deliver on better patient care.

In the payment reform space, as we've discussed, the federal government has essentially decided back in the Affordable Care Act that ACOs would be the vehicle by which providers could come together and be able to

share risk and rewards with payers, as long as they do a good job, and then also allowing ACOs to offer value-based payment programs that incentivize value over volume and take some of those fee-for-service dollars that are flowing through the system already and converting them to value-based fixed payments, which essentially provide the providers of OneCare with a predictable payment stream.

Lastly, the way that we're able to do this is that we have to invoke certain payment waivers to allow for these investments in other organizations both inside and outside of the ACO, such as the state-led payment reform initiatives. So I believe that's my last slide, and I want to turn it over to my colleague, Tom Borys, who is the Vice President of Finance for OneCare Vermont. Thank you, Tom.

MR. BORYS: All right. Hi, everyone. This is Tom Borys speaking, just to orient you to my voice if you're not on video. The upcoming finance section of the presentation today has been broken up into two parts. The first section will be in regard to the 2021 ACO programs, and these are the, the arrangements that OneCare enters into with its payers to convert from a volume-based system to a value-based system, and we'll talk about components such as attribution, total cost

of care, and risk and reward. The second section of the presentation here will then shift to the OneCare budget as it pertains to OneCare as an organization facilitating these programs for our network and for our state.

The quote here from Claudio Fort, President and CEO of Rutland Regional Medical Center, is very poignant and related to the ACO programs here, "The pandemic has made it clear that fee-for-service is unsustainable, and we're fully committed to value-based care as the solution to stabilizing Vermont's increasing health care costs".

I think this points out a really important factor here, which is that moving into the value-based care is the beginning of and creates the purpose for all the work that we do at OneCare Vermont and is the reason that we exist as an organization.

All right. So let's talk about which programs we have on offer this year. The headline here is that there's continuation of all programs offered in 2020. So we are neither expecting any new programs nor sunsetting any programs. To me, that's a good outcome, in light of the tumultuous year we've had in 2020 as a result of the pandemic. This pandemic really affects all of our programs. So, at the macro level, we are

working with our payers to address a few key areas.

Attribution, what we're trying to avoid is an attribution dip that results from deferred or delayed care in the first six months of this year. Attribution is driven largely by a claim or a code, and, if people were avoiding health care services during the heavy stay home, stay safe period, we want to make sure there's not an adverse effect on attribution.

Total cost of care, complex process has set a fair expectation of health care costs into 2021, particularly hard knowing that 2020 is a very unusual year and almost impossible to rely upon. So we're working to make sure that we have a methodology with the payers to come up with a fair target. And then, lastly, risk arrangements, which I'll speak to in a moment, but really just responding to the financial impact of Covid on health care providers across the state.

When we look at each of the different program offerings, no huge headlines here for Medicare. We are following the all-payer model lead and putting a 4.35 percent trend rate per the CMS United States per capita cost forecast. In Medicaid we will be continuing with the expanded attribution model. This was in place for the first time in a large scale in 2020. We hoped to

glean a little bit more information about it, but, of course, the pandemic affects much.

And in Blue Cross Primary the big force here is working with Blue Cross to increase employer understanding of the program model. There was a lot of confusion about really what this program was, how it worked, and we would like to keep working with Blue Cross on that.

All right. 9.4 percent growth in all, in scale-target attribution, really, two key areas where this is a change from this, from the 2020 year. First is in Medicare. Happy to report that we will have about a 17 percent, 18 percent increase in Medicare attribution due to the Rutland HSA participation. They're joining this program for the first time, large community. So we expect quite a bit of attributed life growth in that program.

Next, we have some attribution growth anticipated in the Blue Cross Blue Shield Vermont Primary program. That is the program for self-funded plans and fully insured large group. Really, the Blue Cross Primary program is one program but with two components. There's a risk track and non-risk track, as elected by the employer plans. We have anticipated in this budget model that some employers move from the non-risk into

the risk model with Blue Cross, and, therefore, those lives would count for scale, so, really, a shift from the rightmost column to the left, the column just to its left.

As Vicki mentioned before, the $1.4 billion number is the total of our health care costs in value-based contracts. Again, a bigger number here. It doesn't represent more spending; it means more accountability for Vermont providers. So 17.1 percent growth over what we are anticipating for 2020. The big area, again, is Medicare, largely driven by Rutland's participation for the first time.

Also important to note, the other growth factors for particularly the commercial plans are based on attribution and insurance rates as approved in the rate filing. So we linked back to those filings as a source of information for how much the trend rate will move. There's ultimately an actuarial process that the payers go through to determine the fair target, but that's what we use for our source data points to project the total cost of care for each of these programs.

So, despite the fact that the prior slide had our best estimates of total cost of care and they will move once the actuarial process and the attribution comes through, they are important estimates in that those

total cost of care numbers give us a sense or an idea of how much risk or reward the providers have, OneCare has in this budget model.

The big change coming up in 2021 is really significant reductions in risk. And why are we doing that? There's really two reasons. One, we needed to respond to the financial impact of Covid on the provider community. I think the providers, as well as many of us personally, are a little bit risk-averse right now with some uncertainty in the future in terms of what this pandemic means for us all economically. So everybody, really, a little bit of risk aversion at this point in time.

So the goal was to balance that pressure with the desire to stay on the value-based care path, and by that I mean continue to have some two-sided accountability, as we think that's very important. So it's a balance between those two different pressure points. I can say there's a lot of momentum within the provider community right now, and finding that balance is really important to help keep this network together for 2021, and we've largely done so with these budget modifications.

You can see I compared in the table the 2020 pre-Covid budget of $36.6 million of risk or potential

reward to what we have anticipated in 2021, so a significant reduction, $17.5 million less in total risk. That was a really important change for us to build into this budget model and negotiate with payers to keep the network at the table in these unusual times.

The budget does not include the Medicare risk protection arrangement we've had in the past. I can speak in more depth if you'd like, but, simply put, with a narrower risk corridor, the cost of a policy relative to the protection that it buys doesn't make a lot of sense. It becomes expensive for relatively little protection overall. So we've not budgeted that expense in this year's budget model. I'll also note that the MVP program is upside only in this budget model and has additional $1.5 million upside opportunity with no downside risk.

All right. Next, we'll talk about the risk model evolution. In 2021 savings and losses will be distributed differently amongst OneCare providers. At the highest level, the OneCare aggregate results, so whatever the shared savings or shared loss result is between OneCare and its payer, contracted payer, will be allocated proportionately to the health service areas.

In the past, we have set up what we referred to as mini-ACOs for each HSA where we gave each HSA its own target and then settled with them independently and tried to do so in a way that reconciled the HSA settlements with the aggregate OneCare settlement with the payer. This change moves us to a model where all boats rise together, and what it does is helps in four different areas. One, it creates a statewide system of health. The all-payer model calls for Vermont to do well managing health care cost growth. What we've learned over the last few years is that OneCare's statewide network --

CHAIRMAN MULLIN: If we could ask somebody to mute themselves, whoever is not speaking.

MR. BORYS: Thank you, Chair Mullin. This model creates a statewide system of health. We are one network of providers, and we've certainly learned over the last few years that there is a lot of cross-HSA, cross-provider care where a life might attribute to Berlin, but they're receiving care up in Burlington or in St. Johnsbury, a lot of cross-HSA care. So we're trying to create more of a system where we're all working together, and, if everybody does the little things that we ask of them in these models, we can all succeed together.

Next, we hope that this model results in provider success, aligning more closely with Vermont's success under the all-payer model. Again, the all-payer model is a statewide initiative for all Vermonters and their health care costs. If we succeed as a state in this model -- we'd like the providers to succeed as well -- we all have a shared mission, shared goals in that way, rather than looking at, How is my own HSA doing independently of how Vermont's doing overall in the all-payer model?

This is important, but it's much simpler and much more stable to do it this way. I can tell you, from an analytic and actuarial standpoint, taking our total cost of care and slicing it down into HSA components is really difficult and really difficult to explain. This change will help ensure that our network participants understand their results more and there's more clarity in terms of what they receive, or hopefully not, but all at the end of the year.

Last is it avoids some actuarial challenges with small populations. Some of the communities that attribute lives have very few members and wouldn't even be allowed to participate in standard Medicare models, because they attribute too few lives, and, when you have a population that small, a few high-cost cases can

really dictate your end result, even if you're doing really good population health work. So, for all of those reasons, we'll be moving to this proportionately shared results model in 2021.

The next big evolution in the risk models base is that, for the first time, providers other than hospitals are included in the accountability model and have an opportunity to claim shared savings. So for two-sided risk programs what this means is that the OneCare primary care investment will start at a base amount and increase from there based on performance.

So, looking at the chart here, it moves from left to right. We'll start at a base of $1.75 PMPM, so still at the tip. If the program breaks even, we restore the $1.50 PMPM up to the $3.25. That's the historical amount received. So that's if the program were to absolutely break dead even and have no shared savings and no shared loss.

What's new this year in terms of financial opportunity is that, if the program earns shared savings, we will first use a portion of those shared savings to pay a $1.50 PMPM to all attributing providers to give them access to some of the shared savings dollars that we would earn in this scenario at the network level. So this gives the financial

opportunity of $4.75 PMPM, which is higher than the historical opportunity of $3.25.

The reason we decided to do it this way where we changed this base PMPM investment to a variable performance-based model is that it avoids the need to invoice primary care at the end of the year. Having spoken to primary care practices for a number of years in regard to their decision to participate, the specter of a downside risk payment at the end of the year, I think, would have prevented a lot of participation. So we wanted to come up with a model that included all primary care, hospital, FQHC, independent, in the accountability model without the potential for a year-end invoice.

The last bullet on this slide, "Expanding accountability more broadly across the provider spectrum, we believe, is a strategy to encourage increased engagement". Certainly, the hospitals have been engaged, because they have a financial stake in our results, and we hope that the same happens more broadly with the FQHC and the independent and hospital employee primary care as well so that we're all driving towards the same shared goals of success in these programs.

I'll also note we have a couple of different

program designs. Some are upside only. Some are two-sided risk. Some are planning to hold risk centrally at OneCare. This model, where the base payment is $1.75 and goes up from there, applies only to two-sided risk programs where the network has downside risk.

If it's an upside-only program, we'll keep paying the base PMPM payment at $3.25. There's no need to start at that lower level, and we'll still offer the $1.50 of shared savings opportunity. If the program is such that we're holding the risk centrally at OneCare Vermont, we'll pay the $3.25 out. There will no opportunity for the $1.50 in that model.

So that concludes the summary of the ACO program terms. I wanted to hit on the high points. There is a lot more information in our submitted budget documents. I invite you all to look at those, as you can just see how all of these numbers break down, and there's many more year-over-year comparisons to see in those documents.

So, next, we're going to shift to OneCare Vermont's budget. Again, this is the budget of the organization of OneCare. What do we do as an entity? First, I'm going to start with an overview. $46.7 million budget, Vicki referenced this at the beginning

of the presentation on that total accountability slide. Again, a balanced budget. No profit or loss built into the model, no additional contributions to reserves. We're comfortable with the number that we have at present.

Key strategies in this budget bill, "Enhance sustainability of Vermont's health care reform efforts", and there's two sub-bullets here. One, "Increased focus on program areas with opportunity to yield positive total cost of care and quality outcomes". To make this sustainable, we need to have some strong performance, earn the shared savings that help offset the costs of reform.

And then, next, speaking of the cost of reform, "Do our part in reducing health care reform costs placed on dues-paying hospitals". I'll pause on this for just a moment and say why it's important to reduce the dues for hospitals. The hospitals are really important players in our model. Not only do they bear the bulk of the risk that somebody needs to hold in these two-sided risk programs, they also invest in the payment reform programs and initiatives.

Based on both Covid and its financial impact on the network, we needed to reduce dues to hospitals to allow them to stay in, and, importantly, right-size the

dues with the financial opportunity they have in these programs. If the dues are so sizable that they can, the hospitals can never really or reasonably earn those dollars back through strong performance, it's unlikely they'll stay in the model for any long period of time.

It's important to keep the hospitals in the model, because they are the gatekeepers that allow all the other providers in the communities to participate, so independent primary care, FQHCs, home health, DAs, etc. So keeping them at the table is the strategy to make sure that we can do the next bullet, which is, "Sustain core programs and commitments". Without the hospitals, we will be unable to really sustain those commitments. Lastly, we need to continue to invest in primary care.

All right. As Vicki mentioned earlier in the presentation, the $46.7 million budget has two main components. 30.6 is earmarked for population health management investments. These are investments that give the providers the financial resources to engage in these ACO activities and value-based care activities. And then we have our 16.1 OneCare shared infrastructure costs, which are to facilitate these programs, work with the provider community, and help us all succeed in this model.

In keeping with the theme of hitting on the

highlights here, we'll start with revenue. We've budgeted consistent reform investment through payer contracts, so nothing earth-shattering in that space. Those are the investments that we negotiate with payers such as Blue Cross, MVP, Medicaid to help invest in these reform efforts. So no big changes anticipated in that space.

The budget does anticipate level delivery system reform funding of $3.9 million subject to state and federal approval. Because this is a very sizable revenue stream, just wanted to note that, if this does fail to materialize, we will have to come back to this board for some budget revisions. It's a very significant part of our budget model.

Next, we no longer have the health information technology funding revenue. It was $2.8 million in 2020. It really supported our technology infrastructure and development of new analytic tools and capabilities. The federal funding source for these dollars ended. So there's no longer access to the funds.

New line here, we have an $861,000 contract with the Blueprint for Self-Management Programming. This is an effort to, again, continue to align what OneCare does with other state initiatives so that we have a

more coordinated and succinct care model across all of these different initiatives.

And then last bullet, a $9.5 million reduction in hospital dues over the 2020 pre-Covid budgeted level. So, just for everyone's knowledge here, we submitted a pre-Covid budget in 2020. After the pandemic hit, we made numerous changes to our operational model and submitted what I call a post-Covid budget. The dues budgeted for 2021 are $9.5 million less than that pre-Covid budget, and then the sub-bullet says, $3.3 million reduction from the post-Covid budget. So we're still able to offer continued dues reduction even relative to the post-Covid budget level.

For those who like the numbers a little bit more, this all references some of the same content, but I'll point out a couple areas. The top row, payer program support, again, these are negotiated through our contracts. It is up almost $600,000. That's just attribution change, no significant changes to the actual model underneath. You can see a few rows down the health information technology funding going from $2.8 million to zero. That was one of the bigger challenges in this budget build is how to accommodate the loss of $2.8 million of revenue.

And then, at the very bottom this is the total.

See the hospital dues. This is the $3.3 million reduction in dues, and just note the 2020 numbers there reflect the revised post-Covid budget.

All right. Next, we'll shift to the expense side of the equation, and this will be broken into two parts as well. This first section will reference the population health management investments, or the $30.6 million we spoke of before. First, continuation of longstanding population health initiatives really to protect the established revenue streams. We've been investing in the provider community for a number of years now and really asked them to do something with those investments, and one of the challenges is we don't want to pull the rug out from any of those funding streams. So a key goal here was to make sure we could sustain those longstanding initiatives.

Comprehensive payment reform programming, again, in short, this is the program for independent primary care where we're able to move them off of the fee-for-service basis and now pay them under a capitation model. Continued program growth at a number of practices in 2021, which is exciting, and in that model there's a $5 PMPM enhancement for participation to help them really in this transition afforded by shifting off of fee-for-service and onto a fixed

payment model.

Next, we have a two-pronged strategy to quality. What we're trying to do through program negotiations is align the quality components with the way Medicare and actually many of the commercial programs incorporate quality into these programs, whereby the quality score affects the amount of shared savings you can earn or the amount of shared losses that you would owe. So it ends up being a component of settlement at the end of the year.

So, as a quick example, let's say you're going to earn shared savings but you have a poor quality score. The amount of shared savings you actually receive would start to go down. In tandem with that, we would like to separately fund a value-based incentive funds in similar form but in a way that allows for more targeted focus and timely rewards for strong performance. We have certainly learned over the last few years that the value-based incentive fund is a nice concept, but the payout was very far after the program year and I think, in my opinion, diluted the impact of it.

So what we'd like to do is have a little bit more of a nimble value-based incentive fund with more targeted measures and being able to pay out rewards for strong performance much more promptly to keep quality

and quality measures on the forefront of everyone's mind, rather than this back end that comes many months after the program year's over.

Last on this slide we have that new Blueprint Self-Management Program initiative. So there's some expenses associated with that along with the revenue. That's a pretty common theme in our OneCare budget. If there's a revenue stream, there's often a network expense that goes with it. Again, creates further alignment between Blueprint and OneCare programs.

So, looking again at numbers, two different views of the same numbers. You see the $30.6 million number at the bottom of this table here. This shows the population health management investment areas, so really, the, the function or the source of the investment. So on the top we have primary care services included in this row, things like the $3.25 PMPM. We have primary care engagement payments where we pay primary care to engage in those geographically or expanded attribution of lives to enhance primary care access.

Next, we have care coordination efforts really designed to enhance the coordination of care across different providers. We have quality, primary prevention, helping to keep a healthy population well.

Specialty and innovation investments, again, investing in innovative program pilots with the opportunity to improve care or generate savings. And then last row are the Blueprint programs and sustaining funding for the SASH, Community Health Teams, and Patient Centered Medical Home initiatives.

The next slide, you'll note the bottom row has the exact same dollar figure but just a different presentation. We've now broken it down, rather than investment areas, but by investment recipients, what type of provider or recipient is receiving these funds. ACOs are largely primary care models and, in alignment with that, primary care providers show up at the top row, $19 million in investment. They receive funding through the base PMPM, the care coordination program, the value-based incentive fund, the comprehensive payment reform program, etc.

Moving down, we have SASH, the community health teams, significant amount of dollars invested in those two areas. Home health, some, definitely big participants in our care coordination program and recipients of value-based incentive fund dollars. Community investments, largely in line with the primary prevention initiative, such as RiseVT, getting the community involved in health care and through things

like amplifying grants. Helping to improve the health of our population is now going beyond just what you would call a traditional health care provider. Specialty and acute care we have next. Designated agencies and mental health followed by area agencies on aging in the last row.

