STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY2022 ONECARE VERMONT BUDGET

Hearing held before the Green Mountain Care Board via Microsoft Teams, on November 10, 2021, beginning at 9 a.m.

BOARD MEMBERS

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Robin Lunge, JD, MHCDS
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I N D E X

CHAIR MULLIN: I'm going to turn the meeting over to Marisa and Sarah to tee up the OneCare Vermont's budget presentation and once they have keyed it up I'll ask JoAnn to swear in anyone from OneCare who is going to testify. So Marisa, Sarah.

MS. KINSLER: Thank you. For the record this is Sarah Kinsler, Director of Health Systems Policy, and I am joined by Marisa Melamed, Associate Director of Health Systems Policy, and we will do a quick introduction to remind the members of the public the process for the Board's review of OneCare Vermont's budget and to provide a little bit of context before we hand it over to OneCare.

As the Board knows there are two components of GMCB oversight of accountable care organizations or ACOs. First, certification which occurs once following an ACO's application and eligibility is verified annually. It is applied to ACOs seeking contracts with Medicaid or commercial payers. So not Medicare only ACOs. Secondly, budget review, which generally occurs annually in the fall prior to the start of ACO program here, noting that an ACO returns in the spring when payer contracts and attribution are finalized to present a final budget.

Marisa is on mute.

MS. MELAMED: Thank you, Sarah. Thank you, Mr. Chair. Next this slide is an overview of the timeline of the process. We are here at November 10th which is the hearing, and as a reminder, like Susan said at the beginning, we do accept public comment on the ACO budget submission and hearing, all materials, throughout the process, however, we request as you would like us to be able to consider your comment prior to our staff analysis on December 8th please make comments by December 1st. The Board will then consider the presentation from OneCare and the staff analysis and recommendations and tentatively vote toward the end of December.

There will be another opportunity, of course, to submit public comment prior to the final presentation and vote from the staff. We finalized a budget order early in the new year and then as a reminder this is a two-part process really. The prepared budget is reviewed and approved in the October to December period. However, payer contracts are not finalized until potentially the end of the year or after. We're almost through this budget process. So we have OneCare prepare a revised budget based on their finalized contract and come back and

present that to the Board for review against the approved budget sometime in the spring, and then, of course, there's ongoing monitoring and reporting as part of the oversight process throughout the year.

As a reminder in your review of the budget and the certification the Board must consider Green Mountain Care Board Rule 5 Section 5.405 in deciding whether to approve or modify the proposed budget of an ACO projected to have 10,000 or more attributed lives in Vermont during the next budget year. The Board will take into consideration any benchmarks established under Section 5.402 of this rule, the 16 criteria that are listed in 18 V.S.A. Section 9282 (B)(1), the elements of the ACO payer specific program, and any applicable requirements. 58 V.S.A. 9551 this relates to the Vermont All Payer Accountable Organization Care agreement for the State and Vermont CMS -- sorry -- between the State and CMS. Any other issues also may be considered at the discretion of the Board. We also consider public hearing and comment and participation by the Office of the Health Care Advocate.

There are 16 statutory criteria. Many of these, as I mention, relate to the strategy underlying the All Payer Model. As a reference they

are provided at the end of the slide deck so you can read through them, but, for example, to summarize the criteria requires the Board to consider the effects of the care model, appropriate utilization, the cash confidence, fiscal responsibility, and soundness of the ACO principles, efforts to integrate with the Blueprint for Health, and community based providers in primary care, social determinants of health, and preventing and addressing adverse childhood events; ACO administrative cost, the effects, if any, on Medicaid reimbursement rate on the rate for other payers, and the extent to which the ACO makes its costs transparent and easy to understand. That last one I think is a big part of what we do today at the hearing which is allow the public to hear from OneCare and describe how their model works, and again full criteria provided at the end of the slide deck for your reference.

I'm going to turn it over to Sarah for a quick word about the All Payer Model targets which are also part of your consideration in this review.

MS. KINSLER: Thank you, Marisa. So, as Marisa noted, number three on the prior slide says that we need to consider the All Payer Model agreement requirements, and so we listed the targets

that are embedded in that agreement here. First, total cost of care. The agreement sets the cost for that in line with Vermont's historical economic growth. Secondly, there are quality and population health outcome targets embedded in the agreement and they all kind of line up to three high level roles. First, increasing access to primary care. Second, reducing death due to suicide and drug overdose; and, third, lowering the prevalence of chronic disease.

Finally, the agreement includes targets for scale, and I just want to note that Vermont received a letter from our federal partners in October recognizing that the agreement detail targets were not attainable based on information that was not available when the agreement was signed, and we thank scale enforcement for the remainder of the current agreement. That letter is posted to our web site and the Board will continue to produce reports on scale performance. That will still be something that we track, but we will not be held to that standard.

MS. LUNGE: Marisa, you're on mute.

MS. MELAMED: My apologies. Finally, the ACO 2022 budget guidance summary is here on this slide. This is the outline of the guidance that the ACO is required to follow when they submitted their

materials. So for your review you will hear information, background information, information on provider networks' payer programs, total cost of care, risk management, their budget details, the care model, quality of population health, community integration information, and any information related to the all payer ACO model that may be relevant, and, in addition, the guidance includes information about ACO budget targets, the revised budget process as I mentioned, and the yearly monitoring.

So the agenda for today you heard from Sarah and I. OneCare will have about up to an hour and a half, if they need it, for their budget presentation. We will have some questions from the Green Mountain Care Board staff. Then we will turn it over to Board questions. There will be a potential break, if needed, for executive session, and that will be explained, if necessary. We will break for lunch or bio break as necessary at the discretion of the Chair, continue Board questions if needed, the Health Care Advocate has an opportunity to ask questions, and then we will have public comment at the conclusion of the meeting. So it is expected to go -- to stop for lunch and continue afterwards and that concludes our staff remarks.

Thank you.

CHAIR MULLIN: Thank you very much, Sarah, and thank you very much, Marisa. At this point, Vicki, if you could introduce all members of your team that will be testifying today and I'll ask JoAnn to swear you all in as a group.

MS. LONER: Yes. Thank you, Chair Mullin, and I'm going to do my best for my voice, but I do have a bit of a cold so it might not be as strong as usual. So for the record Vicki Loner, Chief Executive Officer OneCare Vermont. We also have with us today Sarah Barry, Chief Operating Officer OneCare, Tom Borys who is our Vice President of Finance, and Dr. Carrie Wulfman who is our Chief Medical Officer, and running our slides for us is Ginger Irish who is our strategist at OneCare Vermont.

CHAIR MULLIN: JoAnn, if you could swear everyone in.

(The OneCare panel was duly sworn.)

CHAIR MULLIN: Okay. So whenever you're ready to proceed with your presentation proceed.

MS. LONER: Great. Can you tee us up? So I want to thank the committee for taking the time today. We have a fairly robust presentation that we

hope to get through in 90 minutes or less and leave time for some questions.

Next slide please, Ginger. Next slide. So for background for those of you who might be new to this testimony from OneCare Vermont, OneCare is an ACO operating in the State of Vermont. We contract with thousands of Vermont health care providers and hundreds of organizations with a shared goal of improving the health of Vermonters while slowing the cost of growth, and we collectively believe as a group partnering together that the best way to really accomplish this is through shifting away from the current fee for service system to a value based care system that really rewards providers for taking better care of their patients and for the outcomes. You know transitioning to value based care really does take a village. It takes the providers, the ACO, the Green Mountain Care Board, the Legislature in this state to move collectively in this direction because it really is a seismic shift in the way that we are paying for and delivering health care.

With that said, today's presentation will be solely focused on what OneCare is doing to really make that shift to value based care and how the budget supports it. So I want to start off with

the growing statewide attribution, and really this is obtained by being able to contract and having a engaged provider network that truly believes in value based care. Right now we're over 5,000 providers strong, and I just want to take a second for that to sink in because that's a lot of providers growing in the same direction with a common vision, and so that's something that we as a state should be very, very proud of. I haven't seen this sort of provider network from different organizations in any other country that are moving together towards value based care. We have over 90 percent of eligible primary care in this model too because the foundation of this is really to support primary care.

I also want to point out that we are really looking to make sure that all of our programs are supporting the delivery system by enabling them with population health investments, and through OneCare we are able to directly invest in the providers who are serving Vermonters 28.9 million dollars directly for care coordination, quality improvement, things like advance comprehensive payment reform for independent primary care, and that funding would be gone absent the ACO and the participation around the state. So that's a really

important note that this work takes investment in the delivery system and that's what's available through the ACO.

Also really important in supporting this delivery system transformation you really need to shift away from a fee for service construct where providers are incentivized by doing more services and not necessarily rewarded for being innovative in the services that they do in a way that is more patient focused. So OneCare has been able to develop and implement very comprehensive payment reform programs. Right now we're looking at about 1.3 billion dollars of existing. So that's not new money into the system. That's existing health care dollars, half of Vermont's eligible health care spend from the latest data I saw from the Green Mountain Care Board that is being shifted away from a fee for service construct into value based care, and under our current agreement a hundred percent of that is in advance payment models.

Ginger, next slide please. The important thing to not lose sight of is that Vermont is not alone in this goal to improve care and slow the rate of cost growth by shifting to value based care arrangements. CMMI, which is an arm of CMS that

you all know very well, put out a white paper to look at what they were trying to accomplish over the next 10 years, and their goal is to have every Medicare beneficiary in an accountable care relationship by 2030. So that's moving every Medicare beneficiary out of a fee for service construct into one that looks at value and cost of care. So putting the accountability in the hands of the providers. This is a fairly lofty goal and it really can only be accomplished if, as I said earlier, if you really had your whole system of care moving in this direction, and that's what was contemplated under the All Payer Model agreement was to have that public/private partnership where all kind of oars were moving in the same direction.

I believe in Vermont that we have a good opportunity based on the model design that we have to meet this lofty goal. If you look at the current national statistics, about 42 percent of Medicare beneficiaries, and this would include Vermont, are in an accountable care relationship compared to Vermont where we're already ahead of this curve with 47 percent of Vermonters in an accountable care relationship, and what I really want to point out here is that this is hard work, and also I don't

think I have to tell anybody on this screen today that it's only been made harder because of the pandemic and the stress that has been put on our health care work force and our system today, but yet they are so committed to this work that we have not lost ground over the last couple of years. We've continued to engage providers. We have not lost momentum in that way. We continue to successfully implement value based care contracts, and you'll see that there's a growing number of providers in our independent program, and we continue to deliver on the necessary infrastructure that's needed on a statewide level to really support providers in making this transition.

Next slide, Ginger. You all had a presentation just last Friday by NORC out of the University of Chicago, and I think this was a really important study looking at the first couple years of both Vermont's All Payer Model and the impact that the ACO is having, and the thing that I want to point out in this model that I believe you did a good job at last week is that this is an independent evaluation. It's really using a robust qualitative and quantitative analysis on whether or not this type of model will bear fruit and make progress, and it is

indeed showing that we are moving in the right direction as a state and for the ACO with statistically significant Medicare gross spending reductions and reductions in things like acute care stays and 30-day readmission.

This really positive report, coupled with the work that we did as an ACO with our provider partners earlier this year to really look at who we were as an organization and what work that we should be doing, has really put us in a better position to understand both our strengths and the opportunities and to be able for us to examine using a national framework what kind of steps do we need to be able to take as an ACO to ensure our success and sustainability into the future.

Next slide, Ginger. Out of that strategic planning process we had to really look at who OneCare was, what we represent, and what we do, and one of the things that would seem obvious but it really became obvious and kind of striking through the process is that we as an ACO are very unique in that we are not one organization. We are hundreds of organizations, over 5,000 different providers, and thinking about how that uniqueness and what strengths that brings with us and then also what challenges it

might bring with us as well because obviously having that many organizations coming together with a common purpose not all organizations are going to have the same needs, resources, and strengths. So thinking about what we as an ACO really needed to be able to provide the collective whole so that they could be successful in this journey, and this Board understands, as does many providers in Vermont, that you can't be all things to all people. So you really have to think about what your core focus areas are going to be and what are the expectations and supports that would be provided through an ACO. So that's how we landed on these core capabilities through this strategic planning process and working under a national framework of what would make an ACO successful to do this work.

The first one is network performance management, and that's not completely obvious at first blush what exactly that means. That's really the contracting arm of the ACO and bringing and engaging providers together to work under a common framework setting expectations around accountability to make sure that we're all working together towards a common goal, and as you will see in this budget we continue to deliver on that engagement and

contracting through multiple providers within Vermont and through multiple public and private payers.

The next thing that's really important for us to be able to do at the ACO is to provide that data analytics directly to health care providers to give them insights out of where the strength and opportunities are and how they can deliver on improved outcomes for their patient populations, and then there's that supportive payment reform behind it. What kind of payment structure is needed to provide predictability and flexibility to providers to really be able to deliver on that patient centered medical care, and so with that I wanted to formally introduce once again, but in a little bit more detail, Dr. Carrie Wulfman who is our brand new CMO. Carrie has been an innovator in health care delivery reform for years ever since the ACO's inception. She is also a very dedicated primary care practitioner actively practicing in Brandon, and I think it's really important to understand from a provider's perspective why these capabilities that are offered to the ACO are important to physicians like Carrie and to her patients, and so with that I'm going to turn it over to Dr. Carrie Wulfman. Thank you.

DR. WULFMAN: Good morning. Thank you,

Vicki, for that introduction. I'm really feeling honored to be in this position working with the OneCare team to keep pushing ahead towards our goals for high value care. Next slide please.

All of us know that the COVID-19 pandemic has brought unprecedented strain on the health care system at large. Patients, providers, and systems have all had to adjust in ways we never had imaged and Vermont has not been spared by the impacts of the pandemic. We continue to see and read about the grip that this infection has on our state and on our country. Innovation has been required and is paramount in order to take care of health care business. In both primary and specialty care, inpatient and outpatient worlds, we have had to adopt new work flows and embrace new ways of managing such as telehealth appointments, staggered in-person appointments, and increased patient portal messaging to give a few examples. There are many other ways we have had to adapt.

I'm also surprised at the resilience and willingness of my patients to seek access in new ways, and in fact many of them seem to feel even more in charge of their own health, at least in some ways, with their ability to perform home blood pressure

monitoring, improved glucose monitoring, symptom monitoring and reporting. More innovation is needed such as e-consults with specialists in order to enhance access as we continue to see the effects of delayed care and backed up schedules as well as staffing shortages.

As a primary care provider I see ACO efforts and programs as a vehicle to move forward. For example, you will hear later about our comprehensive payment reform program or CPR which is a fixed payment program that supported 11 of Vermont's primary care practices when fee for service fell off during the pandemic, and we believe that care coordination is at the center of ACO success. This was true actually before the pandemic, but is brought to bear even more dramatically now with growing stress, distress, and lapses in care of all kinds.

The care coordination platform supported by OneCare is evolving this year in collaboration with our members. What we know for certain is that if Vermont's population lacks housing, food, transportation, emotional and mental safety, and access to health care overall health is at high risk. Assessing and then addressing the social determinants

of health requires a team, resources, and solid data and analytics to help guide processes.

I believe we have abundant opportunities for improved collaboration. We've made great strides partly due to the pandemic in collaborating and communicating across all of the health care spectrum and throughout our communities. The team at OneCare is committed to making connections and seeking feedback from our stakeholders including our members who are both independent and UVM affiliated. The general public, patients, our payers, our state, and government partners including you, the Green Mountain Care Board, we need to work together if we want Vermont's population to experience life with less illness and greater access to all the components that lead to health, and now I would like to hand this over to Sarah Barry, the COO of OneCare Vermont.

