STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

BOARD MEETING

IN RE: ONECARE BUDGET

Meeting held before the Green Mountain Care Board at the Pavilion Auditorium, 109 State Street, Montpelier, Vermont, on October 30, 2019, beginning at 1 p.m.

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Maureen Usifer (via telephone)
Jessica A. Holmes, Ph.D.
Robin Lunge, JD, MHCDS
Tom Pelham

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# I N D E X

CHAIRMAN MULLIN: At this point we'll proceed as if all members are here except one absence until she joins us on the phone. So I'm going to turn it over to Susan Barrett for an Executive Director's report.

MS. BARRETT: Thank you, Mr. Chair. I have a few announcements. I wanted to let the public know that a couple weeks ago we went to the St. Albans community for one of our traveling board meetings. We do this about two times a year. We get out for other reasons, for hospital budgets, et cetera, but we do take the time at least twice a year to visit local communities throughout the state. Our goal is to get to all 14 counties soon. We're getting there, but just to give you an idea of what we did that day when we go out for these traveling board meetings we ask the community and the accountable communities for help to come together to talk to the board about how they are implementing the All-Payer Model. So we ask them to focus their presentations around the three high level goals of the model, and for those in the room who do not know them they are, number one -- these are the high level population health goals of the All-Payer Model -- number one, reduction of deaths due to suicide and

overdose; number two, increasing access to primary care; and, number three, decreasing the morbidity and mortality of chronic disease.

So on the morning of October 16th the board went to several sites in the St. Albans area and they had tours of different health care providers that exemplified and showed the board how this community -- (interruption)

CHAIRMAN MULLIN: Maureen, are you now on the phone?

MS. BARRETT: Okay. Well I'll keep going. So we separated into three different groups and we had tours of the emergency department at the Northwest Medical Center. We toured Northwest Partners In Hope and Recovery at Valley Crossroads, and these were examples of how the community is reducing deaths due to suicide and drug overdose.

Then we also had visits to Northwest Primary Care which is on the campus of Northwest Medical Center as well as Northern Tier For Health which is a local FQHC, and they also have an office on the campus of the medical center, and that exemplified the ways the community is increasing access to primary care; and last, but not least, because this was the tour I was on with Board Member

Pelham we went to the St. Albans City School and we saw the ways that RiseVT is getting children in school moving and dancing, and there may be a video of Board Member Pelham and I doing a dance with the kids which I am more pleased with than Board Member Pelham.

MR. PELHAM: I was in the back of the room. I thought nobody saw anything.

MS. BARRETT: And, lastly, the last visit that was exemplifying how the community is decreasing the morbidity and mortality of chronic diseases starting at a very young age, and then in the afternoon we had a public board meeting where we heard from Northwest Medical Center CEO Jill Barry Bowen and her team talked about the way they are implementing the All-Payer Model, both the challenges and the opportunities, and we came away learning quite a bit from that meeting.

I'll just close by saying we were very grateful to the entire community for that day and also really impressed about -- with how many community members came out, how many legislators came out, and how many business owners came out to learn more about the All-Payer Model and the work the board does.

So that was just an update on that really great day in St. Albans. I want to remind the public also that our schedule for November is on our web site. We have a very busy meeting schedule next month. We're going to be hearing from VITL on their quarterly report. We're going to be hearing from partners at DVHA on their HIT plan, and also continue the discussion around this budget process for OneCare Vermont; and then last, but not least, there is a current public comment period that opened on October 1st when we received the OneCare budget. This is posted on our web site, and I would ask if anyone would like to share a public comment via our web site, you could call our office, you can also send a public comment by mail. The public comment period opened on October 1st and it runs through November 12th. These dates will allow us our staff to incorporate the public comments into the recommendations that they provide to the board on the ACO budget, but I just want folks to know that comments are accepted at any time at the board 365 days a year. So if you do get comments in after that November 12th date, the board will still review them and that is all I have to report.

CHAIRMAN MULLIN: Thank you, Susan.

Next item on the agenda are the minutes of Wednesday, October 16. Is there a motion?

MR. PELHAM: So moved.

MS. HOLMES: Second.

CHAIRMAN MULLIN: It's been moved and seconded to approve the minutes of Wednesday, October 16 without any additions, deletions, or corrections. Is there any discussion? Seeing none, all in favor signify by saying aye.

(Board members respond aye.)

CHAIRMAN MULLIN: Any opposed? (No response) Okay. That brings us to the business of the day. It's really good to be talking about the All-Payer Model today, and I just want to preface the start of this meeting in that despite all the good work being done most Vermonters don't seem to know even what an All-Payer Model is or what we are doing in health care, and so I'm hoping that we can all do a better job of making it explainable; and one of the things I'm going to ask today from our staff and from OneCare staff when they make the presentation is to try to stay away from the PCP, PHMA, the ACOs. Just speak in clear english so that everyone understands what you're talking about, and I think that unfortunately we get so immersed into a very complex

structure in health that we sometimes forget that most people are not in that same position and don't have a clue and think we are talking in code when we're trying to explain things, and so we all have to do a better job of just speaking plainly and clearly, and really the assumption that you have to make in this communication is that you are talking to someone that really doesn't know anything about the All-Payer Model, and I think if we all start to try to frame it from that direction, I think that more Vermonters will start to understand this very good work that's being done in health care.

So with that before I call our team up to do an introduction I did want to recognize, and this always gets me in trouble, but I did recognize Representative Theresa Wood and I want to thank her for coming. Thank you, Theresa, and Representative Mary Hooper is here. Thank you. She's under the radar, and we really appreciate legislators coming to these meetings.

So with that if I could invite Alena and Melissa to come upfront and kick this off.

MS. BERUBE: I'm Alena Berube, Director of Value Based Programs and ACO Regulation, and this is Melissa Miles, Deputy Director of Value Based

Programs and ACO Regulation. So we wanted to start with a little context today before we dive into the main event and provide an overview of all All-Payer Model and why we came here in the first place, and then some of the levers that the board has as it relates to All-Payer Model and why we're here today to hear OneCare's budget.

So today we're going to introduce this context and OneCare will present their budget and then we'll get questions from the board, questions from the Health Care Advocate, and then public comment.

MS. BARRETT: Could you speak up a little, Alena? Thank you.

MS. MILES: So I am going to give a background on the All-Payer Model agreement. Can everybody hear me -- okay -- which was signed three years ago this month by the Agency of Human Services, the Administration, the Green Mountain Care Board, and the Federal Government, and each party has a respective role in implementing the agreement. This slide depicts the reason why the agreement was pursued, what the strategy was and is, and the vehicle for doing so. The interventions.

So I would like to read a quote from the

board's decision to sign the All-Payer Model from that day. "The rising cost of health care imposes unsustainable financial burdens on Vermonters and their families, impedes equitable access to preventive care, and threatens to cripple our state's economy. Left unchecked and uncontrolled it will prevent Vermont from reaching its goal to ensure that all of its citizens have access to affordable high quality health care."

So these are the three pillars or what we call our All-Payer Model agreement logic model. The All-Payer Model is going to be running from 2018 to 2022. We're in year two currently. So these are the levers that will inform the delivery system reform.

The model was designed to reinforce and enable transformation in care delivery and primary care as there is strong evidence that the primary care foundation with an enhanced focus on preventive services can improve health care quality, improve the health of the population, and help to keep costs down. We are testing this through payment changes, including prospective payments and enhanced care coordination models, to move providers from episodic care to the provision of preventive care. We're also

transforming care delivery and testing what a more predictable revenue stream can do for providers to allow them to initiate additional delivery system reform care in their offices. For example, we've heard from primary care providers that they are hiring additional care coordination staff and mental health support to expand access in their primary care office. It's also creating a stronger network for the continuum of care including home health, designated agencies, and the area agencies on aging. So, finally, with these two main changes of testing payment changes and transforming health care delivery we are aiming to improve the outcomes that Susan described earlier, and I'm going to speak a little bit more about them on the next slide.

So these are the large goals that are in the All-Payer Model agreement. I will speak to each one individually. So one goal is to limit the cost growth. This requires Vermont to achieve sustainable cost growth for certain services for both Medicare and All Payer beneficiaries which includes most Vermonters. The limit for cost growth in the agreement is 3.5 which was selected as a sustainable growth target because it's tied to economic growth.

The state is responsible for ensuring

that the programs that the ACO participates in with payers are aligned in certain areas including attribution, quality measures, financial accountability measures, and the different payment methods so that we're moving everyone in the same direction. The All-Payer Model also has responsibility for steadily increasing the scale of the model over the life of the agreement with the goals on the bottom, 70 percent of Vermonters in the All Payer target and 90 percent of Vermont Medicare beneficiaries. So evidence shows when programs are aligned providers have strong consistent incentives to make the changes in their practices, and then, finally, the state is responsible for meeting 20 different quality measures which are bundled under three big population health goals, and the evidence behind these broad goals at the time was that 78 percent of Vermont deaths were due to chronic disease. Vermont's death rates from suicide and drug overdose were higher than the nation's average and the state wanted to instill that underlying value of access to primary care, and the goal for that is 89 percent.

MS. BERUBE: So these two signs of the equation, health care expenditures and quality of

access, are goals of the state, but the Green Mountain Care Board has a number of levers that can be addressed to kind of affect these outcomes. That is the ACO oversight process which has two pieces, the budget review and certification, as well as the design of the program and rate setting; hospital budget review, health insurance rate review, and Certificate of Need. So it's not just this budget process. There are a number of levers that can influence the outcome of this model.

As it relates to ACO oversight why you're here today there are statute 18 V.S.A. 9382 and Green Mountain Care Board Rule 5 that prescribe exactly how we are to go about these processes and criteria against which we evaluate OneCare's budget and any ACO certification. Certification occurs one time following application for certification and then eligibility verifications are done annually to check any differences in year over year in meeting those criteria. So OneCare has been certified and we are in the process of evaluating their eligibility criteria under their September 3rd submission of materials. The budget review -- the presentation today is an annual review and we are in the midst of that process.

So some highlights from the 2019 budget order. So that's not the final. There's another step in the process, but almost final stage of the review when the Board makes recommendations and codifies the budget order. So scale target ACO initiatives, All Payer ACO agreement, and data reporting, payer contracts, regulatory alignment, risk, reserves, administrative expense ratio, finance statements, population health management and payment reform programs, the comprehensive payment reform reporting, and then value based distribution methodology, specialist payment pilot and certification monitoring. So these are just examples of areas that can be included in the budget order that might kind of guide OneCare to achieve some of the state's goals.

To just provide further context of where we are in the process for 2020, GMCB published guidance over the summer and OneCare has submitted their certification and their budget materials. We are where the star reflects today in the budget hearing. To come we have the staff analysis and recommendations, the GMCB budget vote, as well as the budget order, and the final review of attribution budget and contracts. So we want to make clear even

once this budget is set forth there are still a number of variables that remain to settle that will solidify what the budget is that OneCare will be working with. That's our presentation. Thank you.

MS. MILES: Does the board have any questions?

MS. LUNGE: I do have one question. Could you explain a little bit more about why we would take a look in March after we've issued the budget order in December?

MS. BERUBE: Absolutely. So the attribution numbers are not yet final in terms of what population that we'll be serving, so without that all the board can do is set a contingent path forward. We have some good estimates, but once those numbers are final the total dollar amounts will be known.

MS. LUNGE: Thank you. That's always been a frustrating part of this process. I think it's good to spell it out so everyone --

MS. BERUBE: Our hands are tied there. We would like it to be sooner.

CHAIRMAN MULLIN: Thank you. So we had a couple more Representatives come in since we made the introductions. So I just want to welcome

Representative Christensen to the meeting today. We're always happy to see legislators. So thank you for your service. At this point we're going to invite the OneCare team down, and while they are walking down I just want to say that I think that Melissa and Alena did a really good job of describing what the strategy is, and I guess the one thing I wanted to address with everyone in the room is that what was the problem that was trying to be solved because Vermont has truly good health care outcomes when it's measured to other states, and when you hear the U.S. compared unfavorably to other countries on quality measures like infant mortality and things like that Vermont does much better and we have a lot to be proud of, but if you take a look back 25 years ago, health care spending was between 11 and 12 percent of our state's economy and it grew to over 19 percent of our state's economy, and so we want to make sure that health care is sustainable so that as all of us grow older we're able to afford the type of quality that we would expect, and that's really what the strategy is laid out, and if you look at those benchmarks that were put up on the screen by our team, 3.5 percent was tied to the previous decade and a half's growth rate in the Vermont economy, and so

what we're really saying is that we're looking for health care to grow at or below the rate of inflation in Vermont so that we can afford it and that's really the bottom line.

So today we start -- it started quite a while ago with the submission, but we hear firsthand from the OneCare team about their budget presentation and they get to basically inform everyone of what the budget contains, and that's one of the key components of the description of an ACO organization is that the organization has to be accountable and accountable to other stakeholders whether it's providers, patients, and I would say even the general public in Vermont because OneCare has the heavy weight of being the only accountable care organization in the State of Vermont, and in some respects that could be something that's very positive because in a small state like ours could we really afford two sets of administration, two sets of technology and so on, but with that comes the extra responsibility, especially on this board and in our role as regulators, to make sure that OneCare is held accountable; and so we welcome the OneCare team today, and with that I'm going to turn it over to you and I hope that you heard my premeeting instruction that is we're going

to try to keep this acronym free. We're going to try to make it easily understandable and please assume that you're addressing whoever in the room has never been to any meeting before about OneCare or the All-Payer Model. So with that I'm going to turn it over to you, Vicki. Actually, sorry, if we could just begin by swearing in the witnesses.

(The OneCare panel was duly sworn.)

MS. LONER: So for the record Vicki Loner, CEO OneCare Vermont. I'm joined here with my colleagues.

MR. BORYS: Hi everyone. Tom Borys, Director of Finance OneCare Vermont.

MS. BARRY: Good afternoon. I'm Sara Barry, the Chief Operating Officer for OneCare Vermont.

MS. LONER: I hope there's not a buzzer if I do too many acronyms associated with this.

CHAIR MULLIN: We didn't put out a fine jar either.

MS. LONER: I'm going to try my best. So again thank you very much for the opportunity to be here today and have this really important exchange with the committee and those of the public and our stakeholders that are here today. I am fairly new in

my role as CEO at OneCare Vermont. I'm not new to health care. I've been a registered nurse for about 26 years now and I was brought here to this fine state probably 23 years ago by Jim Hester who has recently passed, but was a wonderful man and also kind of ahead of where we are today in that Jim was talking about this probably when I came here 23 years ago. So I'm thankful to him for that.

You know as a nurse this wouldn't normally be the slide I would put up first, but I thought it was really important because there's been a lot of questions, misinterpretation of what our budget is and is not, and so I tried to break this down with the help of my finance friends to be fairly simplistic. So the first number that you see at the top is the one that's most often quoted. That's the big number that everybody talks about. When you really break that apart 1.36 billion dollars is money that's already existing and circulating in the system. This is the cost of health care as it stands for those payers that we're looking to have contracts with. This isn't new money to the system. This isn't added administrative cost to the system.

So when you take that 1.36 billion dollars what you're left with is the OneCare budget

which is 62 million dollars. At first that seems like a big number as well until you really dissect that number and think about what it is. So when you go down a little bit further it says less network investment payments. So that's 43 million dollars that's going directly to the health care providers. So home health agencies, physicians, nurse practitioners, hospitals who had said yes to be the vehicle under the All-Payer Model to help them make important investments, right investments, right, and in helping Vermonters be the healthiest people they can be. That's things like care coordination programs, prevention. We talked about RiseVT. Those are all really important investments that we need to be making if we're to make this transition to a value based system.

The operating cost is roughly 19 million dollars, and if you even dissect that some more if you look at it, and Tom will get into more details about that, really what that is, is about 70 percent of that funding is directly support providers to do things like understand their data, right. How many patients haven't been seen in the last year? What are their care gaps? Do they need to get in for a preventive visit? Have they hit the emergency room

at the inpatient hospital and really need to be seen?

That's the sort of infrastructure and support that the ACO can provide at an economy of scale so that each individual provider doesn't have to pay for those services and supports in their communities.

So when you get down to the end we have zero. So that's also similar to how OneCare looks at its expenses. Every year we look to break even. So that means even if there's shared savings as part of the ACO, that money is reinvested into the communities and the communities can then afford to continuously reinvest in some of those services that I talked about earlier today around prevention and RiseVT and care coordination because when you really look at what's happened since year zero of the model, and we'll talk about why it's called year zero, later, the health care providers had made significant investments of their own money into making this system work.