All right. Now we shift to expense highlights in regard to operations, or the $16.1 million number referenced earlier in the presentation. We're largely an organization of people. So I think spending a moment on staffing is important here. I've displayed three different columns, the pre-Covid budget, the post-Covid budget, and the 2021 budget. There are two rows, position count and paid FTEs.

Position count is literally a count of the people working for OneCare Vermont, and paid FTEs reflects both a position's effort -- so, if a position is a four-day-a-week position, it would be prorated accordingly -- and, also, when the position is hired during the year. So a position hired on July 1st -- that's the midpoint of our year -- in this approach counts for a .5 rather than a 1.0.

What we see here on the position count is that we started with 79 different positions in the pre-Covid budget. When we went back and recast the budget in

response to COVID-19, we reduced that down to 68 positions, largely by deleting new growth areas. We had an anticipated pharmacy program and a couple of new initiatives planned that we put on hold or cut entirely. So that's how we got from 79 down to 68 positions between 2020 post-Covid and 2021. There's a lot of moving parts. It's not just two positions, but there are two fewer positions overall in this 2021 model than there were in the 2020 post-Covid.

Paid FTEs, it's important to note, particularly in the 2020 post-Covid column, we implemented a hiring freeze in 2020 in order to offer dues related to the hospitals. So the actual paid FTEs in 2020 is down substantially, 59.03 relative to the 68 positions that were actually included in our model. What we see when we move from 2020 to 2021 is a restoration of many of those positions held vacant during the hiring freeze.

The table below shows just a quick view of salaries and benefits per FTE. So you see we set the blue line at the 2019 level. It went down a little bit from 2019 to 2020 pre-Covid. It will move just based on the mix of staffing at OneCare Vermont and what new positions you may add or remove. You see a drop in 2020 post-Covid. That's going to be due to both the hiring freeze and also implementation of compensation

reductions during the Covid period, again, in, in spirit of offering dues relief to hospitals. When we restore the compensation reductions and the hiring freeze, we now get back up to, it's just about the 2020 pre-Covid level on the salary and benefit per FTE.

Below, we have our operating expenses just like everybody else, general expense management, trying to be good stewards of our resources. There is uncertainty still in regard to our 2021 work structure. We are working remotely in this organization right now. We're not certain which direction we'll be heading and when. The budget assumes some returning to normal at some point just to be conservative, but not at the pre-Covid levels. So that just remains an area of uncertainty, I think, for many of us right now, but wanted to note that in this presentation here, and then we do have an increased budget for the Green Mountain Care Board billback.

Staying true to theme here now is an opportunity to look at this from a numbers perspective. The most important number I want to point out and explain is this change in salaries. It is going up $1.4 million, but, as the previous slide showed, it's not from new positions, and it's not from big raises. It's from lifting the hiring freeze and restoring compensation

reductions implemented during the pandemic.

We do anticipate transitioning some contracted positions to staff and really using contracted services only when absolutely necessary. This is part of our expense management, why you see this reduction in contracted spending. Many of the other budget lines, pretty neutral or normal. No big changes in that space. Now you see the Green Mountain Care Board billback is a growing expense in the budget. When we look at the table or the chart at the bottom, the most sizable increases are in three areas. One, central admin, this is where those leadership compensation reductions hit. So, again, just restoring that back up is what the increase here references.

Two areas of investment, finance, complexity, and the number of these programs continues to grow. Need to resource accordingly. And then population health analytics is another key area. Now that we are incorporating more providers into the accountability model, we need to make sure that we can deliver the right information to them to keep them informed.

Again, putting the economies of scale, as we've basically retained a pretty similar core infrastructure here at OneCare. As we grow, our total accountability, this ratio of total health care costs to operating

expenses, continues to decline, and the hope it continues on this trajectory as we move forward.

This slide brings it all together. We show both the total cost of care targets, the $1.4 billion number, alongside the payer contract revenue, DSR funding, other revenues, and hospital dues. Here's the $1.46 billion total accountability model and then the corresponding expenses below, and, again, a zero dollar gain and loss.

Pie chart on the right, nearly 97 percent of this model is made up of health services spending, so existing health care costs that are now part of a value-based care model. 2.1 percent are the population health management investments we're able to deliver to the provider community, and then 1.1 percent is for the OneCare operations and shared infrastructure.

Difficult to squeeze onto this slide. So, again, I'll point to the submitted budget documents but wanted to include an income statement and balance sheet view just having a little bit more detail about some of the different programs and initiatives for each of the years. Sorry for the small font. We have a lot of different initiatives and components to the both income statement and the balance sheet.

I feel obligated to note that this is a non-GAAP

presentation, because many of these funds don't belong to OneCare. We have total cost of care targets. They're the measuring stick for performance is the actual total cost of care paid to providers. How are those targets in reference to the actual experience? So they aren't funds that flow through OneCare. They don't belong to us. So, therefore, they don't show up on a OneCare financial statement, but they are part of our total accountability. So this is designed to show the full scope of OneCare's operations and programming, but just need to note the non-GAAP nature of the presentation.

For the balance sheet, I think it's important to note in the cash investments and accounts payable section we get prepaid for the Medicaid fixed payment. So they pay us in December for January's fixed payment. So that large number there reflects the amount we're paid in December that will be paid out to hospitals and primary care participating in the CPR program in the following month. So there's always, in my estimation, an inflated view of cash on the OneCare balance sheet because of that prepayment model.

And that is it for the finance section, and I'll turn it over to Sara Barry from here.

MS. BARRY: Thanks, Tom. Good morning,

everyone. This is Sara Barry. I'm the Chief Operating Officer for OneCare Vermont, and I'm just going to highlight a couple of key areas that we're focused on in our population health management programs and share with you some of the progress that we're making. So, Tom, if you could advance the slide.

Hopefully, by now this general graphic is quite familiar to most, if not all, of you. Today I really want to use it to highlight some of the core activities that we have underway to improve care and outcomes for Vermonters that are served by the ACO, and so I call your attention to the bullets within each of the boxes as I touch just briefly on some key activities in each one.

So, starting at the top left, here we focus on the health and wellness across the life span, and really central to achieving and maintaining health are access to preventive services from health care providers. While the majority of individuals have a relationship with their primary care provider, where they don't, such as in our Medicaid expanded cohort where individuals are attributed based on where they live, we're working really hard with our providers to promote creation of that relationship and develop a longstanding trust to help facilitate, not only

preventive care, but any other acute needs that might come up over time.

In quadrant two, a new area of focus for us is on the collaboration between OneCare and the Blueprint to evolve self-management programming to really be reflective of today's best practices and individual preferences about how individuals want to access services and supports. As we move into 2021, OneCare will assume oversight for the self-management program, and we've been working very hard with the Blueprint and the Health Department in evolving those programs and the vision together.

The initial focus areas will be on developing programs to support Vermonters who experience hypertension and/or diabetes, because we know together they impact more than 50 percent of our population, and, to earlier points made, they're very much in line with trying to improve chronic disease management under the State's all-payer model goals.

In addition, we're not only focusing on those individuals that currently have hypertension or diabetes, we're also looking at some new ways to move upstream and identify individuals who are at risk for full-blown disease and try to help them intervene early by making different lifestyle choices, receiving

information and supports to help hopefully prevent that disease from happening.

In Quadrants 3 and 4 we know that 95 percent of the high-risk individuals in these 2 cohorts have multiple chronic conditions, and more than half of them have a combination of physical and mental health concerns. In these areas OneCare's focus continues to be on investing in care coordination through increased engagement and specific actionable data, such as our COVID-19 application that we launched in early April this year and is described in more detail in our narrative.

By early September this year, we had achieved an over 600 percent increase in our number of individuals, our number of Vermonters who are engaged in our care coordination programs, moving to more than 4,000 individuals. So we're really excited about that, because, as we move through 2020 and into 2021, it will give us the opportunity to understand in more depth and sophistication really the impact these care coordination interventions are having, not only at the individual level, but also at more of a systemic level.

And so I'm going to pause now and ask Tom to turn us over to a very brief video. This is an example of an individual, a real Vermonter, who has experienced

our care coordination and a bit of his story about what's happened during the last year.

(Video recording playing.)

MS. BARRY: Thank you, Tom. So I think that was a great just brief example of the types of impact this community-based care coordination program can have on individuals, and we're really looking forward over the next months to continuing to work with these community-based care teams to gather additional case studies and examples, as well as really look at the outcomes that we're able to see at more of a population level over time.

So, next, I want to focus just a little bit on some of our quality data, but I do want to point out that key utilization data and results are highlighted in our narrative budget submission, not included in slides for the presentation today, primarily just due to the length of time that would take up to go through.

And, globally, I want to start by staying that providers in OneCare's network are contributing to the State's overarching all-payer model population health goals through their work on decreasing fragmentation, aligning and coordinating care, and improving screenings, assessments, and referrals to needed services. In addition, they're very active in

supporting individuals in their decision-making processes around the care that those individuals want and need. At the same time, many of the all-payer model indicators represent challenging and complex systems to change and yet also represent tangible goals for us to be working towards as a system. All in all, OneCare providers are doing their part in support of Vermont's all-payer model goals.

So, as we looked to the data from the end of the second year of the all-payer model, so late in 2019, we noted some interesting progress. So I'm going to just briefly go through those three overarching all-payer model goals and give you a couple of highlights. So, in the area of reducing deaths related to suicide and drug overdose, we can see that providers are working to improve follow-up from an emergency department visit for alcohol and other drug dependence as well as for mental health concerns.

Currently, one of the areas that OneCare is exploring in partnership with local hospitals and designated agencies is a funding stream where three designated agencies have embedded mental health clinicians in their local emergency departments and are supporting follow-up care, as well as working upstream to promote access to community-based mental health

services and supports.

On the next slide, in this area we're really focused on chronic disease management, and here, for example, in 2019 OneCare demonstrated statistically significant improvement in caring for patients with hypertension and diabetes, and I think that's in part because, as we've gotten more experience and worked more closely with providers of all types across our network, we've really learned that we need to focus in on very tangible areas in need of improvement and really promote opportunities to focus in on those rather than take more of a scattershot approach with a larger set of measures.

So, over time, the goal of our population health strategy committee and our other clinical committees is to identify those gaps, promote those as top areas of focus, and then move on while maintaining measurement to ensure that that quality improvement that occurred is being maintained.

In the area of chronic disease, we are also really thinking about how to make changes to our quality incentives to drive that focus on specific areas of opportunity and really provide more timely or proximate reward for the organizational improvement activities. This is done to really try to right-size our quality

incentive pool while our scale is growing while the number of Vermonters increases and also respond to providers' voiced desire to focus on these specific initiatives with very focused and intentional change.

And so Tom described this a little bit earlier as our two-pronged strategy to quality. We're really excited to move that forward and have been working hard through providers in our population health strategy committee to really set the structure of that for 2021. I'd also call attention on the bottom of each of these slides that there are a whole host of investment strategies that OneCare has underway to help support the improvement or maintenance of high-quality care in these areas. Next slide, please.

With respect to access to primary care, this is a statewide measure where patients are asked to complete annual surveys, and what we've found is that 82 percent in the more recent survey had reported receiving timely care appointments and information. While this is good, when we look at national benchmarks, we do continue to work on this by investing resources in primary care through population health management activities, our incentivizing quality, and by testing new payment models to help primary care deliver optimal care in these types of value-based care arrangements. Next

slide.

As part of our learning health care system, in 2021 we're taking a very focused approach to our core programs and our investments. Within the area of care coordination, we are continuing our community team-based approach to supporting individuals with high-quality care management interventions to achieve improvements in their care and in their outcomes, and in 2021 the core focus areas that we've identified are on refining the identification of special high-risk populations to prioritize for outreach, on conducting quality assurance monitoring activities to ensure fidelity to the model, and on advancing our knowledge of best practices around care management.

As you heard Tom describe earlier, we're evolving our approach to quality and really have a laser focus on key metrics as directed by our population health strategy committee. We're moving our financial incentives earlier in our performance cycle to align them with this very focused approach to improvement.

We continue to evolve our provider accountability model to create a statewide system of health and ensure that providers are actively committed to and engaged in reform efforts, and, finally, we continue to evolve our analytics capacity to deliver high-quality actionable

data to our network to drive performance.

For example, in 2021 we'll be enhancing new reporting to primary care to help them in their performance throughout the year. This really aligns with that focus on both provider accountability and the focus on quality. So, altogether, we believe these are the right strategies to drive care delivery success and to improve provider financial predictability and accountability. Thank you, and I'll turn it back to Vicki.

MS. LONER: Thanks, everybody, for hanging in with us. I know it was a long presentation, and I wanted to thank my colleagues, Sara Barry and Tom Borys, for their part in the presentation. I also wanted to just take a second to thank all the providers who have come together to make OneCare possible and that make up OneCare Vermont.

It's a pretty phenomenal effort, and I would say that, collectively, we're proud to do our part to change the way that health care is paid for and delivered, and, you know, in this really difficult and unprecedented time, we're doing it here with less and bringing on more lives while keeping costs flat, and so I think that's a real accomplishment to the dedication and investments that Vermont providers are making in

this health care reform effort, and there's a reason why they're doing it is because they believe that value-based care is the investment that's needed for our future.

And so, with that, I just want to leave you with some words from Tomasz Jankowski, who is the CEO at the designated agency in the Northeast Kingdom. Tom, take it away.

(Video recording playing.)

MS. LONER: That concludes our presentation. Thank you again to my colleagues, and, Chair Mullin, I'll turn it over to you.

CHAIRMAN MULLIN: Thank you, Vicki, Tom, and Sara. At this point, we will take a short bio break to 11:15, at which point we will come back and go for another hour to an hour and a half and then take a half-hour lunch break. So this meeting is in recess until 11:15.

(A recess was taken from 11:06 a.m. to 11:15 a.m.)

CHAIRMAN MULLIN: So I'll call the meeting back to order, and the next item is questions from the board, and we're going to go in reverse alphabetical order and start with Board Member Maureen Usifer. Maureen?

MS. USIFER: Thank you. Thank you for your

presentation, and I will address some questions, and I know my other board members are going to be probing other areas as well.

First, can you talk a little bit about maybe what's not working or areas where you could improve? It's not really addressed in your presentation, and I would love to hear your perspective on that.

MS. LONER: I'm still on mute. Yeah. I'm going to get a T-shirt that says, "I'm on mute". So I would say that one of the opportunities to improve is really starting to show at a health service area level or community level where there's some variations in care and where there's some real opportunities. We've focused at a high level on where there's opportunities at the ACO, but there's also an opportunity to really drill down and see where communities might need to make some changes or adjustments in their overall approach.

And so we're planning, for next year, we've rolled out a series of more easy to digest consultative reports for the individual communities, and we've kind of trialed them and got some feedback this year to say, Here's your major areas in how you're doing in terms of utilization and quality, here's where you look same or similar to the ACO, and here's where your specific community has some opportunities. Could we talk about

what you could do in your particular community?

And, you know, that has to be done in tandem with the communities, because they know their communities the best. And so I would say that's one of the areas that we really want to work on next year, because, as we eventually expand our overall financial accountabilities, the providers need the tools and resources, and they really need it at a level that is digestible to them.

Previously, we've used a lot of self-service tools. We've given them a lot of data, and really trying to hone down what those data points are that are important to them. And, I mean, I can't underscore that this health care reform movement is new, and so some of the things that really need to come together when we talk about this private-public partnership is the data that we receive is only as good as the data that we receive from the payers and from VITL, and so really making sure that we have complete and robust data sets to be able to provide to the providers that need it and need it to deliver care better and differently.

MS. USIFER: Okay.

MR. BORYS: I can build on that a little bit, too, in the finance space to say we've learned that

splitting the, the OneCare aggregate target and spend down into the HSAs was really hard. There are some data blind spots we have around confidential claims, or sometimes there's end-of-the-year adjustments that occur that we have no ability to model and, in particular, have no ability to model at the HSA level until sometimes after they've occurred.

So that's really one of the reasons for this different risk-sharing strategy is to address that challenge that we've had in taking our overall OneCare performance and splitting it down into the HSAs. It's just been really hard, and we've learned that, for sure, over the last couple of years.

MS. USIFER: Okay. And, since you touched on the risk-sharing, I think I'll skip ahead to the risk-sharing question that I had. So you've done several things, it looks like, on the risk corridor, right? You've reduced the risk corridor, and you're now allocating it proportionately to the HSAs.

First, do you know how much of a change this is from the prior methodology by HSAs, so, if we looked at an HSA, what their, what their risk corridor would have been under a like risk corridor if it's 2 percent, obviously, risk corridors have changed, but what that would do?

MR. BORYS: Yeah, we absolutely have done that, and we've looked at it with our finance committee. So taking the risk corridor down limits the risk for everybody, but what we did was compare at a similar corridor the old HSA accountability model to this new proportional model. Very similar in overall magnitude.

Basically, what happens is any HSAs that have a historically high total cost of care relative to the average ended up in this new model with a little bit less total risk and reward, because they're going from their individual HSA high PMPM down to the average, and somebody with a low PMPM historically ends up with a little bit more risk as they come up to the average, but, in terms of the overall magnitude and materiality, it was pretty low.

MS. USIFER: And then, you know, how is this incentive going to drive change in, like, the smaller HSAs? So, if everybody's now all tagged in together under this performance, you know, what are the incentives really in an individual HSA? Because it could be, like, well, you know, I'm only a really small percent, and whatever I do isn't really going to drive the needle, potentially. I mean, obviously, the intent is there for everyone, but, you know, how is this going

to drive incentives?

MR. BORYS: That's a great question. I think, when we were discussing this internally, we recognized that this new approach has many advantages, but one aspect you lose is that individual community accountability that you referenced. I think the strategy that we're trying to push forward is a little bit of a both, where you do this allocated risk at the end of the year, but then we build in measures, specific targets for individual HSAs to basically retain as much of that HSA local incentive as possible.