MS. BARRY: Good morning and thank you for the introduction, Carrie. Next slide please, Ginger. So in this section Dr. Wulfman and I are going to walk through some of the highlights of advancements that we're making here as an ACO as a collective group of primary care and specialty care providers, continuum of care providers across the state, and within these collective goals we are

really focused on how as a network we can improve the quality of care, appropriate utilization of services, and cost of care. So in this section we're going to use the framework of the core capabilities that Vicki introduced moments ago to focus our remarks, and we'll end by sharing some lessons learned particularly over the course of this last year and through some of the processes of gathering feedback that Carrie just described. I do want to pause though, and though this may seem a little out of order, we are referencing this as budget section 7 to keep everyone well grounded in the narrative and how we are aligning with the budget template, but in this we're taking the opportunity really to set the stage and reflect upon all of the work that has been accomplished over the last year, the changes that have been made coming out of the strategic planning process, and really looking to the future, how we're setting up the ACO to continue success and growth and evolution in 2022 and beyond. Next slide please.

So to begin the first core capability of network performance management really encompasses three critical components of ACO performance. First we serve as a hub and a connector organization bringing together this diverse network of providers

through annual contracting processes as Vicki described earlier. I think it's critically important to recognize that these organizations are voluntarily participating in this model because they believe in the concept of value based care and this belief has not wavered. We continue to have a very large and diverse network that is statewide with more than 5,000 providers supporting almost 300,000 attributed lives, and we took a pause and looked at how many organizations this represents in the function of how we contract across payers, and with our network and today we have more than 160 different organizations that are supporting these payment reform and care delivery transformation processes.

The next key element with the network performance management is really the quality of care. Making sure that as a network we are focused on providing the highest quality care to all of the patients that seek services throughout the state. In a moment I'll discuss a bit more about how we focused our network on key quality metrics over the past year and worked to align incentives based on their feedback, but first I do want to acknowledge that the pandemic continues to impact quality of care as people delayed care and we will have some ground to

regain in this area over the next few years.

Finally, with the network performance management it encompasses our care model and this includes well care, preventive care, as well as acute care with a significant emphasis, as you will hear, on activities to improve coordination and collaboration across the local community and the broader system of care. So in a moment we'll share a bit more about how we've been evolving programs within our care model to continue to optimize both care delivery and focus on achieving the outcomes that we all want to see for Vermonters.

Next slide please. So now I want to take a closer look at our quality program which we call our value based incentive fund. As I mentioned we've been working hard to align our focus and incentivize providers around a small list of key areas to help alleviate providers feeling like there are too many priorities, and when there are too many priorities none are truly priorities, right. So our population health strategy committee through a process of reviewing and reflecting upon key data that OneCare was able to provide and gathering feedback and perspectives within local communities selected four key measures, two for adults focusing

on individuals with hypertension and individuals with diabetes, while there are some who may have both, and two for children and adolescents, depression screening and followup and developmental screening in the first three years of life. These were selected because they really represented areas where there was opportunity to improve both geographically, so across our state, as well as when we look from one program say commercial to a Medicare population that really across the board there could be some deep engagement and thinking about where there are opportunities to provide the highest quality care for these populations.

So in response as part of this discussion of focusing down on these selected measures we heard very clearly from our primary care providers in particular that they needed more access to timely and specific data, data that was not just aggregated within their local community, but really what was happening for their patients, and that in a number of cases that was information that was not otherwise accessible to them. Certainly not on the frequency with which they wanted to see it. So as a result OneCare reallocated staffing and has worked to advance our claims and clinical information, and we

really supplemented it by having several staff members manually abstract data from electronic health records over the course of this year in order to get enough information and that timely information to inform realtime performance monitoring and changed focus at a local level.

So as you'll see on this slide there are 54 separate organizations that are receiving quarterly performance data and coaching support to review and understand the information they are receiving and to identify ways that they can change work flows. They can partner within their care teams and across organizations in their local communities to improve performance in these areas.

The table on the bottom of the slide is a snapshot of the first quarter of this performance here of 2021. Looking at briefly just an example of an organization here abbreviated as a TIN, and also a health service area and obviously this is a much longer report, but what this does is it shows you for the organization and for the health service area in which they organize and support patients what's performance look like in each of these four domains, and did they meet the target, did they meet the stretch goal, and so I think one of the things that's

important here is if you look at the bottom row of this table, again recalling this is the first quarter of the year, when you aggregate up and you look at the CMMI affiliate level information, you'll see that as of the end of the first quarter of '21 as a network we were performing below target in hypertension, we met target for diabetes and depression, and we were actually a bit ahead of our stretch goal for developmental screening. So the question that may arise well then how does this provide a signal for providers, and I think what's important is that we recognize that unlike data that are collected annually that align with ACO payer contracts and are really used for kind of a judgment or accountability framework, this is really intended to be small scale rapid snapshots of data collected to inform quality improvement processes. So as such the numbers, the number of individuals that were sampled to collect this information, varies and in some cases is quite small, and so it's really intended not to make judgments again, but to provide those signals to say okay if I'm a care team coming together to reflect upon how I'm supporting patients who have hypertension, am I seeing unexpected variation, how might we think about this from a

population perspective, and create some different programs or work flows or processes to help support person centered care and attainment of say better management of hypertension, and so in order to advance this program and this focus that we've described we've also aligned funding, and we have over 2 million dollars of incentives that come from hospitals, sources that support action through meeting and exceeding these targets and stretch goals, and so that funding is distributed throughout the year rather than in past processes where any incentive funding would have come say as much as 18 months after activities had started. So, again, receiving some pretty significant positive feedback from our provider community both about receiving more timely data and information and also about aligning the incentives in more timely manner.

Next slide please, Ginger. So in this slide you can see a de-identified example of a new transparent data reporting tool. This is specifically aimed at primary care practices that are working through those focused value based incentives fund measures. This report is in addition to the specific data that they received about their individual performance on those target and stretch

goals, and what it does is it uses a simple stoplight approach to benchmark performance against one another and ideally create some energy for practices to connect around opportunities to improve. So, for example, if I were in a practice where I saw I had signals that were red or yellow and I had some colleagues either in my community or in another part of the state that their performance looked green, OneCare could help facilitate some outreach and connection to identify what are some of the processes and systems that that practice that's performing so highly has in place and how might I learn from that. This is in beta testing right now. We've received some very positive feedback and we're going to be rolling out the live report very shortly.

Next slide please. So now with respect to our care model we've engaged quite deeply with our network to gather feedback and involve our care coordination program as part of an ongoing learning system. This started just after this time last fall when we surveyed over 120 care coordination staff out in the field providing services and asked them about what was working, what needs they had, the barriers they were experiencing, and as a result of that first survey we really focused some activities and took

action around beginning a process to evaluate the shared care communication platform called Care Navigator. They asked for and we conducted specific educational sessions particularly around motivational interviewing and we worked to develop with them an education plan. One of the reflections that I think won't surprise you, particularly given the conversation earlier this morning, is that the work force challenges are tremendous and that includes care coordinators across the state, and so one of the ways that OneCare has been able to be helpful in that space is that as work force turnover has occurred we have been there to provide training and support to facilitate skill development of new care coordinators as well to support advancement of care coordinator skills, and we do that through in part our e-learning platform, through one-on-one interactions, and certainly through group education sessions as appropriate.

That was just the first of several mechanisms we used to gather feedback. We also have considered the feedback and recommendations in the state's All Payer Model improvement plan, and we gathered tremendous stakeholder feedback from our strategic planning process that took place over the

winter and early spring, and through those conversations it became clear that we needed to engage more deeply with our network through a series of focus groups and listening sessions that occurred over this summer. So just over the last few months, and during those sessions we really focused on reflecting and gathering feedback on the core principles of OneCare's care coordination program, the payment model itself, what was working, what wasn't working around that, the tools and resources, whether it be the communication platforms, the way that data and information and reports are shared, the educational supports, all of those things were on the table for discussion, and I just want to stop and say this was an incredibly deep and reflective process that took place. I think that it's something that while we've used it in the past it's something that I think you will see more of from us in the future, and in the end through these conversations I'm really pleased to say that we confirmed all of the core components of our care coordination program including the centrality of person centered care, shared care plans as tools, team based care concepts that extend throughout continuum of care, the value of lead care coordinators, particularly those the individual

selects I like to call the quarterback of their care team, the use of care conferences as a facilitative tool to help communicate with goal setting and goal establishment, as well as the barriers that may need to be addressed or that arise, and so that was I think a really strong foundation then to move forward from.

The next thing that became very apparent in those conversations is that there really was an opportunity to separate out the payments that OneCare provides to our network from the documentation in the shared communication platform Care Navigator, and this was really a strong, strong request from our network to work towards simplifying the program and reducing the burdens for providers. So as a result through many rounds of feedback and kind of iterative learning we designed for 2022 a payment model for the care coordination program that relies on a base payment for network accountabilities and an incentive component based on performance. So you'll see from the little chart in the bottom right that in '22 the ratio is set at 85 percent of the total will go out in base payments and 15 percent will be aligned with incentives. However, I do want to note that we anticipate this ratio will be adjusted over time with

a higher proportion moving into the incentive component, and that's because it really needs to align with our desire to achieve measurable and consistent outcomes for individuals served in this program. So we'll be working over the next months and through the spring with our network to define kind of what that stair step approach will look like, but that is clearly the intention and something that our provider network felt like made sense and can provide them with both the resources they need to maintain the care coordination services that they are providing as well as view of the future to help them plan from their business perspectives.

Next slide please. So diving a little bit more deeply into the care coordination program one of the new strategies our network has engaged in this year is utilizing some new what we call subpopulation reports that OneCare has provided, and the intention of these reports is to really help focus and prioritize outreach and engagement. If there is a list say that a care coordinator receives with hundreds of names of individuals that might from a data driven perspective indicate that they could potentially benefit from this program, sometimes that can be overwhelming to figure out where to start, and

so what we've done is provided these narrower lists as well to say well one of the places you could start is you could look for individuals that have frequently engaged with the emergency department and reach out and have some conversations about how we might be able to more appropriately serve their needs in another setting of care. We can make sure that they have an established and trusting relationship with primary care, that they can break down some of the barriers that might exist over say timing or transportation, for example.

The second subpopulation is really looking at those individuals that have frequent inpatient hospitalizations. So where are there opportunities again that we might be able to create processes to support individuals before they get sick enough that they need to use acute care services, and then also looking at individuals who have high medical, mental health and/or social needs. Again key indicators when we look at opportunities to better support Vermonters and to facilitate high quality coordination of care.

So in this setting I also think it's important to recognize that despite the pandemic and changes in utilization that we've seen we've

continued to see high engagement in our care coordination program. We have more than 4,000 individuals in active care management and several thousand more in early stages of engagement.

To support the ongoing evaluation of our care coordination program we continue to focus on key process and outcome metrics as we have in the past, however, we're also working with our network to collect the key data points in a simpler fashion. Again this is in response to feedback about how we can reduce the burden associated with the process, and so we are in the process of working with our network right now in some educational opportunities providing some communication to make sure that they are ready for these changes that will go into effect in January. Now I'm going to turn it over to Carrie to share a bit more about the program specifics for 2022.

DR. WULFMAN: Next slide please. To summarize OneCare's accountabilities for 2022 and what we are calling this first core capability network performance management we will continue to push patient panel reviews, management, and outreach. This will help us identify patients on panels where access is lacking, there are lapses in care, both

preventative and in management of chronic disease, and you keep hearing the term team based care. This is part of team based care. We'll invest time and resources to redesign our care coordination platform, as Sarah just explained, and the reporting that comes out of that. We will require our members to participate in biannual attestation for care management and to incorporate professional development for their care coordinators. We plan to expand our cross organizational connections, collaboration, and communication starting with a look at our committee structure to ensure inclusivity and focused work. We hold ourselves and our members accountable for ongoing process improvement which is essential if we aim to improve quality and health equity and to reduce cost; and now I'll hand it back to Sarah to talk about our second core capability data and analytics.

MS. BARRY: Thank you, Carrie. So, as Carrie mentioned, as we dive into data and analytics we're really focusing on how we can provide actionable data and insights for the providers across our network, and similar to what I was describing a moment ago in terms of seeking feedback from our network in this arena we distributed a survey and

found that three-quarters of respondents were currently using data provided by OneCare to perform some pretty key functions within and across their organizations. First of all, they were using it to make informed financial decisions. They are using it to facilitate their quality improvement activities informing them around where there are opportunities as well as, again, where there could be collaboration or new connections built. They are refining work flows. This really gets back to some of the panel management opportunities that Carrie described a moment ago, and they are importantly communicating and coordinating services and care across their communities.

Finally, many reported that they were using it to identify variations in care and quality. At the same time providers also asked them to meet them where they are currently at in their data journey and that they needed more variety of supports from OneCare. So we are responding to this feedback both with some new focused reporting, but also with increased access to analysts for elbow support. So at this point we have assigned individual analysts into each of our health service areas with some priorities for outreach and to really help facilitate

deeper connection and deeper understanding about the data so that it truly is providing those insights not just information.

So now what I would like to do is share with you a couple of brand new reports that our team has been developing so that you can see how we're responding to these requests. Next slide please. So, first, here's a snapshot of a new financial performance report that we rolled out earlier this summer. This report brings critical information together in one place and communicates new year-end forecasted financial performance. An important component of this report is that it moves through the system starting at aggregate kind of the macro level ACO results down to a local community, a health service area indicators of performance, and then lands at practice level financial outcomes. So while you'll see this is just a representation of this report, we've now been distributing it for four months now receiving very positive feedback and again providing us new opportunities to support this process through enhanced education providing some explanations and training about how not only to interpret the information here, but really how to utilize it most effectively.

Next slide please. So this is a new report for primary care we call panel report and it's in beta testing right now so we have not fully distributed it. This report is focused similarly to the financial report, but this one is about bringing critical cost utilization and quality data down to the practice level with panel information provided all in one place so that you really get a comprehensive snapshot of what is going on say in an individual practice.

The other thing that I think is really a great opportunity provided through this new report is that it provides benchmarking against a group of similar practices. So, for example, if I work in a federally qualified health center, one of the data points I now have accessible is how does my performance relate to other federally qualified health centers around the state. As I mentioned this one is still in the final stage of design, and we will be moving it forward very shortly and so we're looking forward to that.

Hopefully what you're seeing through some of the examples I'm providing is that we've really focused in a lot on making sure primary care as the foundation of so much of our model has the

information that they need both at the local level, so within their organization, but also kind of environmentally in the broader context of then what that looks like in terms of opportunities to benchmark locally and across the state. So now I'm going to turn it over to Carrie for a few comments.

DR. WULFMAN: Sarah just showed two types of reports that are examples of what our providers are craving. OneCare will continue to provide data and analytics that are trustworthy and actionable. As a provider myself it's great to see more actionable reports coming out of OneCare being made available so that we can see our progress and set new goals.

To quickly demonstrate how this second core capability data and analytics is being utilized by our members we would like to share a short video clip that demonstrates how our Brattleboro partners have used data and analytics to improve health and reduce costs in their community.