I feel like the Green Mountain Care Board staff did a really good job of this, but I want to emphasize a few more points. So the All-Payer Model sometimes that does get a little blurry of like who is the All Payer agreement with. So that is

indeed between the State of Vermont and the federal government. We, as the ACO, are the vehicle to effectuate that change, and the reason why the provider delivery system -- and when I say provider delivery system I'm actually referring to all the providers who have decided to be part of the ACO -- said yes and the reason why they said yes is because they believe in the goals of the All-Payer Model. They believe it's important to have access to care, right. They believe in prevention of suicide prevention. They believe that we really need to do better with preventing chronic diseases, both the prevention of and the mortality of chronic diseases, and they understand that health care costs are rising and they need to be proven, right. These are all very important goals that are important to the delivery system as well as the State of Vermont.

The other thing I want to talk about just a little bit we have heard a lot that this is an experiment. That word has been used a lot. To put it into context an ACO is not an experiment. An ACO came out of the Affordable Care Act. There are ACOs all around the country that have been operating for a very long time and they do provide the legal vehicle for which providers can come together and share

supports, and that's really important that they be able to share those supports, and, more importantly, it provides them the mechanism to be able to leverage some of these benefit enhancements that are provided by the federal government, things such as being able to go into a skilled nursing facility without spending time at the hospital, right. These are very important waivers, being able to be seen by your home health provider after you leave the hospital even if you don't have an acute care need. Absent the ACO we would not be able to engage in these type of great benefit enhancements. We believe that all of this work is really important not just to the health care delivery system, to the state, but also for the health of Vermonters. The system that we have right now is, I agree, not sustainable and that's the reason why we entered into this agreement with the federal government.

Despite some criticism we believe that we've made some significant headways in our short, short time that we've been on this journey together and I would like to talk a little bit about that. Sorry. There's a lot of words and a lot of pictures on this page, but I just couldn't help myself. So year zero. This was really a foundational year and

the reason why it was called year zero, in my mind at least, is because both the state and the federal government recognize that in order to sit -- set up this type of system we really needed to test the model, make some operational changes, do some initial investments, and so that you didn't want to go in with all of Vermont all at once. So this was really a planning and development year, and Medicaid agreed to be our payer partner in that first year along with four brave health service areas that are listed up there; Burlington, Berlin, Middlebury, and St. Albans who still are moving forward in the model as we progress over the years, and then some of our initial payments and programs that we started that were really fundamental was the care coordination program and understanding that primary care was foundational to this work, and so we really needed to bring in some supports and services to help them along this journey.

I would say that 2018 and 2019 were great years of expansions. I know that we have a lot of challenges in terms of meeting our scale targets and I believe that there's other levers that we need to be pulling as a state to be able to meet those goals and the ACO recognizes that they have a part in

that as well.

So as of 2019 we do have the majority of payers in the program. We've really grown the network in that most health service areas are participating in at least one of the programs; programs meaning Medicaid, Medicare, commercial or self-funded program, and we really evolved in our investments over the years. You can see starting in 2018 we started to bring in a lot of prevention programs. 2018 was the year that absent the ACO the Medicare Blueprint payments, the SASH payments would have gone away, and those would have been at least upwards of 7.5 to 8 million dollars that would have been lost from the state absent the ACO.

2020 is really a significant growth year for us if things go as planned. So, again, this is a matter of timing when we look at what our numbers are and what our contracts are, but we're looking to have at least 50 percent -- up to approximately 50 percent growth in both attribution and total cost of care accountability adding in new payer programs through MVP, looking to partner more tightly with Blue Cross Blue Shield, around self-funded offerings, and adding on the majority of health service areas so we cover essentially the whole state.

Our payments and investments to providers continue to grow through the years. Those are things we're going to have to have discussions about because, as we noted, one of the challenges for the hospitals that are supporting these investments is the balance between the amount of risk and risk exposure, the amount that they are able to invest in the model if we are really to get to scale.

Let's talk a little bit about the value of OneCare, and again when I say OneCare I would like to put a face on that, of the 2400 providers who are participating and using the ACO as the vehicle for reform. It's not just the 70 some odd people up in Colchester that are working on this. This takes a provider community. It takes a village in order to do this type of reform. This is really about how the system is coming together to deliver better health care for Vermonters at a price that is sustainable for them and grows at the rate -- inflationary rate.

As I said earlier, one of the programs that we first launched was the care coordination program, and really what this is aimed at doing is helping to support some of our most vulnerable Vermonters to make sure that they get the help -- mental health needs met and that their goals are met

so they can be the healthiest people they need to be.

We've actually been recognized by the Robert Wood Johnson Foundation around our model in that it is extremely inclusive and uses a team based approach meaning that your caregivers, your primary care, somebody from your primary care offices, your home health, your designated mental health agency is the person that's working together with the patient to make sure that their goals are developed collaboratively and met.

We have seen a sixfold increase since we started in the amount -- in the number of people who are being served through these care coordination programs, and when I say being served through these care coordination programs I don't mean that they picked up a call, right, from somebody in the doctor's office and said yes I'll be involved in care coordination. People that are working with our care coordinators in this system, right, with their primary care physicians have actually agreed to participate. They set their own goals and they set and plan -- a plan in motion to be able to meet their goals. So it's the deepest level of engagement that you can think about. So that number is fairly significant considering it takes upwards of one to

three months to move that far along in the process, and speaking as a former case manager as well I know that it's not always easy to form those relationships and move things forward in order to meet people where they are at.

As we're looking at things, and I don't want to steal all of Sara's thunder here but I'm just going to steal a little bit, we've seen a significant reduction in emergency room use for both the Medicare and Medicaid populations; up to 33 percent in Medicare and 13 percent in Medicaid patients, and through a project that the VNA launched they were able to show that they had upwards of $1100 per member per month -- sorry there's an acronym -- savings associated with providing this level of care coordination.

I think the second piece that's really important that we talked about that's foundational to our work is making sure that primary care offices had the services and supports that they need. We launched a comprehensive payment reform pilot, and that's another terrible acronym that we'll have to work on, in order to make sure that primary care were able to have the access and supports in their offices regardless of who the payer was, and this process and

this program has been very successful and grown significantly since we first launched it. I think I have a slide in here later Dr. Joe Haddock who is really talking about some of the good things of that program, and when I even look at our budget this year, if you dissected a little bit, it's about 22 million dollars going out to primary care because of the ACO being in place.

We've also, as I said earlier, sustained the patient center medical home community health team and SASH funding through the Blueprint, and this is very important money that communities and primary care offices would not have if the ACO wasn't in existence.

A big piece of our budget is really around data and how data informs the payer, and this is really important when you're asking physicians to take accountability both financially and clinically for some of these tough but good outcomes that we're looking at under the model in that it can provide them with some realtime data to understand which patients haven't come into the office in the last year, who hasn't received one of their preventative health visits. It also lets them know, like I said earlier, if somebody is in the hospital or

immediately needing some supports wrapped around them.

We have seen one of the big measurements, and Sara is going to talk more about this later, is a significant increase in the number of high and very high risk -- I sometimes refer to them as risky -- patients that have had a visit with their primary care physician, nurse practitioner, or physician assistants.

So smarter care. This is where I think I need my spectacles a little bit so I'll just turn to my actual piece of paper here is really what we're seeing is this system has enabled us to make more investments in primary care programs such as RiseVT and a DULCE program that was launched last year for kids who are at risk for adverse childhood events, and because of these investments we have also seen a reduction in some of those high cost care such as emergency room use. I also like to think about this as a better care experience for individuals and patients who are receiving their services, and when I say -- when I say that I'm referring to things like the skilled nursing waiver, so this enables somebody to go directly from their home, if needed, into a skilled nursing facility without having to first go

to the hospital or go to the emergency room to receive their services. This is good for the system because it lowers cost and it's a better experience for the patient.

One of the really important things that we partnered with Medicaid, right, although it was a little bumpier than we thought it would be was really stopping the prior authorization process for those individuals that were part of the ACO. So instead of the practice having to call the insurance company to get approval prior to, which is costly for the insurance company to have those resources, it's costly for the health care provider to have somebody in our office to make those calls, and it takes away from time with their patients and potentially delays people from receiving the care that they need. So this was a huge benefit of the Medicaid program. We're working with our other payers to assess what the timeline would be for doing something similar now that we had a few years of data behind us to show that the overall cost doesn't go up when you remove these requirements.

And then the reason why this is all made possible to us here today is because we are able to really live under a fixed budget. So what has

happened with the Medicare and Medicaid program is they have been able to set a budget for the programs that providers are participating in, and this is really important so people understand where investments can be made and how much funding that they had for the year.

This system really incentivizes versus penalizes for quality. So it incentivizes providers to really make those upfront investments in quality. We are one -- I think the only state who is living under a fixed prospective budget for all or most of

All right. So if you're still questioning the value of the ACO and what it means to providers, I leave you with this testimonial from Dr. Joe Haddock who is an independent physician at Thomas Chittenden Health Center, and the key thing that I would like to take away from his statement here is that the care coordinators have reduced their fragmentation of the health care system and it has resulted in fewer hospitalizations. So that's what we're talking about here. Really creating systems, breaking down those silos, and reducing that part of the system.

So with that I believe I am going to punt it over to my colleague Tom Borys who is going

to talk about the 2018 results.

MR. BORYS: Hi everyone. So we're going to start with a little bit of our overview of the 2018 results and in doing so I would like to also try and explain the way in which these programs actually work. They are quite complicated, but I think we can achieve both outcomes here. So on the screen I'm going to start with Medicare on the left section. The bar you see on the very left is our contracted total cost of care. This is the result of the agreement that we, the providers, made with Medicare, the payer, and we agreed that we will take care of the attributed population for 339 million dollars. At the conclusion of the plan here we add up all the claims -- all the costs that were incurred and it turned out to be 322 million dollars. What happens then is that there's a settlement process that essentially reconciles between the initial agreed upon price and what the actual total cost of care experience was, what the providers were paid, and in 2018's performance year this resulted in a 13.3 million dollar payment to the provider network.

Next Medicaid in the middle works generally the same way with one nuance that I'll explain in a moment. 117 million dollar agreed upon

price to take care of the attributed population. The providers were paid 118.6 million. So that resulted in a 1.5 million dollar payment from the providers to the payer to reconcile that program. The one nuance within that's really important to consider and factor into the analysis of the results is the fixed payment model. In the Medicaid program the fixed payment is an unreconciled payment and to try to explain this think of it like a salary. If you're set you make a set salary over the course of the year, you try to live within that so that your mortgage payment, your car payment, groceries, et cetera, are all within those means. In 2018's business the providers were able to live within those means and benefited to the tune of 7.6 million dollars. So when you net out the payment that we did have to make to Medicaid in the year with the performance under the fixed payment model it was a positive outcome of 6.1 million dollars.

Blue Cross Blue Shield of Vermont for the qualified health plan program we agreed to take care of the population for 120 million dollars. The actual cost of care was 122 million dollars. So we owed that money back to Blue Cross Blue Shield to reconcile the program. That's the providers taking

accountability for the costs and quality of the work that they deliver. So it's really important to understand 2018 was a really strong start and we had a net of all these programs really favorable outcome. One hundred percent of these funds were reinvested in the provider network. Nothing stays at OneCare Vermont and those funds go to reinvest in the population health management programs which Sara will speak to a little bit later, and also sustain the funding for the Blueprint program which we're able to keep alive in the state by entering into the All-Payer Model agreement.

The last note on this particular slide is we shouldn't expect this really favorable outcome every year. We're trying to live within a stable growth rate over time. Some years we're going to net receive positive reconciliation money back to the providers and other years we're going to owe money, but that's actually these programs mechanically working the way they should. They are building in stability when we do these year-end reconciliation processes to maintain hopefully that flat and sustainable growth rate that we're all looking for under the All-Payer Model.

MS. BARRY: So to continue the story

around 2018 I want to take a moment and reflect upon our quality performance as a network, and you can see by looking at the summary across the top that we had very strong performance across all of our payer programs ranging from 85 to 100 percent achieved in those programs, but it's not enough to look solely at that summary information. Instead we need to dig a little deeper and understand the context in which this information is being collected, and I think one of the important points for us all to recognize is that as the All-Payer Model advances through the years of the program there are models in place that advance the underlying assumptions around how the ACO will actually earn those quality scores making it more and more difficult each year as we enter into and then progress through the program.

In the early years, which is really what we're reflecting on as we look back at quality scores in 2018, we have to recognize a couple of important points around context. First of all, Vicki spent some time showing us what the network looked like in 2018 with just a few communities and then how it's progressed in this year and we anticipate it progressing in 2020. So when we have just a few communities participating we have to pay attention to

nuance details, things like how many patients actually had specific conditions that we're trying to measure in these communities, what was it about the actual measures themselves that either stayed consistent and allow us to do some comparison or in fact did changes occur such as definitions around how data are being collected and those types of changes are not driven here locally. They are driven through national performance benchmarks. So that we're able to then assess our performance in each of those programs be that for a population insured by Medicare or Medicaid, for example, against other national standards.

The other nuance that we're often asked about and I think is important to understand is that while OneCare is actively using data and providing it very frequently to all of our providers in our network to help inform the changes that they are trying to make, we don't have access to all of that information. We are not allowed to receive information for individuals who choose to opt out of sharing their data with OneCare nor are we able to see information related to substance use disorder claims in the system, and so that does make some of the comparisons that we are asked to perform

challenging when we don't have the entire data set. So some of that information comes from our payer partners.

We are, however, able to look at some of the particular quality measure performance for chronic conditions where our staff are actually going out and collecting that information from electronic health records and charts from across the state, and when we do that and we look at the four communities that participated in 2018 in the program and then we look to see what's happened in their performance I'm very happy to share with you that two of those four communities have improved the rate of care for patients with diabetes. Three of those four communities have improved the care of individuals with hypertension or high blood pressure, and again two have improved their screening for depression and have the appropriate followup steps in place for individuals who are identified as potentially experiencing depression.

The final measure that we collect that way is around tobacco cessation counseling and we're not able yet to provide comparisons because that was a new measure for us in 2018.

So looking at both some of the areas of

strength across our provider network as well as some of the opportunities where we may need to focus more attention as a provider community we see on the left, for example, that when patients are asked directly they are reporting that they feel that their providers communicate effectively with them, they have the access to primary care that they need and are looking for, and that their care is well coordinated. They also note, for example, in the Medicare population that providers are doing an excellent job of caring for individuals with diabetes and helping them to maintain good control of their blood sugar levels and help them live healthier happier lives with a condition.

In terms of areas of opportunity, at the same time we do see that there is opportunity in some of our other payer programs to focus more specifically on helping individuals that do have hypertension or diabetes. We identify a need to continue to work with our hospitals and our community providers of all types to help individuals not end up being readmitted to the hospital, and we also are focused in particular on addressing new and creative strategies to try to bring adolescents into their primary care office more often because we know that

is a great opportunity to promote health and wellness opportunities, to screen for potential areas of both strength and opportunity, as well as to set good health promotion messages that will carry them throughout their lives.

I do note that while we consider that an area of opportunity when you look at the national landscape OneCare is currently performing 11 percent above the national average for Medicaid and 19 percent above that median for the commercial qualified plan exchange program.

So just a few highlights to show you some of the work that our providers are performing day in and day out on behalf of patients, and we're going to spend some time now talking about the budget, but I will be back in a little while to share some success stories and some of the results we're seeing from all of this great work.

CHAIRMAN MULLIN: Before you start, Tom, I just want to confirm, Maureen, can you hear everybody okay?

MS. USIFER: Yes I do. Thanks.

CHAIRMAN MULLIN: Thank you. Tom.

MR. BORYS: All right. So let's break the budget component of the presentation into two

different parts. The first is going to be our ACO program budgets. This is really that total cost of care attribution and risk space. The second part will be more focused on the actual OneCare organization and its budget.

So I'm going to start really building on the first slide that Vicki shared with us today and look at Vermont's health care accountability in a little bit different way. The pie on the left represents the health care costs for Vermonters. So this is our Vermont residents and the cost for them to receive health care regardless of where it's delivered, whether it's locally or in a different state. That's about 6 billion dollars on an annual basis. The yellow section of the pie is OneCare Vermont's accountability per the budget submitted this year. That's about 23 percent of the overall health care costs for Vermonters. So we're growing in that space, but still comparatively small slice. Again the yellow slice is not new cost, not new funding, just represents the portion for which the providers are financially accountable.

As Vicki mentioned before, this is about a 50 percent increase over the prior year. So another large step in total cost of care

accountability. Underneath that total cost of care accountability we can do some innovative things and one of those things is the fixed payment model. So when the providers are financially accountable for the cost of care we can work with the payers to change the way that they pay for health care, and the fixed payment model is one that we've been operating for a couple of years now and anticipate again in 2020. 35 percent of the anticipated health care costs under OneCare's accountability in 2020 will be in that fixed payment model which is great. We anticipate and hope to grow this in the future. It will never be a hundred percent fixed payments just for basically logistical reasons where somebody receives services out of state it makes more sense for the payer to continue to pay those funds directly.

Another interesting point doing some research that Vermont's one of eight states with more than 20 percent of the residents in a value based care program. So we're a growing cohort in this country of states that are really putting a lot of effort behind the accountable care model.