This is a little bit more technical, but in the actual settlement policy, there is a 10 percent pool of shared savings that will go to communities that have outstanding performance in the year, so there remains some financial incentive at the HSA level. Those specific measures are in process through our governance are being finalized, but we wanted to have a couple of really important measures focused around spend, because that is what the shared savings really is for, that would reward the communities who just perform excellently relative to the average.

MS. USIFER: And have you considered -- did you want to go ahead, Vicki?

MS. LONER: Oh, yeah. I just was going to

add a little bit to that. When we were looking at this, we asked communities, you know, would you be going into a risk-based model with payers on your own? And the answer is "no". We wouldn't be building 14 separate ACOs, and the reason for that is the numbers are small, and there's a lot of volatility in the numbers too.

And what we're trying to do here is create a system of care, and we see that there is a lot of collaboration and referral patterns around the state. So, if we don't start acting like a system of care and being financed as a system of care, we're not going to change. We're going to continue to do things within our communities and not kind of cross community borders in that aspect.

So I think those are two other things that came out of this was no one would do this alone. We wouldn't have a Brattleboro or a Bennington or a Morrisville go into these arrangements alone, because their numbers are just too small, and, secondly, we need to start acting like a system of care in order to be successful under this model.

MS. USIFER: Just, just adding on to the system of care piece, one of the concerns I've had with the old risk model, and it would continue with this

risk model, is that in some of the smaller HSAs the care that they're providing at their hospitals is still relatively low to the total cost of care that are attributed to their lives.

So I'll just throw out numbers, and these were examples from before, but, you know, a hospital might have 20 million attributed lives that equal to $60 million worth of spending, but 20 million is in their specific area, 20 to 25 are in other hospitals within OneCare, and then the remainder is outside. And so when, when we looked at what that percentage of risk was on their actual money that they were getting, it was high, you know, and this was under the old model, right, but it could be as high as 10 percent. So they could have, in that model when you're at 60 million, they could have had almost a $2 million risk corridor, a little under, onto their $20 million.

So, you know, one potential alternative is a lot of that care was done at UVM. You know, I'll just throw out there that that's where a lot of that care was being done. So they had the opposite effect. They had their attributed lives, their percentage of risk to their attributed lives, and then they did service for a lot more of the patients.

And so on a systemwide, right, we want everybody

rolling in the same direction, and, even though those people are from outside their area, I'm just not sure why we -- you know, one way would be to align the risk with where people are getting things done, especially now that we're kind of taking out that individual hospital performance, per se.

So just wanted to know if that came up at all. You know, I know it's a tough decision where you do things, but there still may be a concern that should we -- I guess, another question I'm going to ask, which you can add into this is, Was part of the reason we reduced the risk corridors was the pandemic and everything else, do you see us going back to higher risk corridors at some point and that become more of an issue then, right? Lowering the risk corridors has obviously reduced a lot. But just can you talk to that about alignment?

MR. BORYS: Sure. The points you raised are right on. Each community is structured differently. In a more rural community with a smaller hospital, just naturally more of the care is delivered out of that HSA. We've talked about this a lot at OneCare. We hosted, before the pandemic, a series of finance retreats with finance committee members and other financial stakeholders and discussed a number of

different options.

There are some interesting options out there, but, generally, the sentiment is this is a population health model and all of these people reside or receive their primary care in a community, and that's, that's the, really, the important attachment point, and there wasn't a huge desire to make a shift. But I absolutely recognize that kind of dynamic of Community A has a different proportion of their care delivered at their local hospital than Community B.

But, still I, just everything about our programs focus on the population and where they attach for their main health care services, and, if we're working like a system, as Vicki said, I think the downsides of this end up becoming smaller. If we're all working together to make sure that this, all the care is coordinated well, whether delivered locally or at a neighboring HSA, we still think we can have the right results and kind of balance that equation a little bit.

MS. USIFER: Okay.

MR. BORYS: At least for --

MS. LONER: Yeah, I was just going to agree with what Tom said, and, you know, part of this is learning how to work with different providers that are serving that population. So you need to work with your

academic medical center, right, if that's where your care. So continuing to not acknowledge that people are receiving care and we need to start to work together as a system kind of just perpetuates the fee-for-service mentality that we've had. So I do understand, and it is difficult and complex, but we're trying to make it as simple as possible to best support the patient.

MS. USIFER: Okay. And then, when you, when you talk about -- and I like the fact that you do have the incentive for providers and, you know, they can go up to -- I'm talking the upside, right? So they could have another $1.50 upside. And you talked a little bit about in the book where that's funded, but, just wondering, is that taking away somewhat from, from what the hospitals could receive, right? Because you're, you're kind of taking one of the payers, taking that and not allocating that out, and how did that go over? Because, if that expands -- I think it's a good thing to incentivize. I just know you're balancing a lot of things. So I wanted to --

MR. BORYS: Yeah, you're absolutely right again. By offering some of the shared savings opportunity to attributing primary care across the network, it does take that opportunity away from the hospitals. I, I don't want to underscore, like, the

magnitude of this, because different -- you know, one number is big to one person and small to another person. Relative to the hospital risk, it's a pretty small proportion overall but still an important, important part of its expanding accountability across the network.

On the other side, it also reduces their downside risk, I mean, not a lot, but it does contribute on that side as well in that we use some of those dollars that we didn't pay out to help fund downside losses if we're earning. So that shields the hospitals a little bit.

MS. USIFER: Okay. And I know this is really kind of a lot put on OneCare's shoulder, because you're the only ACO in the state, but, you know, how do we drive more growth in scale, you know, for attribution? So I know you're doing a lot of things and you've had some growth, but we know we're still not at the scale that we'd like to be. So what other programs do you have to drive scale?

MS. LONER: I would say, Maureen, that it comes back to that public-private partnership. You need to have payers that are willing, right, to be able to offer these programs out to ACOs, and in Vermont we have essentially two payer groups that provide services or insurance to Vermonters, but we also have a lot of

national payers out there who have not wanted to participate in Vermont's health care reform efforts, and, you know, they have reasons for doing that.

And so I think that's something that needs to be looked at as a state to say, Is it practical to be able to bring in those lines? And our particular focus at the ACO -- I know that the State has scale target goals, and I think that scale is important to the providers as well, but, really, our push and thrust has to be around accountability, because, if we continue to grow and we don't have any significant changes in the way that care is delivered or providers taking accountability for it, that's not a good plan for an ACO when risk is being transferred over to the provider network.

So our focus has to be around increasing those accountabilities, providing the resources that are needed to make the changes, and to continue to create some attractive programs that providers will want to participate in, but it's, you know, a multipronged approach. I think all stakeholders, not just the ACO, has a role to play in what some of our policy decisions, payer decisions has to be made in order to increase scale.

MS. USIFER: And maybe as a follow-up, and it

doesn't need to be -- maybe it's even confidential. I'm not sure. But can you maybe provide particularly those out-of-state providers and, and what, you know, how many lives are attributed there? Because I think that is a very good point, right? It may be hard to get those people in, and I don't know if we've quantified, you know, how many lives are there and then plans at some point to be able to go for whether it's Cigna or whoever may be in these places.

But I think that gives a good perspective for people to say, you know, we may have this vision, but, you know, because we may be very small to their total, it may be hard for some of these larger players to commit to it, and, you know, it would be good to have that as a follow-up.

MS. LONER: I, I do think that we probably have some estimates. I don't know that we have the perfect numbers, but we could certainly provide you with the information that we had.

MS. USIFER: You talked about the Medicare increase and the potential offset to maybe looking at the cost shift and, and working on cost shift and commercial payers, and can you talk a little bit more about that and if you have any plans to, to be able to do that, or, you know, how would that work, I guess?

MR. BORYS: It's a good question. It's not an easy one to answer. One of the challenges that we face here is that we're, we're kind of at the tail end of many of these rate developments. The commercial rates have already been built, and the commercial payers very much want to link the targets that were given back to those QHP rate filings, and, you know, I think this goes to some of the conversations we're starting around regulatory alignment. How do we make the system, our Vermont system, work together a little bit better?

I guess, my simple view is the Vermont all-payer model offers some pretty good terms in the Medicare space, and step one is to leverage those favorable terms as a way to start working to address the cost shift, but it has to be a really statewide system approach. I don't think it can be just in the ACO budget. I don't think it can be just in the insurance rate review process either. I think it needs to be a very coordinated effort.

But one of the tools that we're given under the all-payer model is the Medicare approach and the trend rate, and I think that's a really important arrow in the quiver for us to think about if we want to address the cost shift.

MS. USIFER: Okay. I'm going to shift to ask several questions on the P&L and cash flow, things like that. So, first, you talked about the shifting of timing of payment of the VBIF funds from a program settlement to a distributive model, which I think the program settlement was about 18 months and a distributive model would be in a shorter timeframe, but what impact does this have on cash flow? As programs grow, is that going to create any issues? Because I get the intent is right, right, trying to get it closer to when the performance is, but you don't actually receive the funds until later.

MR. BORYS: Another great question. So in the old model that we have, the sole VBIF model, we were required to pay our contracts to fund a certain percentage of the total cost of care, so 2 percent. The way we bucketed those, the VBIF pool, was through hospital dues. So, when we built our budget, we said we're going to have $5 million for the value-based incentive fund. That flowed right into the hospital dues calculation, and that's how we generated those funds.

With our growth over the last few years, more lives just increased programs overall. The amount of the value-based incentive fund landing in the dues

calculation became very significant, and it was driving up the dues in a big way. So, in our budget strategy for this year, that's where the two-pronged approach came from, how can we move some of the quality accountability to the back end, meaning that it affects settlement.

If we were going to earn shared savings and we have a poor quality score, we're not going to get it all, which still has the quality accountability, and pair that with a more right-sized value-based incentive fund that will fund in the same dues mechanism but at a lower level. So those two components keep the bulk of the quality and accountability from a financial standpoint in place, but helps to balance the pressures on dues and deliver this more nimble model for rewarding the network.

MS. USIFER: And, you know, probably the biggest potential issue for, for cash flow problems, and you've brought it up in the book that you sent out, was if you didn't receive payments timely from one of the payers, and, I guess, what's the risk of that? What would you do? Because, you know, that has obviously major downstream implications. Has that happened? Has there been any delays as we've gone through?

Obviously, we don't want it to happen, but you guys had brought it up, and I just wanted to know what your plans would be.

MR. BORYS: Yeah, yeah. I mean, when answering that question, that's the big one for me is that we, we get substantial money coming from the payers that we are, then we turn around and pay the network in lieu of fee-for-service reimbursement. If a payer were to miss a payment or have some sort of a problem from that standpoint, we would have a cash flow issue. We'd have to evaluate the nature of it. Is it a one-month issue? Is it a multiple-month issue? There's a lot of question marks that we'd have to understand before saying, Here's exactly how we'd address it.

But that is certainly a concern to be aware of. It has happened. Very early on, we had one month where the Medicare, if I recall correctly, payment was delayed, but they told us in advance, We're going to pay it in the next month. So we got a double payment the following month. We were able to communicate with our network and manage that.

Since then, knock on wood, we have not had that occur. We've been very consistent with the payers, and I -- you know, when we engage in these programs where

we're converting fee-for-service for fixed payments that flow through OneCare, that's a big responsibility, and we pay very close attention to it, and, if we have any timing issues with payers, we make sure we're communicating with them to fix it, but we haven't had many to date.

MS. USIFER: Okay, thanks. And, just looking at the income statement, and I'm going to kind of separate out, you know, all the revenue that you get in from the payers, because that obviously gets dispersed out to the hospitals. So, you know, it looks like your revenue streams have been impacted about $6 million or so, I mean, $3 million from the fact that you no longer receive any HIT funds and then a reduction in hospital dues, which I think is where we should be looking for reductions as well.

But you, you then reduced your payment reform programs by $6 million, so you've basically gone from $36 million to 30. So you kind of took that reduction that you're getting from other services besides payers and taken it out of the payment reform programs as we're growing the size of the dollars that we're receiving. So that's kind of a little bit counterintuitive, right? You think you'd be spending more there as we attribute more lives.

So, I guess, what programs do you reduce or cut? How are your measurements for that? How do you know what's working, what's not? And, and did you think about, you know, is this the right thing to do is to cut those programs? And, and I know you have to make a lot of decisions, but it's just --

MR. BORYS: Yeah. I mean, getting at the crux of the budget challenge this year is that we have less revenue to play with, and how do we manage the expense side? There's a couple different areas that I'll highlight. The first is the value-based incentive fund that we talked about before. The number is lower on the expense side. What's not on our income statement, because there's really no great place to put it, is what the financial accountability is under the settlement model. So we can lose those shared savings dollars or more.

It doesn't have a great home on this illustrative income statement. So it makes it look like the quality component is smaller than it really is if you aggregate how much we have at stake for quality. So that's one piece, but it also helps to alleviate the hospital dues to do it this way. So there's, that's probably the most material piece.

We had some tough decisions to make around some of

the really cool and exciting initiatives that came through via the innovation fund programs and, for example, and the ideas were great. We had lots of them. But, when we came back and really prioritized what are we going to fund in 2021, we really wanted to sustain those core investment areas that are statewide. They've been established. Providers are relying on those funds. We've asked them to do something with them and make sure we can keep those in place. So that's why you don't see a big drop in the base OneCare PMPM or, or even the care coordination program.

So not easy decisions, but we, just like every other entity out there, you have limited resources to play with, and we've establish what can we get from revenue through our contract negotiations, the hospitals, etc., and then what's the best way to use those funds, and, like I said, not easy decisions.

MS. LONER: I just wanted to emphasize for the group is that OneCare is a provider-led organization. So none of these decisions are made just by the management team. We have clinical committees. We have population health committees. We have finance committees which represent providers from every sector of OneCare Vermont who are looking at what our revenue streams are, what our expense streams are and making

some decisions about where to focus moving forward with declining revenues, like what do they need to be successful, and I think they have helped to shape what the core programs and focus areas need to be for OneCare moving into the future.

And, you know, in the early stages we did a lot of innovation. We looked at a lot of things, and, when we look at the overall return on investment and how they really fit into the role of an ACO, they're great things to do, they provide individual value, but they're not sustainable under the current environment.

MS. USIFER: Okay. And then another thing on the income statement was the increase in salary and benefits, which are going up by $1.5 million, and what, what I don't see on the balance sheet that was provided was what your original '20 projections were. So you gave that on the FTEs and things like that, right? And so we saw a pre-Covid, and we saw that decline, but, when we look at the actual, the approved budget, because it was done so late, really ties into your current projection.

So, you know, if I go back to, you know, 2019, you had about $8.2 million in the salaries and benefits, or budget submitted was 8.4, and that's what your post-Covid, but there was an extra step in there,

right, where you were originally anticipating you were going to have higher staff and higher expenses, because, you know, we're actually seeing from the 2019 actual and the 2020 budget and projection are about the same.

2019 and 2020 are going to end up about the same, but then we see a relatively large increase, the million five, which I know you did discuss some, but I wanted to give you the opportunity, because part of it is contracted services have shifted, part of it is the pay freeze, and part of it is the incremental staffing, but, obviously, as these expenses go up, when you're reducing some of the other revenue areas, you had to cut programs. So just, just understanding, you know, the staffing, the staffing changes, and if you can correlate it to what was that, where did we think '20 was going to be prior to Covid?

MR. BORYS: Yeah. A lot of moving parts in here is the first thing that comes to mind. We really did a lot of work over the last few months to evaluate what OneCare has for staffing resources and make sure it positions us for success in the future in terms of addressing our priority areas. So we, we have made some shifts in terms of just organizational structure internally.

You know, really, our overall staffing model hasn't changed that much over the last couple of years. What really kind of looks like a big change is that we anticipated some significant growth in 2020 for some exciting new initiatives that just didn't happen in response to Covid. We went back and took out things that we just had to to make sure that we, you know, we could offer that digitally to hospitals.

So, when you look at year over year what our real salary and expense was on a per-FTE basis, it stayed really consistent. So we haven't made many changes to that to adjust. But, in terms of the work that OneCare does as an organization, we do a lot more now, we have to do a lot more than now than we had to do three years ago. When we had just a Medicaid and a Medicare program and an upside only or maybe even upside only programs, that requires much less effort than it does now to have five programs that are very complicated.

The commercial programs, the Blue Cross Primary is one that has a lot of components within it, and the financial demands and the analytic demands and the need to meet the network's needs has grown tremendously, and we're just always faced with this balance of, How do we resource OneCare with enough staff to manage these super-complex programs, support the network,

support the Vermont statewide partnership? There's just a lot of demands, and the fact that we really haven't grown our staffing, I think, is telling. I think it's -- we're doing a lot with not a lot of staffing resources right now, and that's not easy.

MS. USIFER: Just a question on -- I know you lost the HIT funding, but it does look like your software expenses are staying consistent year over year. So, I guess, you know, there has been some concern of losing those funds. Are you cutting back at all on your deliverables for analytics and data? And, you know, all looking at your software expenses are fairly flat. So I'm thinking that you're not, but would like to hear that from your perspective.

MR. BORYS: You know, we're not making any significant cuts, and, in my opinion, I don't think we can. We rely so heavily on the data coming into the ACO to do just about everything we do, whether it's making sure we have fair total cost of care targets, reporting to our network, reporting to you folks as regulators. We need that data, and to inform, inform the care, more importantly than anything else, make sure that the providers have good clinical information. So we, we had to find a way to build this budget model, absent the HIT funding, that didn't erode our

analytical finance capabilities in order to be successful.

MS. USIFER: Wrapping up my questions. But you, you have the $3.9 million reserve that, you know, we've, that has been built up over the years, and there's no additions to that this year, and probably doesn't need to be, since you've reduced kind of the reserve, the corridors. However, you're not doing reinsurance. So, you know, what's the maximum that you, that OneCare would be responsible for for those hospitals that they're providing backing for, I guess, would be the first question there, and then the second part is, What other uses do you see, if any, for the reserves, and what approvals do you need to get them?