(Video presentation) We were looking at the data, OneCare data, not just for health outcomes, but also for cost of care. Every month, every quarter, our highest cost of care was all around

cardiac events; heart attacks, transferring patients. We started to think about how we could intervene earlier with patients and that's where the idea was born for our cardiac prehab program. Patients who are selected go through the entire education series, the exercise series. They learn how to prepare meals, how to shop for the correct food. Think about preventing a heart attack. It means a longer life for that patient. It also drives down the cost of care.

MS. BARRY: So as you can see that was just a very brief snapshot, but I think one of many stories that are occurring across the state as we think about how providers are working collaboratively to use data to really inform them in their care delivery processes and to work towards providing optimal care for everyone that they serve.

So finally now I'm going to move into the third core capability which is payment reform. The goals of our payment reform programs are to stabilize provider revenue and health care costs and move away from the volume based incentives inherent

in a fee for service system. Again, as in several previous examples, we surveyed our network uniquely to this topic and we wanted to learn more about what is working and where we could improve. We learned that additional supports were needed and that these supports should focus on increasing participant's understanding of the payment reform programs that currently exist, how they are being refined, and how it works, the mechanics of them, and that people really needed a deeper understanding about information as well as where they are going. There was also some helpful feedback about technical and formating changes to improve upon existing reports to make them easier to understand or easier for others to explain them back to their teams.

The chart on the right tracks the growth of non-reconciled fixed prospective payments over the past few years. Those are the bars in kind of a teal color and I think it's pretty impressive to see really over the course of those four years the value in those fixed payments has tripled. So I think we're on a good path there and again more work to be done. Providers have shared with us that non-reconciled payments encourage flexibility in testing care delivery changes and providing stability

to support reform efforts.

So now I'm going to turn it back to Carrie for a bit more detail about some of the ways that we're supporting practices in payment reform.

DR. WULFMAN: You have heard us speak earlier about OneCare's comprehensive payment reform program or CPR which was developed to transition independent primary care practices to stable monthly fixed payments. These monthly payments are based on core primary care services. Non-core services such as behavioral health provisions, procedures and labs which are not provided at every single primary care site, can be reimbursed in a fee for service method as an add-on.

The CPR program includes a supplemental per member per month amount to support care delivery evolution, and as you can see on this graph here participation is growing. We hosted a series of focus groups this past summer to gather feedback and ideas from those participating in this, and these comments, ideas, and feedback were considered in our 2022 program adjustments. As you have or will be reading written positive comments from some of our primary care members about this program and how it helped their clinics survive the impacts of the

pandemic, and it's also allowing them to recruit staff who are interested in working in a high value care environment. Next slide please.

We have and will continue to learn as we work together on the road to value based care and improving the health of our population. We are committed to engaging and reaching out to our participants, and likewise participants are showing engagement more and more and are willing to contribute to the evolution that's necessary. All of us affirm that we value a topnotch care coordination program and that is it is essential to reach our goals in population health.

Prevention efforts warrant more focus and energy. We are in discussions about how to push social determinants of health, screening, and response, food insecurity initiatives, movement and exercise programs, mental health screening and treatment, suicide prevention, return to work programs, and others. Vermont's population deserves this. The COVID-19 pandemic has reinforced the importance of value based care. It has jolted all of us to boost our support for providers to really engage in team based care, to collaborate with our community partners, to participate in and expand

coordination of care and payment reform programs, to fully utilize data and analytics, and to encourage digital patient engagement via telehealth visits, e-consults, patient portals, et cetera. We are encouraged that providers have increased recognition of the value of progressive capitated payment models. We fully admit that there's work to do in the areas of education, engagement, equity, and transparency.

So I just want to say thank you for allowing us the time first to show you how we are advancing high value care, how we have honed in on our three core capabilities, and what we are planning for 2022; and with that I'm going to hand this over to Tom Borys, our Vice President of Finance.

MR. BORYS: All right. Thank you, Dr. Wulfman. Hello everyone. Tom Borys, Vice President of Finance. Thanks for the opportunity to come and speak today about our budget. For a little bit of context I view this OneCare budget as two components. The first being ACO program terms, things like attribution, total cost of care and risk, and the second component speaks more to the OneCare entity budget in our operational plan and financial figures there.

(Interruption.)

CHAIR MULLIN: Whoever doesn't have their system muted if you could do so that we could clearly hear Tom, that would be greatly appreciated.

MR. BORYS: Thank you, Chair Mullin. So this presentation will follow that same order. I'll start with some ACO program budgetary components and then shift into the OneCare operating entity budget. As I go through the first part of this there's an order of operations that we follow. I just want to point this out in the beginning to help enhance the transparency behind the way in which this budget is developed. So I'll try to call that out as we go that we're taking a step wise approach, and with that the real first step is the ACO provider community. So next slide please.

So on the left-hand side our great State of Vermont. We continue to have a statewide network with participants really blanketing our entire state and some in the Lebanon area of New Hampshire. The number on this slide that continues to wow me every time I see it is the 288,000 people that we estimate will be attributed through our payer programs. This is my fifth budget for OneCare and I'm still amazed how far we've come in that period of time. We started in 2017 near 0 in the All Payer Model with

about 29,000 lives. That's tenfold growth over a relatively short period.

The other point I would like to make with this slide that I think is really important is that we have a very diverse provider network. You can see all the different provider types listed. This is unique in my view relative to other ACOs that often start with primary care at the center and may have a handful of preferred provider relationships or established relationships with our provider types. We began out of the gate with a very widespread and diverse provider network, and I believe that gives us the opportunity to really effectively coordinate care across all the different providers treating our attributed population.

Next slide please. So next after we've established the provider network there's a contracting session that occurs in the summer preceding any program here. Then we shift our focus into the payer programs.

Next slide. The budget includes continuation of all the payer programs offered in 2021. Sometimes a goal in a budget is to grow and expand and other times a goal is sustain what has been already established and built. In this pandemic

period, which makes value based care more challenging than it ordinarily is, sustaining what we already have I think is a great success to this budget. COVID and the pandemic continues to create challenges for these programs, but also in my view and reinforced some of the points Dr. Wulfman and Sarah made reenforces the need for value based care.

When we look at each of the programs; Medicare, Medicaid, Blue Cross, and MVP, we're anticipating the programs continue in a similar form and function each year. We do sit down with the payer partners and discuss the program; what's working well, what changes might we want to build in. For 2022 we anticipate the changes to be relatively minor, but those negotiations are ongoing and we'll be sure to communicate with you if anything substantial were to come from those negotiations. Next slide please.

Next slide please. Thank you. Perfect. All right. So from the payer programs order of organization we -- go back one to the attribution slide. That would be great. So from the payer programs then comes the attribution estimates. So through our budget process we do our best to estimate the attribution that will come to us between now and

really a little bit into the actual performance year itself. We largely base our attribution estimates on the existing data that we have in-house and some rough assumptions about what we expect, participation changes, or other industry factors to come into play. We don't have the ability to run basically a mock attribution model that looks at the payers and they are looking at running those attribution numbers next year at present.

Again you will see the big number. 288,000 lives anticipated in our 2022 programs. 257,000 of those lives we expect to qualify for scale. Where we're anticipating some change between 2021 and 2022 is in the Medicaid program. There's an update being processed to the way in which FQHC attribution is determined. So we expect that to deliver a modest uptick. We're also anticipating a modest uptick in the Blue Cross Blue Shield program both the QHP and primary programs. This is a result of increased provider participation in those two programs. So we just estimate the number of lives we expect those new participants to bring into the program. All in all another year with tremendous amount of lives moving into a value based health care arrangement.

Next slide please. Once we have established our attribution estimates we begin our work to forecast the total cost of care targets. Move to the next slide please. This slide shows in the bar charts at the top the anticipated 2022 total cost of care targets by program. 1.33 billion dollars of health care cost moved into value based contracts or continuing through in value based contracts in 2022. Another big year. That's a significant number in my view to have transition into value based care. As Vicki noted at the beginning of the presentation, we're looking to move all of those health care costs or attributed lives into some sort of value based arrangement. So there's certainly more opportunity for growth out there, but nevertheless 1.33 billion is a large number.

Impacts of the pandemic. Certainly challenging every aspect of our lives and forecasting total cost of care is no exception. A lot of moving parts and new variables at play resulting from the disruption the pandemic has caused and really affecting health care patterns makes it very difficult to project future year health care costs amidst the uncertainty around our health care system. These forecasts from the total cost of care figures

they flow and follow attribution increases, insurance rate changes or increases, COVID rebound in some cases, and any other payer reimbursement modification. So we do our best through this process to really estimate what we think those targets will be.

In terms of process we are starting or in some cases already deep into the actuarial process whereby the payers establish total cost of care targets. We have the opportunity to review those, use our data to validate, and ensures we think they are reasonable, and then hopefully move forward with a program arrangement.

Next slide please. I want to spend a moment on program trend rates. This is a topic that often comes up due to the relative nature of the 3.5 percent in the All Payer Model relative to our programs. This is -- we use the best available data to develop these estimates and it's very much complicated by the 2020 would typically be the base year for some programs, and the way these often work is that you have a base year, apply a trend or actuarial forecast to get to the actual performance. Here because 2020 is not a representative year the challenge that we're facing right now is how to work

around that unusual year. So we're in conversations with each of the payers. There are different perspectives. All have some validity to them. One perspective, for example, used 2019 as a base and do a multi-year hop, a three-year hop from that point forward. Another perspective is to use 2021 emerging trend as there are some new patterns coming out to establish the 2022 targets. That has some validity as well. Third option is to do some sort of a blend where you blend multiple years together to try to establish a reasonable base. So challenging in a normal time. Certainly more challenging through this pandemic.

Next I'll speak about the Medicare program a little bit as it relates specifically to this Green Mountain Care Board itself. There are some unique program factors. What we decided to put into our budget model was for the end stage renal disease and ESRD and non-ESRD components. We relied upon the United States per capita cost trend forecast. That is the factor indicated in the Vermont All Payer Model. This approach is intended to support providers and reform efforts, potential to affect the cost shift in a favorable way, also building off of the NORC report that indicated

there's some savings being generated through our collective statewide effort here. It seems like a really good opportunity to build upon the work that's already started here and maximizing the federal investment in our program seems like a good idea to me.

The multi-payer advance primary care practice component, MAPCP, which funds the Blueprint expenses, were budgeted conservatively at 3.5 percent. The rationale for this decision was that the Blueprint revenue stream, this funding stream that funds the Blueprint, did not face the same volatility that claims-based components faced throughout the pandemic. With that in mind we elected a conservative 3.5 percent trend rate. It aligns with the All Payer Model growth rate. However, despite that assumption and the assumption about ESRG and non-ESRG trends the rates will ultimately be established by the Green Mountain Care Board in roughly the next month or so as you folks do your rate review for that particular program line.

Next slide please. Okay. So we budgeted the total cost of care targets. Really now that shifts us into the risk space and risk management. Next slide please. The primary reason

to develop total cost of care forecast is really to give us a sense of the risk and reward opportunity that we'll be taking on through these contracts and therefore passing through to providers. We are maintaining a moderated risk -- aggregate risk level in 2022. After the pandemic we -- there are a couple adjustments made to payer contracts to limit the risk exposure for providers. It felt very reasonable to me and we are continuing with this moderated risk level in 2022. I will point out, though, it also limits the reward opportunity. The potential shared savings from these programs as well. We're starting to feel that pressure. To make this model sustainable we do need to have some returns through shared savings, and limiting the opportunity in some ways is actually a ceiling for us. So as we're moving forward into the future years and hopefully get some stability back in our health care system whether or not the pandemic has abated or not, really the stability is what we're looking for in the numbers, then we can begin to move towards greater risk and reward levels for providers to get back to what I think is a more traditional level of risk.

Next slide please. I want to spend a moment on the risk and reward model and a little trip

down memory lane. Back in 2020 in response to the COVID pandemic, some actuarial concerns around small numbers, as well as resource constraints, we moved to a pooled risk sharing approach. However, in concert with this we are starting, and Sarah spoke about this earlier, to include performance based components to our population health management investments; and the point that I think is really important to make here is that we are trying to bring some synergy between those two components. Shared savings is one tool to use and the population health programs and investments is another tool, and we're trying to make these two components really work together to thoughtfully spread accountability across our network without overloading community providers with untenable risk.

The graphic at the bottom shows those two components, shared savings and loss, by directional arrow with population health program accountability. Under the shares savings and losses component it largely remains with the hospitals through this pandemic, gives them an opportunity to offset their participating fees which I think is important pooled by HSA. We do have some HSA performance factors, and accountability pool

incorporates primary care of all types into this shared savings shared loss model.

Next on the right many of the OneCare investments now have specific performance based components. Sarah mentioned earlier it's a modest transition to having a performance based component in care coordination, for example. Over time we'll evaluate that split. Those performance based components mean that providers meeting or exceeding targets have the opportunity to earn more relative to their peers. That's the essence of value based care awarding those who achieve excellent outcomes.

One of the really important strategies behind this particular approach is that it enables the financial accountability to align with the size of the investments that OneCare is making into the providers. There's some balance here. Our community providers need to be thoughtful of their financial circumstances outside of OneCare programs, and if there is a large amount of potential downside risk placed upon those providers, we risk losing them from the network, and that's not an outcome we prefer at this point. So we're really trying to right size the accountability with other investments that are being made into the provider community.

Next slide please. Fixed payments. Fixed payments in a good way have been getting a lot of air time lately, and I thought it might be nice to pause and share a few thoughts about the fixed payment programs. Underneath these total cost of care accountability programs we're able to facilitate payment reforms for our providers. So that total cost of care contract is really the value based care component, and then underneath that there are some benefits that we can leverage. One is to change the way providers are paid. There's a lot of reasons to do this, but for me really I viewed this as a benefit to providers. Going back to my provider side experience, if I could choose a stable fixed payment over a variable payment, all else equal I would take the stable payment everyday. It's also a need to stabilize health care costs under these total cost of care contracts. If you can lock in a decent portion of the health care costs, it helps to build some stability in these programs which I think makes the transition into value based care and accountability a little bit easier.

All that being said, there are some limitations to what we can do with fixed payments. The first we're limited by the contracted payer

program so we can only do payment reform for programs that were under contract whether or not the payer program offers a fixed payment, and those conversations continue but not all came with a fixed payment option off the shelf. The size of the attributed population. We can do a payment reform for the attributed lives only at this point in time.

Number four is important. Proportion of care in network versus out of network. This is not relative to where care is delivered, patient choice or anything like that, but OneCare is not structured to pay out-of-network claims. For example, if an attributed life goes to Boston for care, Florida for care, we don't have the relationships, the contractual arrangements, in place to pay claims for those particular providers whether it's a fixed payment or some sort of fee for service for them. So the reach of our payment reforms at this point in time is limited to those providers that are in our OneCare network and in the corresponding payer program.

The last point that I think is important is provider readiness. It is easy to get the financial reforms out in front of the care delivery reforms, and I think it's very important for

providers to be ready not only to administratively handle a shift to a fixed payment which hopefully in the long term is easier but may not be on day one, and also be ready to make the practice evolutions necessary to succeed under a reformed payment model. So I'm offering here a couple different ways to really measure the fixed payment evolution through these OneCare programs, and the way I've structured this is to compare the fixed payments on offer relative to the in-network spend for the corresponding programs. Three views at the bottom. Bottom left isolating just -- just the public payer programs which is where we began with Medicaid back in 2017. Brought on Medicare in 2018. Of those in network health care costs 61 percent are now in a fixed payment model. I'll note Medicare is included in that it does reconcile a fee for service, but again we view that as an on-ramp to the unreconciled model so I wanted to factor that in here.