So all of the work that you're going to hear about downstream in this program is dependent on

these program contracts that OneCare enters into with the payers, and in 2020's budget we have a continuation of a number of programs and a couple of new program offerings that I'll share with you today.

First, starting with the existing programs Medicare will look relatively true to form and consistent with the current year operations. The one number that in the financial space I'm always looking at is the trend rate and that is modeled in our budget as 3.9 percent. That is sourced from the Medicare's national United States per capita cost forecast which is a term that's referenced in the Vermont All-Payer Model contract. So that was the basis for that increase.

Medicaid the big story here is geographic attribution. I'm going to stop and speak about this for a moment. Attribution is generally driven by an active primary care relationship, but what happens to someone who doesn't have an active primary care relationship. They are largely unattributed and missed in this value based world. So we've been working with Medicaid to understand the population that do not attribute to OneCare what are their characteristics, what are some sub pools and categories within those slides that are missed, and

how might we responsibly incorporate them into our programs, and this is really exciting. We're learning a lot in this space about why somebody might actively be receiving health care but not through a primary care provider, and the budget does not actually include model attribution growth because that's just the timing and availability of data, but we are really excited by this opportunity and hopeful that it will be something that we share in March when we come back for our final attribution numbers and show you the results then.

Blue Cross Blue Shield of Vermont with the qualified health care program, the story here is that we are anticipating a pilot fixed payment model likely to begin in Q2 with a select number of providers just easing into that model, but would really like to develop the fixed payment concept with that payer as well.

The University of Vermont Medical Center self-funded plan. This is the OneCare at UVM Medical Center ACO arrangement we had in 2018 and 2019 for their health plan. We actually aim to sunset that program and roll it into a program that's now in the right-hand column. This is a Blue Cross Blue Shield Vermont self-funded program that is new and something

that we in collaboration with Blue Cross Blue Shield have been developing over the last few months to bring in a significant number of their self-funded business. So this is multiple employer groups for whom Blue Cross Blue Shield Vermont is the plan administrator and develop a program with Blue Cross and OneCare to roll these lives into a scaled target qualifying program. This is really in the next couple of slides a significant advancement into this commercial space; and last, and certainly not least, is a new program in development with MVP to bring their qualified health plan lives into a scaled target qualifying program in 2020 anticipated to be upside only for year one, and just like our other QHP programs linking the benchmark to the Green Mountain Care Board approved rate filing so we have that connected in the rate filing and the ACO program, and in our discussions really been focusing a lot on the clinical initiatives and how we can collaborate to building the strengths of both organizations and have an integrated and coordinated model.

All right. Moving on to the next slide 47 percent attribution growth, and what you'll see the way I've displayed the slide here is the gray was the existing 2019 attribution and then the color

component on the top is the year-to-year change. You'll note the big change is really in that commercial self-funded category. That's reflective of this new program anticipated in partnership with Blue Cross Blue Shield of Vermont. In the commercial QHC space the growth is really driven by the MVP program, and in Medicaid while there is growth here it's largely driven by new provider community coming in as well as a couple new providers joining for the first time as well. If we're able to succeed in our geographic attribution endeavor, that has the potential to add even more lives into the Medicaid program.

So it's really important to note here that attribution is one of the core and key components that drive everything that comes downstream. So when we grow our attribution, which is what the Vermont All-Payer Model calls for, that results in the growth in the total cost of care that ultimately shows up that as big number at the top of the page in the beginning of our presentation. So it's just important to understand the connectiveness.

When we think about the future and growth opportunities and attribution I think it's really going to be the magnitude of risk, which I'll

talk about in a few minutes, as well as the attribution methodology that will really help us yield continued growth in the next few years. If we're successful in the Medicaid geographic attribution model, transitioning that into the other payer programs will be the next logical step and really sustaining the growth that we've experienced over the last few years.

All right, and from the attribution growth comes total cost of care growth. A similar theme. We'll see the commercial self-funded growth as being the most significant portion that's relating directly to the lives coming into the model, and then more modest growth in the commercial QHP and Medicaid just reflects attribution growth accordingly there.

One of the other interesting notes, at least to me, that we'll see up in the next slide really is on the prior slide the Medicare attribution bar was the second smallest, but on this slide here when you look at total cost of care it's by far the largest. Nearly double the next largest program. That's where the risk discussion often goes. When we talk about risk it's often around the Medicare program and this is exactly why, the spend for the Medicare program on a per person basis is

significantly higher and that's basically a result of the aging population and their health care needs.

All right, and then next we have total risk. So is the number that results when we take our total cost of care estimates and we apply our risk sharing terms and come up with what I think of as the worst case scenario. So the worst year we could possibly have and it's a big number. We're up to 44.1 million dollars. In 2020's model hospitals remain the primary risk bearing entity and the magnitude of risk, particularly in the Medicare program, is a barrier to continued growth. That's something we experienced in our 2020 network development process was that risk, particularly Medicare, was substantial.

Reserving for that risk remains essential in my opinion and really is an important aspect for the sustainability of these programs. Really what I would like to see is that any one of our participants can make a downside risk payment if it's owed and also sign up for next year, that's what we're trying to achieve as the sustainability of this model and approach. It's really also important to know that these hospitals which are bearing the risk on behalf of our network they are on the hook for

four out of ten dollars of risk and they are not even providing that care. That can be somebody down the street providing that care. Could even be out of the state. Two out of every ten dollars of risk is out of the network. So they are bearing risk on behalf of the network and reserving for that risk is a really important factor to consider.

All right. So that was the overview of our ACO program budgets. This is really the OneCare Vermont budget. So I'm thinking about the budget that we maintain for the operation at Colchester. This is it. I'm going to start with an overview of the process and really how we build this budget and then the slides will follow suit in a similar order, but I think this perspective is helpful to understand. The first thing that we do is really evaluate our population health management programs, what are the clinical initiatives that we would like to focus on in the upcoming year, what are the gaps that we may have not focused on in the prior year but it's appropriate to get into that stays now, and what are the associated costs of those programs.

Next we take a look at the operating budget. This is really the OneCare Vermont call it the floor, but it's the team at OneCare and one of

the FTEs, the positions, and the other clinical tools that we may need to support those population health management programs as well as facilitating all of these contracts with payers. Those two combined really result in our expense budget. That's what it costs to run OneCare Vermont.

Next we look at and forecast payer and state investment revenue, what other revenues might we be bringing into the ACO to help us on this journey and help pay for the expense, and then last we evaluate unfunded expenses and that's really the hospital dues. So, as Vicki mentioned before, we operate this as a breakeven model so we're calculating those dues just to get us at a breakeven point. If when we get to step four those dues are unpalatable to the participants in the network, we go back through the loop; what might we be putting in that first section, population health management programs, or in operations that we could do without and like might we cut some things. Ultimately results in dues that our hospital partners can afford.

It's also important to note this really is an ongoing process. We do it for this budget cycle, but as the team mentioned early on once we get

our final attribution numbers we'll go back and redo it because the attribution will affect many of the costs in the population health management budget. So it's an ongoing iterative process.

All right. So the same order I'm going to start with the population health management investment areas. So we offer a number of programs and Sara will speak to these in more depth, but we decided to craft this slide to break them down into a number of investment areas and really speak to what the purpose of each of these investment areas is, and again the contracts with the payers upstream is really what's critical to unlock the ability and the incentives to do all of this work. So starting at the top we have care coordination investments. This is just over 10 million dollars. These are payments to fund our care coordination model that aims to encourage cross provider collaboration around our highest risk patients.

Primary care another 10.5 million dollar investment. Really intend to supply the resources to move us towards a population health focus and also paying attention to the All-Payer Model goals. Next we have quality 8.5 million. This is a significant investment here. Incentivizing focus on the quality

measures that we believe will help us do well under the All-Payer Model. Primary prevention just over one million dollars going to the network. These are investments in wellness initiatives that are designed to help keep the well population healthy and prevent them from becoming higher risk patients. Specialty care is development of specialized program models to enhance access and coordination of specialty care. This includes mental health, also exploring the pharmacy space.

And then, lastly, we have Blueprint programs. This is sustaining the funding for the supports and services at home SASH program, community health teams, and patients that are medical home patients. Again these payments would have ended coming into the State of Vermont if it were not for the All-Payer Model and OneCare's contract with Medicare.

I'll note at the end all of these figures in total tally up to 43 million dollars. This is a significant investment in these programs. This does represent funding opportunity. We are shifting many of our program payment models to pay for active engagement in care management rather than capacity building. So what our actual cost will be

is going to be dependent on provider engagement as well as the attribution that we experience as we move into a new performance year.

All right. This is a different perspective on the same numbers. So you'll note that the total at the bottom of the page is the same, but the categories along each row are different, and this is intended to show who is receiving the investments that I spoke of previously. So we're starting at the top. Again we have our primary care providers. 22.7 million going into primary care. The box to its right you'll note is quite filled. The primary care is centerpiece of many of our programs. They receive the OneCare PMPM amount. Participants in our care coordination program. Value based incentive fund opportunity. Comprehensive payment reform program, innovation fund, and Blueprint programs. Specialty and acute care just over 5 million dollars. The specialist program that we operate contributes funding as well as the value based incentive fund.

Next you will see SASH as one of the Blueprint programs we sustain the funding of. We have designated agencies and mental health providers 3.4 million dollars care coordination system, value based, incentive fund, specialist program, as well as

the innovation fund. Community health teams, another Blueprint program. Community investments. These are largely RiseVT. Primary prevention related investments in community entities that are not necessarily health care providers, but can provide health benefit to our citizens. Home health providers, care coordination participants, as well as value based incentive fund opportunity. There is a to be determined category. That's largely related to innovation fund. There will be a proposal process in 2020 to solicit ideas into OneCare and we will select the ones that we believe have the most significant impact and can be scaled across the network, and then, lastly, we have area agencies on aging and these organizations participate in our care coordination program as well.

Okay. So we just covered our population health management expenses in two different -- through two different perspectives. Now we're on to the operating expenses of OneCare Vermont. So just like any other organization each year we evaluate the anticipated demands on the organization and make adjustments as needed, and some of the FTE areas, the employment, employee, areas that we've targeted in the 2020 budget include analytics, finance, and legal

functions, all of which we recognize as areas needing additional resources.

We also, just like any other businesses evaluate our overall expense management, look at the contracts we have, are we being good stewards of our money and make adjustments accordingly. One of the other views I like to share we look at our OneCare Vermont expenses through different functional groupings, and you'll see on the bottom the bar chart breaks down our operating expenses into a number of categories. The six on the left are really categories that provide support for our network. Just about all of these could be directly hired by network participants. They could hire analysts. They could hire clinical consultant type people, but it's more efficient for us to do it at the ACO and supply those supports for them. In total these network supports just over 13 million and is just shy of 70 percent of the OneCare operating expenses.

The next category I've called out here is regulation expense. This includes the Green Mountain Care Board bill back and time and energy that goes to the regulatory process, and then the last one on the right is I think of as general administration, just about any business has to stay

alive and in operation, and that's about 24 percent of our budget.

All right. This next slide really shows the economies of scale we're starting to realize through this model and Vicki mentioned this at the top of the presentation. What we're seeing over time is that as we grow attribution and grow our total cost of care our operating expenses as a percentage of that total cost of care is continuing to decline. I think this is a really important metric for us to pay attention to, to make sure that we're maximizing this economy of scale concept, and at the end of the day that OneCare operating cost, and that's -- the total is only 1.4 percent of the total cost of care. I mentioned this in the budget narrative, but it's hard to find benchmark data for other ACOs, but in the few data points I've seen this is quite low.

Okay. So when we combine these two expense groupings, the population health management investment expenses with the operating expenses, this is the result, top section on the left are all of those population health investment areas that we spoke of about totaling 43.1 million dollars.

Next we have our operating expenses in those three buckets; network support, regulation,

general administration, and in total we have our 62 million dollar budget that Vicki mentioned at the beginning of the presentation.

When you break that down into the pie chart on the right you'll see just shy of the 70 percent those are direct payments going right to the provider community, 21 percent of the budget is network support for those providers, 3 percent goes towards regulation, and 7 percent goes towards general administration. Just note the percentages on the slide reflect the proportion of the 62 million, whereas, the previous slide was just the percentage of the 19 million operating budget.

Okay. One of the areas in our budget that has -- generates some attention is the state investment category. I'm going to attempt to shed some light on this and explain it, but let's note it's pretty complicated territory and there is some nuance in here that's important to understand. So in our income statement on the budget there's a state investment slide. That's where the bulk of this revenue shows up, but underneath there are some caveats that are really important to understand.

The top section of this grid represents delivery system reform investments commonly referred

to as DSR funds. These were funds that were made available to the State of Vermont to help us on this journey delivery system reform to transition our health care delivery system to a value based paradigm. In 2019 we received just shy of 3 million dollars in delivery system reform funding. In 2020's budget 7.8 million is included which is an increase of just over 4.8 million dollars.

Next we have other state investments. The state helps us fund our health information technology platform. This is the data warehouse and analytic tools that really support all of the work. We cannot do this work without those tools and in the 2019 budget there was 2.75 million. In the 2020 budget 3.5 million. So $750,000 increase year over year.

This next piece is certainly nuance, but it is important to understand. This is the OneCare fixed payment care coordination allocation. When we sit down with Medicaid -- DVHA to set our Medicaid total cost of care accountability the actuaries come up with a total spec, here's what it should cost to take care of these lives. We then have the option as one of the pay reform opportunities to convert some of that funding into a fixed payment or a payment to

cover care coordination. So in OneCare's budget going from 5.1 million up to 5.3 million in 2020 we are converting 5.3 million dollars of what I'll call old claims funding into a fixed payment concept to help us fund the care coordination program.

Another way to think about this is that there's no care coordination billing code that can be billed so we are essentially creating that within our OneCare program where we pay for care coordination and just trade it for what would otherwise be claims in a fee for service system. That actually comes at net, no cost to the state. It's already baked into our health care costs and already incorporated into the actuarial science that determines how much it should cost to take care of the attributed population. When you total all of these up it results in the two rows that you will find on our OneCare income statement.

Health care reform investments 13.1 million dollars and health information technology 3.5 million dollars. This does represent an increase over the prior year all told of 5.75 million.

The other factor to consider when evaluating these funds is the state match. That essentially means that the State of Vermont pays a

share and the federal government will pay a share. The match rate can be varied and complex in nature, but we've done our best to estimate the state's contribution to each of these different funding initiatives. For the DSR funding 3.9 million dollars of state dollars to unlock the 7.8 million in DSR. $630,000 for the health information technology. So it costs the State of Vermont 4.53 million dollars to bring in the full 16.6 that we will use to help us on our care transformation journey.

When you look at the year over year increase -- not shown in the slide -- in terms of the state's investment we basically take the year-to-year increase and apply the state's match rates, we're asking for an additional 2.75 million dollars of funding for the State of Vermont in the 2020 budget.

All right. This is the full OneCare budget summary. So this combines, in the top section, our incomes with the expenses and you get to the bottom. So starting at the top I didn't go into tremendous detail in the payer program investments. Generally they are PMPM investments similar to what you have seen in the past 10.7 million. We have itemized the delivery system reform dollars for new programs 6 million, as well as delivery system

dollars for existing programs 1.8 million. So some of the new DSR funding that we're asking for is actually existing programs that we just would like to continue in the future. We have our 5.3 million in the OneCare fixed payment care coordination allocation. We have 3.5 million in health care -- health information technology investments, a few other investments, and then the last two are related to hospitals. The first one is hospital contributions to Blueprint. That funding in the first year of the All-Payer Model came through in the Medicare target. Those dollars are effectively at risk if we were to have an overrun in our spending. It essentially means the hospitals will have to come to fund these. So it's contingent upon performance, but I did want to identify those as really hospital contributions to Blueprint. The last is the hospital investments line of 24.4 million in total under our total budget of 62 million dollars.

A couple other notes here. Again breakeven budget. So we're anticipating that revenue equals expense for OneCare Vermont. We're also not building any reserves in the 2020 budget model. The way in which we would do that is to run an operating gain. We're not an insurance company and we cannot

book expenses to reserves or at least have not found a way with our auditors to do so. So we are running in as a balanced budget and maintaining the reserve amount that we anticipate having at the conclusion of 2019's performance year.

What we need to do and would like to do in partnership here is evaluate our actual 2019 performance, confirm that the ending reserves are adequate for our needs, and then, if needed, come back with any requested adjustments.

Continued investment in the provider network. You saw population management investments of 43.1 million. We think this is a really important path forward to sustain the momentum we have already begun to generate, and then the last point All-Payer Model continues to rely heavily on these hospital investments. Really we would not be here without their contributions, and through 2020, if this budget model goes through as proposed here, it will total 74 million dollars of hospital investment through -- over the duration of that All-Payer Model era, and that is one of the topics that we're going to have to look into in the future.