MR. BORYS: Good question. We are or do have in the budget some risk protections to protect certain providers or just help them get into this risk model as we've offered in the past. The number that OneCare, absolute worst-case scenario, would have to absorb is somewhere in the one-and-three-quarter million range. So it's not anywhere near a point where we fully consume these reserves.

The other way to use reserves, this is an interesting one from just a kind of an accounting standpoint, I suppose, but the reserves come from the

providers that pay dues. That's how we are able to generate reserves. We have no other way to do it than to honestly operate with a positive net income that we can then put that cash aside and say, this is, these are our reserves.

So, if we got to a point where we felt the reserves were too high and wanted to -- and I'm not at that point, just to say -- but, if we wanted to kind of distribute those back out to the network, it becomes a little bit of a tricky exercise where the opposite is to run a loss, right? So we, we're not here to present that scenario to you, but that's one of the ways we would actually consider refunding reserves, so to speak, is to build a budget with an operating loss that effectively reduces hospital dues as a way to give it back, and that's not, from a finance perspective, that's not really a comfortable way to run the organization, but it is an option at our disposal.

MS. USIFER: Okay. One last question. Just on the cash flow, you're showing a negative $5.1 million change in '21. Help me out with that, because the other areas you've actually been a slightly positive with cash flow. Is that, you know, reimbursing the loan, or, you know, what's driving a negative cash flow in '21?

MR. BORYS: Sure. Yeah, we do anticipate -- we took a loan out from the UVM Health Network to help fund the financial guarantee required by the Medicare program. What we've done since then is get a line of credit with the bank that allows us to issue a letter of credit to CMS to satisfy this financial guarantee. So we are paying off a $4.2 million loan that we had with the health network. I can look in more depth and get back to you on any other details in there, but that's the one that comes to mind as the most material.

MS. USIFER: Okay, thanks. I know there are many, many more questions and bunch of questions on quality and things like that, but I'm going to let my colleagues ask those. So I am done, Kevin. Thanks.

CHAIRMAN MULLIN: Sorry about that. UPS just delivered one of my binders that was sent by the office. Might have heard the dog barking. We're going to move to Tom.

MR. PELHAM: Thank you, and thank the three of you for your presentation. There is a waterfall here is that two of my nine questions Maureen has already hit. So it ought to speed things up here a little bit.

So my first question has to do with fixed prospective payments and the risk adjustment number,

and in Appendix 6.6 you profile that at $460 million across all hospitals in terms of, of that, and the approved NPR for 2021 for all those hospitals is about $2.8 billion, and so that's about, that is a 16.5 percent of revenues coming in through the fixed prospective payment.

And so I'm just wondering where does that number fit, that 16.5 percent, is, relative to you inducing the reforms at the levels we'd like to see them in Vermont?

MR. BORYS: So the, the way we get that number is we look at the attributed lives and then how much care they receive at the hospitals participating in a fixed payment model. We, we talk about scale a lot at the aggregate level and say, Here's Vermont's population. Here's how many lives are in a value-based care program. But, if you look at that on a community-by-community basis, a community that's all in with Medicare, Medicaid, the Blue Cross programs has a much higher proportion of their lives at, in value-based care than the statewide average.

And I think the same holds true with hospital fixed payments. If you have your Medicare and your Medicaid and your one that's interested in going to some other models that we're trying to put up for

future years, that individual hospital or primary care practice in the CPR program can have a pretty big proportion, at least a material proportion, of their revenue stream under a fixed payment. That, of course, can get diluted when you look at it statewide, but I think that's another important perspective is, What's the community, and what's the individual practice, and, if you're all in, I think it does become material enough to drive some change.

MR. PELHAM: That makes sense. Thank you. Looking at the distribution of downside risk, the downside risk number was around $19 million, and so, if you look at how it gets spread over the different hospitals, 35 percent of that $19 million is associated with UVM Medical Center at around $6.6 million, and, as another example, for Northwestern it's $1.6 million, which is about 8.6 percent of the total $19 million in downside risk.

But, when you kind of flip that over and you look at that, you look at those numbers relative to the approved NPR for each of those hospitals, it ends up being four-tenths of a percent for the UVM Medical Center and 1.5 percent for Northwestern of their revenues, which kind of gives you a different spin on it in terms of risk and, and the potential impact of

the downside risk on the hospital. And I'm just wondering if you have any thoughts of, you know, for example, the payer mix for UVM Medical Center is richer than it is for Northwestern Hospital, and I'm just wondering whether or not this comes into your calculation as to how that risk gets spread.

MR. BORYS: Yeah, this is very similar in kind of spirit to what Maureen was pointing out earlier, too, is every community is a little bit different. Some hospitals have a big proportion of their local care, other small. Some are referral destinations. UVM, for example, gets a lot of referrals from New York as well. So every community is different and has a different financial dynamic.

At the end of the day, though, we go back to this is a population model, and keeping in line with that has been kind of the aim thus far. But you raise a good point and, certainly, one that we've talked about internally, not only with OneCare management, with our committees and our stakeholders of, Is this right?

And I think one of the paths that I do worry about is that, if we build in some sort of an NPSR adjusted model, we only have data about the attributed lives, so we have a big blind spot without -- we can collect the data with some effort, but it would add a lot of

complexity, really, to the sharing model and really trying to keep it back to our job here as an ACO is to take care of this population as best we can and do it in a systematic, statewide way. So that's been the direction to date, but the point you raise is fair in that it is a different dynamic for every different provider.

One other nuance that I think is important is that we don't -- like, our risk model doesn't assign risk to a hospital specifically. It assigns risk to an HSA, a community. The hospital has been identified as the risk-bearing entity, but, from that perspective saying, Here are the HSA lives that this group is accountable for, part of that might be referring care outside of the HSA when it's really this, this group, and keeping the risk model aligned with that, I think, is important to recognize.

MR. PELHAM: So, when you're in negotiations with a hospital, does this issue ever come up at the micro level between the ACO and the hospital itself as to, you know, payer mix and risk assignment?

MR. BORYS: Payer mix and, and things like that have not come up. We have good, robust discussions about what is the appropriate risk model for sharing risk. I have not heard a lot of, Well, I

have a different payer mix than somebody else, and, therefore, I should have a different, you know, maximum or risk or opportunity number.

MR. PELHAM: So my next question goes to one that Maureen touched on a bit, which is the cost shift, and I'm just wondering. You know, in your narrative you said, for example, opportunities to leverage the Medicare to terms, and I know what those are is that, if you're spending Medicaid money, it doesn't count against the total cost of care.

Leverage the Medicare terms in the APM to help offset the commercial cost shift in flow funds to population health investments. Can you put a number on that, and do you have any sense of, of how much or, you know, some kind of dollar value relative to mitigating the cost shift that, that you folks have leveraged?

MR. BORYS: I don't have a specific number. I think my thinking on it has been mostly a thought exercise to say, How would you use the resources we have available to us to then offset commercial rate increases and affect that cost shift? And, when I think about it at a macro level, that Medicare, the Medicare terms are, like I said before, an arrow in the quiver for us to think about as a state in terms of how to use it.

While I don't have a number, I, I definitely think it's material in that the Medicare spending is significant, especially as we have an aging state, and any increase, percentage increase you can get in that space is going to go a long way.

MR. PELHAM: So, when the, when DVHA presented its budget to the legislature in the last session, you know, they made the announcement that they would not be increasing any of their reimbursement rates for 2021, except for those that are federally mandated. So I'm just wondering, kind of going to your Appendix 4.3 where you have your expected growth trends, does that, is that something that's calculated into those, or is that -- you know, obviously, we still have to go through all the actuarial process with the Medicaid rate, but does that, does that affect your thinking at all?

MR. BORYS: We, when we set the trend, we're trying to come up with the best estimate to go from a base year. We have some experience data to rely upon to the performance year. We use some -- we have a couple of years of the actuarial development. So we look back at those and also looked at some emerging trends.

One of the hardest factors for us to incorporate

is anything related to repricing. There's a lot of detail in there. Even if the general sentiment is that there's no significant rate changes, there's always something going on that's a little bit more detailed. So we try our best to build it in, but, really, the rubber will hit the road in that actuarial process you mentioned.

MR. PELHAM: Well, I mean, because it's a big jump from the prior rate to, you know, what's in that table, and, you know, with their, you know, DVHA saying that they're going to flat-line their reimbursement rates, I just hope that doesn't turn out to be too severe a problem.

Looking at the provider network, just an aside curiosity, looking at those that have answered "yes" or "no" to using Care Navigator, I'm wondering, you know, why would Porter and Central Vermont Hospitals answer "yes" to that question while Helen Porter and Woodridge Nursing Homes answered "no"?

MS. BARRY: So this is Sara. I'm happy to take that question. I think it's a matter of the focus in our care coordination program has really been around trying to ensure strong linkage and connection between our primary care providers, our mental health care providers, our home health providers, and our area

agencies on aging, and so that has been a tremendous workload, frankly, to, you know, continue to inform and engage and train and revise those sorts of programs.

And so, as we move forward, I think there's continued opportunity to kind of expand the ripples of individuals that are connected, but there hasn't been a specific kind of high use case for something like a skilled nursing facility at a large population level yet. There could be very well in the future.

MR. PELHAM: Thank you. Obviously, you know, for some folks the operational costs and the population reform investments of the ACO are somewhat controversial, and people are always making this analogy of what that, quote, unquote, money could be used for elsewhere. I will say that, if, if you applied your operational budget to lowering QHP rates, it, it wouldn't even address the rates that we had this year, and that would be a one-time event, and ongoing then you'd still run into the same problem.

But I, I'm kind of -- you know, the binder is just filled with incredible information, more than I can consume, great tables. Your analytics, you know, kind of looking at the, at the quadrants that Sara presented earlier, you can look at, you know, the very high-risk by each hospital and the, and the high-risk folks, and,

you know, I just kind of totaled those up systemwide in just those two areas in terms of, of the amount of money spent in the first quarter, of which are the most recent numbers you have out, and that's $139.8 million just in those two quadrants.

And I'm, the thing I'm missing here is, is someplace where I could go to, and the public can go to, in the binder or in the ACO information and say, Yes, here is a reasonable and fair profile of the return on investment of these investments, because I have a feeling that that would be a big number, but it, it's not here. I mean, so there's got to be avoided costs that are accrued through Care Navigator that -- and, even during this pandemic, I'm, I bet some individual lives were saved because of Care Navigator, but, if that gets lost in the discussion because we're looking at the expense lines, you know, and not on the return-on-investment line.

So that's more of a kind of a cheerleading thing is that someone needs to go, you know, look at, through all this quality stuff, the improvements, especially where they're statistically significant, and put a number on it and that they can stand behind and say, This is what you're buying in terms of, you know, versus the do-nothing alternative.

I notice, for example, that DVHA, in their budget to the legislature, takes credit for savings from the, from the waiver, the prior approval waiver. It's, you know, in their budget it's a savings of $370,000 in fiscal 2021. You folks don't have -- I mean, I'm sure that it's a bigger number for the providers out there, you know, but there's no number on it. So it just kind of gets lost in the atmosphere, and it's, it's a, an analysis, I think, that would, you know, would help you folks.

Maureen asked the question, you know, you had a great discussion about the, you know, statewide approach versus the HSA approach, and I get, I get the volatility issues in the small size. One thing I was very happy to see in your presentation is this, the transition or the emphasis of the self-management programs with the Blueprint. That's something, you know, I kind of harped on for the last two years, you know, and one piece that I think is missing in your approach is aligning that work with the benchmark plans supporting the QHP benefits.

You know, they, they don't support a pre-diabetes approach similar to the one that the Blueprint operates, which is, you know, aligned with the CDC, which is supposedly the best there is. And so you can

get some help on nutrition counseling through the, through Blue Cross Blue Shield. I don't know about MVP, but you can't get any help in terms of fitness, and those are the two big issues in terms of pre-diabetes.

So, if you can -- and now, especially now with the Blue Cross Blue Shield and MVP under the tent with their QHP populations, you know, hopefully, people can put a lid on, on aligning the, the prevention-related benefits without kind of making it, opening it up to a wide assortment of demands on that resource.

Maureen hit the salaries and occupancy is the same. And so this is why -- my last one is just because it's such a big number, and I, I just want to, kind of want to ask it and get it off my chest. So the ACO is owned 50/50 by UVM Medical Center and Dartmouth, as I understand it, and, when you look at the UVM Medical Center's budget, they, that, that equals about 25 percent of the total health care spend in Vermont, which is around a little over $6 million. The total hospital spend is $3 million, and the UVM Medical Center is about 1.4, 1.5 of that, so they're about 25 percent.

And they presented, in presenting their budget to us, you know, they've profiled how their expense growth

is growing since 2016 at a 5.8 percent annual rate, and, if, so, given their size and that long-term growth rate, it, I, it's, it just seems not in accord with also the ACO's goal of total cost of care, you know, within the ranges of the slides that we've talked about, 3.5 percent and up to 4-plus percent, you know, as the upper guardrail.

So I'm wondering how internally you folks deal with UVM Medical Center, given that they are one of the largest contributors to the statewide total cost of care.

MS. LONER: I would say, and, Tom, you can add on to this, it goes back to the fact that what we're looking at in the ACO are the populations that are attributed to the ACO. So every hospital, institution, primary care practice has panels and operating costs that exist outside the ACO. So, when we're trying to design our budget, we're designing it within the ACO, which is very different, to your point, that the all-payer model is looking at the total state and the population of care.

And so that's, again, one of those places where I think that we have to look at what role we all play in this, and for the ACO it's those that are attributed to the ACO, and then I agree the State does have a larger

role to play in terms of bringing down the overall cost of care and keeping it true to the promises that the State made with the federal government to keep it at a 3.5 to 4-ish percentage. I can't remember the top number.

So that, that's my thoughts on that. Tom, I don't know if you have any others you'd like to bring in.

MR. BORYS: Just one simple one that the very first step is to install a value-based care paradigm, and does that solve every single problem underneath? No, but it starts to build a framework where providers -- and UVM is an incredibly important provider in this state in terms of our overall success -- but start to have the incentive to focus on population health, focus on prevention. That's the beginning of the process.

So I think, while there's a lot to figure out in terms of, How do we make the health care system sustainable at a macro level, how do we succeed under the all-payer model at the macro level, it's really important as a very first step is to install that value-based paradigm and start rewarding providers and incentivize them to think about it in this way, and, absent that, I think we have a much bigger problem.

MR. PELHAM: Well, I appreciate that you folks are looking at an attributed lives population

mostly, you know, and the APM target is a statewide target, but it just, you know, worries me that the bigger player that's, like, 25 percent of the total pie is growing at a rate that is well in excess of what the target is in the all-payer model, that we're not going to get there unless, you know, something changes, and I'm not quite sure what that is. But thank you, thank you both for your time, and I'll turn it back to Kevin.

CHAIRMAN MULLIN: Thank you, Tom. Member Lunge, Robin?

MS. LUNGE: Thank you. So I'm trying to kind of frame my questions into three buckets, because, when I think about delivery system reform, I go back to the lessons that we learned from the decade implementing the Blueprint for Health Primary Care Medical Program and the Community Health Team, and that is that for payment and delivery -- I, I think someone needs to mute. That sounds better.

For payment and delivery system reform to actually be successful, I think there are three kind of legs of the stool that we, that we really developed through the SIM grant program as well, and those are payment changes themselves; providing actionable data, which is a combination of health information technology data and the ability to use the data; and providing tools for

actual care redesign at the provider level. So I'm going to -- that's, I just wanted to say that out loud so that you had the framework for where I was coming from.

So I think I want to actually start with the data and the health information technology and use of data components. I think one of the areas that we, as a state, have struggled for a long time is making this transition from data to actionable data, and I know that you mentioned, Sara, that you're focusing on that for 2021 in terms of moving from providing tools where providers themselves can go into the tool and come up with different reports and whatever to more usable sort of prepackaged data elements, and I wonder if you could provide a little more depth there. Because I see that as a potential failure point with any delivery system model.

MS. BARRY: Thanks for the opportunity to talk about that a little bit more. I think that we've learned that, you know, the data, unless structured appropriately and in bite-sized pieces appropriate for the audience, really can be meaningful, meaningless. So, as we've learned and every year kind of iteratively tried some new things out, received some feedback, we've focused on a couple of areas.

First, I would say is data transparency within our network, and that started at a policy level and now has really gotten to more of an implementation perspective, so getting people used to, not only having their data shared within the network, but sharing it with others and benchmarking against one another, not only just kind of opaque national benchmarks, but then also really trying to align kind of our focus areas with actionable information at once.

So diabetes and hypertension are a great example. Those are clinically based measures where we need to understand, not only what we can get out of our health information exchange for our individual EHR, but we actually are investing next year in some staff time to do ongoing manual data extraction, which is a process that normally we only do annually, in order to make sure that, at least quarterly, all of our primary care providers have that kind of real-time or as close to real-time data to actually make adjustments in the way that they're providing care and the way that they're learning from that system and those processes. So I see that as a big advancement.

At the same time, kind of the next level up of the system thinking across the health service area, we've been very focused on providing monthly reports by payer

across each health service area and showing some benchmarking data of other HSAs as well as OneCare at a whole. I think that continues to be really important, but the way I'm thinking about it is that we need to kind of surveil across quite a number of measures but, at the same time, hone in and have really specific focus on where there's opportunity to improve.

So, for example, we talk a lot in our clinical committees about avoidable use of the emergency department and how nuanced that is. I mean, it seems just like kind of an obvious thing to change, but from one community to the next, the drivers underneath that vary quite a bit and have to do with access to services and consumer preference and hours of operation and all sorts of other things.

But I would say it's that tension for me between we can't take our eyes off the ball and stop paying attention, but, at the same time, we need to help people see more narrowly where to focus. And I'm excited, as Vicki spoke of earlier, that we have these new mechanisms through some consultative reports where we're really bringing together the population health analytics and the financial analytics to say, Here's where the spotlight needs to be focused.