Next the middle pie shows the percentage when you look at all programs that offer a fixed payment presently, 55 percent, and then when you look at all programs in totality recognizing that some do not offer fixed payment at this point in time, 41 percent, and I'll note those are 2021 data used for

those illustrations.

All right. This is a transition point. So the previous slides really spoke to ACO terms, concepts, and now we're shifting into really the OneCare entity budget and all the work that supports everything that Dr. Wulfman and Sarah spoke of, and the ACO programs I just discussed. Next slide please.

44.1 million dollar budget. When I really think about the OneCare organization itself that's the budget size that comes to my mind first. It is a balanced budget. No profit or loss planned through the budget model. No additional contributions to reserves in this particular year. Key strategies and in some cases challenges is accommodate the delivery system reform and health information technology revenue, continued focus on care coordination. I'll speak to that a little bit more in a few slides. Sustain investments that have become reliable revenue streams for participating health care providers. This is something I think about often. We've been around now for a number of years. We've made population health management investments into providers in the 28 to 30 million dollars each year. Many of those revenue streams

have really been built into the financial fabric of our participants. We need to be very thoughtful about the changes that we make.

Last bullet. Maintain capacity to support the provider network. I'll speak about that a little bit later in the presentation. In total two big numbers to point out. 28.9 million population health management program investments provider community and 15.3 million in OneCare shared ACO infrastructure.

Next slide please. Revenue highlights. Main challenge in the budget is accommodating a 3.9 million dollar revenue loss relating to the delivery system reform and health information technology funding. This was known that there was an end date for the -- particularly the DSR funding stream. So through this budget really tried to accommodate and work with that known revenue loss.

We're including consistent reform investments through payer contracts. Many of these are structured as a PMPM so the revenue level will flow with attribution, but in terms of the underlying model the budget submitted includes a consistent structure, deferred funds that accumulated largely due to the pandemic, and also some program ramp-up

have largely been consumed in 2021. That is strategy to help us bridge through this really difficult pandemic period. The finite pool of funds that we used very strategically is not available to us as we build our 2022 budget, and then in total to balance a 3.6 million dollar increase in hospital participation fees.

Next slide please. Look at the numbers. About a million dollar increase in payer program support. Again for those with attribution you will note the two negative numbers in the change column on the very right, the DSR funding, health information technology funding. Other revenues includes deferred revenues, reduction there, and then the hospital participation fees increasing by 3.6 million dollars.

Next slide please. Shifting over to expenses. Also two components to this -- this landscape here. One is population health management programs, funds that come to the network to support our initiatives. The other is that ACO shared infrastructure. So I'm going to start with population health management expenses. In light of the revenue loss trying to maintain as much of the population health investments as possible, again, that financial -- those dollars have really been

built into the financial fabric. Do not want to pull out the rug from our participants. Investments in care coordination were specifically identified as an area to sustain funding. As Dr. Wulfman mentioned, care coordination is often at the epicenter of an ACO model and it is a program that requires hospital investment. Because of that last point in particular we convened a group of our finance committee and population health strategy committee members to specifically discuss care coordination in the context of the DSR revenue loss. That group made it clear that we need to continue to protect care coordination investments and really rally around that program as the epicenter of our ACO care model. So despite some necessary changes we are able to sustain 28.9 million of funding to participating providers. Another year of really material investment into our provider community.

Next slide. When we look at the population health management programs and program by program first area I'll focus on is care coordination. As I said, significant effort to maintain this program. Moving the financial model off of Care Navigator, as Sarah discussed, despite that change trying to sustain the actual investment

amount in total just change the way in which providers are reimbursed for their work. Each payment stream in this program now has a component for outcomes and performance. A really important evolution linking back to that risk management slide is the shared savings model, but we also are building in accountability to our population health management investments.

Continuation of the longitudinal care program for home health. Encouraging outcomes from that program, and reduce DULCE expense for OneCare, although happy to report the program's maintained in full from additional support from the Vermont Department of Health. Top right PCP primary engagement payments. The revenue stream that historically supported these payments has been reallocated to support the care coordination program. Having to make some tough decisions in this budget, and with care coordination being a priority area we in some cases move revenue to support that effort.

Value based incentive fund. One of the more exciting evolutions that took place in 2021 I think relative to what Sarah presented earlier, but we're continuing to move and advocate for a real payer blended approach that enables OneCare to reward

providers effectively, and timely payments is one portion of this so that we're not making payments six to nine months after the year's over and settlement occurs, but we're able to make payments throughout the year to keep quality and quality performance front and center for all of our providers, and that second point, practice specific quality core, being really important. That's no longer just distributing the value based incentive fund based on aggregate performance, but really evaluating each practice specifically, and for those meeting the targets making payments, and for those with some work to do helping to support those providers that they are included in the financial distribution in the next payment batch.

Next slide. Prevention. Budget includes six months of the RiseVT funding in the same form, and then we're beginning work to determine the next iteration of clinical prevention and health equity. So transitioning our prevention strategy a little bit. Blueprint expenditures 3.5 percent inflation. This goes back to that trend rate slide and the MAPCP adjustment that we discussed. Payment reform programs. This includes the CPR program largely. We are anticipating additional practices so

the expenses increased a little bit there. We're working on a pilot with FQHCs. It does not look like it will launch in 2022. It will likely launch in 2023. We're going to continue to work with the FQHCs throughout 2022 so that we're all ready in 2023 to be live with this particular program.

Lastly, specialist, innovation fund. No new expenditures in this budget, but there are some expenses that represent a continuation of previously funded or obligated initiatives that just have continued on some delays through the pandemic is why we're still seeing it in 2022.

CHAIR MULLIN: Tom, before you get started on the population health investment area I think it would be good to take a bio break, and if we could break until 11:05 and then come back and then we'll proceed to approximately 12:30, take a lunch break, and then come back. So we'll put this meeting in recess until 11:05. Thank you, Tom.

MR. BORYS: You're welcome.

(Recess.)

CHAIR MULLIN: Okay. Tom Borys whenever are your ready to proceed go ahead.

MR. BORYS: Thank you so much. The next two slides are included more for reference than for

deep discussion. The first is I'll break down the population health management investments by investment area. You can see the totals for primary care services, care coordination quality. Note the recipient types is a little bit different and that is the next slide. Advance one please. Shows the same total dollars but broken down by the organizational type; FQHC, designated agency, et cetera. Again really in here for reference so you all can see the different breakdowns and then the corresponding program in which the investment was made.

Okay. One more shift here. Now into the operations aspect and this is really the OneCare shared ACO infrastructure. From a landscape perspective the resource demands from the provider network are higher than ever and that's a good thing. I'm really happy to see this. Participants are asking for additional data, insights, and direct support. There is an evolution here that I think is a good one. In the early years all right we'll join the ACO and see how it works, and now there's a transition to help me understand my opportunities, what we can do differently, how do I stack up relative to peers. So really good and important transition here.

We continue to operate a complex suite of value based ACO programs. It takes a lot to run these programs, everything from data to the financial actuarial operations. Many components necessary to run these programs as smoothly as we can. Participants need support to understand their roles and accountabilities. This was something noted in the NORC report as well, and I agree with it, that we have these ACO programs, we have a vast statewide network, and there's inconsistent understanding of how everyone fits into the model. So we need to spend more time working directly with our provider participants to help enhance their understanding.

Fourth bullet. We're learning as an organization and we're maturing as an ACO. We're learning new things everyday. You know it's easy for us to take those new learnings and just implement, but it's better yet more work to really make sure that we're incorporating our insights and the providers and their insights into the work and the evolutions that we endeavor to make over time. So it's a good thing. It's good work to do, but it is more and more work as we advance and mature as an ACO.

In addition, similar to any other

business, staffing time to meet demands outside of direct provider support that needs to be considered when we evaluate this budget and establish our needs. So in total the bottom box the operating budget needs to sustain the capacity to continue supporting participation providers while also being mindful of costs, and if we increase the cost, that additional expense will be borne by the hospitals.

Next slide please. Next slide. Thanks. All right. Taking a look at numbers. $618,000 of expense reduction included in this budget. I'll note a little bit of a juggling act going on between the software and informatics tools category and supplies and other. We have recast or recategorized software professional services. So historically they were in that software informatics tools, but the professional services are now contained in that travel, supplies, and other row. Most of the reduction that we're able to offer comes through restructuring our VITL contract collaboratively with VITL. That's where most of the expense savings comes from. The staffing model I'll speak to in a moment. Very comparable year over year. Basically flat in terms of salary expense and benefit expense.

We're looking at the bottom left. We

can see the expense by functional area within OneCare Vermont. I'll just point out the analytics bar, the grey section in the middle, represents the software tools. Those software tools, though, support the entirety of the organization. For example, finance cannot -- we cannot do our work without those underlying software tools that allow us to use the data so effectively. So it is really an expense line that supports the entire organization.

Next slide please. Real quick look at staffing. Remains our single largest operational investment. Largely people organization. Software is behind and such a necessary component of the ACO work. When I was looking at this I did point out in the slide we continue to operate with over 16 fewer FTEs than planned in the 2020 preCOVID budget. That's all to say we had aspirations for new endeavors, initiatives, programs. Many of those remain on hold as we go through the pandemic period really mindful of the expense charging the hospitals. All in all looking at the chart pretty stable when you look at salary and benefit per FTE as well as the total budgeted or paid FTEs. Next slide please.

Take a look at operating costs over time and I have two perspectives here. The top one will

be familiar, I believe, in my view. This top chart shows the efficiencies of a shared ACO infrastructure model. The OneCare operating expenses represent just 1.1 percent of the total cost of care of accountability through our programs. Every participant in our organization could build their own ACO and enter in their own independent ACO arrangements with payers. That is possible. I think it would take an enormous amount of time and I think there would be duplicative resources. So really what I'm trying to show with this slide is that having a shared ACO infrastructure that all different providers across our state can tap into is a much more efficient model.

Bottom left we look at operating costs over time. The big reduction we made, as I alluded to in the salaries slide, was the change between the 2020 preCOVID and 2020 post COVID budget where we put on hold many of these new initiatives that we have planned. We continue to maintain operating expenses at this reduced level through the pandemic. Again when I go back to my thinking about a budget sometimes it's a goal to reach to sometimes it's really more of a ceiling. I think in this particular days it's the latter. So maintaining this lower

operating budget does limit the initiatives that we can take on. We'll continue to evaluate this over time as we potentially move to greater risk sharing arrangements.

This pulls it all together. Summary income statement along the left. I used some simple categories for the revenue lines, total cost of care targets, payer contract, revenue, other revenues, and hospital dues. Total revenue 1.365 billion. Note we don't touch all those dollars. Many of those funds are existing health care spend dollars that we're accountable for, but they are in our total accountability budget; and then on the expense side the actual health services, population health management investments, and operating costs, and a zero dollar bottom line.

The pie chart to the right shows the relative proportions. 96.8 percent of the budget health services spending. 1.1 percent for operations. 2.1 percent for population health management investments. The way I think of this budget is that the 1.1 percent operation component and the 2.1 population health management component are the investments to help manage the 96.8 percent portion of this pie. That's what we would like to

see over time.

Next slide please. Included a little bit more detailed. Income statement and balance sheet. I apologize it's small on this slide. I invite all those listening to this meeting today to go onto our web site. There are a number of Excel submissions that will have these data over multiple years in much more detail, but just wanted to include this slide for reference here, and with that I am going to hand it back to Vicki.

MS. LONER: Great. Thanks so much, Tom, for that presentation and I just want to echo what Tom has been talking about for the past half hour or so in that really this budget that we've designed in collaboration with our provider partners and our Board is really designed to keep the momentum of health care reform going even in the midst of all the challenges that they are faced with in terms of hardships for delivering care, hardships on their financials, and sustaining their core business in order to keep their doors open.

So with that in mind as I think about health care reform and making sure that we keep the momentum going, as I noted earlier in the conversation, it really takes a village approach to

moving and transitioning to value based care and accountable care relationships, and if you look at the box, it's on the right-hand of my screen, and it has the top three facilitators for maximum success in value based care, and this was a survey that was done last year by HCPLAN which is essentially a consortium of health care leaders, payers, and providers whose goal is to really advance payment models that reward value over volume and getting to that preferred state, and what was pretty unanimous in that was that it does take a village. It takes providers to be interested and support this value based care promotion. It takes health plans to be interested and ready because remember this is a change for them as well in their daily operations and how they work with provider communities, and also takes government influence to be able to help support this change, and what I see in this budget and what I see through OneCare is you've got the first box checked on that through OneCare and its statewide network. You have broad accountability and engagement across 162 independent organizations. This is really unheard of in the health care industry and especially in the ACOs. I would say that we're very unique in that way. Over 5,000 providers serving Vermonters have

come to the table to say we believe that it's important to make this transition to value based care adoption for both our practices and for the patients that we serve, and in that budget it also talks about the population investments and continuing to invest in the delivery care so that the payment reform isn't the only component of it because I think as we talk through this it takes both payment and delivery reform. So making sure that if we're developing innovative delivery reform, we have some payment or delivery reform to go along with it, and then thinking about how we consistently change our model because, as Tom also noted, we are a learning organization. So how do we adapt and adopt new ways of thinking and new ways of monitoring to make sure that we're continuously improving on our quality, and as I look to the next five to ten years and CMMI's lofty goals of having all Medicare beneficiaries in our accountable care model, there's still a lot of work ahead of us that we need to do as a state and as a country because this is a national platform that we're looking at and a big component of it, and I think COVID has laid bare the importance of this is moving away from that fee for service as the basis for setting these targets for the ACO because the

last few years have been anything but normal, and the volatility in the numbers makes it exceedingly difficult to continue to look at fee for service as the basis.

I think we want to make sure, as we noted, to maximize those risk reward opportunities. We're at about 16 million dollars right now and we would like that to be higher because with risk comes reward and with reward comes even more opportunity to make those investments in population health that we wouldn't be able to sustain right now if it wasn't for the hospitals really supporting this initiative, and then our work with both the Green Mountain Care Board and the Agency of Human Services is really working with the federal government to look at models that support rural health care providers, and as a first step getting them some clarity on critical access hospitals and how they meaningfully participate in this type of model.

So I think that we should take a look at what we've done as a state and be proud of where we've come even in the face of this pandemic that, you know, has hit us all at some level, including our health care providers and our patients, and we should continue to work together to move this model forward

because the results are very promising and we just need to be ever vigilant in our approach moving forward.

So with that I thank you for your time and I will turn it back over to Chair Mullin.

CHAIR MULLIN: Thank you very much, Vicki, and we're going to start with our staff questions. I'm going to turn it over to Sarah and Marisa.

MS. MELAMED: Hi. Thank you so much Chair Mullin and thank you for OneCare for a very thorough presentation. This year the ACO oversight team has prepared some staff questions at the request of the Board and those questions will be shared between myself, Sarah Kinsler, and Patrick Rooney. So I'm going to kick it off.