MS. LONER: So we promised not to leave on a challenge note. We still have a lot of really

good information to share with you about the success of our model and Sara Barre is going to go into more details of that, but I thought it was really important that we step back and recognize that operating this level of reform is hard work, and it's really easy to sit on the sidelines and criticize the work and progress to date and it's another thing to really roll up your sleeves and be part of the solution, and we believe what the State of Vermont is doing with the federal government, as well as the providers in our network and the legislators that sit here in the room today and our stakeholders in the administration, are really rolling up their sleeves to be part of the solution. It isn't without challenges though. I mean we have seen that we've talked about scale and being able to get to scale. Getting to scale is really important for the delivery system as well because until we really had the full magnitude of people in the model is really operating two business systems; one that lives in a fee for service world and one that is reimbursed for value where they are able to invest in prevention.

This is new work for the payers as well to -- operation wise fixed prospective payment or all inclusive population payment or whatever other term

that you want to use for really managing under budget is what it comes down to, and this is all about sharing data too now with providers and how that exchange goes back and forth because as we've seen it's really vital to be able to share and that was kind of funny that I said vital. It is really important to be able to have that information to be able to make those decisions. Tom talked about the magnitude of risk exposure for the hospital and the midpoint of the model where the risk exposure is growing the investment needs are growing as well, and really leaned on our part and the ACO with trying to find risk mitigation plans for the hospitals. The founders have stepped up of the organization to be able to put in some plans for some of these smaller rural hospitals to be supportive of the model, but it's hard to do that, and we really have to think about what are some of the other policy levers that we could be pulling at either the state or federal government in order to allow them to continue on in this model, and I do believe there are solutions. It's really going to take all of us coming together to be part of those solutions though, and then we talked about making sure that the policy is in alignment. The timing pressures have been really

tough. We talked earlier why today about the attribution not being finalized until March so we really don't know our complete budget until March. We are sitting here before you in October and we haven't had a discussion with the Legislature yet about some of the investments that we're hoping to make. We have had those discussions with the Agency of Human Services and CMI, but really the timing of all these events really has to be looked at to see if there is a way to restructure things so that we're all marching in the same direction as we move along, and I know and I want to give a lot of credit to the Green Mountain Care Board. They did a survey earlier on this year to talk about what are some of those challenges to getting to scale to really achieve our ultimate goal and all of these came up, and so I think it's important that we continue these discussions together about how we can make this work because, again, it's really going to take a village to be able to move this work forward. Now I'm going to turn it to Sara.

MS. BARRY: Thank you. So now that we've spent quite a bit of time talking about the finances I get the pleasure of talking about all of the results of the great work that we're seeing

across our unified provider network. So I want to take you back first to the large number of 62 million dollars, and what I'm going to spend some time talking about are the investments that our providers are making in improving the care and outcomes for Vermonters across our state. As we know, one of the All-Payer Model goals is about improving access to primary care and that's critically important to all of our providers, and so it's one of the things that we pay a lot of attention to, and here I'm showing you a couple of examples taken from different perspectives as we look at the Vermonters' experience of primary care.

So one of the things that we notice when we ask Vermonters directly about their experience, about their access to care, that for children on Medicaid, their caregivers and the adolescents themselves responding to the survey indicate 94 percent of the time they are very satisfied with their access to primary care, and for adults on both Medicare and Medicaid that ranges from about 85 to 88 percent, and we know we have challenges around the rural nature of our state, around access issues, work force. So one of the things that our provider network has done through our population health

strategy committee is to really have some discussions about where do we focus our efforts, and one of the areas, which hopefully makes tremendous sense to all of us in the room, is that we want to focus on our vulnerable populations, individuals that we think we could directly outreach and impact in a very short period of time by helping uncover disease, but helping individuals better understand how to manage their own disease and connecting them to community based resources and supports.

So what we see when we've taken a look at our data for that vulnerable population in the first six months of 2018 about 85 percent of individuals in the Medicare population had had at least one encounter with primary care experience, and this year, 12 months later, we're seeing about a 6 percent increase. So now 91 percent of those Medicare individuals who have vulnerabilities related to their health and well being have an experience in primary care.

So I want to take a couple of moments and give you some stories from our local health service areas, from our communities that are serving individuals and populations. So first I want to start down in the southern part of the state in

Brattleboro and this is a really interesting story for me about collaboration across sectors. So in the Brattleboro health service area they really focused on, again, the vulnerable populations, the vulnerable communities that they are serving and how to best proactively outreach and engage them in our care coordination programs, and, as Vicki mentioned earlier, this isn't a phone call, a one time experience. This is an ongoing relationship building process that often takes months to establish trust, to understand what is important to the individual in their life, and then to help identify the resources that could best support those goals the individual is setting up, and so the teams are multi-disciplinary. They often call on important different resources and expertise in different points in time, but in Brattleboro what we're seeing is that 10 community organizations have come together, and in doing so I'm going to talk you through these two graphs. So on the left this is a graph where we're looking at the actual rate of individuals being admitted to the hospital in Brattleboro, and what we see, if you can track-- I know it's not dark, but if you look about two-thirds of the way across, you'll see that the line starts to sharply decrease. That's late in the

fall of 2018. Correspondingly if you look at the graph on the right here, we're tracking the number of individuals that are actively engaged in our complex care program who have built those relationships, and again if you look across the timeline you'll see in that same window of time, late in the fall of 2018, the number of individuals active in our program starts to sharply increase, and so really what we're starting to see in this example is the direct impact of all of that time and energy of providers of all types pulling up their sleeves working collaboratively to identify how can we support each individual in their unique circumstances, and then how do you look as a community at how those systems and services are organized and how we can best then support the continued evolution of programs like this.

In a second example, this time in the Berlin health service area, the teams at Central Vermont Medical Center identify an opportunity to help patients with diabetes, and the graph that I'll get to in a minute is specific to the Medicaid population, but the information and the experience transfers across the population in their community. They are treating individuals holistically regardless

of whether they are in the ACO or not, and so in this community they focus on two key strategies. First, they were looking at what we call panel management, and what that really means is making sure that in the primary care provider's office there is somebody who is responsible for looking ahead of time at the population, whether that be a population of individuals with a particular disease, individuals that haven't come in for visits, who need screening appointments, and that they are making arrangements to help those individuals connect to services. Often times means coming into the office, but sometimes it means ordering a lab test or procedure encouraging them to follow up with a resource.

The second strategy that they focused on in Central Vermont was aligning provider incentives. So they looked at actually the physician compensation plans and aligned goals under the All-Payer Model. So really quality goals and associated that with the physician's compensation, and those two strategies we can see now in this graph are really starting to pay off. So what the graph is showing us here is the percent of patients, again this is Medicaid patients, that have diabetes who had a laboratory test to assess their blood sugar over the course of the last

year. This display is also an example of how we're advancing our approach to how we share information with providers and help them understand opportunities to share the successes that might be happening in one community to those that might be challenged or struggling in this area in another community.

So the green dotted line near the green dots represent OneCare's average month to month and you'll see that is increasing at a nice steady rate. The blue line, however, represents the experience in the Berlin health service area, and you can see over the course of the last really close to 18 months now they have had a continual improvement, and they have maintained their performance well above the average of OneCare overall, and so part of our job then is to help shed the light on what they are doing that's different and help share that information with other communities so that we can experience the best of those things that work as well as learn from the things that are maybe not working as successfully. So we don't waste time and energy and resources in those directions, but instead focus on the promising practices.

These types of stories are things that we share every month through our clinical governance

committees, through community visits, and collaborating activities to the accountable communities for health, and so I think there's tremendous opportunity over the next couple years in the ACO to shine more spotlights on these great successes.

In the third example this time we are looking at variation in use of the emergency department across our state. One of the things that I mentioned a moment ago is that it's always an interesting opportunity to hear from providers in our network about how they want to experience information and data in a way that's accessible and meaningful to them. So in this example we're taking a visual look at what our performance looks like. The two maps on the left represent the Medicaid population. On the right the Medicare. The very first map in Medicaid is looking at the rate of emergency department visits and the second map is comparing that to engagement in our complex care coordination program. That pattern is mirrored in Medicare, and specifically what we chose to look at in this example is having set clinical priority areas as an accountable care organization and communicated those out across our network consistently are we seeing change happen

relative to those priority areas.

So the blue colors indicate communities or health service areas where we have seen improvement from 2018 to our 2019 year-to-date improvement, so knowing the calendar is not up yet, and orange represents an actual decline. The darker the shade of the color the larger the scale of the improvement, for example. So what we're seeing here is that in that Medicaid map on the far left eight of our health service areas have improved by at least 10 percent from their performance in the prior year when it comes to looking at how often individuals are going to the emergency department. I will note that where there are some opportunities where you're seeing some of the orange color as we've dug go into that information we can relate that back in many cases to reports from those communities around specific access issues in primary care where some providers have left in recent months and they are working very hard to recruit additional providers to that community. So I think that's an important note for us all to recognize. It ties back to the underlying premise of the importance of primary care in providing preventive care appropriate and timely access to services.

So just pausing for a moment to recognize OneCare's unique value in providing data and timely information to providers, all types, across our network. We have spent tremendous time asking providers what is most meaningful to you, how do we better support you with that information, and some of the things that we're learning are that it's helpful to break information down into small pieces. Now that sounds intuitive, but for those of us who like to experience all sorts of the data and be able to play and learn from it, it's taken a little bit of reminding here's an opportunity for us to be very focused and specific in asking and answering questions that providers want and need to know to better serve their patients.

We have spent tremendous time adapting our tools, providing looks that start to dig into the variations of care and the patterns of care that might be experienced say across one payer population to the next, across one community to the next, and even down to the level of how does care vary from one provider to another within a practice organization.

We send staff out into communities all of the time to help people understand the information and help them connect it to best practices and

evidence based guidelines or ideal care, and we use this information in our clinical governance committees and certainly at our board to help drive decision making both about opportunities as well as potentially successes around the population health investments that we're making.

So one of the interesting areas of note is that when we look at our analytics tools, the software and the databases that we're using, we've actually doubled the number of organizations that are directly accessing that information to solve problems in that your communities to answer both easy and complex and vexing questions they might be facing.

So I want to move now to talk a little bit about our provider networks' experience in the All-Payer Model and specifically our population health goals and some of the strategies OneCare has been deploying to support those goals. Again I think it's really important to recognize that we take this from an unified approach to our provider network inclusive of primary care, specialty care, our home health agencies, our mental health agencies, as well as community based organizations, skilled nursing facilities. So it really is providers coming together both at the community level as well as the

statewide level speaking with one voice about what is important for patients and for patient care and outcomes.

So just briefly we take this left, right, we talk about access to primary care. We've spoken a little bit today about the investment in primary care. Looking to 2020 that is about 22.7 million dollars invested into primary care to make sure that we are providing both preventive care as well as disease specific care and referrals to resources as needed to support population health, the coordination of care, and better outcomes for Vermonters.

A specific program that we are planning to advance in 2020 is our comprehensive payment reform program, our CPR. This is a program that specifically highlights the unique needs and opportunities for independent primary care practices and rewards high value care, and as we continue to learn and receive feedback from providers in these types of programs we continue to evolve them in new directions, and so some of the new directions for that program that are anticipated are really more directly tying some of the underlying funding to quality measures and outcomes as well as to

advancements in the coordination of care for vulnerable Vermonters.

In goal two focusing on reducing deaths related to suicide and drug overdose, OneCare has been very excited about a partnership that we've invested in between SASH and the Howard Center in the Burlington area that has embedded a mental health clinician in two congregant housing sites in order to both reduce stigma associated with mental health as well as reduce isolation. OneCare is committed to continuing this funding next year and we're very excited to see that there are some initial outcomes that we're starting to achieve that really look at not only the coordination and the holistic services that promote health and wellness both physical and mental within those settings, but also connecting those programs more proactively to reduce things like unnecessary utilization of the emergency room or more proactive use of preventive care and services.

Also this is an exciting opportunity for me to share with you a little bit about our innovation fund, and so new in 2019 OneCare's board invested more than a million dollars in a program or really a process that would highlight areas of promise and innovation at the local community level

and provide funding to assess the impact of these promising ideas. So we're very early in the processes, but one of the examples of an investment that has been made in a program that is up and running is called psychiatric urgent care for kids, and this is a program down in the Bennington area which is a partnership of United Counseling Service and Southwestern Vermont Medical Center, and their focus is on creating a child psychiatric urgent care center which serves as an alternate source of care from care that was typically being provided in the hospital emergency room, and so what was happening was that individual children, often young children in elementary school, were experiencing disregulation. Behavior that was challenging in the school setting that wasn't necessarily able to be appropriately addressed there, and they were being transported oftentimes by police to the emergency room for services, and that community got together and said this does not feel like the best way to provide care to vulnerable children in our state so what can we do different, and what they have already put in place and they launched in the beginning of the school year a program that utilizes expertise of mental health providers who are used to caring for children with

some of these concerns and doing that in a setting that is more accessible, more friendly, less trauma inducing, and so that is out of the hospital grounds in a safe and friendly environment with the goal of being able to help that child return to school that same day, and if not that day, certainly within the next few days. The program is run holistically involving parents and caregivers as well to help teach coping skills as well as supporting family strengths.

And then as I move to goal three we're really looking at the prevalence of chronic disease, and so when you think about the work of an accountable care organization oftentimes a lot of time and energy is focused on chronic disease management, and that is certainly true here at OneCare and in the state as well, and so some of the levelers that we use are focusing on things like clinical education, having sessions where we are bringing experts together from the primary and specialty care practices, from our continuum of care also here, hearing very specifically from patients and our caregivers with lived experience; and one of the interesting anecdotes I'll share that in those sessions, which are often attending by 70 or 100 more

providers, it is usually that lived experience, the individuals experience with the delivery of care, with the relationships that they have formed, with the way that it has impacted their health and well being that really resonates the most for our providers, and so they take that back and they think about how do I incorporate those best practices into their work, into the way they are delivering care.

One final example here also innovation. This time in Addison County. We are very pleased to be able to support a program that is looking at how to better serve patients with diabetes. Oftentimes individuals with diabetes need to have their eyes checked and that often involves a separate specialist appointment, maybe traveling out of town, waiting for an appointment to be available, and so what this group of primary care practices innovated around was really saying let's bring the technology into the primary care setting. Let's bring cameras that are specially formed to be able to take pictures of individuals' eyes and send those pictures securely off to the appropriate specialist to read that information and report back to primary care whether any further followup is needed, and so in doing so we're not only improving the satisfaction of

individuals, the timeliness of the care that we're receiving, but we're also more likely to have those individuals receive the screening that is necessary because we've removed a barrier, whether that be transportation or time or busy schedules that we all face. So we're very excited to be proctoring that program and watching for the outcomes over the next year or two.

As I move forward I want to spend a little bit of time talking about our complex care coordination program. In previous testimony we spent tremendous time talking about the start up of this program, the tools and resources, how we were educating our providers around the network, and now I I'm really excited to share some of the first outcomes that we're seeing from this investment. So as Vicki mentioned at the top of our discussion, we have in the last nine months, ten months now seen a sixfold increase in the number of individuals that are active in our care coordination programs, and just to put some numbers to that we had about five hundred individuals that were active in the program in January of 2019, and we keep watching this often on a daily basis and as of the middle of October we're now above 3,000 individuals statewide that are

accessing this program, which means that they not only have the connection to resources and supports that can help them, but they actually have a plan for their care. They have goals set. They have people identified to help them make progress with those goals. You'll see through the program more than 11,000 individuals have been touched and you can see by the graph actually the rates of increasing engagement in care management or in care coordination over the course of this year.

I think it's really compelling as we talk about our network of providers and recognize the unique skills, the license, the supports, the education that they have that we now have 75 organizations representing more than 700 people on the ground in communities statewide helping to support the coordination of care for vulnerable Vermonters. That is a really impressive number and a support shift, and I think it speaks very well to the spirit of collaboration across the organization within and, again, across communities in our state.

We will continue to monitor a whole series of both process and outcome measures associated with this program, but I wanted to highlight just a couple of components now. So

returning to the topic of primary care engagement, we first looked at those individuals in Medicaid and Medicare programs that are actively care managed, and then we dug in to see for those that have been in the program at least six months, kind of our threshold of in the program long enough to see if this makes a difference, we've seen that 99 percent of both the Medicaid and Medicare populations active in care management have had a visit with their primary care office and that's an impressive feat. It really speaks to the way that care is being organized so that we see underneath that, that when we talk about care teams and the organization of the team around an individual that 86 percent of the time they have a primary care team member listed as one of those core members of the team, if not the quarterback or the lead care coordinator.

One of the earliest indicators from an outcomes perspective that we would expect to be watching, and in fact we are seeing, is what happens to the rate of the use of the emergency department for individuals that have this proactive care coordination and a plan around their care, and in fact what we're seeing for individuals again that have been in the program at least six months is a 33

percent reduction in use of the emergency room for the Medicare population and a 13 percent reduction for the Medicaid population. These are both highly statistically significant reductions and represent I think the first signals that we're expecting to see about the impact of this community team based care process.