That's still a new enough process for us in this

model that it's a little too soon to be able to tell you about the outcomes that are resulting, but I can tell you that, coming up in our next board meeting, we will have one of our health service areas in the public session kind of spotlighting what they're doing in response to the data that they're receiving.

MS. LUNGE: And that brings me -- I'm going to kind of jump between the two quadrants of usable and data and actual care redesign. So, when you provide that -- I know that you were talking about the quarterly data on diabetes and hypertension that you would provide to the primary care level and then the HSA sort of spotlight data, I'll call it. Who does that HSA-level data go to in the HSA?

MS. BARRY: Yeah. So, because this is all, you know, confidential information, much of it, you know, we have to be quite careful of and sensitive about, it's posted every month on OneCare's secure portal, which is accessible to anyone in our provider network. We send out kind of reminders around that, and we include key performance reports at the ACO level in our board packets that go out every month.

In addition, about a year ago, we evolved one of our staffing supports in our analytics team to be a population health analyst, and she goes out and

actually uses those reports and engages in the community-level meetings that are happening for those participating in the ACO.

So whether they're called accountable communities for health or regional clinical performance committees, everybody's got their own kind of label, but that's a place to really talk at the local population level about what's going on and look at some comparative data.

MS. LUNGE: Okay. That's helpful. Do you think that we have, we collectively, not just the ACO, do you think we, as a state, have collectively invested sufficient resources in the care delivery redesign component of change? And the reason I ask that is because, going back to lessons from the Blueprint, the Blueprint's payment component was small and always recognized as small and not necessarily the driver of the delivery change, because it was so small.

However, the Blueprint provides practice facilitators to primary care so that there's a person who goes to the practice, sits down with them, and helps them redesign their care, and that's still available at the primary care level, but I think the kind of care redesign we need moving forward is bigger than just primary care, obviously.

And so that same kind of resource is not available to hospitals. It's not available, although they may have internal resources to do that. I don't know. And that probably varies depending on the hospital. And we, and that kind of resources is not something that I know about in the broader community provider level, the home health or DAs.

So one of my areas of concern has always been getting from the top drivers down to the actual care redesign, and I'm a little concerned that we have not, as a state, focused enough on what providers need to facilitate that care redesign. So I welcome your thoughts on that, and then connected to that is, Whose role is it to fund and/or provide those supports? Because you have the Blueprint model where it's actually the State that does that. I think in other states it's the ACO that is doing that. You could also argue for a model that the community providers themselves should be, you know, in charge of their own care redesign. So I'll stop talking and let you respond.

MS. BARRY: Great. So I think you identified, Robin, a key factor that is integral to thinking about the kind of systems change within Vermont, and that is that there's a longstanding

history of the Blueprint for Health and its work, certainly, in patients that are medical homes, but also more broadly in the community, and so OneCare's goal has always been to find ways to partner with that and to build on and amplify, not to duplicate, and that's incredibly important to our provider network as well. I think where we're headed with the self-management program is a great example of kind of one way in which that collaboration can evolve, and we continue conversations between OneCare and the Blueprint about other avenues to explore.

In terms of the kind of that dichotomy between practice-level support and community support, I do think there are some components that exist in that space but probably aren't fully realized, in part because of lack of funding and lack of ability to invest, and I think that the challenge from our providers' perspective has been the lack of delivery system reform dollars that have been realized in Vermont over the first four years of this model in terms of potential opportunity to have a faster or more accelerated impact in those care delivery transformation models.

I think, to the extent that some of that does exist, we've identified that every community looks

different for some good reasons and maybe for some reasons that we should challenge. That, oftentimes, that view is being held by a Blueprint project manager who brings together folks from OneCare, from the QI facilitators, from other really important community partners that are also volunteering their time to do that work.

We've been really focused on how to encourage the all-payer model population health goals as the frame around which people decide to focus their energies, find opportunity, and I think that, as OneCare has increased the number of lives in the model, our ability to support the data that needs to drive that decision making has really become much more important and much more integral to that process, but I would say in the end it's much slower than I would like to see, and it needs more investment in order to realize its full potential.

MS. LONER: Robin, I was going to agree with Sara to say I think there needs to be much more investment made in this area. We've tried to hit a balance through the ACO, because the providers themselves are using the ACO infrastructure to be able to support some of those things that you just talked about, but there is not -- most of that money is coming

from the providers themselves, right, to be able to share resources and bring that together.

There is a need, though, to make more of those investments, and whether they be within the ACO, because maybe it makes more sense to have a shared resource than each and every community having their own QI facilitator in it, or whether it be directly to the provider source, I think, is something that, if there were funding opportunity, that we would really want to look at, because I do believe that is an area of risk, and we're doing our best to align the resources that already exist, but I just don't think enough resources exist.

MS. LUNGE: Thank you. Going back to data and HIT for a moment, in terms of Care Navigator, my recollection from last year was that you were exploring ways to potentially feed the information directly into EHRs, because one of the provider complaints from those providers with robust EHRs is having to go to another spot.

So I'm wondering if you could talk about that and any other sort of initiatives that you have that reduce the provider burden of using Care Navigator, because, to be frank, we hear some people who very much complain about it, and then we hear, for example, in Rural

Health Services Task Force, we had a subcommittee on care management and are there policy steps that should be next, and we had other communities who loved it and wanted to give it to everybody in their community.

So I feel like it's a tale of two Care Navigators, and my guess is that some of that discrepancy has to do with the community and how they've implemented it themselves and the provider type and what other sort of, you know, electronic health records they may have to monitor as well, but I'd love your thoughts on that and also an update on how you've been working on that.

MS. BARRY: Sure. You're absolutely right. I'm hearing an echo. You're absolutely right that you talk to one community compared to another and you get different perspectives. I would say what I have been hearing in the last 9 to 12 months tips more towards the favorable side of, Care Navigator has made a difference now that we really understand how to use it and our community has come together around it, and in other communities that are struggling with that implementation a little bit more, it's because there's a chicken-and-egg conversation happening, I don't want to use it until my neighbor uses it, and my neighbor doesn't want to use it until I use it.

And so trying to break that down and really say,

Let's understand what this is meant to do and how this can help facilitate better care delivery, has really been critical to that, and that, that's often a small group conversation that really needs to center around individuals where gaps maybe have occurred, and when that conversation can happen, I've seen a real shift.

In terms of the integration with EHRs, that is a huge challenge. I would not say that we've made significant progress in that area, nor has it been as much of a focus for us in this year. We've been more paying attention to how to operationalize a significant change in our payment model that really is meant to align with our value-based care strategies, and, overall, I think that's going very well. It's also providing some really interesting insight on who is active on the care team, what types of organizations do they come from, again, how does that vary a little bit from one community to the next, and where are there opportunities for us centrally at OneCare to help facilitate some of those linkages.

In addition, we've really expanded some of our use and integration between PatientPing and Care Navigator to get real-time event notification information as well as some reporting to sit on top of Care Navigator that helps us shine that spotlight, as we were saying

earlier, on individual patients so that we know earlier that, just because a report that's run in a local EHR doesn't necessarily identify that somebody went, you know, to their local emergency room twice but went down the road to another ER seven times in the last sixty days. All of a sudden, they can see that, and they can develop a plan for outreach and engagement, and I think those are some of the critical factors, along with some of the training and education that we've done, that have led to such a huge uptick in our care managed rate.

Having said that, with any technology there's always opportunities to continue to improve it and refine it and look for, you know, even questions of, Does it become redundant at some point in the future? And I think we ask that question a lot, and the answer we keep coming to through our provider conversations is, until we can really robustly demonstrate the outcomes that we're trying to achieve in this community team-based model, we won't know to what degree is it really that facilitated communication through technology that is leading to that versus the actual, say, one-to-one, individual-to-care-team-member engagement. So I think, in that sense, it's exciting, but there's a lot more to learn.

MS. LUNGE: Thank you. Sorry. I muted in case I was causing the echo. In terms of the new payment model in the complex care coordination program, how, I wanted to get an update on how that implementation was going. Because I know you pushed it back a little bit due to Covid. So that still seems like it would be in the early stages.

MS. BARRY: Yes, we implemented the new payment model in July, and, you know, it was a huge lift. It was a huge change and frankly relied on a lot of data and payment systems internally to OneCare being up and flowing well. So that took tremendous resources. I think it's going very well from that standpoint. I think a couple of decisions that our board made during the early days of the public health emergency made a big difference, so things like making sure that the organizations that had already kind of exceeded what their capacity target was and would be doing better financially in the new model were compensated for that, not kind of harmed through that process. So that was very appreciated by the number that were there.

You know, I think there's still lots to continue to learn about the levels of payments that are set, the nuances about, How do we understand ideal state of the

size of a care team? Because of the COVID-19 pandemic, I think there is still a lot we need to think about with care teams as one of the incentive payments when there is an annual care conference that happens, and we've modified some of our rules around that in light of the pandemic to say that it can, for example, happen virtually, even though, in a best practice scenario, that would be a live, you know, in-person event.

So I think, you know, we're on a good path. We asked some questions about whether there were immediate kind of tweaks or refinements we needed to make going into 2021, and the answer was, It's still early. Let us get used to this. We think it makes sense, and we think it's going to work, but let's watch as we move forward.

MS. LUNGE: Thanks. In terms of the Blueprint self-management programs, I have not been following their current usage as part of the Blueprint, and I'm curious if you know how many people are currently participating in that. Do you have kind of a goal or target for once that implementation shifts to you, and do you have plans to change the actual programs?

MS. BARRY: I'd be happy to follow up on some more specific in numbers and detail that I don't have

in my head, but I would say, globally, I'm really excited, because the overall strategy is to move from kind of one model that has been operational, which is a pretty intensive model which often has a lot of people falling out of it, because they can't necessarily make every meeting, or, you know, long, dark nights prohibit somebody from leaving their home, to one that provides options that can be well-coordinated through those decision-making conversations, say, with their primary care provider.

So for one individual it might mean one-on-one health coaching. For another it might mean group visits, as we've had in the past as the primary model. For yet another it might be trying out technology and really looking at how we might be able to do health coaching in a virtual environment, either synchronously or asynchronously.

And one of the key partners I just want to make sure to call out is that the health department has been really critical in this conversation and done some tremendous work. We're aligning through their 1815 grants, and they're actually providing some funding to OneCare as part of this overarching strategy next year to test some of those new electronic technologies and models and see if they prove really valuable, and then

it becomes kind of another conversation to say, How do we scale this up?

MS. LUNGE: Thanks.

CHAIRMAN MULLIN: Hey, Robin, before you ask another question, how many more do you have?

MS. LUNGE: A few.

CHAIRMAN MULLIN: Okay. I think that then this is a logical time to take a break so that we're not killing people who may be diabetic or what have you.

MS. LUNGE: Definitely.

CHAIRMAN MULLIN: So, at this time, we'll go into recess until 1:00 o'clock and resume then.

(A recess was taken from 12:33 p.m. to 1:00 p.m.)

CHAIRMAN MULLIN: Okay. Welcome back, everyone. So we left off with questions from Member Lunge, Robin, if you could proceed.

MS. LUNGE: Absolutely. Thank you. So my next question is around some information that you provided in the binder, which is in Section 3 of the, Section 3, which is ACO care programs, Page 17, relating to the Medicaid expansion population, and there was something that I thought was interesting in looking at this information that I wanted to ask you about, which is, so the Medicaid expanded population

are the groups of people in Medicaid who aren't attributable through a normal mechanism, meaning their primary care visits, and so the purpose of this program, as I understand it, was to engage those folks with primary care.

And what I was curious about in the data you provided is that 71 percent of them were considered high- or very high-risk, and so could you talk a little bit about that? Because I found it interesting that, if they're high- or very high-risk, you would hope that they had at least some connection with the health care system. Was it that they were seeking care but it just wasn't primary care, or do you have any sense of what was going on with that population?

MS. BARRY: Yeah. So this expanded cohort represents a whole host of individuals, from those who have received no care or services but live in a region all the way up through those who might be frequent users of the emergency department. They could have had an inpatient stay, they could be using mental health services, but don't have a primary care relationship.

And so I think one of the things we've learned in the first year of expanding this program is that there was a little bit of messiness in the data that we needed to work on between us and DVHA around this. And

so some of them might have had that relationship, it might have been a little bit older, and we needed to understand that better, but then in other places there's huge opportunity to facilitate and build those relationships.

MS. LUNGE: Great, thank you. I wanted to next turn to your proposal around the Blueprint and SASH level funding for the Medicare levels, and this is not really a question. I just want you to be aware of my position on this as one of the people who negotiated this model, but it's my -- in the negotiation we were able to receive additional funding through, in that first year, which we were then allowed to trend forward as part of the benchmark, and so I, I don't personally believe that you should be getting a trend on those dollars if those dollars aren't going to Blueprint and SASH.

So, to me, level funding means leaving those Medicare dollars on the table. You're welcome to react to that if you'd like, but I'll just be very clear that I'm not supportive of this particular proposal in your budget.

MS. LONER: Robin, if I could just say something, I think, to give some context to this. You know, we were supposed to get that trend in 2020, and

now we're looking at that trending clawed back in 2021. I understand that the Green Mountain Care Board is looking to try to restore that, but that has not been decided yet, and we won't know that until April of next year, and those dollars have already gone out the door to support that trend increase.

I'd also like say that for 2021 it's very unclear whether or not the, you know, Covid and the exogenous factors and any kind of trend adjustment will be applied in 2021. So to prematurely give raises while we don't know what will happen in 2020, nor do we know what will happen in 2021, doesn't seem fiscally responsible.

MS. LUNGE: Well, I appreciate your perspective, and I totally agree, Covid has really created quite a challenge in the benchmark, but I do think we have to disentangle that, because, if we're not investing the money, we're not getting the money from Medicare either so --

But, moving on, I was heartened to hear about the longitudinal care program, which the, the original test site in Burlington resulted in a savings of 1,150 PMPM, and to, to see in your binder that you're extending that to 6 additional health service areas. Can you tell us which health service areas will be included

next year?

MS. BARRY: You're going to test my memory, so it might be best if I follow up in writing.

MS. LUNGE: That's absolutely fine. Yeah. I'm just interested to understand better how the program will be expanding beyond the initial pilot site, as well as if you have any changes to it, but, certainly, you can follow up with that.

MS. BARRY: Great.

MS. LUNGE: I was also interested in, in the binder you talked about the levels of care coordinator turnover throughout the network and highlighting the importance of care coordination skill training over time to ensure that skill set is available in the HSAs. Could you give us a little more information about the turnover rate? And, again, happy to have you follow up with anything that you don't have off the top of your head.

MS. BARRY: Yeah. So, generally speaking, we've seen somewhere in the neighborhood of 120 to 150 positions turn over out of about 800 a year, which has been pretty shocking to us, but I think a lot of it is a competitive workforce. I think, you know, differences in reimbursement rates occur, changes just in preferences and so forth. And so our intention is

to try to really build some professional understanding and some true, like, enjoyment of this complex work at the local level, and one of the ways to do that is for OneCare to facilitate, not only the entrance level, you know, kind of skills and knowledge building, but really to create professional development opportunities.

And so one of the things that you might recall we wrote about in the binder is around providing an opportunity to bring in some national experts in case management and provide certification opportunities, and that's really being done in a train-the-trainer model.

MS. LUNGE: Great. In terms of care variation analysis, also in the binder you talked about how HSAs that exhibited a higher than average fee-for-service equivalent spend also had a higher than average inpatient spend driven by higher utilization of inpatient and higher specialty visit PMPMs. I'm, I found that interesting, and I'm, I just wanted to get a little bit more information about that. Did you also, did you look at sort of price variation and hold that constant in some way in looking at those variations to really drill down that it was the utilization of inpatient and, and not the, for example, the cost or the variations in the cost, hospital cost?

MS. BARRY: Tom, I don't know if you have any

other insights. Otherwise, I would just want to go back to our analytics team to answer that question.

MR. BORYS: Yeah, I think that's right, for more detail. We do tend to look at variation on both a PMPM and a PKPY, per thousand per year, basis, and the reason for doing that is sometimes you'll see a divergence where utilization is low but spend is higher, and that gives us the opportunity to look in a little bit more depth to see if there's something about reimbursement, and particularly with Medicare with so many critical access hospitals that are paid at a cost-based reimbursement, there's a lot of variation there that does need to be accounted for.

MS. LUNGE: Great. So any follow-up you have on that would be interesting to learn about. Similarly, in Tab 14 you've provided us with exhibits related to most prevalent conditions and then most prevalent conditions in high-cost patients, and I was struck by the fact that there was a lot of similarity between those two tables. So what can you tell us about what's driving then the cost of those high-cost patients? If it's not the, like, a particular condition, then is it the severity of the condition? Like, can you help me unpack sort of more meaning into those two charts?

MS. BARRY: So I think, briefly, this is a dissertation in and of itself.

MS. LUNGE: Yes.

MS. BARRY: So I think the one thing that you can't kind of let go of or lose sight of in any of these analyses is that many high-cost or high-risk individuals have multiple conditions, and so you really have to develop some pretty sophisticated models to try to break that down, but it's often the intersection of those conditions along with their social determinants and those social factors.

MS. LUNGE: Thank you. Well, perhaps we can have a follow-up conversation in lieu of a dissertation sometime, because I'd be interested in unpacking that a little more.

MS. BARRY: Happy to do it.

MS. LUNGE: Great. One other HIT question. Tom, you, in answer to, I think, one of Maureen's questions or maybe in your presentation, you had indicated that the, obviously, you get data sets from the payers and VITL and that the data there is only as good as you get. Does that -- should I take away from that that there are some issues with the data that you get, and, if so, could you speak to that?

MR. BORYS: Yeah. I think it's an ongoing

journey with the payers to make sure that the data that we're receiving is timely and accurate. That's just kind of regular business, and we want to make sure we get our data sets as early in the year as possible and we consistently get them so that we can do consistent reporting to our network.