First of all, we wanted to know that staff has noted as we've been going through the slides that there appear to be some discrepancy between budget numbers and FTE numbers that are noted in the slide and in the submitted financial sheet. That's something we're going to want to dig into with the OneCare team, but it's likely not a productive time to do that now verbally, but we did want to make a note of it that it's something we want to connect

back with OneCare about some of the figures don't appear to be aligned with the newly formatted financial sheets. There's a couple places where we may note that in my questions or Patrick's questions, but so with that I'll go on to my first question which is in regard to the operating agreement, the updated operating agreement that we received, submitted to the Board from OneCare earlier this month which reflects the change in governance and member managers of OneCare reflecting the change of the withdrawal of Dartmouth-Hitchcock Health Care as a member manager and how that affects the operating agreement and the board of managers roster.

So the overarching question is if you could take some time to describe the changes to the operating agreement at a high level and the impact of the OneCare's board of manager's roster. Specifically if you could explain the rationale for designating an additional seat from the UVM Health Network. Just for everybody's understanding previously there were three member managers designated for UVM's Health Network, three member managers for Dartmouth. In the updated operating agreement the three Dartmouth seats one is now designated for an academic medical center in New

Hampshire which would function to be Dartmouth. The second is an academic medical center located in Vermont which would mean there are now four seats for the University of Vermont Health Network, this is our only academic medical center, and the third seat is an at large seat. So we would like to hear discussion of the rationale behind those changes. In addition, explain the reasoning for having the Board Chair limited to a UVM Health Network appointed manager, and I will leave it at that and let you respond and receive any followup.

CHAIR MULLIN: You're muted, Vicki.

MS. LONER: That's unfortunate because I said amazing things in that time of being muted on the phone. I'm sorry you missed that. So I'll take that for the team and then I'll look to my colleagues, see if there's anything else that we missed.

So as part of the membership changes there was some governance changes in our operating agreement which you should have a fully executed copy of that. It did move the three UVM Medical Center member seat to UVM Health Network as the sole member of the organization. That left three Dartmouth member seats vacant. What we voted on as a board,

and remember all of this goes through our board of managers and was fully approved by them as part of this process, is that two of the Dartmouth member seats would be designated as academic medical centers in New Hampshire and Vermont serving Vermont ACO participants and participating in programs. Currently the two academic medical center seats are Dartmouth and we'll be voting on the UVM Medical Center academic seat coming up in the November Board meeting.

I think you also understand under CMS ruling we are required to have a representational board that represents the constituents that have participation within the ACO. That's why it's very important that we had the academic medical centers as specific seats just as we had Federally Qualified Health Centers as specific seats, independents specific seats, so on and so forth within our organization.

It's important to note that the UVM Health Network seats are not representational seats. They are member seats and they do not need to be filled by UVM Health Network employees. They can be appointed by UVM Health Network for anybody that will serve as an appointed member. So I just want to make

sure that that clarification is clear that they do not need to be UVM Health Network employees, thus, not be participating in ACO programs. So that's why it's really important to make sure that you had those academic medical center seats. So I think that those were the major changes in the operating agreement.

OneCare Vermont still remains an independent LLC. 501(c) organization not owned or operated by UVM Health Network. They are our parent organization. So I think that needs some clarity because I have heard other members of the public say that we are owned and controlled and that is not a true statement. We still have a very independent board of 21 managers.

The third manager seat we assigned to a MVP consumer representative. So now we have four consumer representatives on our board. Those were the only changes that were made to our operating agreement other than a very agreed change in that if the members of the board couldn't come to consensus, meaning the 21 members couldn't have at least 14 members agreeing on something, is that in the past it went to dispute resolution between the two member organizations which were Dartmouth and UVMMC. Now it will be a special committee of the board that would

contain the CEO, a board member elected by the board who was not a member, and a member organization. I want to just emphasize that this is a tool that would only be pulled out in a worst case scenario in that the organization would likely be contemplating folding. So this would be extreme circumstances that you would pull out this type of process or tool that we have in our toolbox.

Those were the major changes to the operating agreement. I just want to pause and also take a drink so I can get my voice back a little bit and see if there's any questions about that piece before I move onto the chair being a UVM Health Network appointed manager.

MS. MELAMED: Okay. Thank you for that. We noted that one change. So thank you for that explanation. I did just have a quick followup regarding your explanation of the appointed seats by UVM. Can you describe for us the process and criteria for nominating and selecting those members? I believe it goes to the executive committee. So I would be curious to hear a little bit about how that works or for my understanding.

MS. LONER: For the member seats those can be elected at any time by the members. So that

doesn't have to go through a board process. However, we have always made it a practice to bring these changes to the executive committee and notice to the full board of managers, but never at any point in time, even when Dartmouth and UVM Medical Center were members, was there a process to have those individuals approved by the full board. So that's not a change.

MS. MELAMED: Okay. Thank you. Continue to the next part of the question about the chair.

MS. LONER: So this was also a decision that was approved by our full board of managers just to provide clarity on that piece, and this provision was actually included at the request of the officers of the board, myself included. So I am an officer of the board of managers who can be solely appointed or discharged by the board of managers as is the chief compliance officer in that regard. So those are the two officers of the board. As currently sitting CEO I felt it was very important that the board chair be capable of linking the coordination of services between the member organization and the OneCare board of managers, and that coordination would be very critical to maximizing the efficiencies and cost

savings that are intended to be achieved through these shared services between the two separate organizations.

MS. MELAMED: Okay. Thank you.

MS. LONER: You're welcome.

MS. MELAMED: I'm going to move onto my next question which is in regard to OneCare staffing. So we had a couple questions about the difference between the organizational chart that you submitted during last year's process and changes that we noted in the updated or the newly submitted operational chart. If you could please discuss the changes. We noted the elimination of an evaluator position which I think was vacant last year and maybe discussed during these proceedings, but we noticed it's been eliminated. Also the elimination of the medical director role I believe serves under the chief medical officer and the elimination of three of the five care coordination implementation specialists.

MS. LONER: Sarah or Tom, I'm going to let you guys fight for who takes that one.

MS. BARRY: Thank you. I can talk through those specific examples and see if Tom has additional details to add. I think that a number of the specific positions that you just described,

Marisa, were really contemplated in the transition from the 2020 to the 2021 budget. For example, a key component of the medical director's work previously had been in the sphere of education, and as we described in our testimony last year we really were scaling back some of the clinical education, the grand rounds, some of the kind of older style learning collaboratives that we were wrapping up, and so that was really a decision made at that point in time.

With respect to the evaluation position that was a very hard choice in a budget constrained environment. I think if we had an opportunity, that's a position that we would continue to like to see. What we've done in its place is really a two part strategy. One, we have a staff member on our analytics team who has a strong background in that area and we're working with him to expand some of his role in that direction. We're also looking at opportunities to work collaboratively but more on a contractual basis perhaps with researchers from the Health Services Research Program at the University of Vermont to see where they might be able to contribute some unique skills and value that we can then capitalize on the expertise that we have in-house

with our analysts to kind of build a complimentary program and at the same time have some efficiencies, some cost savings in doing that, and then in terms of the care coordination implementation specialist as we were looking at kind of the 2020 to 2021 calendar year transition we originally had a vision as we were expanding in the self-funded space that we would bring some care coordination implementation specialist positions online to do a lot of what we were thinking of as surveillance work. So it wouldn't be direct outreach to individuals in care coordination, but a lot more of kind of a monitoring function, and again because of budgetary constraints we decided not to move in that direction, and through conversations with our network really have focused our care coordination implementation specialists in that very small but mighty team on working hard to meet the needs that people are reflecting today to make sure that we're most current. So I'll stop there and, Tom, see if there's anything you would like to add.

MR. BORYS: I'll just add real quickly staffing changes are sometimes painful. You are trying to build resources in a certain area and other times it's a response, somebody leaves we can't fill

a position. So we really look at the staffing model very holistically every year through this budget process to make sure that we have the right resources in the right places within OneCare and that's evolved over time.

As I mentioned in the slide about the resource demands, they are different today than they were two days ago, and really through the budget process we're trying to make sure that we use opportunities, which might be a vacancy or staff transition, at times to make sure that we can kind of shift our resources into a space that aligns with the strategic goals of the organization.

MS. MELAMED: Okay. Thank you. That's helpful. I do have one more question about staffing. We do appreciate and happy to hear from Dr. Carrie Wulfman, your new chief medical officer. We're actually wondering if she's available to come back on and just describe and give us an overview of the roles and responsibilities of the chief medical officer. That would be helpful. Thank you.

DR. WULFMAN: Sure. Thank you. I just started October 1st so I'm still learning about the role. I see the role as oversight for clinical and quality committee structures. So we have a

population health strategy committee at the board and we currently have a clinical and quality advisory committee that is populated by our members, and so at this point in time unless that structure changes I will help oversee both of those committees, and stemming from those committees comes our work with population health in the areas that we described earlier today. Things like quality metric evaluation and establishment and monitoring, quality improvement, focus groups and projects, and the care coordination platform.

I also think a big part of my role is establishing relationships with our members and with our key leaders at those member sites. So I plan to establish relationships with other chief medical officers, other clinical leaders of various types, and building those relationships, learning what the different members need and expect is a big part of the role as well. Any followup question regarding that answer?

MS. MELAMED: No. Thank you very much. Great to hear.

DR. WULFMAN: Thank you.

MS. MELAMED: Okay. My next question relates to the value based incentive fund changes. I

don't know -- first of all, I can't remember what slide number it was, I don't think I could see the slide number, but I wanted to just get a clarification. It appeared on the slide that it said the value based incentive fund dollar amount is 2.2 million dollars coming from hospitals, and that didn't seem to line up with my understanding that it's a million dollars in the financial sheet. So I was wondering if you could clarify that if I'm misinterpreting or the 2.2 million dollar number I'm remembering as last year, but maybe I misunderstood your slide.

MR. BORYS: Sure. This is Tom. Happy to take that one. The 2.2 million is the 2021 amount that's obligated or directed through contracts to the budget assumed that we would be able to move to a different model. A little bit less funding in the pool. Really is designed to accommodate the revenue change that we have this particular year. It is a negotiated term. We'll see where it ultimately lands, but the difference there 2021 versus our assumption for 2022.

MS. MELAMED: Okay. So the 2.2 is the 2021 number and then the assumption for '22 is a million. Okay. I know it was a little confusing

between the two years so I wanted to clarify that. Okay. So that brings me to my question about which is that the 2022 budget assumes the one million dollar money from the sources and uses a table that you provide us at 6.4. The financial sheet. It shows that that dollar amount is sourced approximately $460,000 from the Medicaid fixed payment allocation and $540,000 from hospital dues. Last year we noted that the FY21 amount was sourced entirely from hospital dues. Can you explain the change in the funding source assumptions from 2021 to 2022?

MR. BORYS: Sorry. I'm looking at the budget submissions. Really not a substantive change planned here. The fund is a pool of funds that we're obligated to generate or through contract. We're trying to move away from that frankly to a different approach, but again that's a negotiated term. The -- really at the end of the day we need to come up with the dollars through some means. So it's either through hospital dues or that fixed payment slice off the top that we take and retain to fund programs. So in every year one of the exercises we do for this budget is try to do the sources and uses mapping to make sure that we have a clean accounting of all the

funds coming into the organization. So I can look into that further for you, but really just at the end of the day it comes from OneCare sources of funds that we need to be generated so we can have that pool of a million dollars in this budget to be distributed out to providers who excel in the quality arena.

MS. MELAMED: Okay. Thank you, and yes of course if there's things that we ask that you feel like you can't answer on the spot, we would rather have you come back to us with the information than leaving it out. Okay. I think I will see if I have a followup. I guess I'll just ask this followup in case you want to comment on it any further.

You submit to us a variance analysis that states regarding the VBIF lower funds budgeted to morph the program to a payer blended quality accountable model. So I will guess we're looking for a little more explanation. Sometimes it helps to hear verbally what it means and sort of explaining a year over year change in the VBIF. What we note in the financial sheets is that, you know, there's been a reduction from a high of I think it's about 6.7 million in 2019. So we're trying to make sure we understand the variance as it shows up in the financial sheet how it relates to the evolution of

the VBIF model.

MR. BORYS: Sure. Good question. So this strategy is actually something that we pushed for back in 2021's budget as well. We move off the payer contract obligations and onto a value based incentive fund model that is more flexible and allows us to deliver a better more effective program to our participants. We made some progress in 2021's budget negotiations I should say. I think we discussed this in the spring meeting, but just to refresh everyone's memory kind of got halfway there. Half was able to be moved to a settlement component, half through contract. We must fund 1 percent of the total cost of care. This relates to the Medicaid program. Because of that the entirety VBIF pool of funds is linked back to the Medicaid program. I don't prefer this program. I'd much rather we have this payer blended model, but we have limited funds. We cannot put 2.2 million for Medicare and another similar amount for a commercial insurer as well. So we're really working hard to build in the flexibility that we need to deliver a really good program to our participants.

MS. MELAMED: Great. Okay. Thank you that helps. I asked for -- or we might have some

additional questions for this because as you know the All Payer Model agreement requires benchmark shared savings, shared losses, or a combination or tied to quality of care or beneficiary and/or beneficiary health. So we need to make sure we have a clear understanding of the relationship there.

I just have one more question before I turn it over to my colleague regarding the payer program arrangements. Could you please describe OneCare Vermont's large value based arrangement and non-risk payer programs? What do you mean when you use those two terms in your budget submission? What are OneCare's goals in engaging in flex contract and how does OneCare think it will support the network in the state more broadly in moving away from fee for service?

MR. BORYS: Sure I can take that one too. I want to be careful not to speak on behalf of anyone else in this but I'll express my understanding here, but through our Blue Cross program there is this primary component which includes employer self-funded plans. Employer self-funded plans, through their relationship with their TPA, have an option of whether or not to be included in a value based arrangement. That's the discretion of that

employer plan. Some plans have opted out of that choice to move their program into a value based arrangement which then comes through OneCare. So the non-risk lives reflect the lives from those employer plans who have opted not to be part of a value based arrangement with Blue Cross through OneCare.

MS. MELAMED: Thank you. I'm going to turn it over to Sarah Kinsler who has the next set of questions.

MS. KINSLER: Thanks, Marisa, and thank OneCare for that presentation. The next question is about growing Medicare Advantage market penetration. So -- and OneCare, I should say, alluded to this briefly in its response to questions. Specifically question 2A. What does OneCare anticipate will be the impact of growing Medicare Advantage enrollment in Vermont, and what plans, if any, does OneCare have to contract with any plan as ACO participating peers in the future? I'll just note that we are particularly interested in this given the new plan being offered by UVM Health Network.

MR. BORYS: I can take a stab at this one too. So our programs work within the existing health care system. These types of changes between different insurance plans happen all the time, but to

your point we're definitely seeing some increased MA penetration in Vermont. Vermont has historically had low Medicare Advantage penetration. It's an interesting one for us to contemplate as we move forward. So I don't have solid answers about the direction that we'll have in the future, but I view a Medicare Advantage program to be a value based program, although I think the value based elements live with an insurance company rather than with the providers. It's kind of the way I think of it. So when I hear of a partnership between the UVM Health Network and a commercial insurer that seems like a nice step forward, and as this program matures and evolves, any MA program frankly, I'm interested in learning how an ACO like OneCare can partner up and make sure that the work that we're doing with these programs that we offer to our providers are aligned and uniform across all the platforms whether it's traditional Medicare, Medicare Advantage, Medicaid, or commercial.