In a second outcomes example one of our partners, the University of Vermont Health Network -- Home Health and Hospice -- I got that one out wrong -- they have focused some of the care coordination dollars that they were receiving from OneCare on experimenting with a program called the Longitudinal Care Program, and what it really does is allows an individual who still has significant health needs, physical needs, mental health needs, maybe some social or economic challenges in their life, who no longer is under a fee for service system traditionally be able to access ongoing home health services to in fact continue to receive them, and to receive them in multiple and creative ways. So they can receive telemonitoring in which they might have their blood pressure monitored from their home and that information sent to the nurse at the home health agency who then calls them up if something looks

abnormal. They might continue to have visits by a nurse or by a social worker or by somebody in the community who is connected to other resources that can help with their individual needs.

In this small pilot program we've seen some incredibly dramatic results. We've seen a $1150 per person per month reduction in cost associated with that individual's care. We've seen that the use of the hospital -- so actually people getting admitted to the hospital in this program has been reduced by 26 percent and use of the emergency department has decreased by 20 percent. This was really exciting news to us and the kind of transformation and innovation that we want to see and promote, and so one of the things that we are committed to in 2020 is actually expanding this pilot program into nine additional health service areas really being able to test this model in rural areas of the state and assess whether we can see outcomes that approach the magnitude of these outcomes in this initial population.

So as we advance through the years of the All-Payer Model there are always opportunities to iterate to learn from what we've done to date and to improve upon that, and so at the direction of

OneCare's board back last winter we were then charged through the Population Health Strategy Committee with identifying what the appropriate next steps should be to evolve the payment model associated with this complex care program. We understood that this was an opportunity to come together with partners across the state representing all different aspects of the continuum of care, and then our common goal was to figure out a strategy that would allow us to move from the initial capacity based payments, so paying to make sure that there were individuals there ready, to really moving to a payment model that pays for value, one that is producing the results that we all believe are the right direction in providing better care and quality for Vermonters.

We used an iterative process with multiple focus groups, lots of discussion, lots of disagreements along the way, lots of pushing to see how far could we go while not going too far so as to make this a model that was not sustainable on a month-to-month basis as organizations needed to meet their payroll and ensure that they had the staff able to provide these supports.

The result was a consensus based recommendation to OneCare's board of managers back in

the late spring, and we have spent the last few months traveling the state and speaking with leaders of all types across the state to help them get ready for this transformation.

So what will be happening is in April of 2020 OneCare will be evolving the way it is going to share the 10 million dollars that Tom was talking about earlier with providers across the network, and the new model is one in which we are paying significantly increased monthly amounts of money based on the individual care coordinator's role in supporting patients in the complex care program. So what I mean by that is if a person identifies that an individual, let's say a nurse from a home health agency, is the person they want to be their lead care coordinator, the quarterback of their team, they will get a payment for that role. If there are other people on the care team, say a primary care practice and maybe somebody from the mental health agency, they will also get paid for those roles.

In addition, when we look at best practices in care coordination one of the opportunities our providers saw was to actually focus more on something called a care conference really bringing together and convening the individual, the

caregiver and family with those supports and organizations that can best then both build the plan of care together, but also execute and evaluate and assess and modify it as needed, and so there will be payments associated with the successful execution of those care conferences as we move forward.

Finally, I think it's important to note that there was an active discussion and commitment that the organizations that were currently receiving funding under this model including primary care, the area agency on aging, the designated agencies for mental health and substance abuse, as well as home health would continue to receive funding, and that SASH was a very valued partner and, in fact, very engaged in our current program and that their funding would continue but be aligned under a central contract with OneCare, and that anyone who is brand new to the ACO in 2020 be given the same opportunity that those that joined earlier have to have some capacity building time in order to make sure that they can organize the services, reup the staff to provide the expertise and time that individuals need to best support these care plans and eventually the outcomes that we're all looking to achieve.

So now as we look to 2020 I think it's

important to recognize the scale growth that we've been talking about today, that our goal here is to bring more Vermonters into an aligned model and for providers themselves to practice in one new value based system which increases the likelihood that all populations, whether they are within the ACO, under OneCare or not, receive the high quality care that we as Vermonters all want and deserve.

This is realized through things like this complex care coordination program, through things like the innovation that we're discussing around geographic attribution at the Medicaid population. So as we turn to 2020 one of the things that we will be paying particular attention to is how we are continuing to monitor and evaluate the programs and investments as directed through our committees, our board, around the value that we are delivering to Vermonters.

In 2020 we hope to launch a major new initiative that addresses quadrant two. So this is the quadrant in our population health model that focuses on individuals with chronic conditions, and we hope to do that by partnering clinical pharmacists as part of the primary care team and really looking at how we can use evidence based models of practice

that exist around the country to both extend that care team and focus on individuals who may need closer and better management of their conditions, including at times the way that they are receiving medications or managing multiple medications.

As I mentioned earlier, OneCare plans to invest in spreading the home health longitudinal health program to additional rural communities around the state, and we are making specific investments in mental health and innovation. So I spoke about a couple of examples earlier, but there are additional investments in programs that we are in the process of launching in partnership with Vermont care partners and our designated agencies around the state that are really looking at how we can address some of the needs of individuals that are accessing mental health care through the emergency department and how to help them navigate the systems, the resources that are needed in the community to help them avoid needing to access care in that site.

We also are focused on continuing to improve engagement in primary care. So I spoke earlier about focus today on the high and very high risk populations, our vulnerable populations, but we also need to pay attention to how we improve access

to care more broadly and how we think about using our care teams in new and innovative ways to provide screening opportunities to promote prevention as well as to access care in all sorts of settings in communities where people are living, working, and playing.

CHAIRMAN MULLIN: As you're passing the mike I want to point out we're about 15 minutes behind schedule already, and so if anything that can be done concisely, we would greatly appreciate it.

MS. LONER: I can be very concise. So I just want to close to say why are we doing this. I think it's important that we reflect on why we're doing this work. We're really doing this work because we want to have better health and wellness for Vermonters, right, and we want to be able to have health care that is affordable and sustainable and into the future so we need to be able to curb some of that spending.

What this budget really supports is those continued investments to advance those goals we talked about earlier in the discussion around access, preventive suicide, and chronic diseases. We really want to be able to grow the model so that all Vermonters at one point in time can have the benefit

of this enhanced system really looking at hospital payment reform as a crucial part of this so that they can be sustainable into the future. Primary care and community based investments they are really important to us as we look at the full continuum of care to fully wrap around individuals to support them the best way we can, and also let's not forget we don't want to lose any kind of momentum along the way and give up some of those valuable Medicare Blueprint funding that absent the ACO wouldn't continue to exist.

So with that I leave you with an amazing quote and another testimonial from Jill Lord from Mt. Ascutney Hospital who really kind of synthesises what we're trying do here. "Instead of working in silos, we can approach this as a system. We are developing stronger relationships." Thank you.

CHAIRMAN MULLIN: Thank you, Vicki. I have had a number of requests for a bio break and looking at the clock I'm not sure that's the best use, but I do want to ask the court reporter how she's doing. Five minutes. Okay.

(Recess.)

CHAIRMAN MULLIN: We're going to resume. We're going to start with board questions and,

Maureen, are you still on the line?

MS. USIFER: Yes I am.

CHAIRMAN MULLIN: Okay. How is your itinerary? Do you have a time constraint or --

MS. USIFER: No I'm fine.

CHAIRMAN MULLIN: Okay. So I'm going to start with Member Pelham. Tom.

MR. PELHAM: Thank you and thank you OneCare for an in-depth presentation. I've been told by a couple members up here be quick and short and definitely don't do any dancing.

MS. LONER: We want to see that. Come on.

MR. PELHAM: Not going to happen, but that does make me turn to RiseVT because it was a RiseVT event and I got caught. So my question about RiseVT is I've seen it in Ascutney, I've seen it at Northwestern, I've seen it at Southern Vermont, and I just wonder about at the upper level -- at your level whether or not I have any metrics that profile the connection of RiseVT to the areas of primary care physicians. Just thinking about somebody that comes in an office, they are prediabetic, you know, how does that physician steer them to the opportunities that RiseVT provides?

MS. LONER: Sara, do you want to take that?

MS. BARRY: Thank you for the question. I think it's actually really insightful as we think about spreading RiseVT activities into more communities. We've been very focused in the initial launch and uptake in working in cross sector relationships within communities to build understanding and knowledge. I do think that there are many areas of strength as it pertains to the connection to primary care, but there are also some opportunities to continue to enhance that, and so that will require continued education, continued support of the local program managers in connecting to the resources within their community. One of the ways they can do that is through their local accountable community for health infrastructure, and as you likely know that can look different from one community to the next, but I think it provides kind of a central organizing framework around how we can then best identify the strategies and the priorities to promote prevention activities, and do it in ways that are creative, innovative, and don't take lots of time and energy, and that's one of the key things that we've been so pleased to see in the RiseVT

structure is around these amplified grants, taking the time to look at something that is the bright seed of a great idea and how a little bit of money can help amplify that and spread it more broadly. So I think as we move forward we'll continue that with our primary care providers in more concentrated efforts as well.

MR. PELHAM: Thank you for that. My next question has to do with the choice of the trend rate in Medicaid. In the narrative -- I think it was in the narrative there was a discussion about a building and trend rate based on 2018 to 2019 experience, and that led you to about a 2.2 percent rate versus an one-half of one percent which I think was admittedly described as something like very modest, and so in your models you use the one-half of one percent rate, and I'm always a little bit concerned about the cost shift kind of being a bit of a chronic disease within the health care system, and I'm just wondering what went into your thinking about the choice having to do with the one-half of one percent versus the 2.2 percent.

MR. BORYS: It's a really good question. So at the time that we're building the OneCare budget we don't have information on the actual attributed

lives. We don't have final information on the provider network either. So we try to make the best assumptions that we can to give the providers the opportunity to make a decision to participate that's reasonable and would give them a fair reflection of their downside risk, for example, and what their population management payment would be and things like that. So we choose a relatively modest Medicaid increase for a couple of reasons. One is the All-Payer Model holds us harmless to rate changes for Medicaid. That was one particular area in the contract that was noted. So if I were to project some rate changes, my concern is that in the evaluation of our overall trends it would look like we're breaking the All-Payer Model boundaries a little bit even though some of that within is actually exempted from the growth trends. So that's one component. The other component is that many -- when you actually go through the rate with DVHA and their actuaries there's a lot of components; population based components to it, demographic components, as well as the actual attributed life to our community. There's just so many unknowns in there. So going to something that's been relatively middle of the road has been helpful.

MR. PELHAM: Thank you. My next question has to do with the kind of growing portion of your revenues coming from Blue Cross Blue Shield and the QHP populations and you're projecting revenues at 167.7 million. Our last rate review with Blue Cross Blue Shield indicated that they had about 311 million dollars worth of claims that they projected. So you're substantially into that market.

My question has to do with the review of the benchmark plan that is used for the QHP population. It really hasn't been -- as I understand it, been looked at since 2014 and it's a plan where I'd probably be today with the silver proposal from Blue Cross Blue Shield for the 2020 bronze group, and it shows that if Joe had diabetes and it was in a good appropriate care approach, it would be about a $7,400 expense roughly and the patient's share would be four to $5,000. So that's if you have crossed the line and become diabetic. If you're prediabetic, there's really not much in that benchmark plan for you. You can get a free preventive care visit that might tell you that you're prediabetic. You can pay $90 in the bronze plan for a visit with a nutritionist, but the clinically based best approach of nutrition and physical fitness isn't there, and so

that makes me wonder whether or not it's time to revisit the benchmark plan used for the QHP population and do so in a way that emphasizes the All-Payer Model approach to investments in preventive care.

MR. BORYS: That's a really good question. I'm not intimately familiar with this qualified health plan benchmark plan that you reference here. Totally interested in learning more about it and how we may be able to incorporate something in the All-Payer Model, but I think I'll go back to as a provider system all the work that you heard about earlier is to prevent people from becoming diabetic. So manage the diabetes better and that has the potential to help that actual member save costs downstream. So very interested in learning more about that space.

MR. PELHAM: I'm almost certain that the actuarial value of prevention is minimal relative to the value of the $7,400 a year annually of treating diabetes.

My next question has to do with -- thank you again for the profile of the 13.1 million in health care investment. There's always a lot of layers to this and I think that you went through the

layers and diminished some of the concerns some folks might have with that number. I would just like to add to that, that in the context of 2020 there are other numbers that affect some of your closest providers, the hospitals generally, where the DSH payments have dropped over the last two or three years for a total of 14.7 million down, and the taxes from the hospital provider tax has gone up in 2020 from 2018 by 13.4 million dollars, and I just think in terms of your presentation you're looking at one small piece of a relationship with the state, and in the entirety there are a lot of relationships going on and cumulatively I'm never sure where they add up, but at the state level I think they add up to a cost shift that we documented over 200 million dollars just for Medicaid. So that's a point I would like to make.

Two more quick questions I think. I'm trying to be as fast as I can. On salaries you have -- what is the rollout from 2019 into 2020 and what do you expect the fully loaded increases in 2020 to be in 2021?

MR. BORYS: We're actually rolling out any positions now in anticipation for the next year. The demands are current. In terms of what 2021 looks

like it's hard to know at this point in time. It's one of those questions we evaluate through the year. Do we have the right resources in place? Do we need additional resources in certain areas? But just like any other business we're very mindful of our financial resources and try to make decisions that allow us to support the network effectively and support the goals of the All-Payer Model without being excessive.

MR. PELHAM: And my last question is having to do with the proportion of your revenues coming in as fixed prospective payments. In our hospital budget for 2020 it was about 405 million dollars of their 2.7 billion dollars that were identified as fixed prospective payments which is down around 15 percent. In your presentation you're like 471 million and that's at about 36 percent for the ACO system.

You have in your presentation -- I'm quoting here -- "when the point is reached that most of the revenues are paid on a population basis, the underlying incentives to invest in prevention and wellness have emerged as a core business strategy for all of the state's providers," and I'm just kind of looking down the road here and wondering if you have

any expectations of when the majority of payments will be based on fixed prospective payments and, therefore, we should begin to see that pressure in the system to help constrain costs for ratepayers and taxpayers.

MR. BORYS: I'll start. I think the prospect of the fixed prospective payment for Blue Cross Blue Shield is a huge step forward and opportunity for us so that will certainly help change that pie a little bit. There's a lot of other payers out there as well. So if I'm honest about the barriers, it's just a multitude of payers that contribute to the health care system, and converting them all to a fixed payment in a relatively short period of time is a little bit of a daunting task. Really the goalpost that we think about, and this relates to Vicki's comment about two different business models, is we have in a fixed payment capitation model and then the fee for service volume based reimbursement in a smaller portion of their business, and the decisions are made based on the larger section. That's what we're trying to achieve. It's never going to be 100 percent, but we're still trying to get that balance so the providers receive more of their revenues on fixed.

MS. LONER: I would just add to what Tom said in terms of when do we think we will really reach that threshold and I would say that some of it depends as well, right. So when I say it depends, I say it depends because right now the Medicare population based payment is not indeed a true fixed payment. Really what it is, is it provides you with that fixed payment upfront and then it reconciles on the back end fee for service. That's not predictable or sustainable. So really what we need to do is move our federal partners to a place so that they can make that a true fixed payment and be able to do it in a reliable way for our hospital partners, and, you know, we also have one of the challenges that the Medicare risk corridor for some of the smaller risk -- smaller rural hospitals right now is very large and it's not feasible for them to be able to do that.

So I think one of the biggest challenges for us all to solve for this in this room is how do we enable more providers to sign up with the Medicare program and how do we get them to actually fix payment.

MR. PELHAM: Thank you.

CHAIRMAN MULLIN: Robin.

MS. LUNGE: Thank you. I'm going to

start where we just left off and I'm just going to apologize in advance because I have questions throughout a bunch of different materials. We might get a little redundant as I flip through things so my apologies.

On the Medicare risk corridor for the rural hospitals, as I think you know the Legislature passed a Rural Health Services Task Force last year that has 14 members across the provider spectrum and I am the Chair on behalf of the Green Mountain Care Board, and so we as a task force have been starting to delve into the issues that are at the top of mind for rural health system in terms of sustainability. So I was curious to know if you have any suggestions around the Medicare risk corridor and specifically that could help bring along the rural or small hospitals, understanding of course that's something that the federal partners would have to agree to which means a negotiation and that's not quick, but I'm curious if you have done some thinking about how that could evolve.

MR. BORYS: I've done a lot of thinking about how this can evolve, and I think you're right to separate it into different components, and the first one at the top is the risk corridor with

Medicare which is at minimum five percent and that's a pretty significant amount and for rural critical access hospitals that's a very significant amount. So that's one topic I would like to address over the next year is how do we still maintain some downside risk, which I believe is effective in driving the change that we like to see, but make it a little bit better fit with Vermont economics and health care.