In a little bit more of the finance space, it's just appropriate to recognize that our data is in some ways limited by confidential claims and other nuanced factors that sometimes make it hard to have the total picture. We have a pretty good chunk of it, but there are missing pieces due to 42 CFR Part 2, for example. So we're always working with the payers to improve the data reporting to make sure we have what we need, but that other piece is very relevant in the finance space.

MS. LUNGE: Okay, great.

MS. BARRY: I'd just add to that that a number of payers have made changes in data vendors and data platforms this year or last year, and so there have been some fairly significant, not only delays, but also new processes and systems to work through. So I think there's opportunity, as we turn to '21, to keep optimizing those processes.

MS. LUNGE: Great, excellent. Maureen had asked for your, your thoughts around the future of the

risk corridors, and I didn't think I heard an answer. So maybe I missed it, but I thought I would reask the question.

MR. BORYS: Oh, yeah, sure. Thanks for bringing that back up. It's hard to know what the future holds. It is clear to me that we are reducing risk corridors very much in response to COVID-19 and what it's done. I can say that we continue to believe that two-sided risk is effective. I think it garners much more attention from the population, from the provider participants.

But I do think it's also appropriate to consider the overall magnitude of risk that the all-payer model calls for, and these numbers will be general, but I've done some math in the past where, if we actually hit the scale targets as a state, regardless of whether it's all under OneCare or other ACOs, the magnitude of downside risk at the levels we previously had would be huge. We're talking over $150 million, and that's a conservative estimate.

So I, I think we need to factor that in as well, what's the appropriate level to balance reasonable accountability with the fact that we're a small state with a lot of rural health care that just doesn't have the ability to absorb a huge downside loss year. So I

think that's a space for, for us as a state to keep working together to figure out, like, how do we work with the payers and make sure that this is right-sized and appropriate, and I do think, if we stayed with the old risk corridors fully maxed out, we would be very heavily laden with downside risk, and I believe that would be a risk to participation.

MS. LUNGE: Thank you.

MS. LONER: I think, Robin, the short kind of answer is for the next couple of years, for 2021 and 2022, due to the uncertainty caused by the pandemic, I think you're going to see us shifting more towards less risk, but with less risk means less reward as well, and, if we're looking to grow, you need that reward opportunity, especially if you want to continue to invest in programs like we're, like we're investing in them right now. It's just, it doesn't balance out.

So after that I would say that we're going to be moving more towards higher risk and reward, but you have to make sure that you go into that with a network that's ready to take on higher risk and reward. So you have to be certain that they've made the necessary changes and investments themselves to be able to move to that next level.

MS. LUNGE: Thanks. That lends itself nicely

to my next question, which is the expansion of fixed prospective payments. I, when you were last here, I asked you how the pilots in the Blue Cross fixed prospective payment pilot was going. It sounded like it was going well. What, what is the future there? Are we expecting to see that go beyond the initial pilot site? When would that happen? What are we thinking about that?

MR. BORYS: Yeah. The report as of today is that the pilot has gone quite well, so pleased with that. Really, the, the couple things that we're working on is what's the design of the fixed payment, and there's different versions. There's reconciled fixed payments, unreconciled fixed payments. They, honestly, each of them have their own pros and cons. I think the reconciled version does have some benefits too. We are working on exploring expansion of this. It's in discussion with payer partners.

I will say one of my priority areas is to get the CPR, comprehensive payment reform, practices for commercial into this fixed payment model. We kind of run a hybrid where the public payers were capitated, private were in the model, but we've relied on the fee-for-service payments to round it out. That, to me, is a really important priority.

But we have evidence to believe and that suggests payment reform's been effective. The hospitals that have been under the true capitation have really showed positive performance there, and I think we need to keep it going. The more that we go back to some sort of a fee-for-service basis, whether it's for evaluation of performance or setting the targets, the more we go back there, the more linked we are to some of the flaws in a volume-based paradigm.

So more to come in that space as we discuss with the payers, but it's certainly a priority area for us to continue expanding the payment reform initiatives across the network.

MS. LUNGE: Well, I look forward to more information when your payer contracts are closer to final, but I hope to see some expansion in that space.

MS. LONER: I would just add, Robin, a little bit to that in terms of the fixed payment. I think that it's been operationally challenging to have fixed payments that are reconciled, and so, in terms of where we'd like to see a push, it's not so much an expanding reconciled fixed payments through commercial payers. We need to get Medicare, which is the largest chunk of dollars, in a truly fixed payment mechanism, because it doesn't incent providers to do really well and then

have it clawed back at the end.

MS. LUNGE: Yeah, I hear you, but Medicare needs 18 months to do any sort of operational change, so that sort of change is not going to happen quickly, even if they were willing to do that, quite, agree to that tomorrow. So I think, in the meantime, there may be more opportunity to actually expand in the commercial sector. So that's just my two cents on that, but I don't disagree about Medicare. It's just Medicare's slow with, in terms of operationalizing.

MS. LONER: Yeah, I know, and I would just say, from the providers' perspective, they need to get some signals that they're actually going to do that and that 18-month clock is going to start ticking.

MS. LUNGE: All right, okay. That's interesting. Thank you. In terms of the self, the Blue Cross Blue Shield Primary, I know that self-insured employers have the opportunity to decline participation, because they are self-insured employers after all, but I was curious how that impacts the attribution and the model, because that was not particularly clear to me from the provider agreement or the payer contract, which I just barely got last night, so I haven't thoroughly digested it. Can you explain that?

MR. BORYS: Sure, I'll give it my best but look to Sara and Vicki also on this one. It's really one program, overarching program, and then the lives are then divided into the two groups. So my understanding of the way that Blue Cross manages on their end is, once they've received word from their employer health plans who is participating in the value-based model Blue Cross is offering to them, when they run the attribution, they'll say, Okay, this employer group decided not to be in a value-based care model. Put the lives here. This employer group did decide to be in the value-based care model. Put the lives here. For the lives that are in the non-value-based care model, we don't --

MS. LUNGE: You mean the non-risk model, right?

MR. BORYS: Non-risk model, yeah.

MS. LUNGE: I just want to make sure, because that's the terminology that was used in the binder, so --

MR. BORYS: We do not receive data for those, so they're completely anonymous. There is a PMPM that comes to OneCare for those lives still based on the way that Blue Cross designed their programs so that the same $3.25 PMPM comes through to OneCare for those

lives, but we have no financial accountability for their care and no access to data.

For the lives that are in the risk model, it looks much more like the other programs. We get access to the data, and we have financial accountability for cost and quality.

MS. LUNGE: All right. I am almost done, believe it or not. My last question was related to one of the materials we had asked you to submit from the last budget, which is the patient reengagement quality improvement tool kit that you and Blueprint and Blue Cross Blue Shield developed for the Blue Cross Blue Shield Primary Program. I was curious if you or Blue Cross have any way of tracking whether or not providers are using it. I took a quick look at it, and it seems like it's both short but also pretty good in terms of getting people thinking about the care redesign in a short-and-sweet document, but do we know if people are using it?

MS. BARRY: We do know that there were eight or nine practices early on that engaged around that process. Frankly, I think with Covid a lot of things got put to the side.

MS. LUNGE: Sure.

MS. BARRY: Plenty of opportunity for us to

look at reengaging folks around that.

MS. LUNGE: Okay, great. All right. Yeah, that sounds good, because it looked like a good tool. I just wasn't sure if people were taking it up. And that is my last question.

CHAIRMAN MULLIN: Thank you, Robin. Member Holmes, Jessica.

MS. HOLMES: Great, thank you, and thank you, OneCare team, for the presentation. I have no doubt how much work you all put into putting together that binder, and, rest assured, we've been combing through it and will continue to do so. So it wasn't a waste of your energy and efforts to do so. I also just want to, you know, thank my colleagues for asking a lot of the questions that I would have asked, and so it's kind of nice to go last or almost second-to-last.

CHAIRMAN MULLIN: Next-to-last.

MS. HOLMES: Yeah, second-to-last. But I will echo some of their concerns without reiterating them around the new risk model. It's not clear to me that it's aligning risk optimally or that it's going to incent the type of behavior that we all hope to see, but I'm just going to say that for the record there.

Also, echoing Tom's comments about needing to see more ROI metrics, I think it's really important to

understand the value of the ACO and actually to quantify the value of the ACO. So the more we can see of that, I think it's better.

And so, I guess, my first set of questions is building on what Robin just asked but in a bigger way, and, again, it's about assessment. So OneCare is spending the majority of its operating budget on data analytics, care coordination tools, clinical consultations, you know, dissemination of best practices, these kinds of tools and reports and data analytics going out to the provider network.

So my question to you is, Can you talk about if and how you're doing a comprehensive and systemwide assessment of the value of these tools? You know, does the value of these tools vary by provider type? Are they using them in significant ways? How do you know how often they're using them, the value of them? What have you learned?

I'm trying to get a sense of -- we have been hearing mixed reviews on some of these tools, whether the data is coming too late or the data is not sharing information that providers really need. They already know who their high-risk patients are. There's a whole bunch of things we anecdotally hear, and some communities, as we've heard, love the care coordination

model, Care Navigator.

So we're hearing lots of different stories about the types of tools that the ACO is providing. So I'm wondering what kind of comprehensive and systemwide assessment you're doing and what you've learned about these tools. It would be helpful to hear and see the results of.

MS. BARRY: This is Sara. I can start by saying, you know, there are a lot of metrics that we are tracking across, not only the, you know, the way care is delivered, but thinking about the way that we are supporting those programs, and some of it is still very early and way too difficult to draw any conclusions yet.

So, of course, we're looking at things, as we've reported to you, like care team composition and how frequently, say, care team members or lead care coordinators are coming from primary care versus a home health agency, and there's some new learnings in that that are starting to emerge. We do look at utilization of different tools, and I think we've gotten much closer to a feedback loop with our providers around how to enhance those.

Having said that, OneCare does not have -- I'll speak transparently. OneCare doesn't have the

resources to do an in-depth systematic evaluation, and we had actually hoped in our pre-Covid budget to hire an evaluation expert, somebody with some more of that experience, and that had to be put on the shelf in light of some of the transitions that had happened because of the pandemic.

I think it's a huge opportunity, and one of the things we hope to see emerge from that is, through the federal evaluation of the overall model and approach, that we can start to learn some of those key areas as well. Having said that, there's always more that could be done. It's a matter of balancing resources.

MS. HOLMES: Yeah. I mean, just a quick question, then, on follow-up with that. I mean, there are low-cost ways to, you know, using simple tools like Survey Monkey or things like that, that just get out and get a little, you know, sense and assessment of how providers are feeling about the tools. Has that, anything like that been done across the different, even a random sampling of different provider types to do that kind of assessment?

MS. BARRY: Yeah, so there's a couple things we focused on this year. We actually are just compiling the results of a Survey Monkey tool of all of the local care coordination staff where we asked them a

whole series of questions kind of about what's working, where could we improve things. And so the team will really be focused on analyzing those results. They were just downloading them last week. And we're committed to making actionable change and being very transparent about what we're doing in response to that feedback.

Another area that's just emerging through our primary care work group is to work to better assess current feelings, beliefs, and perceptions around the patient-centered medical home NCQA framework, because we continued to hear everything from, The new system works beautifully, to, It's the worst thing in my life, and, you know, causes all sorts of administrative burden. And so we want a more systematic way to figure out what the current state is and, therefore, understand what role, if any, should OneCare play in that dialogue moving forward.

MS. HOLMES: Okay.

MS. LONER: Sara, I would just add to what you said. I think it goes back to the theme earlier is that we are a provider-led organization, and so that means we're listening to the voices of our providers each and every day, and we have very structured governance committees to be able to elicit that

feedback and to help them help us design what they need in order to be successful, and so that's an ongoing, it's not a formal assessment, but it's an ongoing assessment and evaluation, and it's, nobody is ever going to be happy with everything that you do in thousands of providers.

We have thousands of providers in our network, and part of it sometimes has to, comes down to is, you know, we have responsibilities as an ACO to provide data to you, to provide data to our payers, to provide evaluation, and, if we don't have a tool to be able to measure that, then we can't give it to the people that are asking for it.

So I think that's part of a thing that has to be looked at is, Are the expectations that are put on us as the ACO realistic? Because they do get passed down to the providers of OneCare to be able to report on that information, and so I just think that needs to be part of the larger discussion of, How do some of these oversights, whether or not they be OneCare oversight, payer oversight, regulatory oversight, what is the cascading effect of that on the OneCare network?

MS. HOLMES: Fair enough. Quick follow-up question. You talked about the governance and the committees and how that's a mechanism by which you can

gather insights from your users, and I'm just wondering. Do you feel as though the, the, the committees that you're gathering those insights from around the value of these tools is representative of your provider network so you're hearing truly the voices are really being heard and represented on those committees?

MS. BARRY: I would speak to that a bit and just say we very deliberately structure them. So, while we have committees that report directly in and make recommendations to our board, we then have subcommittees under those like primary care, clinical and quality, a lab committee, and so I think we've built a nice structure, and at kind of the bottom of that pyramid it's very inclusive. Anyone can come, and so it creates plenty of opportunity for that.

I also think, as we have gotten more experienced, for example, the chair of our population health strategy committee has been very intentional about creating some open space to make sure we are not just kind of working our way through an agenda but also hearing about, what is top of mind, what are the concerns, how might we, as an ACO working together as a system of providers, be able to address those issues.

MS. HOLMES: Okay. My second question is a

little bit of a follow-up, again, on assessment. But thinking about the CPR program, to some degree, I think about this program as a microcosm of what we might hope we might be able to see at the statewide level, right, more capitated payments, more predictable and fixed payments to providers. So I feel as though there's a lot of lessons to be learned there.

So what can you tell us, any recent updates on how, for providers that have been in the CPR program for multiple years now where you have, you know, several years of data, what can you tell us about how the total cost of care has changed for those providers, how their delivery of care has changed? How do you think about the lessons that we can learn from that particular model? Are we seeing the process and investment type changes that we would hope to see on a larger scale if we were actually to get true capitated payments?

So on both the cost and on the quality, I don't necessarily anticipate that we would see outcomes changing to some degree, because I think it takes time, but are we seeing the process changes and the investment changes that would then lead to the population health outcomes that we would hope to see in a few years? Can you talk a little bit about that?

MR. BORYS: Yeah, I can take a little bit of this one. I don't have a full analysis prepared, but I can speak to what I've heard, so this is third-party, but many of the practices have used the financial resources that come their way through the model to bolster the services that they can provide in their primary care shop.

So adding behavioral health for even a day a week, if you can do it with the resources here, helps them provide a more robust point of care. And we've also seen evidence of more group work, diabetic groups getting together, all of which is afforded through what we hope is some additional financial resources, but, more importantly, a different way of being paid for the work that they do. So I think there are some good stories, good examples of the ways that the practices have used the flexibilities afforded under capitation to do some new things.

What is also a little bit of a -- we just need to recognize that this is a piece of their business still. So it's not as if we can fully capitate their whole practice, which would be awesome, and then they could really go do some different work. So there still is a little bit of the foot in two canoes issue that we hope to address over time, but, overall, I think, at least

what I hear from the provider community participating is this model has been a better way for them to be paid and, and has afforded them some opportunities to do some things they wouldn't have been otherwise able to do in fee-for-service.

MS. HOLMES: So I guess I would follow up with stories and anecdotes are great. Is there a plan to do really an evaluation? And I understand that it's not their full practice, their full panel isn't it in it, but, you know, is there a more comprehensive assessment that you're planning on doing?

It seems like this is a place where we can really learn a lot and where the experiment is, you know, potentially could be scaled up if we learned what were the successes, what were the obstacles? Did we really see the delivery system reform that we anticipated payment reform would lead to? So is there a plan to do a more comprehensive, really true assessment beyond anecdotes and stories and things like that?

MR. BORYS: I think, back to Sara's point before, the position that had to be shelved for budget reasons hinders that, but we can take that back, for sure, and think about how we might explore something with the CPR practices to do such an evaluation.

MS. HOLMES: That would be great. I think

there's a lot we can learn there.

MS. LONER: A more formal evaluation -- sorry, Jessica -- this year, but then with Covid coming in, some of the practices said to us, We can't take the time to, you know, go through this data and do the manual extraction that's needed on the quality measures that you're looking at. And so we said to them, We understand. You need to take the time and attention you need to pay attention to your patients.

And so that was one of the things for some of the longer term, because, remember, there's been only a handful of practices that have really been in this since the creation. Most of our growth is going to be happening next year, so we have to take it from the framework of looking at those that have been in it the longest and what have been some of the intentional changes that they've made. And, again, it was planned for this year, but it requires the practices to do some heavy lifting, and it just didn't seem the time to ask practices to do any more heavy lifting to do this evaluation component of it.

So it's something that's certainly been on our mind and that we want to revisit when practices feel like there's maybe a little bit more predictability in their life and they're not worrying about closing their

doors. So and I'm sure you get that. I'm sure you've heard that.

MS. HOLMES: Understandable. I do. I just think that's that a unique opportunity to do some kind of analysis, you know, three years before they joined, three years after they joined, what are we seeing? How is it changing? Because we're relying on this, you know, theory and some evidence from other places, right, that payment reform leads to delivery reform. We have a little bit of an example here. Is it working or not, I think, is really important.

Vicki, you had talked about the need to start acting like a system of care to be successful, and I could not possibly agree more with that statement, and I think, you know, OneCare is uniquely positioned to help move the state towards a more collaborative system of delivery, uniquely positioned because you are the network of most of the providers in the state. You know, people think of OneCare as this separate entity. It really is, as you've said, all the providers, not all, a lot of the providers in the state across the care continuum.

So you are that network of providers. Those providers, your providers, have jointly agreed to be accountable for cost of care and quality, and you have

the data and analytics to highlight where we might have overutilization, where we might have underutilization, where low-value care is being delivered, where high-cost care might be better delivered elsewhere. You have all the tools, you have all the people, and you have the incentives in the sense that everybody has jointly agreed to be accountable.