MS. LONER: Tom, thank you. That was the answer that I was trying to get off mute for, but I do believe that the Medicare Advantage programs are already a value based approach, and I think we discussed internally and even with the Green Mountain

Care Board and AHS in the past that those should be counting towards scale targets because they are already in a value based care program, and so we have to be thinking about how we as an ACO fit into that and how we would contract with any payer or participating provider in such approach.

MS. KINSLER: As a followup do you anticipate that growing MA enrollment could impact OneCare's operations or OneCare's finances if more Medicare beneficiaries in Vermont are being attributed or are being -- are choosing Medicare Advantage plans instead of being potentially attributable through traditional Medicare?

MS. LONER: It certainly could. I would just speak on a national level that Medicare Advantage plans sit side by side ACOs around the country and so I don't see this as looking or feeling any differently than on a national level.

MS. KINSLER: All right. Thank you. The next question is -- relates to something you hit on a little bit before that Sarah Barry and Dr. Wulfman hit on earlier related to a little bit of Care Navigator and also the role of continuum care providers. Can you please describe how OneCare engages with continuum care providers and

particularly how that will change in the absence of Care Navigator? How will the changes to Care Navigator and its role in care coordination payments potentially impact these network participants, especially those who were previously designated as lead care coordinators in Care Navigator and got to my understanding a payment related to that?

MS. BARRY: Sure. I would be happy to address that, Sarah. I think the simple answer is that there's not a lot changing. They continue to be incredibly valued parts of the care team and central to our model. What is interesting is that in the listening sessions that we held this summer, some of which were kind of cross cutting across our entire network and others were sort of domain specific so that we could understand their unique needs or issues that arise, what came out of those conversations is a request from our home health partners, our designated agencies, and our agencies for aging to mirror the model that we were designing for primary care and that's what we described as that incentive and kind of base payment model.

So we landed on the same approach. Obviously there's some technical details that we need to work out with them, some of which are still being

described such as which of the national measures each constituency will use for the incentive payment, and that's part of really making sure that we're not adding new work, but that we're leveraging say data points that already exist.

In terms of communication and expectations in the community fundamentally they remain the same. There's an expectation that all of our care team members are using share care plans, that they are holding care conferences, that they are really focused on the same methods on promoting person centered care, right, what is it that I as an individual want to prioritize as my needs and the supports and goals I want to work on. They remain consistent. What is changing a little bit is that the Care Navigator -- just hearing a bunch of background noise. Someone needs to mute I think.

So what is changing is the shared care platform. Care Navigator is a tool that will remain available but will be optional for communities and individual organizations in 2022, and that was a very strong request and one that was not necessarily universal. There are communities and organizations that said to us we've figured out some ways to use this very effectively and we want to continue and so

we continue to make that available, and we have other communities that said we would like to try some different things out, whether that be through EHRs or other mechanisms that they have developed, and so as part of this learning process we're trying to create pathways to that evolution.

At the same time there are some data elements that are really important that we understand some process metrics and the ability to link back to the claims data that we have available that can help us answer questions about outcomes and whether this program is successful or not, and so there will be a modest but consistent requirement for some data reporting across our network, and that includes our continuum of care partners, and then we, working to help us link that information, will do the analysis to help us answer the questions as to whether, let's say, focus interventions about helping people stay out of the emergency department, if there are better sources of care for them, whether those programs are working. I'll pause there and see if I missed any part of your question.

MS. KINSLER: Thanks. I don't think you missed any, but a brief followup I would ask. It sounded from your response like we should still

expect that all of the communities in the state have some kind of electronic shared care planning solution available whether or not they are using Care Navigator or some tool that is available to primary care providers, health care providers, continuum of care providers as well.

MS. BARRY: There are definitely tools that are available. I do think that 2022 will have a little bit of natural messiness to it, you know, in some of those learnings and transitions, and I think the question that remains unanswered at this moment is does OneCare need to fill a role in 2023 or beyond to help facilitate, you know, some of those technology advancements and we don't know yet. That will be something we watch and gather feedback on.

MS. KINSLER: All right. Thank you. My next question is related to the population of programs in general. On page 53 of the initial submission in the last paragraph the submission states is that OneCare is evolving away from directly funding community focused prevention activities in mid 2022 in favor of designing more clinical focused prevention activities, and I would love to hear more about what this means, how OneCare is defining those terms, how OneCare is -- will ensure any clinical

focus prevention activities align with community focused prevention efforts that are led by other health system actors, by providers, or Vermont Department of Health.

MS. BARRY: So I'll get started and then ask perhaps Carrie to support me in this conversation for more of the clinical perspective, but there was a very lengthy and important conversation in the strategic planning process that Vicki described earlier, and one of the key components that came out of that is that while there is a tremendous continued belief in and value in community based prevention activities there are also some really strong programs happening in those areas, and so when we looked at where some of the gaps are and where some of the data driven opportunities are, from an ACO's perspective we really heard from stakeholders that there were opportunities to focus in a little bit more in the primary care space in particular and to focus on clinical prevention, and I think some of this arose from earlier conversations that OneCare had with the Health Department and the Blueprint for Health staff really trying to think about how OneCare has unique access to data to identify populations a little bit upstream that could benefit from some early

interventions.

So, for example, looking at patients that we might describe as in a state of having prehypertension or prediabetes where if we could get that information into the hands of the clinicians, they could provide some population health and effective management strategies. We might be able to actually prevent, you know, the full episode of disease from occurring, and so that's really the path that we are starting down is to explore what that could look like, but at the same time we have some ongoing commitments, and so the first six months of 2022 is really about continuing that engagement and helping to facilitate the resources that are providing that community based support to kind of stabilize in their community, and then setting up some infrastructure working through our committees, as Carrie described, to figure out what are the initial focus areas for the clinical prevention activities. Carrie, is there anything I missed that you would want to capture there?

DR. WULFMAN: I like what you said and I agree. I think a point should be made that panel management and screening for social determinants of health all pretty much start in the patient's medical

home. That's where we would like those activities to occur, and so out of those screenings and that work it would be great if we could offer all of the preventative needs through the patient centered medical home or at least have a connection. So if we identify food insecurity or lack of readiness to go back to work or lack of exercise, access to a exercise program, movement program, and we can connect patients to those programs through our medical home with the help of our team and/or support staff, our care coordination, then all of the needs of the patient could be focused in one place and be managed in one place, and that needs to allow better measurement of outcomes as well. We can link those outcomes of those program involvements with some of the other metrics that we're following; diabetic control and hypertension control, et cetera.

MS. KINSLER: Thank you very much. I'm going to hand the baton over to Patrick for a question or two, and then before we wrap up staff questions I will come back with just one more kind of high level overarching question.

MR. ROONEY: Thank you, Sarah. I want to start by thanking some of the members of the OneCare's finance group for working in good faith

with us over the last few months to enhance some of the financial perspectives in this reporting process. Specifically Kim Douglas. I know her and a member of our staff had several back and forths to get those figures aligned and accurate for this process which has proven to be very helpful from the perspective of analyzing OneCare's budget. So I want to extend my thanks for the staff for working on that.

So my first question revolves around OneCare's written extensively in their narrative discussed here today much to do about the triad of their new strategic plan, one component of which is improved analytical capacity, and I'm wondering if using that improved capacity could OneCare in the coming months be able to provide a forecast of what the -- for the Board what the dollar figure of risk would be that is keeping mostly critical access hospitals away from this model. We have heard from a lot of them that it's too risky, but we've never had any -- on a dollar basis any proof of what that number is that's keeping them away from participation. So I'm wondering if that's possible to do by hospital and by payer. We know that critical access hospitals associated with a larger system have been hesitant to get into, for example,

the Medicare program due to the risk associated and there's other factors, but is that something that OneCare is able to do?

MS. LONER: Tom, I'm going to let you take the risk question, but I just want to -- Patrick, thank you for the question and you kind of alluded to this, but I wanted to be clear that it's kind of multi-faceted on why critical access hospitals are not participating in the model. Through the Medicare program there's been a lack of guidance on how to do cost settlement, and I think that by far is a really big challenge for them and something that even those who had decided to participate have found it challenging and as part of their own financial auditing procedures they are doing right now. So that's a very big component that needs to get rectified before we even turn to the risk component of it, and I think the second part of it is having that fixed unreconciled payment is also a very large component of it. So to make sure that critical access hospitals understand what the risk and revenue will be for the coming year and that it won't get reconciled back at the end.

So, Tom, I'll let you take the other piece, but since you alluded to it I just wanted to

go a little bit deeper and say there's other factors on why hospitals are not willing to participate in the Medicare program, and I know people are working on that in good faith right now and so I want to recognize that, but that's been a really big deterrent for them.

MR. BORYS: First thanks, Patrick, for your comments. It's been a really nicecollaborative process to try to figure out how we get the OneCare financials and budget templates to really work together and paint a quick picture. So thanks for your collaboration on that as well.

In terms of the risk tolerance levels of critical access hospitals happy to partner up in that space. I will say it's probably not a formula. Risk tolerance is subjective to a lot of facts within an organization. So critical access hospital A and critical access hospital B can have a pretty different perspective, and it's not only the hospitals, their boards as well, that make decisions about what they are comfortable with, but I would be happy to partner in the space and see if we can zero in on that a little bit further and zero in other numbers that might build up a framework.

MR. ROONEY: Great. Thank you. Yes and

certainly everything Vicki said about the cost report hurdle that's been experienced around this model and also Tom's perspective on risk appetite are very valid points, but as we look at health care reform as an investment I was just curious to see what type of investment from a risk perspective point of view would be required to at least try to get over that risk based hurdle that we feel we know there's several components to it as we state. So yes in the future perhaps that's something we could work on.

I also looked quickly at the -- I think it was slide 44 -- the 1.1 million reduction in software. Can you confirm or deny that that's a result of some of the lack of the HIT funding? That's a pretty major cut to that line item. It's about 30 percent from what it has been, and I know you had spoken about your -- I believe it's your VITL contract, but what's the majority of that cut? What's driving that? Is it related to the HIT funding and the lack thereof?

MR. BORYS: Good question. I'll start and, Sarah, feel free to chime in. I wouldn't say that any of the changes or decisions we made specifically link to any one factor to say like DSR, specifically lack of DSR funding specifically drove

this change. That said, we really holistically look at our entire revenue picture, the PHM expenses, and ultimately the impact on dues, and kind of figure out how we're looking; are the dues rising or at a level that's acceptable or not.

One area that we decided to make a change was to the VITL expense. That specifically was an adjustment of about $420,000 if memory serves me well. The remainder of that budget category just a little bit of expense trimming, but most of it is actually moving down into that supplies and other category, but really the VITL expense which is the most material of the budget changes.

MR. ROONEY: Okay. Thank you. I'm going to turn now to the discussion we have had some back and forth on this throughout since your submission on October 1, but I'm still not super clear on the FY20 refund participation fees to the hospitals so I want to dig a little deeper into that. You are now a mission based non-profit in fiscal year '21 for reporting purposes, and your audit states that that decision was backdated to last year, but from where I sit that's neither here nor there. You are now a non-profit officially as in 2021. So we look at your budget and you do highlight in your

initial submission to us reduced state funding from DSR investment dollars from funding in 2022 that's been on the map for a while now, as well as 1.6 in deferred revenues, and your submission states these combined factors result in significantly less revenue to implement reform efforts across the state. Filling the budget gap was accomplished through expense reduction and includes a reduction in population health investments and an increase in hospital participation fees. Despite these impending funding changes OneCare's board of managers neglected to refund hospital participation fees in the amount of 3.1 million to achieve a breakeven fiscal year '20 bottom line.

So my question is, is OneCare considering, now that you're a non-profit, following a similar path in '21 or '22 and refunding its risk bearing stakeholders, the hospitals, for any operational gains incurred in '21 or '22, and how does this square with OneCare's funding volatility. OneCare has had to source additional revenues in the form of additional hospital fees. So it feels like when it was refunded following 2020 that money was given back and divvied up probably in 13 different ways from participating hospitals, and now you're

having to go back to plug in that number to create a breakeven budget. So I'm trying to get a feel for that decision where it goes moving forward around that as far as revenue volatility and the relationship with having to come back and source that money back from the hospitals.

MR. BORYS: Sure. Good question. A lot there. I'll try to take it in bites. So back at that point in time in 2020 OneCare's 501(c) application was outstanding. So that was kind of up in the air at that point in time. We're also coming off of a massively disruptive year for our hospital participants. The conversations effectively revolved around the fact that the hospital participation fee number in our budget is effectively the variable. That's kind of the number I monitor with a conditional formating function on it to say is this going up or down or by how much as we make changes throughout the budget bill. So at the end of the day if OneCare ends up with positive margin, it effectively means that the hospital participation fees were set too high relative to the expenses we incurred during the year. 2020 was -- we were disrupted. Hospitals as well. Ultimately the decision was made to refund those dollars back to the

dues paying or fee paying hospitals.

Looking ahead, though, now that we have our 501(c)(3) status for tax exemption we have the opportunity, potential, to move to a not-for-profit accounting structure that might give us some ability to use margin earned in one year for programs in a future year and help navigate some of the revenue volatility that we're dealing with now. So I'm hopeful that that affords us some strategies that were not available to us previously in our old construct.

One of the challenges we historically faced was we could earn positive margin and have those kept as reserves, but they are hard to use. You have to effectively run an operating loss to access those funds. In a not-for-profit accounting structure there are different options for us. So like I said as we move forward looking to leverage some of those benefits and help build some sustainability into our model, and also be able to just absorb some of the uncertainty in revenue or other changes that every business faces year-to-year.

MR. ROONEY: Thank you. That does provide some clarity. It would be an odd model for a non-profit to be returning revenues to essentially

their stakeholders in any event. When I donate money to a non-profit I never expect to receive that back because they had a profitable year. So that's why I wanted to clarify some of that information. Is there any time frame for moving to that non-profit accounting perspective?

MR. BORYS: It's ongoing. We just completed our -- about to submit our first 990. That was a big lift. It's a period 990, but from that and in tandem with some of the operating agreement changes around membership, et cetera, going to be discussing this with our auditing firm now basically. We're starting to get -- conclude our fiscal year and ramp up for our audit in the spring. So it's work that's going on right now to make sure we get the right conclusion and understand the options available to us in this new construct.

MR. ROONEY: Okay. Great, and in that same vein in some of the responses and maybe an after thought now as you move to a non-profit accounting perspective you have noted that as far as the refund went, and in all fairness to you I'll leave out the appropriate accounting methods as one of the four items that you listed because that's implied to us, but we asked our question here is to please explain

how contract negotiations, outcomes from the budget process, and the financial condition of hospitals would impact your decision to refund participation fees. It seems like two of the three of those would occur well in advance of any year-end closing activity, and then with the hospitals essentially speaking years '17 to '18 were -- '17 to '19, sorry, were pretty rough as well and no refund was given. So I'm wondering if you could just give us a little perspective inside some of those items that you listed as conditions for potential refunds.

MR. BORYS: Sure. We're in a negotiation period with payers. Our budget assumes basically success or reaching a mutual agreement with all these payers. If that were not to occur for any one program, for example, there would be substantial impacts and we would have to stop and evaluate what that means. Could mean less revenue coming into the organization. Things of that nature. So I think it's important that all the information we have available at that time is considered when we make or the Board makes that type of a decision.