The other just to name it is the OneCare risk sharing model and we put a lot of thought into this and I think it's something that we intend to look at really closely over the next few months, certainly before network commitments are due next summer, and the problem that exists is it's a zero sum gain within our ACO. We have a risk number that needs to be delegated some way somehow across the network. There are lots of ways do it, but at the end of the day some are going to end up making changes with more and some will end up with less. That might be right. It might be okay to do, but it needs to be done really thoughtfully with our network participants in advance of the decision to participate. So that's something that I really want to look at closely throughout the -- over the next few months just to make sure that we involve with our

network and can get the maximum participation.

MS. LUNGE: Thank you, and I should also mention Sara came to one of our care coordination topical meetings and that was very helpful, and we do have a care coordination subgroup that will have some recommendations that will come out, but shifting now to the fixed payment issue, for this will come as no surprise to you since I ask this question pretty much every year, but I was delighted to hear that Blue Cross Blue Shield was moving forward with a pilot on the fixed prospective payment, and I was curious if you could give me more details about that. Are we looking at one partner? More than one partner? Hospital side? Do we know who that is yet?

MR. BORYS: It's a great question and yeah thank you to Blue Cross Blue Shield for investing the time and energy to develop that. That is much appreciated and something that we're excited about as well. Southwestern Vermont Medical Center has agreed to be a pilot site with us and test out some of the mechanics. So thank you to them as well. We're working with UVM Health Network sites and trying to work around their Epic installation dates a little bit to make sure that -- we just have too many competing demands, but we anticipate some iterative

rollout in the UVM Health Network in 2020.

MS. LUNGE: Great. Thank you. So one question I wanted to talk with you more about is attribution methodology. So -- hold on just one second while I get the right page here. So in your materials, which is in part two of the binder, you had some information around potential opportunities about attribution. Specifically on page 13 you had a grid that provides attribution opportunity targets to 2022, and I know that you had indicated earlier that in the budget numbers you didn't include any assumptions about an expansion of the Medicaid geographic attribution, but I was curious about this chart, and in terms of the opportunities are these related to assumptions around geographic attribution, other attribution changes, inclusion of new providers? What's driving that chart?

MR. BORYS: Good question. So I took -- used the word targets pretty literally when developing this chart, and did incorporate factors for geographic attribution what I think it could yield on a per payer basis and our experience in that particular area is limited but growing. So I think we'll have better understanding of what the opportunity actually is in the future, and then also

just looking at the size of each community compared to another similar or like size community what might the attribution opportunity be for that particular community. So it's -- I think it was a good fair stab at what we think is out there, but was really based on our past experience and just matching up with similarly configured communities.

MS. LUNGE: Great, and so did you make any assumptions on the geographic attribution? Were you just thinking about Medicaid or were you thinking that that's a potential for other payers? In particular I'm interested around Medicare.

MR. BORYS: Well we're starting with Medicaid as a partner also interested in this model, and I think what we're learning is Medicare is very transferable to other payers. Medicare would be another one to consider I think, and this is -- I say I think because we're still learning in the space. I think the opportunity is greatest in the Medicaid so we're almost tackling the biggest one first. Medicare the percentage that actually attributes much higher because the engagement in primary care is just much more regular.

MS. LUNGE: Thank you.

MS. LONER: I would just add a little

bit to that in that if you're looking at Medicare, usually these are individuals who haven't been seen by a primary care physician or they are seeing another provider in our network, and so when we're looking at the magnitude of risk too, since we don't have a lot of experience with those particular individuals, we have to have a discussion with Medicare of could you have some sort of tiered risk such that instead of the normal five percent risk corridor because I think that would be prohibited to scaling that model.

MS. LUNGE: And in terms of the Medicaid geographic attribution are you expecting to have more data or information about that program at some point and when would you expect to have that?

MS. LONER: So, yes, that's one of the things we're working very closely with Medicaid on now. Our plan and there's always a plan, right?

MS. LUNGE: Yes.

MS. LONER: -- is that we would be able to close up those discussions around December when Medicaid also has to come in and have their actuarial review done on their rates. So that could be part of the rate discussion.

MS. LUNGE: Great. Thank you. Turning

for a moment to the comprehensive payment reform pilot I was very interested to hear that you're looking to add quality measures. I wonder if you could give me a little more information about that, how many are you looking at, are they aligned with -- at the ACO with the ACO quality metrics? How are you engaging with providers around administrative burden? That kind of thing.

MS. BARRY: Sure. So we engage the independent primary care providers that are currently in the comprehensive payment reform program in a series of conversations as we look to increase accountability under that program as we move to 2020, and so what we are looking at is a program that creates a variable component of payment associated with meeting our target care coordination engagement rate of 15 percent. So that would be one component, and then a series of quality measures that we've agreed upon with them, and within each of them we looked at by payer what does perform and looks like at the ACO level or down to the individual site level where we could do that and we set targets for them.

The measures do vary a little bit. So sometimes, for example, in a measure that might be related to a particular chronic disease that would

normally require manual data collection on our part, we came to some compromises where they can run panel management reports out of their EHR and send us that information, and we use that at a population level as a proxy for their performance against target. So we would be happy to provide you with some additional details on the specifics of that.

MS. LUNGE: Great and it sounds like that shift to allow for the EHR report is really trying to attack the administrative burden issue that we often hear related to quality measures.

MS. BARRY: Absolutely. We're trying to find the efficiencies and these are proxy measures. We still will have the quality measures at the OneCare level, but we think they are reasonable estimates on the monthly or quarterly basis to signal the change we want to see.

MS. LUNGE: Great. Thank you. I was curious -- this may be a bit of a sensitive question, but I was curious if you could speak a little bit to the situation with Springfield Hospital as it's known Springfield has moved into -- has filed for bankruptcy and been moved out of the Medicare program because of the risk as we talked with earlier, but I was just curious how you were thinking that will

impact their broader participation in the ACO model, if you have concerns about the bankruptcy related to the financial relationship that you have with Springfield, or any other information that you think we should be aware of.

MS. LONER: So that's a great question and we had a series of discussions with Springfield, both hospital and FQHC, prior to having to determine what our provider roster would be for the payers because as you know with Medicare once you submit your roster that's it. There's no new adds. So we wanted to make sure that we had some thoughtful dialogue about the next steps and approaches, and in talking with leadership at Springfield they felt like the program itself was very valuable in terms of having the predictability with the Medicaid payments and moving to something similar with the Medicaid program -- I mean the commercial program though risk for the Medicare program was, as you said, too high for the hospital, and so what we've been doing is having some discussions with the FQHC to say really primary care is foundational to the work that we do. We don't want you to lose momentum in the work that you're already doing so let's have some discussions to see how we can continue to support and advance

that work so that when you're able to move back into a Medicare program you can be successful and not lose ground.

MS. LUNGE: Any other financial issues on your end that you want to touch on?

MR. BORYS: Just to say that we pay attention closely to the 2019 performance to make sure that we don't have any risks for OneCare. So we're trying to balance but support Springfield, give them what they need, but also look out for OneCare and its network too. So we pay close attention to that.

MS. LUNGE: Thank you. Related to the complex care management program and the shift in the payments I just wanted to clarify something to make sure that my understanding is correct. So for new providers coming into the program in order to give them this initial year of capacity building will they be receiving the funds that were the same payments as everybody received this year; so the $15, et cetera?

MS. BARRY: Yes. So what we will do is apply the formulas we use today to their entire very high risk population proportionately to give them that onboarding opportunity.

MS. LUNGE: Great. That's what I

thought, but wanted to clarify. In terms of -- so one of the investments -- and this is on page 43 of section 5 of your submission -- is around primary care engagement and looking at how to engage Vermonters more proactively, and I think that refers to the Blue Cross Blue Shield program around primary care that is to me new where it's not a scaled target model, but it allows for engagement with folks in the QHP population who otherwise haven't engaged in primary care.

MS. BARRY: It's really taking the foundational work that we've been doing under that non-scale target eligible program and looking at how we could expand it in new ways. So we are thinking about, for example, how we could resource communities around some innovative ideas to promote access if we expand the Medicaid geographic attribution pilot, for example, because we know these are individuals that don't have a relationship with primary care, otherwise, they would have already been in the model.

MS. LUNGE: Great.

MR. BORYS: I'll add one other point. It's a nice tandem with geographic attribution as well where we may be attributing lives to our model that don't have an active primary care relationship

and this work can help get them engaged with primary care.

MS. LUNGE: Great. On the innovation fund I was very interested to see that you had created an innovation fund. We had done this with our state innovation model grant which I thought was one of the perks of the grant that providers really appreciated, and it did allow us to test some really cool innovations and some of them worked well and some of those didn't.

So one of the questions I had about the innovation fund is how you would be looking at evaluating each of the projects that you're funding, what's your time frame for that. That may vary by project, but just giving us a general sense we're investing in these cools things, but then what.

MS. BARRY: Sure. As part of the structured request for proposal process that we ran two rounds we were very clear at the direction of our population health strategy committee of what the areas of focused interest were. So that was the framework for receiving applications and then in the applications themselves they had to answer questions about what the core measures would be, and we found that through followup conversation with the sites

that were preliminarily selected that they often needed to do some work to refine some of that to get really feasible about can you actually ask that many survey questions or that frequently, for example, and so what we've done is we've structured a process that, first of all, we believe anything that was funded has a high likelihood of success and has the potential to both be scaled to other sites and sustainable within those settings, but then beyond that in their first quarter's deliverable to us they have a final evaluation plan due, and so those are the metrics that we will be monitoring. Many times the sites themselves collect the data, but other times they were very open with us upfront that they needed support or claims data, information that we had access to, and so we will partner with them on those analyses.

MS. LUNGE: Great. Thank you. You had mentioned briefly in your presentation today and also had discussed it in Section 5 of your submission around DVHA Medicaid prior authorization waiver, and I know last year there was changes to that to further allow -- to make it less administratively burdensome on providers. Are you still looking to do some further refinements? How is that going? Are you

seeing providers appreciating the reduction in administrative burden, and could you speak to that a little bit in a little more depth?

MS. LONER: That's another great question. We've definitely seen an evolution of the benefit to providers as we removed some of the prior authorization requirements and then who they were removed for over the course of the last two and a half years that we've been working with the program, and so as we continue to have discussions with Medicaid about the geographic attribution and start to push the envelope of why not do this for the entire Medicaid population, and so I think it's going to be a delicate balance of, you know, what's the penetration that's needed for the Medicaid program to say we're going to go ahead and say we're going to lift it for our entire Medicaid population.

So I think those are the discussions that we're having right now to look at what the benefits would be, and that we would continue to be able to receive enough data and information to tell Medicaid okay this is how it's looking in terms of trend, our prior authorizations, things that require prior authorizations, are they going up, are they going down, are they staying steady so that they can

continue to evaluate the model.

MS. LUNGE: Thanks. I am getting done, Kevin. Getting the eye from the Chair. In your answers to our questions -- I'm all out of the binder and gone to the supplemental material -- we had asked a question about churn or turnover in attributed lives by payer and by year. So thank you for providing that. That information is particularly interesting to me because I would expect that when you have a new patient whose come into the model it's often because it's a new provider coming into the model or it may be a patient whose just engaging in the primary care under some of the new programs, but it does sort of call the question of making it difficult to evaluate, for example, quality metrics year over year when you have a constantly shifting population, and so I was wondering if it's possible for you to -- from what you know about the provider changes to look at the new patient year over year and figure out how much of that is driven by new providers participating. I know you don't know necessarily things like changes in enrollment, but in the pieces that you can quantify, that would be interesting and helpful for me at least in terms of trying to evaluate the quality -- the quality metrics

and sort of what we need do as we are looking at the program, and that's not something you have to answer right now, but if that's something that you might be able to share more depth on, I would at least appreciate that.

MR. BORYS: We can definitely do that for you.

MS. LUNGE: Great, and then my last question I think -- taking a quick look is -- actually I have two. I'm sorry, Kevin. We had asked you about clinical priorities by HSA and I certainly understand that because clinical priorities are set at the community health team or the accountable community for health level that your window into that is the regional clinical representative, and that really a lot of it is clinical priorities are still being set through what we would have called the Blueprint for Health prior to the ACO. Since the ACO is required by statute to build on top of the Blueprint I think it gets a little confusing sometimes because you're supposed to be working hand in glove, and I at least think I've seen a lot of improvement in that over the last couple years, but do you happen to know if the Blueprint tracks those -- all of those activities at the HSA level and

obviously you're not answerable to the Blueprint, but if you know I was just curious.

MS. BARRY: I don't know the answer to that. I'm sure there's anecdotal information, but I don't know if it's systematic.

MS. LUNGE: Okay. Thank you. I wanted to get an update on the status of your contract with the ambulatory surgery center and the payment model you're negotiating with them.

MS. LONER: So the ambulatory surgery center has submitted a contract to be part of the program. What we said -- what our conversations was with them was that we needed to get some history because the surgery center has just opened up to be able to evaluate what would be the next type of payment model. So for 2021 I'm always like -- we're always operating one year like lag and in advance sometimes I'm not alert and oriented times three. So for 2021 we'll reevaluate that for them.

MS. LUNGE: Okay. Thank you, and then, lastly, do you have any updates -- sorry, Kevin -- on when you're expecting your payer contracts to be finalized, particularly for the two new programs that we don't have a lot of information on in the budget submission.

MS. LONER: So the plan right now is for the -- both the MVP and the Blue Cross Blue Shield program to go to our board in November. Obviously December is the last date that we could get signatures to be able to go for January, but the plan now is to have those go to the board in November.

MS. LUNGE: Thank you.

CHAIRMAN MULLIN: Okay. Maureen.

MS. USIFER: Sure. First, I apologize for not being there. Last year it was a week earlier and I had the wrong date on my calendar. I want to talk about the risk and basically I want to understand the 4 million dollars that you have budgeted. I know a lot of it is carryover from the questions you answered. You said the hospitals so on the risk mitigation fees it looks like you're now saying the 4 million dollars is going to be back stopped by UVM and Dartmouth, and first I wanted to clarify is that true?

MR. BORYS: So the -- this is Tom. In 2020 the founders, Dartmouth and UVM Medical Center, will be the backstop for the specific risk mitigation agreements, which are in that 4 million dollar ball park, which really means that OneCare is not retaining any risk that would otherwise be delegated

to the network any more, and the remaining reserves that we keep at OneCare are specifically what I think of as OneCare risks, and in the example I used in the narrative or the question response was we have a hospital that owes an obligation as part of settlement but either cannot or will not pay, and we still need to write that check to the payer. So there's some reserve for that.

The other reason I like to have some reserves on the OneCare books is our balance sheet has so much cash flow throughput that just having a little bit of liquidity on the balance sheet helps make sure that I can make good on payments in light of timing of contracts and when we actually receive payments for any of our pay relationships or state awards. So that's really why having some reserves left at OneCare to me is an important strategy, but all the risk is fully delegated to -- either to the network or to the founders in this particular case for those specific risk mitigation agreements. Does that answer your question?

MS. USIFER: Yes it does answer my question. I'm a little -- you know in the past we had -- you had put up enough reserve to cover risk mitigation at the hospitals that you were covering

and you had talked about that. Other than in the answer to one of the questions that we asked, you really didn't talk too much about this shift which is a fairly big shift in the reserve policy, and I think it actually is beneficial for the ACO, for OneCare, because you no longer have to take that responsibility, but that was a shift and I was a little concerned with what it said about recovery of settlement obligations because you really hadn't talked about settlement obligations for hospitals that couldn't do that beyond the 4 million risk mitigation. I mean that could in theory be rather significant and didn't know why that wasn't put in the mix because I didn't understand that being part of what you were going to use the risk reserves for. Maybe I'm misinterpreting that.

MR. BORYS: No. I think you captured it right. Beyond the 4 million you're right. If we have bigger risk obligation that one of our network participants owes and they cannot make good on that payment, it is a bigger problem. There is a provision in our operating agreement with the founders which is really the ultimate backstop, but I don't want to have to use that. That should be a last resort or really something went awry and we need

to go. So this is having some what I believe to be reasonable reserves at OneCare in case another circumstance comes up in which the ability to make good on a settlement obligation is in question.

MS. USIFER: Okay, and then, you know, continuing on with the risk we know for the hospitals reserving the risk has been a bit of a concern, and I think it was 534 you stated reserving the risk is essential for the sustainability of accountability programs, and just wondering, you know, how is the ACO monitoring and what guidance are you giving the hospitals that are bearing the risk about that reserve?

MR. BORYS: Really good question and one I hope to improve upon next year as we just have more user experience in the programs, but I think a really important distinguishing factor is the portion of risk that I think of as new risk versus their old risk is really helpful for many of these organizations. Everybody had risk in fee for service. If you just have low volumes or you lose one of your top billers, your revenue is going to be affected. That remains, but when the hospitals take on risk for services outside of their own walls that's brand new risk to me, and I think that they

should be able to reasonably plan for some sort of a risk payment in that particular case. So that's one of the new ways that I anticipate slicing risk in the future to itemize that a little bit more clearly, and then this links in with questions earlier about just the risk model in total and making sure that it's I guess in balance with each of the participating hospitals and that it's really the right incentive -- the right size incentive to help move us on this path.