So I'm wondering how -- you know, we're doing a lot of work with our hospitals right now on sustainability planning to start to think about how hospitals can, can imagine their service lines in this future value-based world, right? They all have service lines right now that are reflective of a fee-for-service environment. We're shifting to a value-based environment, as we all know.

So how can OneCare help the hospitals in its network, right, the hospitals that are already in its network, for which it has the data and the analytics and the tools to help them think about optimizing their service lines, expanding transportation, expanding referrals between hospitals so that we can make sure that we are all ready for, you know, value-based payment but, more importantly, so patients have access to the highest quality care at the most appropriate setting at the lowest cost?

What is the -- how do you envision OneCare's role in, in making this all happen? How much influence can you have?

MS. LONER: So, you know, I really think it comes down to being able to, you know, apply those incentives and to apply that accountability in a more broad way, and we also have to think about, like, what's the effect, too, of all the different moving parts on, Is it better to be in value-based care, right, and that's not just kind of a OneCare decision, or, Do I do better financially by just churning out fee-for-service? Because some providers do a lot better just by working on fee-for-service payment, right, and they can't imagine going to a different world.

And so I think our job and what we've heard from our network over this last year is, Tell us where we need to do better. Like, we're no longer in a place where the ACO is developing priorities and we'll do them, you know, we'll focus on them, but we'll also have our own core set of priorities that we want to focus on.

They're really at a point, too, that they want to be able to narrow their focus and see the opportunities of where they can do better, and, you know, it's, I

can't, I can't say with more, like, enthusiasm, like, how incredible it is that we have this network of providers who sit around the table and talk about how skilled nursing might be impacting the patient care, and they're literally sitting at the same table, well, maybe not now literally, but they're in the virtual room together. Like, that's incredible just in and of itself.

Providers before were only talking about what impacted their own revenue stream. They weren't talking about how what they're doing is impacting one another, and that's because we're changing the incentives, right? Fee-for-service incentivized you to just care about what you were doing in your facility, versus value-based care that says kind of all boats rise and fall together. And so, if we're going to be taking on collective risk for our community, we have to be able to think a little bit differently.

So the shorter answer is I think the data and reporting are really kind of spotlighting, I think somebody called it, where those opportunities are and then seeing what kind of tools and resources they might need to really be able to drive those home in a meaningful way.

MS. HOLMES: Well, I think the HSA-level

analysis that you all mentioned earlier that's going to look at cost and quality differences and variations and having those conversations, I think, is a huge step in the right direction, and I applaud that, because we do know there's variation.

So my last question, I know it's shocking, but so many people already asked so many of the good questions. So I just wanted to ask a little bit about participation. I did notice a drop in specialists and continuum providers, and I wondered if you could speak to that. This is a small 5,000-foot question, but I am curious. And do you do exit surveys to find out why providers who were once in the network are choosing to exit the network? What can we learn?

MS. LONER: I think one of the probably largest areas where we see providers exiting is those specialist providers and that are not part of a larger health care system, so just automatically come in because their parent organization has joined the ACO, and I think what we've struggled is the ACO is really kind of primary care focused. There are specific core accountabilities that we had, and specialists, by their nature, are specialists. They have many different things that they're thinking about and delivering on, and there's just not that many models we can create for

the small number of specialists that we had, and, you know, there's only so much money to go around too.

So they have to think about, in this value-based care, is that quality incentive they're getting from being part of OneCare really worth it to be part of a value-based care system or not. So I think that's one of the struggles we've had with specialists is, by nature, they're specialists, and they do a lot of different things, and our core programs don't really focus necessarily on their particular specialty.

MS. HOLMES: Are there data analytics that would entice them to join in the sense that, you know, one of the things that we talk about is, you know, if you're an individual provider, you don't have the resources to build the analytical system to be able to, you know, understand your outcomes for your patients, but being a part of an ACO, you can, you can benefit from that infrastructure. So, for specialists and some of these other providers that may not have the financial incentive to join, are there data analytics tools and other things that the ACO can offer that would entice them?

MS. BARRY: I think, just to take a swing at that, for some of the larger specialty groups which tend to be affiliated with hospitals, they've taken

advantage of some of the data and analytics to ask some really interesting questions. I don't recall us receiving that type of outreach from some of the smaller independent specialty groups.

And I will just say I was a part of many, many conversations in 2019 and into 2020 where we tried to figure out some commonalities where we could identify some core metrics that, regardless of specialty, might make sense or at least for a subset, and that was a lot of hours we won't ever recover, and we really didn't get to a place other than to say it's unique.

And so you can start to think differently about referral patterns and, you know, E-consult models and things like that that can be very valuable, but we came back to needing to focus on primary care as the cornerstone of the model, saying that those challenges with specialty care might be something we need to tackle further down the road.

MS. LONER: I had, Jessica, early on met with a couple small cardiologist practice, independents, and, you know, their specialty area, even within cardiology, was, you know, very narrow, so the data that we could provide to them on a handful of their patients just didn't make it worth their -- not that they didn't think that the work we were doing was good.

It just wasn't a value add to their particular practice.

MS. HOLMES: All right. Those are my questions. I'm going to turn it back to Kevin, who does get to wrap it up for us. Thank you.

CHAIRMAN MULLIN: Thank you, Jess. Tom, I'm going to start with a couple of expense questions and go from there. A couple years ago, the legislature did change the way a billback is calculated, and you certainly should have seen a significant increase between '19 and '20. There are no changes that I'm aware of that would change that from '20 to '21.

So is this a timing issue? Had you incorrectly budgeted for '20 and so it shows up as a significant increase for '21, or what, what's driving that?

MR. BORYS: Part of it's that our fiscal years are asynchronous. We're on the calendar year, and, if I understand correctly, the billback's on the state fiscal year, so that's a piece of it. We also just have a schedule from maybe a year or two back that we relied upon for the estimate here. So, if there's more up-to-date information, I'd be happy to see it.

CHAIRMAN MULLIN: Well, I think that because next year's budget hasn't been approved yet, but knowing that, all across state government, it's going

to be less than probably this past year's budget, that you should assume that there will not be an increase in what you were billed for this year to next year.

MR. BORYS: Great.

CHAIRMAN MULLIN: So I don't know if the number that you were using there is the actual number you were billed this year, but that would be probably your best-case approximation for next year.

MR. BORYS: Great, thank you.

CHAIRMAN MULLIN: So on, let's move to occupancy costs. Who owns the building that you're in?

MR. BORYS: It's a leased property.

CHAIRMAN MULLIN: Who owns it?

MS. BARRY: A company called Apple Bay.

CHAIRMAN MULLIN: Okay. Are you in a sublease?

MR. BORYS: I'd have to look at the technical nature of this arrangement. It's leased by UVM Medical Center, then we occupy the space, but whether it technically is classified as a sublease, I'm not quite sure.

CHAIRMAN MULLIN: Well, Tom, you mentioned that most people are working remotely, and we've seen throughout the hospital budget process that we've heard repeatedly that some people may continue to work

remotely, and it may result in a reduction in the amount of space that's necessary. Have you had any conversations about reducing your footprint?

MS. BARRY: We actively have had conversations both with our staff and leaders around what the model could look like, as well as thinking about the real estate expense. Our, we are in a window over the next months where we will be renegotiating that space, and we're looking at all sorts of options right now, including how we could reduce costs.

CHAIRMAN MULLIN: Great. You talked about the increase in salary and benefits, and so I want to focus a little bit on total compensation for a second in a year where many organizations have put in freezes and, in some cases, cuts even, and you talked at the start of the pandemic about having to make cuts. What's the average percentage increase for your personnel from '20 to '21 that you've factored into this budget, and when would that increase take effect?

MS. LONER: 2 percent, right, Tom, next year? Next year, 2 percent.

MR. BORYS: Yeah.

CHAIRMAN MULLIN: When you say next year, are we talking January 1?

MS. LONER: Yeah, that's our calendar year.

CHAIRMAN MULLIN: Okay. And is that across the board, are there some anomalies in there?

MS. LONER: It's just what we've factored in. Should be across the board.

CHAIRMAN MULLIN: Okay, okay. I just want to ask one follow-up question on occupancy costs, and, Sara, you seem to have the best handle on this. How far into the future are you locked into the current status?

MS. BARRY: April of '21.

CHAIRMAN MULLIN: April of '21? Okay, great.

MS. BARRY: In conversations right now.

CHAIRMAN MULLIN: Okay. OneCare Vermont was formed to try to create and actually achieve some incredible goals and to benefit a lot of different individuals, and I would put the different, if we're going to use the bucket scenario, the different beneficiaries into three buckets. I would say the most important bucket from my viewpoint is consumers, but the other two buckets that I see are providers and payers.

Looking backwards, what do you think is the single most important achievement that your organization has achieved to benefit each one of those buckets? And you can start with whichever one you prefer.

MS. LONER: I would say, Kevin, by the fact that we had over 2,000 providers participating with over 288,000 Vermonters attributed, that's a pretty significant job we've done, and, when I say "we", I mean the, the providers that are part of OneCare. I don't mean OneCare centrally.

CHAIRMAN MULLIN: Yeah, I acknowledge that, Vicki. I'm just trying to pinpoint what you think for each of those categories what was the single most important thing that OneCare did for the consumer, that OneCare did for the provider, that OneCare did for the payer?

MR. BORYS: I think there's actually quite a long list here, but I'll go with what comes to mind first, and I don't like to speak for anybody else, but I'll tackle the payers first. I try to put myself in the shoes of the payer pretty often. Why would they partner with OneCare for this work? And the risk transfer is the answer, that all, all health care insurers have essentially a budget in some way or another. It's either a big federal budget, or it's their own budget funded by premiums.

Without this relationship, they have health care cost risk. If health care claims go up, they have to eat that in some way or another or go back to the

legislature for more money. The ability to offload some of that health care cost risk and the risk management activities to an ACO is incredibly valuable. If I were on the payer side, that is something I would be engaged in as much as I can to stabilize my own business, to stabilize my own financial paradigm. So, from the payer standpoint, I think that's a really important one is that, just like we say it helps to stabilize health care revenues for the providers, it does the same thing on the other side for the payers.

For providers I think the list is, is long of what we've done for them. In the financial space, really, the amount that we've been able to invest in front-line providers to, to focus on value-based care activities, ACO activities over the last few years, is tremendous. I just can't underscore -- somebody's voicemail.

CHAIRMAN MULLIN: If you could mute yourself, that would be great.

MR. BORYS: So, from the financial standpoint on the provider side, the amount of financial investment to make these changes is pretty incredible when you add it up over the last few years.

And then consumers, this one is very much there, but it's a kind of a by extension. OneCare, we don't sit face-to-face with the consumers on a day-to-day

basis, but what we try to do is give those who do, the front-line providers, financial resources, tools, data, best practice information to help them more effectively treat the patient in a wholistic way.

And does that, is that obvious for a consumer? Maybe sometimes it is. Maybe sometimes it isn't. But I think that is a really important thing that we've done over the last few years is really get the providers to start thinking about population health, value-based health, and that stands to benefit consumers directly.

MS. BARRY: If I could just add to that last bucket on consumers with a couple of really tangible things as well, you know, I think our care coordination program and the fact that more than 800 care coordinators that, in working with individuals across the state, they would not wear a OneCare badge; they would represent their organization of whatever type, and so it might be not be completely recognizable to the consumer, but it's there, and it's tangible, and it's creating real relationships and real value.

Similarly, I think the laser focus on quality of care in areas where there's real opportunity to improve creates better health care delivery and better outcomes for Vermonters.

I think the benefit enhancement waiver, so the classic one there that we've spoken about before, is the skilled nursing facility waiver. That's real value to be able to go directly from your home into a skilled nursing facility if that's what's right for you. And then, finally, making sure that there's more of a focus on prevention and wellness, and so really shifting to that true view of population health, not just acute care, I think, will result in tremendous value from consumers' perspectives.

MS. LONER: I think that most of it -- I'd also just like to add on top of this. I mean, the two big things that the ACO is trying to accomplish is delivery reform changes and payment reform changes. So everything that Tom and Sara had mentioned fits into those two buckets, and, really, when you do that right, everybody benefits from it. Patients benefit from it. Providers benefit from it. Insurers benefit from it as well. And so that's, that's the work of the ACO.

And this isn't, like, ACOs aren't a new thing. ACOs are nationally recognized, and that's why they are the reform vehicle that Medicare has chosen, and so I think it comes back to the point that Vermont's not unique in forming an ACO, that this is something that the federal government has recognized as the right

vehicle to move health care and delivery reform programs.

I think the one thing that is very unique to Vermont is, because of the participants in OneCare willing to take on financial risk, we've been able to continue eight-plus million dollars in funding of state-led reform programs, such as the Blueprint and supports and services at home. That's not something that's offered in any other state.

CHAIRMAN MULLIN: So, as a follow-up to this question, if you take a look at what you've already achieved, looking forward to your '21 budget, what do you think is the most important goal that you could achieve that would benefit these different buckets, consumers, providers, and payers? What do you hope will improve upon or be done differently in '21 that will add great value?

MS. BARRY: I can start from the bottom up, kind of the reverse direction. With consumers, I think it's a laser focus on our care coordination program, and, as I spoke to earlier in kind of the up-front part of that program, it's using our data and our learning to hone in on where we might have gaps in identifying and appropriately outreaching some subgroups of individuals at high risk, and then, on the other end of

the spectrum, really starting to understand more about how to successfully graduate individuals from that program but not drop them off a cliff, so figuring out that step-wise approach to continuing to provide supports but also transitioning people to independence.

For the provider level, I think it's really focusing on the data and analytics, the spotlights and insights that we've been talking about throughout our conversations today, and so that it's not about the quantity of data available to providers, but really the quality of data that can drive that decision making and that action very quickly. And then, Tom, I might turn it to you for the payer one.

MR. BORYS: Well, I think the, the one area, that last one you mentioned benefits everybody, all the different stakeholder groups. In 2021 I think we have to have and find the capacity to go deeper with our analytics to help the providers understand what can they do differently, what are their areas of opportunity, and that's not easy work, but, to me, that's, if we're successful in that in 2021, we should see better coordinated care for those, those consumers who need it. We should see good total cost of care performance, and, frankly, that benefits both providers in shared savings, and it starts to benefit the payers

through more stable health care costs. So, to me, that's the main area of focus is making sure that we can really serve our providers and help them do well in this model as priority 1-A.

CHAIRMAN MULLIN: Tom, I'm not sure if it was Slide 2 or Slide 3 that you put up, that had a very big breakdown of, of the buckets of the dollars, and you had the administrative costs at 1.1 percent. Directly above that, you had the line "Network Investment Payments". Can you talk to us about what those are?

MR. BORYS: I just want to make sure. Do you have the slide number?

MS. LONER: I think, Kevin, you're talking about the $30 million in network investments. Is that what you're talking about, the 2 percent, which is all of our --

CHAIRMAN MULLIN: Yeah, it was one of the very first slides that you had up on the screen.

MS. LONER: Yeah. So that's all of our population health program investments. That's SASH. That's Blueprint. That's the value-based incentive fund, care coordination, patient centered medical home payments, longitudinal care, DULCE. I think there's a whole list of them in there, and that all goes directly out to the provider community. None of that is

administrative, although OneCare is the entity that is responsible for designing the programs, evaluating the programs, reporting on the programs in terms of both clinical and fiscal accounting through internal and external audits.

CHAIRMAN MULLIN: Is there one of those population health programs that you just were wowed by the results on and that you've increased your, your resource allocation to because of that?

MS. LONER: I would say we've seen our -- and I'd look to Sara for this, but I think we've seen the most progress, because it's probably one of our longest running programs, in care coordination, and, now that we've started to change the payment model, we've seen the level of engagement in that program go up significantly.

MS. BARRY: Yeah, I would agree with that. I also think all the changes we've spoken about in the quality arena, some of the work, early work with longitudinal care is incredibly promising, and we're excited to see where that goes into the next year, but all of that has to be put in the context of a really tight year in 2021 in terms of where we have funding availability, and so we've tried to fund the things that we think have the highest potential.

CHAIRMAN MULLIN: And, lastly, the initial seed dollars that were put up by the founders, primarily one founder, how are those treated on your income statement?

MR. BORYS: Well, they're, both founders have a base capital contribution effectively that was $50,000. So it shows up in the equity section. The way that the initial founders' contributions kind of worked in the early formation years of OneCare were that they funded operational costs to help develop the, the organization. So those were spent largely in the early years, the 2014, '15, '16 years, but what remains is that initial capital investment of $50,000 each as their equal stake in OneCare Vermont.

CHAIRMAN MULLIN: Okay. So that's the questions that I had. I'm going to ask staff, before I turn it over to the Health Care Advocate, Alena or Marisa, do you have questions?

MS. BERUBE: This is Alena. I have one question -- I feel like they've been pretty robust so far -- if you can hear me. So you explained that this is not a GAAP-based budget, and, as you know, one of our questions is, Can you provide a GAAP-based version of this budget and help crosswalk and help us understand what's in and out of the proposed budget?

So we'll look forward to that, but can you talk at a high level some of the flows that occur between OneCare and the founders, in particular, UVM, given the shared services that kind of flow through your organization?

MR. BORYS: There's, there's really not a lot, and the, the relationship with UVM Medical Center is basically that they, their PR, or not PR, HR attachment point. So we're all employed by the UVM Medical Center, and then each month they charge OneCare the salary costs of all the employees that work for OneCare, and then we handle that through just regular intercompany transfers.

You know, outside of that, we're a pretty independent organization standing on our own two feet, and if we do have a charge or a bill that UVM pays on our behalf -- sometimes they do AP checks for us -- we reimburse UVM through those same means where they say, Yes, we paid this on OneCare's behalf, and it goes through a monthly process that our accounting teams have to settle that up, and then we process those through due to a due from account.

MS. LONER: I don't know if the board's aware, but we undergo an annual financial audit by PWC, and all of those audit results from the last couple of years are available on our website.