The other perspective that I think is important is really OneCare we exist to support our providers in a lot of ways, and they contribute money

to the shared infrastructure which as I said I think is a really efficient model, but we need to be really mindful of their financial situation and make sure that this work is affordable to them, long stream, long term. I do think about sustainability an awful lot, how to make this just build into our system rather than periodic thing. So that comment is really to say there are many factors that go into these decisions. We've started just conceptual discussions with our finance committee, but we haven't really landed on yes we're going to reinvest and some of the work around the not-for-profit accounting backdrop will be important in this decision.

MR. ROONEY: Okay. So with regard to the contract piece you did state in one of your responses that your board has the ability to adjust your budget in the event of certain circumstances. So when you go through that contracting piece that's occurring at some point during your fiscal year so wouldn't your board take action as soon as possible to make appropriate adjustments instead of waiting for that year-end decision?

MR. BORYS: I think that comment was if we weren't able to renew a contract for the upcoming

year not so much something happening midstream for us. So yes if that information was known today they might decide to make a decision today, but at this point in time there are a number of outstanding items that I think would be really important to consider when making this type of decision.

MR. ROONEY: Okay. All right, and my last piece here, to follow up on some of Marisa's opening statements, Mr. Borys cited -- I have it here at 1114 in his testimony -- on the Green Mountain Care Board web site already many spreadsheets with OCV budget information and that's part of the transparency model that the Green Mountain Care Board practices with their regulated entities. However, I think it was on slide 35 OneCare cited a budget of 44.1 million dollars, and I just want to say that that will not be explicitly called out in any of those documents. That's one of the items of the inconsistency that we want to follow up on. We have the historical look in there which is the full accountability of 1.365 billion for '22, and then we have the gap version which is kind of the nuts and bolts of OneCare, the operating entity budget of 27.3 million.

So I just want to make that clear to

people that you won't see that perspective -- that alternative perspective that was supplied today, and we can mine that out and we will discuss with OneCare what that entails, but we just want to make sure that for consistency purposes we're making that aware to the Board, other staff members who may be interested in this and members of the public who are listening, and with that, Sarah, I turn it back to you. Thank you.

MS. KINSLER: Thanks so much, Patrick. To wrap up staff wanted to ask a higher level question that seeks more of a 30,000 foot view now that we have really gotten into the weeds in the number variance. Can you please describe OneCare's top quantifiable goal across the whole organization for 2022? How were these measurable goals and their targets established for 2022, and how did these targets compare to actual past performance or current year performance as it were international benchmarks?

MS. LONER: I think, Sarah, we're going to need a little bit more about like what you're trying to understand because that was a lot. We have organizational goals. We have budget goals, like strategic goals, and I'm not -- I don't think I'm clear about what you're looking for so I want to be

most helpful in our response.

MS. KINSLER: Sure. Thanks, Vicki. I'm thinking across all of those kind of areas and goals which ones would you say are the most critical for you, the most important for you, and how are you going to measure success against them, and how do you kind of choose where those bars are?

MS. LONER: I would say that comes down to our strategic planning process and looking at what is the value of an ACO. I think we've been asked that question repeatedly, and thinking about the work that we do at the ACO centrally and how that is different from the work that our provider partners do in delivering direct patient care, and so when we look at how we are delivering against stated goals, looking at things like are we delivering actionable data to our providers and doing those survey reports that we spoke of, looking at how we are delivering on innovative payment reforms such as the independent primary care, CPR, having focus groups to understand what additional things can be anticipated, and then in terms of also the payment reform really having that balancing act of what type of payments really should be in a fixed payment model versus which payments are better to be in a quality linked

incentive model and not necessarily fixed.

So by way of example we talked about the independent primary care CPR model and those core and non-core codes. It's appropriate since all primary care offer a basic suite of services that you could take a small practice and link that to a capitated payment. There are certain services that not all primary care deliver and might not deliver it at the same frequency or rate. So you would want those to be linked more towards quality but not necessarily under a fixed capitated model moving forward.

So I think there's always a balance there and this question has come up. There are no national benchmarks on how much should be in a fixed payment model versus how much should be linked to quality and investment. I think the closest you have to that is LAN puts out these are advance payment models linked to quality and every organization should be somewhere within that what they call category two, I think up to category four, could be wrong on that, but you know OneCare is solidly in the highest advance payment model with all of its programs. So we continue to monitor that, and as part of this work we've put on our web site it's called ACO Insights, and it will show you what are

those things that we're linking back to our core capabilities and how are we monitoring them going forward in a manner that is updated on a frequency that could be looked at by the Board or any other members of the public. Sarah, Tom, anything else that you want to add to that?

MR. BORYS: I'll just say at a high level we believe in value based health care, and personally I think it's a better path forward and I think many of our participants are looking at the direction the industry is going following Medicare's lead saying value based care is the new wave and we need to be involved and ready to go. So one of the goals that I have every year is to be able to offer participants who are ready, willing, and able to participate in value based care an efficient opportunity to do it, to contract through OneCare, and that we do the contracting work with the payers to make sure they are able to enter into a value based arrangement and they have support which leads to the second side which is once a practice, a participant is in a value based program it's a big change. It's a big paradigm shift, and the second goal that I have ever year is how can we enhance our support for our network that comes through better

data, better reporting, more at elbow support is something we're hearing. So every year it's really make sure what OneCare delivers to its provider network really helps them succeed as they transition into this value based care model which really does have some foundational differences.

MS. KINSLER: Thank you, Tom and Vicki. I am going to keep dragging forward a little bit with this question. I'm hoping to really get at how are you -- how are you measuring OneCare's performance against those strategic goals and how are you choosing the targets? I think when we wrote this question we were thinking more about, for example, like network performance on quality utilization and cost, but I am definitely very interested in how you are -- how you are measuring yourself against those strategic goals and how you chose those measures.

MS. LONER: I would say this is kind of a multi-part question, Sarah, in that you are all aware that the ACO has very specific goals that they are measured against at both a national and a state level. So we have quality measure goals right now that are nationally benchmarked that we as an ACO contribute to. There are total cost of care benchmarking goals that happen on a state and ACO

level that we are, you know, also available to comment on. So there's a level of framework that's already provided within the All Payer Model agreement specific to Vermont that does use very nationally based; rigorous. In addition to that, OneCare also had our core capabilities and how we want to succeed as an ACO, and looking at what those goals are and Tom's point are we meaningfully moving towards value based care and getting to those lofty goals of improving health care costs and improving health outcomes. So that's the 300,000 foot -- those are the two things we're trying to do and we're doing that through value based care contracts using a national framework for evaluation. Carrie, do you want to say something about that from a practicing physician perspective?

DR. WULFMAN: Sure. I agree with what you already said. I like to think of ACO as a transformation agent through my provider lens. I think we are transforming health care by reaching several goals; the quality of the health of the population is one goal, and two that haven't been touched on so much today provider satisfaction and retention. Health provider community and patient experience. Those are also part of the aim and I

think that's a good summary of what our very high 30,000 foot goals are, and then we do have targets and measurement metrics that we are following and they are in alignment with national benchmarks, state benchmarks, and benchmarks that our partners like the UVM Health Network are also setting. We've learned a lot about unifying in our efforts to increase quality. Instead of having 133 metrics we're focusing on what are the most important ones that will really bring a big bang for the buck, and so it's a relief to providers that we can focus on those and work together across the state.

MS. KINSLER: And when you say -- when you describe focusing in on those core metrics are those the core measures that you are targeting in your value based incentive fund?

DR. WULFMAN: Yes.

MS. KINSLER: Okay. Thank you. I think I will end my questions here and staff questions and give it back to the Chair.

CHAIR MULLIN: Thank you, Sarah. Just a quick throwback to Carrie. We try not to use acronyms, but you lost me at NACR.

DR. WULFMAN: I think -- I beg your pardon. I'm not sure I used NACR. I must have said

something else.

CHAIR MULLIN: Okay. I heard NACR so it's probably my hearing.

DR. WULFMAN: I don't think -- I don't know what that is either. Sorry.

CHAIR MULLIN: I'm not alone.

DR. WULFMAN: Okay.

CHAIR MULLIN: Okay. This might be the logical time to take the lunch break. So why don't we go to lunch, come back at 1 o'clock, and we'll start in alphabetical order with the Board Members' questions. Does that work for everyone? I'll see everybody at 1 o'clock. I'm putting the meeting in recess. Thank you.

(Lunch recess.)

CHAIR MULLIN: We left off with questioning by the Board and we're going to start with Jessica Holmes.

MS. HOLMES: Great. Thank you, Kevin, and thank you OneCare team for the presentation. This must feel like the longest day ever. So I appreciate all the efforts that went into preparing the budget and presentation. I also want to acknowledge and appreciate the ways in which OneCare has evolved as a result of some of your strategic

planning process and the feedback you're getting from providers. I do see a lot of positive steps here, and I imagine all four Board Members are going to have different areas of focus. Perhaps not surprisingly mine will be around, you know, assessment and evaluation.

I think about new organizations having to continually assess their performance, evaluate their proposals in order to evolve. So I want to understand your efforts here particularly as we make sure our scarce health care dollars are generating the highest possible returns. So my first question revolves around you mention that there's this seismic shift towards value based care. It's coming. You have 5,000 providers in the network rowing in the same direction I think was the quote you used, Vicki, and I imagine that some are just starting to dip their paddle in the water while others might be rowing more quickly. So I wonder if you assess the performance of the provider population that's really all in, and by all in I mean providers that are making observable sizable changes in how they invest their resources, how they provide whether their contracts reflect value. So I'm wondering if you have a mechanism to measure, you know, in your

network the degree of engagement.

MS. LONER: I'll start, Jessica, and then I might turn to Sarah and Tom for a little bit more detail, but earlier this year as part of our strategic planning process and looking at our core capabilities and thinking about how we could support our network better because we're hearing from them now tell us what we need to change, tell us where the opportunities are. We brought together our network participants to help form what's called a HSA consultation report, and really what that report is, and it will be rolled out on a quarterly basis and we'll refine it as you said because as things evolve we too must evolve in order to sustain, and part of that is looking at how are specific communities doing as compared to the whole ACO; how are their health service areas doing, how are their individual practitioners doing, and really setting out some key performance benchmarks so that it's easier to be able to identify where those opportunities are and where they need to go a little bit deeper in order to really either meet the standards of their peers or look to improve within the ACO itself.

So that is one of the ways that we've been working with our network to say let's get

together to find what those expectations are, let's make sure that everybody's clear on how we are evaluating performance, and let's do that together on a quarterly basis and reassess if that report needs to be refined moving forward, and that will get at things like cost, utilization, and engagement in the system.

MS. HOLMES: Do you have a sense then, Vicki, of what proportion of the current provider network would you say is fully engaged? Like doing all the right process things, investing in the right way. Has their provider contracts appropriately aligned those criteria for actually making the active changes? What proportion would you say are in that camp?

MS. LONER: I don't think we've assigned a proportion right now. We are really looking at how we are doing as a system of care and benchmarking ourself against our system and then where available using some national benchmarks from there. I think that will help us, Jessica, to really refine where we need to say like what does fully engaged really mean, right, and is it different depending on whether or not you're a primary care practitioner versus are there different performance metrics if you're a home

health care practitioner because I think that's the other thing that we noted as part of our model. Most ACOs are primarily primary care and hospital based models, whereas, we're really a full continuum of care model, and so thinking about what those expectations are across that continuum is going to be really important and we need to be thoughtful about that because it is a coalition of the willing and so people don't feel like their voices are heard. They can opt not to be part of that system of care and for now go the fee for service way.

MS. HOLMES: This is sort of a followup question to that because I agree you have a very diverse network and a very broad network. So I'm wondering do you have a way to assess, and again my questions, a lot of them, are about assessing and thinking about measurement, but assessment to which you really do have a truly integrated and coordinated network of providers versus a network of loosely connected that perhaps share common payment contracts. You can imagine there's a whole continuum there. Everybody has the same payment contract. They are loosely connected versus hey this is an organization that's truly integrated, coordinated, shares goals, and behaves in a way that suggests that

they are truly, you know, all rowing in the same direction. How do you assess the degree of connectedness, integration, and coordination in your network?

MS. LONER: I say that right now we're doing those through those HSA level reports that I'm aware of, Jessica. I think about my days doing managed care. There used to be like no amount of guidelines that said this is a loosely managed care organization, right, where this is like a tight managed care, and there just aren't those level of metrics that are available, and, if there are, I would really like to hear about them of how you really look at the connectedness of the system and how you do that and evaluate that in a way that your system can get behind, right. So from that -- from this point it's like let's think about what are those core utilization metrics that we can all agree on and let's look at how we're doing as an ACO, as a community, and let's have that be the starting point.

MS. HOLMES: So in that way it does seem like the focus of trying to cut costs and improve quality is largely around utilization and assessment of utilization, and I'm wondering does OneCare ever work with member facilities that have high unit costs

-- relatively high unit costs to say hey there may be some mechanisms or some opportunities to lower those high costs which of course would impact total cost of care, or does OneCare ever work with member facilities that have low volumes that may not only impact quality if there's a known volume quality relationship, but may also contribute to high cost. Like that's in part when I think about a truly coordinated integrated network of providers that network would look at systemwide opportunities for efficiency gain and quality gain and cost reduction versus looking at a particular institution and looking only at utilization at that institution. So can you address any of that? Like what role does OneCare play in that sort of systemwide look at efficiencies and opportunity as a network of integrated providers?

MS. LONER: I would say at this point in time we're really looking at those quality indicators that are defined at a national level for how an ACO should be performing, right, and then we look at those utilizations and also the patient experience and satisfaction indicators, and that's at the level that we're looking at things right now. So that's a more macro level of how we're performing as a system

of care and not necessarily looking at those micro levels of how are they working within their specific community, and I can't give you a time frame on when that will happen because as you know this is also about defining relationships and trust within 162 different organizations which is really unique as an ACO who is normally one clinically integrated, one organizational TIN, which has different needs and resources, and so one size won't fit all in this particular approach.

MS. HOLMES: Is it something that's on the horizon? You said you couldn't give a time on it. Is it something OneCare has considered?

MS. LONER: Yes. Absolutely.

MS. HOLMES: Data analytics obviously is one of the core capabilities and just judging by some of the presentation and some of the new reports it looks like you're making some nice enhancements to the data that you're making to providers and it's great to hear that providers are asking for more data. As you said in the presentation that's a really good sign that the data is useful. I'm just wondering if there's -- you know, the video was great and the provider survey that you did certainly points in the direction of provider use of the data. I'm

wondering if you have a more robust way of linking the data analytics that you're providing to actually observable changes in the care process or in claims, patient health outcomes, things like that. Can you link, you know, what we're hearing from provider surveys, what we're hearing in the testimonials actually in the data seeing observable changes in outcomes linked to the types of data that you're providing?

MS. LONER: Sarah.

MS. BARRY: Thank you. That's a fantastic question and I think that's exactly where we're headed. So just from a pragmatic standpoint the decisions coming out of the strategic planning were in June of this year. A lot of the new reports have been designed and are just now being implemented. In our ACO Insights report that Vicki referenced earlier one of the new things that we're doing to support that outreach and make sure that it's effective is that we've developed some metrics looking at how engaged at the community level, at the HSA level, is each of our HSAs, and we've assigned staff to facilitate moving them from whatever level of engagement they are in into a higher level. Part of that process is really trying to then dig in and

understand what actions are they taking as a result of this information and what results are they achieving, and so it's absolutely the path our analysts are on, but we need a little time to actually work through those learning cycles and get the data from them.