MS. USIFER: Okay, and then, you know, one comment I would have for future presentations would be really putting a full financial statement in the presentation. I know we had it in our backup and I think it's good for everybody to see both the full income statement, including all of the payments from all payers and then what you pay out, and then you touched upon the cash flow potential issues depending on when you get payments from the payers and when you have to pay things out. I think anything on cash flow or balance sheet that you would like to bring up because we didn't see that presented today.

MR. BORYS: Fair point.

MS. USIFER: Do you have any cash flow issues as far as timing that you're experiencing this

year? I know there was some issues with one of the payers at one point with settlements and just wanted to know if you had any concerns there because obviously your responsibility is to pay out to the hospitals and maybe covering their cost, but you need to be getting the receipts in from the payers.

MR. BORYS: Generally speaking we haven't had significant cash flow issues. The very first month of our Medicare program was the only month in which we didn't actually receive the AIPP payment. So the biggest risk, even though we haven't had big problems to date, the biggest risk is there would be some sort of a problem for OneCare getting its monthly fixed payment allocation from any of the payers and generally speaking they have all been relatively on time. A couple of maybe one week delays, but that we can manage, but if we had any sustained delay in those hospital fixed payments coming into OneCare, we could have cash flow issues downstream pretty fast and that's a worry that we should all share, and other than that it hasn't been too big of a problem. I mean the claims processing issues in that space are not OneCare cash flow issues, but they affect cash in the providers, and if you have to choose between the providers being double

paid or zero paid for their work you choose double, but it's you pick your poison really. So that's another area that I would like to see fewer problems in the future, but the biggest risk is the timing of those fixed payments.

MS. USIFER: Okay, and there was in the answers to the questions on showing high churn rates from 2018 to 2019 and 16 percent for Medicare, 21 percent for Medicaid, and 38 percent for Blue Cross Blue Shield on the exchange, and you know in a market where we're trying to grow and when we don't really have a lot of players that people can be going to the churn rate seems high going from '18 to '19 and I know part of it is the providers are -- we're adding more providers and didn't know if you had any explanation for such a large churn rate from '18 to '19.

MR. BORYS: I think the payers can speak to this really well, but just my experience thus far is there's a lot of churn in general in coverage, particularly in Medicaid and particularly in the QHP. I think you see more stability in Medicare and some of the self-funded plans, employer based plans, but I would be curious what payers would say, but I would imagine they would say yeah you should expect this

kind of churn kind of on an ongoing basis. Our networking configuration will affect that a little bit. If we have some stable years maybe we see a little bit less churn, but I think it's something we should all expect in the future. I don't anticipate it really going away and it's people switching between products rather than being added in for the first time.

MS. USIFER: Okay, and then state funding, and I missed the very beginning of the presentation so you may have addressed this, but on 13.1 million and I heard your explanation about some of this, you are just redirecting from Medicaid 5.3 million, some of it continuation of programs, and then about 6 million is new, and some of it could be matched with federal money, but if you were to estimate if there were to be a potential risk to this funding source, how much would it be? Seems like it's clearly not the whole 13 million.

MR. BORYS: Well certainly I mean any of the new funding that we're asking for I think would be probably the highest risk area. The -- that's the 7.8 million in total that's included in the 2020 budget. I think less risky but not without risk is health information technology. I say it's less risky

just because the match rate for the State of Vermont is so favorable, 90/10, but that's ultimately not a decision, and then the amount of the OneCare fixed payment allocation that's, you know, a choice that we make in partnership with DVHA. We're developing our program design, but we have some voice at the table when we make that decision to move those dollars out of that bucket. So really the highest risk is that we just don't receive the 7.8 million VSR, 6 of which is really the new pool.

MS. USIFER: Okay, and then just one last question on the risk model are you looking at or do you think in the near future we'll see any alternatives to how the risks will be given to each hospital, particularly where we see hospitals that have less of their care being done in their hospital and more being done in other hospitals within the ACO or entirely outside. They have a larger percentage of risk to what they actually receive for STP, and clearly that's going to grow as we grow the attributed lives and could create even a larger barrier for these hospitals. So just wondering what the thinking is. I understand we've talked a little bit about this before and I understand we want the hospitals to bear the risk for those patients, but it

becomes harder and harder if most of their care or a large percentage of their care is done elsewhere, and it can be a significant -- I mean it can be more than their operating margin at these hospitals particularly when some of them lose money, but that's a separate issue. It's a huge risk.

MR. BORYS: I agree, and there's a lot of nuance in here and I mean I have personal thoughts about things I want to explore with the network, but it really does need to be a network discussion. So I don't need to go too far out in front. We need to go to a process. I'll give an example of a couple of the things I think about. Yes we could take the hospitals that tend to refer more out and give the risk to the hospital to the community that actually provided the care, but I worry about the incentive that creates to start referring more care out is a means to avoid that risk, and there's a lot of nuance in this space and it's a very -- it's a very Newtonian exercise to go through as well to really understand if we do this what might a recipient on the other end then do in response to this, and we want to make sure that the decisions we make support our network participants and their financial health, primary goal, but also support the goals of the ACO

in terms of really the reward that can be received from efficient high quality care.

So it's a complicated topic area and, like I said earlier in the presentation, I want to spend a significant amount of time on it in the first few months of 2020.

MS. USIFER: Okay. Great. Thank you. That's it.

CHAIRMAN MULLIN: So we've been able to negotiate to stay in the room until 5. If we're not done at 5, then we'll adjourn the meeting and come back next Wednesday. The Health Care Advocate has already indicated to me that out of respect to people that traveled he would defer questions if we're getting close to that five clock time frame until next week. I will do the same with my questions if that's what's necessary, but if at all possible it would be really good if we could get this done in the next hour. So with that I'm turning it over to Jess.

MS. HOLMES: I'm shortening my questions. All right. Well thank you very much. So I think about innovation and I think about constant iteration that comes with innovation, navigating obstacles, restarts, and revisions happen all the time. OneCare, as you mentioned, Vicki, has been the

subject of some criticism in recent weeks, and in the spirit of honest self reflection I'm wondering if you can think about which of that criticism of either your structure or your performance is justified and how this budget addresses some of those criticisms that are justified and then what criticisms are unjustified and why. My 40,000 foot question. Then I'm going to dive deeper.

MS. LONER: I'm going to take a stab at it. We tried really hard in this budget testimony as we were setting things up to really try to address many of the inaccurate or I'll call them partial truths and criticisms about OneCare Vermont that were in certain publications over the last three or four weeks, and I do believe that we have set the record straight on many of those inaccuracies. The subject of whether or not we're losing money. No that's not an accurate statement. Is our operating budget really 13.6 million dollars? We covered that at the beginning of the presentation. It's not 13.6 million dollars, and I think the other piece -- billion -- billion dollars. Thank you, Tom, money guy. And, you know, no we're not requesting an additional 13.1 million dollars from the state. Those were the biggest things that I really want to correct the

record on.

I think Sara has done a really good job talking about, you know, how we're doing overall in quality and we're not -- our providers are not failing in terms of our overall quality measures and how we're doing on those outcomes as well as the progress to date that we've been making as a delivery system, and I think one of the big takeaways is that when we come before you next year it shouldn't be a big surprise or it shouldn't be another factor that that number is going to grow because that was the purpose of the All-Payer Model is to really have those additional individuals and Vermonters covered under our value based system of care and not -- and fee for service.

MS. HOLMES: To follow up a little bit on Maureen's question about the risk of the new funding, that VSR funding is about 7.8 million would be the potential funding. Do you have a sense which programs you would cut if that funding did not come in?

MS. LONER: I think it's back to Tom's budget presentation. We had recent discussions with the Agency of Human Services and understand that this would likely be a budget adjustment. So we'll

definitely have to go back and circle around to say what kind of programs we're going to defer until we know that that funding is secured and those are discussions that we'll be having with our board over the next few months.

MS. HOLMES: When you talked about that recent change and the risk mitigation plan shifting some of that risk from one payer to the founders you talk about that risk mitigation now like between UVM and Dartmouth Hitchcock, is that 50/50 or is it not 50/50 in terms of the risk that either entity is liable for?

MR. BORYS: We haven't actually finalized, but I think the initial thought is that it would be 50/50.

MS. HOLMES: Great. Thank you. One of the things we did ask for, which I was disappointed not to see, was the OneCare Vermont variation in care analysis. We got the mockup, but we didn't actually get the data, and we specifically asked for the underlying data because it helps us understand where the areas of high cost across our geographic areas are and where are the areas where there could be more improvement in health outcomes, and the reason that's important is because you're making millions of

dollars of investments across the entire State of Vermont and it would help us to understand are those investments, you know, impactful investments if we were to understand what are the geographic differences in variations. So it helps us understand these investments make sense given what we're seeing in the variation of care reports. So I'm wondering if it's possible for you to actually provide us the actual reports beyond a mockup of what it looks like.

MS. BARRY: So we can speak to that a little bit. I think it's an opportunity for us to engage with our legal advisors on both sides to discuss how we could do that. I think to be very transparent our concern is that that information is sensitive and changes frequently and could be easily misconstrued in a public domain, and that is not fair to our hospitals or our communities that are doing so much hard work to try to transform care delivery. So I think if we set some context for that, we can find a way to meet somewhere in the middle around sharing some of that information.

MS. HOLMES: Okay. Thank you. Helpful. About comprehensive payment reform investment it's gone down. I'm wondering if you can talk about that, this year's budget relative to prior year's budgets.

MR. BORYS: We model every year to be reflective of the participants and one of the changes this year is we had a partial capitation model in last year's budget and felt like that was a nice one year on ramp, but really the idea is more holistic payment reform for these practices. So we are no longer offering that partial capitation model which means there's actually fewer in total participating, but more in the full cap. So it's -- that's the more robust reform model, and we just adjust that amount to be reflective of what we think it's going to cost to deliver that model to those practices. So it's not actually less investment. It's just matching the costs.

MS. HOLMES: To be brief I'm going to have one more question. That's it. The FTE -- your FTEs increasing. You currently have 58 employees it looks like and you're going up to 78. You talked about the need to ramp up your analytics, your finance, and your legal teams, and I'm wondering if you can talk a little bit about that extra 20 FTEs. What is the proportion that's going towards analytics, finance, and legal and what are the needs that are not being met now that you think will -- obviously will be met when you increase your staffing

that much.

MR. BORYS: I can certainly speak on the finance space. Some of the increases in FTE is actually a conversion of areas where we've relied on contracts and are now realizing we need full time commitment in these particular areas. So there's a couple of those examples in the finance space and as well as the legal. I can speak to the finance team is the one that I know the most intimately. A lot of demands, good demands, from the network coming in right now. Good questions about the understanding the performance, wanting to know more about their opportunities. So bolstering the -- really the finance analytics capacity to be able to answer those questions on behalf of the network. I am also really looking forward to being a little bit more directly engaged with the finance teams, particularly the risk bearing hospitals, in the future and wanting to staff up accordingly there.

In more the financial management and accounting space we have some growth in that arena as well. Our business is becoming more and more complicated as we have more programs, more payer partnerships, more communities, more investment, you know, areas, vehicles, and we just need to make sure

we have the right staff and the right capacity to manage all of those new initiatives and make sure that we have the house in order so to speak.

MS. BARRY: So just briefly I would add to that on the analytics side we're really trying to focus more in depth on accepting new payer data and recognizing that that creates some new demands for ingesting, processing, validating that information, turning it around, and then on the evaluation side, as we spoke to earlier, really making sure that we have robust approaches to analyze the impact of the direct investments and programs that we're offering to make those critical decisions about what to continue and what maybe to stop.

MS. LONER: And I would say the last piece when -- we'll talk more -- the CEO decided to move on, a conscious decision was made by our board to have a full time CEO that didn't also have responsibilities for the Adirondack ACO, UVM Medical Center, and that also had an effect on other leadership positions. Our VP of finance now will be our CFO will be a full time person where it was previously split before. We had other leadership positions within the organization that were also shared with the Adirondack ACO. So those

cumulatively add up to some additional FTEs as part of OneCare's budget, but in looking at where we are in the evolution of our model we really felt like that commitment was necessary.

CHAIRMAN MULLIN: Can we ask anyone who is on the phone to please mute their side?

MS. HOLMES: That is all I have. I do want to thank you. I know a lot of hard work goes into presenting and building your budget and also all the hard work you're doing for the All-Payer Model and I appreciate it.

MS. LONER: Thank you.

CHAIRMAN MULLIN: Thank you, Jess. So I just want to do a couple quick follow-up questions. You talked about the 20 additional positions and on your original chart it looks like you've added a new member to the C suite. That's correct?

MS. LONER: No. We previously had an vice president of finance and strategy and that was the position that was split between Adirondack ACO and OneCare Vermont. We simply converted that into a full time CFO position.

CHAIRMAN MULLIN: And what is the cost of that position and what is the time frame for filling it?

MS. LONER: So we are -- currently have that position posted and it's in compensation right now and we'll be happy to followup with you on those facts once we receive them.

CHAIRMAN MULLIN: Okay, and obviously congratulations on your elevation and, Sara, on your elevation and Sara's post creates another vacancy on your work chart. So if these positions aren't filled before the start of the fiscal year, will you invest those savings into population or what will you do with those dollars if they are not --

MR. BORYS: Good question. We have vacancy savings. We have had vacancy savings basically every year as we've grown, and just it comes with a growing enterprise like this, and any decisions about underspending of expenses will just have to be taken into context with all the other moving parts within the organization. If we reach the end of the year and had let's say a substantial gain on the books due to vacancy savings, it would be a decision for our board really to evaluate what's the right step; do we issue credits back to those who paid dues throughout the year, do we reinvest them in different programs. There's a handful of different options we can consider.

CHAIRMAN MULLIN: Okay. Are you committed to meeting the obligations that the State of Vermont has agreed to under the All-Payer Model, the financial targets?

MR. BORYS: I am committed to making sure that the OneCare budget model that we produce every year aims to further the goals of the All-Payer Model and that 3.5 percent we're just a piece of slice. You saw on that slide, but what we produce every year we intend to be furthering the goals of the All-Payer Model and its financial goals.

CHAIRMAN MULLIN: And are you convinced at this time that the costs of the OneCare organization will be less than the savings you will bring to the system?

MS. LONER: I was going to say that's a sustainability plan that we have to find a way to be able to continuously keep up these programs as we grow attribution and to balance the staffing ratios that we have right now so that we can continue under this model.

CHAIRMAN MULLIN: In your submission you show us that you reduced the percentage of the total from 1.77 to 1.4. What's your ultimate goal for what your cost should be as a percentage of the overall?

MR. BORYS: I'm not sure if we have an ultimate goal, but it's really to find the balance of making the right investments, having the right ACO level supports with what the network needs, and I think over time what we hope to see is that the work that we need to kind of push out into the network becomes engaged in our healthcare landscape, and we don't need to necessarily facilitate that so heavily any more, and that I think can stabilize a lot of the work, but I think there's always going to be some value that the ACO can bring in terms of particularly data and analytics and warehousing in a central location, and some of the finance and contracting functions we've built to execute all these contracts. So I'm not sure if there's a set number just to say this is where we want it to be, but it's one we evaluate every year of the model and determine what the needs of the network are and how do we continue to meet the needs of the All-Payer Model.

CHAIRMAN MULLIN: You talked about some of the things that you're going to be focusing on in the upcoming year, and I was especially happy to hear about the focus on chronic illness and the type of basically care coordination that could occur there to reduce costs. Many people have argued that you've

got the low hanging fruit. You have been focused on the Medicaid and Medicare population and those are the populations that certainly would best be managed through a much stronger care coordination system. So the question is what have you learned so far in your handling of the commercial population and Blue Cross Blue Shield, QHP, and the UVM self insured, and what leads you to believe that the large additional rollout into the commercial market will be successful in that people will see, you know, improved quality and improved savings.

MS. BARRY: So you're correct that a lot of our initial work in 2017, '18, and even year-to-date has been in areas like our complex care program where many more vulnerable Vermonters on Medicaid or with Medicare insurance might see the quickest benefit, but having said that, we've spent significant time since this past summer working with the team at Blue Cross Blue Shield around advancing some new clinical ideas. Things like thinking differently about primary care engagement and how to both incentivize and open up some access in new ways. Thinking about primary prevention and continuing to expand RiseVT, and thinking about connection points between those sorts of resources and making sure that

there's continuity back through the primary care system.