MS. BERUBE: Yeah, that's a condition of the budget order, to share those with the Green Mountain Care Board, so we do look at them, but we are unable to tie those audited financial statements to the proposed budget. So I think that's why we're looking for some additional detail, to understand how what you're proposing here ties to those audited financial statements. Thank you.

CHAIRMAN MULLIN: Marisa, did you have anything?

MS. MELAMED: I do not have additional questions that haven't yet been captured today or in our written questions. Thank you.

CHAIRMAN MULLIN: Super. So, at this point, I'm going to turn it over to the Health Care Advocate. I'm not sure which one of you is going to be doing the questioning, so whoever.

MR. FISHER: I imagine, when I start speaking, my image will pop up on your screen.

CHAIRMAN MULLIN: Hi, Mike.

MR. FISHER: Thank you. Thank you for the presentation, and thank you for the great questions from board members, and I also want to thank OneCare for taking the time to meet with us previously. Was that last week or the week before? Vicki and Sara and

Tom, that really did help, help us out to have that time to speak. And then I'll also just say I thank you. I'm looking forward to the opportunity to sit down with your patient advisors in early December in a supportive role to support them and support you with that effort.

So I do, I need to ask a -- racial disparities, I do need to steer us towards racial disparities, given the public conversation and given some of what we know from the Department of Health about how racial disparities show up in Vermont's health care landscape, and I don't know whether -- and we are not measuring OneCare in any way on this factor, and I don't know whether OneCare has entertained or would entertain, but I, work in this area, but I think it's something that we all need to focus on, and I would welcome your thoughts about how to address provider practices that lead to racial disparities in our health care system.

MS. BARRY: Thanks for the question, Mike. We're actually really excited to be diving into this area more with our provider network. We have some limited demographic data from some payers that we were able to start to take a look at as this national conversation really took center stage, and, and it showed us some really interesting things. I would say

nothing that was tremendously disparate from the types of data that the health department would have available.

But, more recently, we've had some providers coming to us asking to help look at specific gaps in, let's say, quality performance, so rates of mammography screening or colonoscopy by geography, by racial demographics, etc., and it's starting to show some, you know, potentially provocative things, and so we're just in the early stages right now of providing that back to those groups so that they can have the conversations about how they can develop some programming and maybe some more either targeted outreach in the case of some of those screenings or maybe need to think differently about access to services and how to create more culturally accessible care. But I'm, I'm thrilled by the question and really excited that OneCare can play a small role in that.

MS. LONER: And also, Mike, just for your information, because you're going to be meeting with some of our boards and committees, at least our Patient and Family Advisory Committee, we've engaged with a consultant, Steven Graves, to help us to understand how we can do better with our boards and committees and making sure that diversity, equity, and inclusion is a

part of our process, so helping us to understand initially where we are with our boards and committees, where there's gaps in opportunities and what some other recommendations that they could provide to help us do better, because we can always do better around this work.

And so we have some really engaged board members who have been working very closely with Steven on this, and we're hoping to roll out the initial survey to all of our boards and committees over the next few months and start to look at some of those results in December. So some very initial work, but I think, to your point, really important work.

MR. FISHER: Great, thank you. So fixed prospective payments have been celebrated during Covid as an important tool in stabilizing the flow of moneys to providers when people weren't getting care, you know, due to the pandemic when providers were not open for business. For me, this shines a light on an apparent conflict that I want to ask outside of the Covid dynamic or maybe in an aspirational way post-Covid.

You've said a few times today that you're a provider organization. In an environment where providers are under financial stress, how do you

balance the financial needs of providers and the goals of reducing systemwide costs of care and the costs for consumers? I, I'm playing a little bit with language here. You provided a quote saying that, earlier today, that OneCare is stabilizing Vermont's increasing health care costs.

Now, I know nobody is trying to stabilize the increasing health care costs, but providers are under stress, and I have to imagine -- and providers do regularly ask for increases for obvious reasons. So how do you deal with this apparent conflict, and how do you do both, provide a stable stream for providers and, and reduce the costs of care systemwide? Can you do both?

MS. LONER: Yeah, I think you can, Mike. I really do. I mean, if you think about the work of the ACO, and I think Tom and Sara both said this earlier, what we're doing is providing predictability to providers and predictability to insurers that should translate longer term right down to the patients that are, or the employers that are purchasing the health care.

So, when you go into a contract with an ACO, you're locking into a fixed amount of money, and regardless of how many services are rendered, everybody

can know that that, that budget is in place for the rest of the year, and so I think that's one of the real values. When we think about the all-payer model and the budget process we're going through this year, when OneCare accepts these total costs of care targets with the payers, we're saying, This is going to be the cost, so we're locking in the savings.

So I think that's, you know, one of the questions that asks all the time is like, Where is your return on investment? We're locking in the savings for health care right up front. So, if there is excess savings or excess loss, sorry, then that is borne by the providers and so that there still is that predictability for the payers at the end.

MR. FISHER: So forgive me. I, you know, I'm coming at this from the, the consumer's perspective who is, who's facing -- I don't have to go through the litany. We know what is happening for Vermont consumers and Vermont small businesses and insurance rates. You know, we don't focus it in front of this board often, but the, the increasing costs for Medigap plans, the number of Vermont Medicare recipients who don't have Medigap or Advantage and the problems associated with that.

Vermonters face tremendous costs when they get

care, and, and that, that provides a -- well, maybe I'll ask it this way, and maybe I've asked this question before. So forgive me. Is the consumer affordability challenge as much a growing risk or substantial, as much of a risk as I describe to your efforts here?

MS. LONER: I think that's a kind of like a "depends" question, Mike, because it depends on how much of the spend is actually running through the ACO, and it also depends on what the rest of the nation and the country does with value-based care, because, as we've discussed today, a lot of these contracts or payers don't work through Vermont's all-payer model. So I think it's both a federal and a state approach to the affordability question that you're asking.

MR. FISHER: All right. I'll leave it, I'll leave it with just the statement that we, in my world I hear too often people not being able to get the care they need, because they can't afford the patient share, and that, to me, crosses paths directly with what we're trying to do here.

So, so I presume we're all in agreement that it will be impossible to pull apart -- maybe this is a -- Covid savings or reduced costs due to Covid-related reductions in care for 2020 and that it would be next

to impossible to draw any conclusions for 2020 about impacts of OneCare Vermont or the all-payer model. I presume we're all in agreement about that, but, I, I need to ask that, and then also extend it.

We, we don't know exactly what's going to happen in 2021, but on some level we are seeing, I believe we will see a reduction in people, people's ability to get the care they need due to the Covid pandemic. How do you pull that apart from your efforts and your efforts to save money?

MS. LONER: Tom, do you want to talk a little bit about the work that you'd be doing with the finance teams and the actuaries? Because it is a pretty complicated question, Mike. I don't know that we have all the answers, but that's something we're certainly concerned about as well.

MR. BORYS: Yeah, I think the most important thing from my perspective is to stay on the value-based care path. That, that, to me, is the beginning of all the good work that happens thereafter, and, you know, we're a population health company, largely. We're trying to help improve the health of the population in spirit of reduced health care cost growth. It's important that we sustain that.

Next year is, probably has more uncertainty than

we've ever faced as a society, and the one thing I'm confident in is that we can't go backwards and go back to a volume-based reimbursement model. That doesn't serve anybody from consumers on up to the state or the federal government. So that, to me, is the most important thing right now is that we stay in value-based care, we keep working together as a health system to improve the health of the population.

I trust you when you say that the, the patient share costs are increasing. So one of the strategies to address that is to improve the health of the population so the health care that they need is less and, therefore, the cost on them is less. That's not going to be an overnight solution by any means, but it just all goes back to the importance of staying on this value-based care track, continuing to work together to improve population health.

MR. FISHER: And I don't disagree one bit. I'm just, I'm not suggesting a change in direction. I'm just recognizing it's going to be hard to measure what we've done, certainly, for 2020 and, I, I believe, for 2021 as well.

MR. BORYS: I agree.

MR. FISHER: A few people have asked about your wage and fringe increase on Slide 26, and maybe

I'll ask if, if afterward you could provide a little bit. On Slide 26 you show a 17 percent, 17.8 percent increase from '20 to '21, and you, and you show, and you note that that includes lifting the hiring freeze, restoration of compensation, and I presume, apropos of Chair Mullin's question, it also may include the 2 percent increase for the, you know, for the pay raise over the years.

It would be really helpful -- well, then I'll also note that, in the budget narrative on Table 4, you list that same number, one million four-hundred-seventy-some, for, with a tag that says it's restoration of COVID-19 compensation cuts. It would be helpful to be able to pull those two or three dynamics apart, how much of that increase is restoration of, of compensation, how much of it is wage increase from year to year, and how much of it is lifting the hiring freeze, and I don't expect you to be able to answer that question here.

MR. BORYS: Yeah, I do not have that breakdown at my, at the ready, but we can certainly supply it.

MR. FISHER: Case management, Sara, it looks like 10 percent of the population is considered high-risk and 6 percent is considered very high-risk

and that you have a goal of an average of 15 percent across all the populations, which I believe, you know, if my math is right, that's 2 percent, 2.4 percent of your total population.

When you break apart the different payers, it looks to us like it's 16 percent of the Medicare and Medicaid population and 3 percent of the Blue Cross Blue Shield Vermont population or less than half a percent for Blue Cross, who is getting this intensive case management, as opposed to 2.5 percent of the Medicare and Medicaid. What's going on?

MS. BARRY: So, Mike, I think, just, in all those numbers you've displayed, which were all accurate numbers to my, you know, best of my hearing, right there in and of itself, it describes the complexity. So, when we started investigating how to build on and expand some of the early concepts that the Blueprint was testing, we looked at other ACOs. We looked at other insurance companies, and we came out with a huge swath of, you know, a count of a certain number of people at the low end all the way up to, you know, some situations where maybe 40 percent of a population was being care managed.

And, in conversations across our provider community, I remember a couple of things very clearly.

One was that we needed to have a wholistic population health view, and that's how we came up with that high-risk 10 percent category, whereas a pretty typical insurance-based model would just pay attention to the very high-risk, and that was really recognizing the complexity of the physical and mental health challenges that often occur simultaneously, and then you add in the, the social, economic issues, and, and, you know, those challenges become even more complex and tangled together.

So it was a great opportunity for us to look at community-based care. We had to set some early targets, and in those days, remember, we were, like, starting from zero. So we set 15 percent of that high- and very high-risk population as a goal. Again, not saying that that was the permanent goal that we were headed for, but that was at an all-payer level where we wanted to be, and then we started to explore and put pressure on the system to try to meet those goals, and so, as we reported, we now have over 4,000 individuals in care management hitting that goal.

And so the next question becomes, Well, is there more need, or is there need to refine and become more specific in where those supports are? And I think it's a little bit of everything there, but what we've

recognized is that there are still some individuals that could really benefit, in our opinion, that need more outreach and support. For example, it might be looking at a nuanced subpopulation of those that are high utilizers of the emergency department and have, let's say, comorbid conditions affecting their mental and their physical health, and so can we be more targeted and more specific in the ways that we support our providers to do that outreach?

The differential engagement rates that you were highlighting do exist, and we think that underneath that is the fact that, when you look at the risk profile of different populations, they're inherently different, and so we try to target some of those early goals to align with those risk profiles. I don't think -- I've not come across the science that will tell us an exact number for any subpopulation.

I think it's always going to be a process to learn and improve, and we need to align that with where we can start to have enough kind of duration in care coordination that we really get a sense of the outcomes and who can best benefit from this type of program, as opposed to something, say, that one of the insurers might still be offering, which is a very disease-specific program, say, for a rare condition or

a genetic condition, where our community-based care coordinators don't have that expertise.

And so we, together with the payers, have said, Hey, you keep that population. You either directly have those highly skilled, you know, case managers, or you're contracting with somebody. And so that's an example of they wouldn't be counted kind of in our data that we're reporting out, but it's a way that we're working collaboratively with, in particular, the commercial payers to make sure that we have those wholistic services.

MR. FISHER: So, so I heard a few things there, but a piece of it, and what I suspected when I asked the question, the, the relative health difference between the public payer population and the commercial payer population is, is that different?

MS. BARRY: It can be that different, yes.

MR. FISHER: Yeah, yeah. Thank you. Lastly, I wanted to thank you for putting up Fred's story. I think those kinds of stories are important, and, and I can't help, because, you know, I've spent almost 30 years as a front-line social worker, to say it recognizes there's a long history of people coming together to organize to provide better care for people that really improves, saves lives, and saves a lot of

money.

And so I think that it's really important that you're a part of that effort and also to say out loud that, you know, we bump into absolutely crazy problems in our system that, whether it be getting people access to dentures, you know, the, the misnomer of affordable dentures, and/or the absolute ridiculous challenge of getting people dependable access to diabetic supplies. Nobody gets continuous glucose monitors for fun. Why do we make them jump through so many hoops to get them? Well, because they cost a lot of money. And so I look forward to a day when, when we fix those kinds of problems to be able to get people the care they need, and so thank you.

MS. LONER: Us too. Thank you, Mike, for saying that.

CHAIRMAN MULLIN: Thank you, Mike. At this point, I'm going to open it up for public comment. Does any member of the public wish to comment on the budget presentation from OneCare Vermont?

MS. ARANOFF: Good afternoon, Mr. Chair. This is Susan Aranoff from the Vermont Developmental Disabilities Council.

CHAIRMAN MULLIN: Hi, Susan.

MS. ARANOFF: Hi. So I just have a couple of

preliminary questions for Vicki and team. This has to do with Medicaid. As you know, the focus of the council is always on Medicaid. Medicaid pays for the only payer for home- and community-based services that people with disabilities, who are Vermont's largest group of disparately impacted Vermonters, who average two and three chronic conditions and would be really low-hanging fruit for care coordination, etc. So I'm speaking about Medicaid.

About five or six weeks ago, we were all gathered for the discussion on primary care, and Julie Wasserman asked Vicki a question about the 14-point-something-million-dollar loss in Medicaid, and Vicki said, No, that's going to turn out not to be a loss. That's going to be savings. So my understanding is that now the Medicaid loss is cleared.

The point that I want to make is, when, when the board, when OneCare, when everyone talks about predictability for the payers of shifting risk to the payers, what is really missing from this conversation, and it's really more of a comment than a question, is that, when Medicaid overspends by $14 million in, in the Medicaid ACO, OneCare's only on the hook for some percent of that, 4 percent, whatever the guardrails are.

That rest of that overage, that Medicaid expenditure, is paid by the taxpayers of Vermont, those public payers, but, in addition to that, it's money that is not available for home- and community-based services. That money becomes unavailable to serve the Vermonters with disabilities who are only served by these Medicaid-funded programs.

So Cory, you know, the Commissioner of DVHA, and others, I've heard the secretary just say this. Medicaid has rightly taken pride in switching a lot to value-based payments. There's not really a need for an ACO for value-based payments. They've been paying for long-term care with case rates for decades without an ACO in the middle, but, when the ACO starts costing more money than it is benefiting Medicaid beneficiaries, I think someone has got to speak up for Medicaid and say and ask the question, and I hope the Green Mountain Care Board staff can ask this as a breakdown: How are people with disabilities better off as a result of the ACO?

DVHA used to do a disability subanalysis on the quality results. So that would be a question. And how is the Medicaid program, as the most reliable payer, as the one with the steadiest increase in scale, as the one who started out with the, the only one with an

additional admin fee, how is the Medicaid program better off for its participation?

And then my direct question to Vicki, but it seemed like she rejected the premise of my question, is I wanted to know what changed in the Medicaid results between six weeks ago and today so that what was going to, when Julie Wasserman asked about the losses in Medicaid, you said those were going to be savings, had anything changed?

And I'll leave it at that. We will be submitting written comments, but I hope that the board, in its follow-up questions, could dig down a little deeper on the impact this is having on the Medicaid program overall and on people with disabilities in particular. Thank you.

MS. BERUBE: Kevin, this is Alena. Can I just add one thing? So I believe we'll be going through the 2019 financial results by payer in the coming weeks, so we'll have more discussion of drivers of those results at that time.

MS. LONER: And, if I could just say for the record, I don't believe I ever said that there was going to be savings. We were still discussing with Medicaid at the time what those numbers would look like. I did say there was going to be savings in the

Medicare program and that, overall, when we looked at the ACO programs, there were savings opportunities.

MS. ARANOFF: We can play the tape. Both Julie and I have listened to it, because we were really surprised by that, Vicki. We've been watching that Medicaid number in the 52 Points of Light all year, and so we were trying to get the attention of legislators, you know, someone please pay attention to what is happening in Medicaid. So, you know, we could both listen to the tape, but I'm pretty sure that how I'm reporting it is how it was portrayed, and I look forward again to a discussion of the financial results. As I said when the quality results were discussed, Mr. Chair or a member, I really would welcome a discussion of the financial results, especially in the Medicaid. Thank you.

CHAIRMAN MULLIN: Okay. Other members of the public? Other members of the public? Hearing none, I wish to thank team OneCare for their patience through all the questions today. We've learned a lot, and you have a, a large set of written questions that have been forwarded to you that I'm sure are probably more than you wish to bear, but we look forward to reading those responses and continuing to figure out how we can move forward to better the lives of Vermonters. So thank

you.

Is there any other old business to come before the board? Hearing none, is there any new business to come before the board? Hearing none, is there a motion to adjourn?

MR. PELHAM: So moved.

MS. USIFER: Second.

CHAIRMAN MULLIN: It's been moved and seconded to adjourn. All those in favor signify by saying "aye". Aye. Those opposed signify by saying "nay". Thank you, everyone. Have a great rest of the day.

(Whereupon at 2:34 p.m. the hearing was adjourned.)

C E R T I F I C A T E

I, Sunnie Donath, RMR, do hereby certify that I recorded by stenographic means the Green Mountain Care Board OneCare Vermont FY 2021 Budget Hearing beginning at 9:30 a.m. on Wednesday, October 28, 2020.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 190 pages are a transcript of the stenographic notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Westminster, Vermont, this 29th day of October, 2020.

//Sunnie Donath, RMR