We are talking as well about areas of focus within chronic disease management that may need targeted and different approaches based on unique population needs. So things like innovative uses of telehealth. We're talking about peripheral devices that might be used say for a patient with asthma to better manage and monitor their compliance with the medications that they are on. Things like how to better address the needs of patients with heart failure, and so I think there's a lot more work to be done, but we see this as an opportunity to get more focused and more specific about populations that are defined around particular chronic conditions or multitudes of chronic conditions, and that is the hope as we are really moving into 2020 and advancing in some of these new areas and programs that you will start to see those things realized in a very focused way.

CHAIRMAN MULLIN: One of the things that's been so frustrating as a board member is to hear complaints about, for example, OneCare being a for profit company, and yet we know as a board that you're constrained by government rules and

regulations that don't allow you to do that, and so that brings up the question people in Vermont have so many questions about OneCare and what are you going to do to try to get the message out there to the public. It seems like a truly dedicated media campaign has to occur so that people will stop criticizing and try to become more participatory in nature to the transformation to our health care system which could yield tremendous benefits to everyone in the State of Vermont.

MS. LONER: I think that's a very timely question for us given recent events, and we've been talking internally. As you know we've just been talking about balancing staff and balancing costs, and so we've really focused our time and energy of doing the good work of the delivery system reform and not so much on the media. It has come a time, though, we do have to really get the message and the word out there. So one of the strategies we've talked about internally is, you know, we have a network of participating providers that's over 2,000 strong and they have forums and opportunities to be able to tell the story because it's really their story to tell. It's not our story to tell. They are the ones doing the real transformation, and I think

that, you know, in communities they know the best way to tell that message, and so having that be kind of the ground up sort of story will be really important, and we do want to see if there is some sort of overall media campaign or communication strategy that we would have to employ centrally at OneCare.

CHAIRMAN MULLIN: I'm just afraid if you don't start telling your story that there's not going to be a story left to tell, and so this is just a suggestion from me to you that I would be reaching out to You Can Quote Me, Vermont Edition, all those type of things, and go on there with providers and talk to them about what you're seeing because the message is not getting out to the public, and with that I guess I could -- last few questions I'll get the answers to on my own. I'm going to turn it over to Mike Fisher.

MR. FISHER: Thank you. Thank you for the presentation. Thank you for your work and the opportunity to ask you a few questions, and I will say given some of the recent conversation I think it's important for me to say out loud that I am supportive of the efforts of your organization and of the All-Payer Model and that you presented some details that represent some good work. So thank you

for that.

Doesn't mean I don't have a few questions. So I am -- and I have a little concern about the population health investments. Assuming that the full monies from delivery system reform is -- comes through the budget process and with the counting of Blueprint and SASH, I know those monies have been counted for some years and not counted in some years and counted now, but with including sort of the best case scenario your budget has a decrease in population health investments from 4 percent of your budget to 3 percent of your budget, and I just want to express a concern about that and give you an opportunity to comment and tell me what's going on.

MR. BORYS: Sure. I can take that. Two questions. So the population health investment each program has its own financial model behind and some of them are based on attributable total cost of care and others are not, and the Blueprint programs are one actually that are pretty disconnected from our actual model. They have panels, panel payments, and their attribution for the Medicaid population actually goes beyond our attribution. So even if our attribution were to decline in Medicare, that payment would stay the same. Statewide attribution.

The other balance that we're just really trying to manage the budget process is the cost on the hospital system as well and every year evaluating are we putting the right investments in the right places and getting the outcomes that we hope to see while also being mindful of the cost that's being put on the hospital. So it is a balance and it's complicated because all -- like I said all of them have different business models underneath, but we're committed to continuing the investments in our provider network and making sure they have the resources they need to take this transformation to the next level.

MS. BARRY: I'll just add one point. So thinking about the innovation fund as an example we learned through this process a lot about what it would take for communities to really develop a proposal and be able to implement it, and so we have obligated a significant amount of funds in 2019 that actually will carry through into 2020 and 2021 as we look at programs that go on for 12 or 24 months, and so as we plan to continue those investments next year we try to do it in a way that feels rational and addresses capacity and maintains focus on those core programs.

MR. FISHER: Thank you. Question about achieving your care coordination target numbers. In your budget you state that you're attempting to achieve a goal of 15 percent. Looking at slide 34 -- well there's a couple things to take away from slide 34. One is the variation between payers and the other one is the overall number. So I have a question about both of those.

MS. BARRY: Sure. So the overall number I will say that one of the interesting learnings that we have had is that since we ran the focus groups and then got out to town hall meetings around the state to describe the changes coming in 2020 to the payment model I could put a marker in the months that we did that and see the results in uptick and focus really, senior leaders and organizations making sure that they have aligned resources, and so pick a date that number keeps changing rapidly, which I think is impressive. It starts to beg the question what's the right target and I don't think we have an answer to that. We've looked nationally and we've used best practice from a variety of organizations to set that 15 percent goal, and we're getting quite close to that for Medicaid and Medicare. As you point out we are not currently anywhere near that for the

commercial program and we didn't necessarily ever intend to be. So as we look at that population the focus tends to be on the top three percent of risk, and you'll see here we're at about 2 percent, and we continue to have conversations with the leadership team at Blue Cross Blue Shield around some unique nuances in that population. So very rare condition management, things that might not be appropriate for a community wide model to best support, and so it's in those phases that we continue to explore what the right evolution of the care model will look like and then how best to allocate resources across the system to support that.

MS. LONER: I think one of the things that Sara shared with me during her rounds to meet with the communities is we had set some targets around high end and very high risk, and sometimes the community said to us those aren't the individuals that are really in need of care coordination services you got to go a little bit deeper than that, and so allowing those clinical decision making to come into play will be a very important part of the model for us to assess what is that right percentage that would benefit from care coordination. Is it really the top 15 percent or do we really need to look a little -- a

layer deeper with that. So that's why a lot of these things are really hard for us to predict right now because health care and the way health care is delivered is not static, and we learn -- we're learning the health system and so we're learning along the way.

MR. FISHER: So my next question is very much a nuts and bolts question. I obviously wasn't paying close enough attention. I have always understood the distribution of risk to be a clinical decision, and when I looked at the numbers you provided to us in answer to one of the questions we asked I saw an interesting alignment that between Medicaid and Medicare and Blue Cross Blue Shield you have an alignment of very close to 6 percent of the categories being at high risk and 10 percent being -- I'm sorry, in very high. 10 percent being in high, 40 percent being in medium, and so on, and I didn't expect to see that so would love some description of what's going on there.

MS. BARRY: Sure. So that is an approach that we call population segmentation and there are different models for that around the country, but basically what we did is we looked at conversations with our providers early on. This is

back in 2016ish. We said that while an insurance based model typically focus us on the top 2 or 3 or maybe 5 percent of risk based on cost and utilization of services, we had a provider network that felt like a lot of the opportunity that really existed to have a positive impact on an individual's life was in that next strata of risk, and so we started to look at that from an analytic perspective, and we started to say what defines different points where we might move from one segment of the population to the next. So, for example, in the early data we looked at -- we were looking at Medicaid and we were trying to understand how often when we saw individuals that had complex physical health needs did they also have mental health needs, and we were able to see that if we extended our model and we thought about that next 10 percent of risk that we hit something in the neighborhood of 80 percent of individuals that could be identified as having more complex needs, and so as a result we really refined that population segmentation approach, and we do have to your point, Mike, six percent is the very high risk, the next 10 percent down is high risk, medium risk is 40 percent, and then the lowest quadrant the risk at 44.

MR. FISHER: But my question is more the

6 percent of the highest need in Medicaid is bound to be different than the 6 percent of the highest need in the qualified health plan -- in the Blue Cross qualified health plan.

MS. BARRY: Yes.

MR. FISHER: That's a different way of slicing it. It looks more like a contractual decision than a clinical decision.

MS. BARRY: It really wasn't. It was something -- we used the same clinical grouper and we divided up by payer program recognizing that there are unique needs in each program, and what we saw in the early data was that there was plenty of opportunities so that we -- as we tried to align around the standard care model and approach to population health we were really trying to make sure that our provider network was paying attention to that holistically and then looking at opportunity in broader segments of the population. So we didn't want to overly restrict that.

One of the learnings that we had this year in active conversations that in doing that, particularly in our Medicaid population, we perhaps underestimate the impact on children because we don't segment by age in that Medicaid population, and so

one of the things we're studying right now is if we break that apart into two populations, a child cohort and adult, what does that tell us clinically about opportunities for intervention.

MR. FISHER: Okay. Last question or questions about the ACO population. I was interested in, Tom, your -- when you were saying that bring a significant number of the Blue Cross self-funded groups into that scaled target qualifying fashion, and I would love you to talk a little bit more about where is the line in order to achieve the scaled target qualifying, and I, of course, have next to no information about what's being discussed in order to bringing these populations in. So any clarity.

MR. BORYS: Sure. Good question. So the Vermont All-Payer Model contract determines which ACO programs qualify under that model, and there needs to be provider financial accountability in some way. Can be an upside only program. There needs to be some provider incentive and that way -- and there needs to be a quality component to the program. The reason I mention that we're transitioning those UVM lives or building that program to be scale target qualifying is that we did an on ramp year -- or we're doing an on ramp year right now with Blue Cross Blue

Shield that incorporates a number of those lives but in a non-scale target way to get some data and start to learn about that population a little bit more, and then we'll be transitioning that into a program that qualifies for those scale targets under the All-Payer Model and the state's accountability for scale. Does that help?

MR. FISHER: I'm interested in seeing the details and it might be that because negotiations are continuing it's hard for me to get those details.

MS. LONER: I would just add to what Tom said and yes negotiations are continuing with Blue Cross Blue Shield and so we don't want to get too in front of that conversation, but the other piece for the scale target is to make sure that we're reporting on quality measures, that we had alignment in overall quality measures, that we have a similar care model that we had for our other populations and approaches, that we're not limiting benefits any way, shape, or form, that we're applying enhancements in the same manner across. So those are the type of aspects that we want to make sure that if we have a scale target eligible program, that it's meeting all the criteria necessary that the state and federal government has put forth to say now you can say these lives are

under a value based system.

MR. FISHER: Last question on that same area. You know all of us are interested in transparency and I'm wondering whether those employers, let alone the employees, know that there's discussion about them being added to being attributed to OneCare.

MS. LONER: It's our understanding that Blue Cross Blue Shield is having those discussions with employer groups as part of their relationship. So really understand that an employer whose working with Blue Cross Blue Shield has the ability to make those decisions. Our contracting relationship is directly with Blue Cross to say we will offer a scale target eligible program and for those whose attribution that would be what our contractual relationship is. So we're directly working with Blue Cross Blue Shield and Blue Cross Blue Shield is working directly with the employers that are part --

MR. FISHER: I'm getting the impression -- I know this is awkward because I'm speaking about an entity that's not you, but I'm getting the impression that this is something that's being offered to those employers who choose to join.

MS. LONER: That's our understanding

that's being offered to them.

MR. FISHER: Thank you very much.

CHAIRMAN MULLIN: Thank you, Mike. At this time we're going to open it up to public comments or questions.

MS. ARANOFF: Susan Aranoff. I am the Senior Policy Analyst for the Vermont Developmental Disabilities Council. People in Vermont with disabilities are more than twice as likely to get their health care insurance through a public program like Medicaid or Medicare. That's more than double people without disabilities. That's from a recent Department of Health study on the health of Vermonters with disabilities which would be a great thing for this board to hear about.

I thought it was really interesting today that part of this was billed as a hearing on the 2018 results. That was added to the captioning for today's meeting sometime between last Friday and today. For months it has been billed and noticed as a notice on the OneCare budget, but at some point it was added to be a hearing on the OneCare budget and 2018 results. So we did get a couple, three, four slides on 2018 results.

OneCare is required through the

regulations and the budget -- really through the budget guidance to submit financial performance results, quality performance results from all of their programs as part of the budget process, but as of right now -- our legislators left the room, as of right now there is no legal requirement that the board itself have a hearing on the financial performance results -- financial quality performance results of the entity you regulate, of the project you sponsor. I think the pilot is still in effect.

So I implore you again -- this is my third time publicly -- to please have a hearing on the 2018 financial results. We hear that they got 100 Medicare because that's -- because they got full credit for reporting, and we know last year their Medicaid quality result slipped 10 percent. We understand they got 86 percent on their Medicaid result, but we know that went down last year on seven of the 10 measures. Maybe just a little, but we need to understand why. We know they lost money this year in Medicaid and are expected to lose more next year, 8 million more, and maybe that's misinformation. Maybe we need a hearing to get the correct information, but that's the information that I gleaned, and as you know I follow this pretty

closely.

So if you please, sometime as you're considering your budget as an independent regulator have a hearing with witnesses that aren't just OneCare. Someone from Medicaid to talk about quality, someone from Blue Cross, someone maybe from Medicare to talk about how they are absolutely performing so that you guys, when you're looking at the budget, can evaluate all of the money, this millions and millions and millions, what is the return on investment. Every other agency and department in state government that spends a dime of public money is held really carefully to account for something called results based accountability. Ask a question. Is anyone better off? If so, how would we know? I don't hear the regulators asking those same questions in a rigorous -- not even rigorous, a basic evaluative function. So please before you vote on the budget you need to have a hearing, a real hearing on the 2018 performance results.

CHAIRMAN MULLIN: Thank you, Susan. Other members of the public? Yes Walter.

MR. CARPENTER: Walter Carpenter, health care activist with Vermont Health For All. Montpelier. Kevin Mullin hit it right on target with

OneCare. I mean about how the media -- nobody really knows what OneCare is and you're right. Nobody knows and I'm out in the front lines and I talk with people, and the real problem is that no one really cares about value paid -- value based or All Payer because when you're hit with a $6,000 deductible, you're thrown off your Medicare and you make $10 over it, this is what Vermonters encounter everyday. In fact I'm encountering it too and I just had a scary diagnosis, but they thought I had cancer and looking at okay if I get thrown off health insurance how am I going to take care of that. Value based, All Payer is -- does nothing for that. The problem is access.

Vermonters also look at Blue Cross Blue Shield, you know, hitting us up for 15 percent, MVP was 10 or 12 percent, UVMMC hitting us up, CEOs getting two and a half million per year, that's what they see. Value based payments isn't going to do a bloody thing to stop that. The problem is access. The problem is the system is always going to be geared to extract as much money as it can and not lower cost, and I'm still 50/50 on OneCare. I haven't made up my mind yet on it, but that's what Vermonters see. They don't see value based doing anything at all for them because the problem is

access, insurance issues, claim denials, all of that. So you were right when you said that.

CHAIRMAN MULLIN: I actually think there are stories where it is really working for Vermonters. Those are some of the stories that we heard when we were in St. Albans, people who were diagnosed as prediabetic and are really doing some amazing things, and I just don't think that the information is getting out there.

MR. CARPENTER: How is All Payer, value based actually going to help Vermonters with a $6,000 deductible on an insurance claim and it won't. That's the issue.

CHAIRMAN MULLIN: Other members of the public? So I don't see any more hands so I did notice that there were a couple of times, Vicki, where you promised to get us additional information, for example, on the physician cost of the CFO, et cetera, and I notice that there were several questions from many board members about the 13.1 million tab 4 page 28. I think you did an excellent job in your presentation on breaking that down, but when the question on what might be cut if you don't receive that funding, I think the answer was pretty vague, and I'm a little bit worried that if you leave

that answer the way you've left it, that you're likely to get a condition on your budget that may not be in the best interests of everyone because it will be coming from this board rather than a reasoned approach thought out by providers, members of the OneCare and others, and so I would ask you to go back to the drawing table and try to put something to us about how you will approach that. You won't know the answer to that question until probably May and that makes it very difficult.

MS. LONER: I was going to say these would be discussions that we're bringing to our board in November now that we understand from the Agency of Human Services that this will be part of the process, and it seems like in the most recent letter to the Health Care Oversight Committee that might even be delayed a little bit further. So that creates some more urgency for us to make those decisions in November.

CHAIRMAN MULLIN: Okay. With that I want to thank you. We've learned a lot today and hopefully you don't take away by our questions that we're not proud of the efforts that you're making on behalf of people in Vermont. This is very hard work and I know that at the end of the day it can be very

stressful, but the good thing is that you can look yourself in the mirror and know that you're doing good things for others in the State of Vermont. So thank you for that work and we look forward to getting the additional information. Thank you.

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

MS. HOLMES: Motion.

MR. PELHAM: Second.

CHAIRMAN MULLIN: It's been moved and seconded to adjourn. All those this favor signify by saying aye.

(Board members response aye. (Whereupon, the proceeding was adjourned at 4:50 p.m.)

C E R T I F I C A T E

I, JoAnn Q. Carson, do hereby certify that I recorded by stenographic means the Green Mountain Care Board hearing re: 2020 OneCare Budget, at the Pavilion Auditorium, 109 State Street, Montpelier, Vermont, on October 30, 2019, beginning at 1 p.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting, and the foregoing 162 pages are a transcript of the stenograph 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 Burlington, Vermont, this 31st day of October, 2019.

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JoAnn Q. Carson
Registered Merit Reporter
Certified Real Time Reporter