MS. HOLMES: Okay and then I guess along the same vein I think about -- and again you're seeing a common trend in here, but I'm really just trying to understand how you're assessing what's happening because you are making so many changes which I think are good, it's a response to what you're hearing from providers, but, for example, how are you going to determine whether the financial incentives are working as you design. So, for example, you have assigned the 15 percent performance incentive in the care corridor initial payment 85/15. How do you start to think about 15? Is 15 percent enough? Should it be more than that? How do you evaluate the process? Say we're at the optimal proportion here to generate the behavior we're expecting. How are you doing that?

MR. BORYS: The very first step to me is establishing a baseline and I can actually relate back to the VBIF evolution that took place in 2021.

We were on pins and needles waiting to see the first outcome; did everybody meet the target, did nobody meet the target, and see where the data landed essentially. So for many of these programs we're in that first phase. Let's start getting the practice level baselines and then that's where we come in. If we see practices that are not meeting those benchmarks, we need to be engaged proactively with them to help understand the nuances, dynamics, in place and maybe come up with some improvement plans, and over time I think that's where the evaluation comes in. You see I'm sure we'll see some practices rebound, really demonstrate improvement, and we may see others that don't and that's going to be important for us, and I think to your point start to quantify that or measure it in certain ways.

The other aspect that I think is important is not only evaluating the performance and outcomes from the practices, but the models that we've built are they effective, are they providing the correct incentives at the right amount in the right ways. That takes a lot of provider input and feedback, and we're doing a lot more of that anyway, but I see it as a really important piece of our work over the next couple of years is to implement these

programs, start establishing those baselines, monitoring change, improvement hopefully, and then collecting feedback on is it working, is it driving -- is it enough to be an effective incentive.

MS. HOLMES: I guess what I think about is having the capability to do an assessment of the return on the investment on your care coordination activities on your CPR program. This is really, really key and important, and the -- and the reason I brought it up before I looked at the CPR report, in the evaluation section was a small paragraph basically suggesting that it needs to happen, but it wasn't -- there wasn't anything quantifiable in there about the impact of changing -- fundamentally changing how we pay primary care providers and seeing whether does it actually reduce costs of care, does it actually improve patient outcomes for that population, and we're in year four and I worry that there's not enough evaluation happening to make sure that these dollars are going in the right direction.

I hear you saying you want to do that, but then I also hear that you have a part-time analyst, you know, who may be able to start doing that and you're going to farm out a lot of this evaluation hopefully to UVM. I guess I just -- I

want to push a little bit on the prioritization of the importance of doing these evaluations so that you're sure that you're setting the financial targets the right way. You have data to back it up so that you're investing in care coordination in a way that's generating the outcomes that you want, that you have built a CPR program that generates the items we -- outcomes we want. I don't know how you know that until you have really dug into the outcomes data and all of that. So can you just talk to me a little bit about that way you have allocated your budget? In particular I know, Sarah, you mentioned a little bit of the vacancy and deciding not to fill that vacancy. I look at how much is spent on public affairs. There's a lot. I don't know how many staff are in public affairs and communication and marketing? Four? So well four, right? To have a halftime person in evaluation, I guess that's the way I look at that. So I just -- I want to just say that I think it's really important and I think it might be shortchanged in this budget because I think these are scarce dollars that we want to make sure are allocated in the highest value possible ways. We may not know that if we don't know some of the outcomes.

MS. LONER: If I could just address one

thing.

MS. HOLMES: Absolutely.

MS. LONER: You said, Jessica Holmes, is that you know you think about the four years that we've been in this, two of them we've been in a pandemic. So establishing a baseline while our hospital and health care system is in crisis it really is going to sway and change your outcomes and how you're evaluating that. So I just want to put it into perspective. We're not dealing with normal times right here that you could look at programs and outcomes and how those are being impacted by that. So I wanted to put that out there and also to say this is -- as Sarah noted, we did our strategic plan and we decided what were going to be our areas of focus so that we can start doing a deeper dive and evaluating because up until this point in time we had tried, which we probably shouldn't have, to have been all things to all people and to meet everybody's needs and expectations, and so this is the first year that we've said no this is what we are going to do, this is what we are going to focus on, and we're going to take approach to be able to do that and so we had those conversations. We did do a care coordination evaluation. It has a lot of noise in

it. I could tell you right now if you try to take that report, you would say don't make investments in care coordination and I don't think that's the right answer given where we've been in the last two years and what's transpired. So that also has to be part of the conversation.

MS. HOLMES: I can definitely appreciate that. I think that we have, you know, last 18 months have been trying for everybody in the whole country and any industry that you're in and certainly in health care more so than many others and so I recognize it's harder to evaluate. I guess looking forward, though, your budget is forward looking and I would like to see and hear and have a plan for how these evaluations are going to happen and make sure you have the resources to be able to do those evaluations. So looking forward that seems important to me and I would hope it would be important to all of you, right, to making sure those dollars are being well spent and have that plan to evaluate that. So it's more of a forward looking, but I totally recognize, Vicki, backwards it's really hard and I recognize that.

MS. LONER: Yes.

MS. HOLMES: I know there's all these

Board Members. I'm just going to ask one more question which is in your assessment does the Medicaid trend rate that you have implemented in your -- or projected in your budget do you think that covers medical inflation and how will that trend impact the cost shift which is already threatening financial sustainability of the hospitals? So can you speak a little bit to the Medicaid trend rate whether it covers medical inflation, particularly you know CPI just came out today, we know what inflation is this morning, it's high, and wondering how that relates to the Medicaid trend and particularly to the cost shift as we do worry about financial sustainability of our hospitals.

MR. BORYS: Sure. Really good question. Unfortunately when we built our budget we don't come out of it with a lens what is an appropriate inflation rate relative to the expenditures that our hospitals, other providers are facing. We have to align with the payer side of the equation. So our math essentially is a forecasted projection of the targets that Medicaid would otherwise have. I don't always wish that were the case, but that's the way these programs work is they are built on top of the existing payer fee schedules and estimates, things of

that nature.

When it comes to the cost shift I agree with your point. I mean in my opinion Vermont did a good thing and expanded Medicaid, but that really perpetuated the cost shift in many ways. At least anecdotally heard, not being in the provider community lately, that Medicaid reimbursements don't cover expenses and, therefore, cost shifts to the commercial space. So I think it's a great space to be exploring, not just the ACO in general, as the lever to affect the cost shift.

MS. HOLMES: Thank you. I'll take it back to you, Chair Mullin.

CHAIR MULLIN: Thank you, Jess. Next we're going to move to Board Member Lunge. Robin.

MS. LUNGE: Thank you. So I wanted to ask you a couple questions about some of the state funding that is sunsetting, both the DSR investments which through the current level commitment waiver sunset over time and also the HIT funds which as we know has been sunsetting at the federal level. Could you speak to how you are thinking about sustainability in the future related to population health programs and analytics as well as your operating cost given that these state funding sources

and federal funding sources are drying up, and also then how you're thinking ahead to the possibility that you may be in an environment where the public payers will be funding simply total cost of care?

MS. LONER: Tom, I can just start at a higher level. I think right now during the pandemic we're in this situation that our risk and reward opportunity is probably at the all time low which doesn't help that it's colliding with the sunsetting of state and federal reform dollars. So I'll just put that out there. This is not the ideal situation for us as an ACO or for health care reform efforts in general.

Long term we have to be in a position that we're able to fund population health investments purely through our shared savings and losses, and so I think that gets back to what Board Member Holmes had said earlier. What we've been talking about is being able to increase that accountability among our provider network and being able to evaluate what the return on investments are and whether or not we should be investing 8 million dollars in care management going forward; is that too high, is that too low, is that the right amount, and then as we become even more advanced how do you start shifting

and how do organizations start shifting away from that fee for service construct as the basis for how the targets are set because that will get us into more of a predictable stable system and we're not fully reliant on the fee for service revenue. Tom, did you have some more stuff to add? I just wanted to hit that at the higher level.

MR. BORYS: Just a little bit more. We've definitely been thinking about the future state here a little bit. So it's not necessarily what's included in our budget in 2022, but I want to go back to that concept of the risk sharing model and the PHM investment model and the intersection between those two. I think over the next couple years we're going to face some budgetary constraints that might limit our preinvestment in the -- in those population health programs, but what we can do is start to add elements from the risk sharing model that add reward opportunity for providers and find some balance there. A lot to figure out and sort through in that space, but it's something we're really thinking about because we have been able to make sizable upfront investments in the provider network which is great, but we have to be mindful of cost and resources as we move forward.

CHAIR MULLIN: Robin, you're muted.

MS. LUNGE: Sorry about that. Thank you. I did have a question to Jess's followup question, evaluation related questions, that I thought I would ask now before I go back to my written out list so I don't forget it. So when you're thinking about evaluation, and certainly totally understand the complexity of evaluating in a situation where we've just come through two years where the data is going to be all wonky, I'm wondering how you're thinking about that in learning perhaps from your peers around the country in terms of how other ACOs might be thinking about that? And now, Vicki, you are muted.

MS. LONER: We all need a T-shirt. We've been thinking and talking a lot with Milliman whose our actuaries on what other ACOs are doing to be able to set realistic total cost of care targets moving forward, and the National Association of Accountable Care Organizations has recently opened up new seats and councils to talk through things like how do you evaluate quality during a pandemic, how do you look at data differently. So I think we will rely heavily on those national forums and actuarial firms to be able to help inform how we do some of

that work moving forward.

CHAIR MULLIN: Robin, you're muted.

MS. LUNGE: Sorry. I throw myself off because I have my questions in a Word document so I'm juggling between looking at people when they are talking then the Word document. So sorry about that. Related to the total cost of care targets, Tom had mentioned some of the discussions right now with the payers related to trend and what do you use as your base year, and I just wanted to test an assumption which I have which is that the Medicare benchmark trend that you referred to, USPCC, I'm assuming that is off of a 2020 base year which of course will be low. This is something certainly that we have looked at and thought about in our prior regulatory processes, both premium rate review and hospital budgets. You know how do you set an insurance premium when you have a year that was low and then a year that's going to be pent-up demand and high.

So I think this is really I suppose more of a comment that you can comment on, but I think that our staff is going to have to help us think through how to think about the trends this year because if we're using a 2020 base, you know, that's going to be low which is going to make the trends

look extra high. So if you have any thoughts on that I would love to hear them, but I just wanted to throw that out there as kind of a comment on the trend issue.

MR. BORYS: Sure. I'll comment quickly. If I recall correctly, when we pull the USPCC trend we try to do it in alignment with the way that the target would be set, which is the year prior to the performance year as the base, and then we calculate the percentage change between the actual performance year forecast that Medicare has prepared. So that will be 2021 to 2022. In reading or looking through that, and Sarah can confirm that for you as well, as I was reading through the actuarial memo that comes with all of the Medicare forecasts they seem to be pretty confident that there's going to be continued escalation of acuity, inpatient demands. We're certainly hearing about them in the state. Hard to know to be quite honest. Are we going to continue to see kind of a rising trend that stems from deferred care, people not caring for themselves personally perhaps as well as they may have in the past, and it's going to be a tricky year, but with the uncertainty I think it's appropriate to note the narrower missed corridors is really in tandem with

that. As I said, we would like to get to larger risk corridors, but there needs to be a little bit more stability first for us to get there.

MS. LUNGE: Thank you. That's helpful. So today we have had a lot of conversation around some of the changes in the data reports which sound great to me. I'm excited to hear about that and it sounds like it's responsive to provider needs and you'll work out some of the kinks in that as they get unrolled out, and you have also mentioned that you're getting more requests from your provider network for at the elbow support, and so what I would like to hear a little bit more about is how that works together with the Blueprint practice facilitators who also are working with primary care practices and changing work flows, et cetera. So if you could speak to how that effort is aligned with Blueprint that would be great.

MS. BARRY: I'm happy to take that. One, there are two components from my perspective. The first is really making sure that all of our member organizations really understand the data that OneCare is providing, and that really at this point as much as we try to diversity that, that is taking the skilled efforts of our, you know, finance

analyst, our population health analyst, our quality folks, and I think they are doing a tremendously great job at getting that information out and being responsive. At the same time I think the space that we're exploring actively right now, really the second component, is a little bit more about that practice supports in the quality space, and the VBIF and the new quarterly reporting is bringing this opportunity I think right into the foreground. So we have a couple of staff who are dedicated and assigned to organizations to help share and educate on that information. During those conversations I think we have worked very hard to make them accessible to the whether it be a practice facilitator or Blueprint project manager just depending how that community is organized, but the way that it works for us is that really has to be at the invitation or selection of the practice because we don't have the contractual relationship with the Blueprint that allows for data sharing. So unfortunately it's always a bit of a wrinkle that we try really hard to work through and make sure that we're following, you know, kind of all of the obligations that we have both to our network and our payers while also recognizing and valuing the relationships that exist between those Blueprint,

particularly long time staff members and the organizations they are supporting. So always opportunities to keep refining, but I think in that space in particular there's a lot of good work and energy and kind of sorting that out as OneCare is introducing some new data and reports.

MS. LUNGE: Okay. That's helpful and it's helpful to identify that there is a data sharing issue because data sharing issues can be solved with data sharing agreements and contractual changes. So I think that is -- that's good to know and we collectively should be thinking about how to solve that problem since that seems solvable.

My next question is about the accountability pool. So I may be confusing myself from last year's budget where it sounded like the accountability was tied to the care coordination program where people were getting a lower amount or can opt for a lower amount of the 325 and there was quite a bit of discussion about that last year. It looks to me now like the care coordination payment is its own thing and the accountability pool is a separate stream where the practice either can pay into it monthly in the case of shared losses or can settle up at the end of the year. Could you tell me

if I have that right and, if not, could you explain it?

MS. LONER: Can I have one clarification, Robin? I'm working on forming my words today. So just a point of clarification the 325 population health management payment is different and always has been different than the care coordination payment. So those have been two distinctive payments that OneCare pays to primary care on top of their fee for service to incentivize population health approach like panel management versus care coordination which has been a separate payment. So the 325 has always been tied to the THM payment. So it's the same approach last year and we're preparing for this year. It's only in those programs that there is financial risk and reward. So within that risk and reward, recall that there is that 1.50, right, Tom, that is linked to risk, but it's also linked to an additional 1.50 of reward. So a primary care practitioner could receive 475 versus 325 if we collectively do well as a system of care, and that I think gets to the questions that were asked earlier about how do you sustain these programs because remember that these are upfront investments that we're making right now that do have to be linked

more closely in the future to our ability to sustain as an ACO, and especially as those dollars are no longer available from state and federal programs we will be solely dependent upon our network opportunity. Tom, did you want to add?

MR. BORYS: Add a little. There has been an evolution here. You ask a really good question. When we initially developed this concept it was more of a variable population health management payment, the 325. So the care coordination money with that 325, that was the concept, starts with a lower level and as performance in our programs increases those funds become available. That was met with some challenges through our negotiations. So we basically took a different functional approach and really created the separate accountability pool transaction stream either through periodic contributions on a monthly basis or through year-end investment. So similar concept, but technically decoupled from any of the other funding streams, and I would actually -- I still like this idea of a variable investment concept, but we need to make sure that anything we do is compliant with our contract terms.

MS. LUNGE: Thank you, and then the

other question I had about the accountability pool, because it does seem to be tied to provider accountability, is why it doesn't show up on table 5.2 which is the risk distributions. Now certainly it would not make sense to include every single primary care provider on that table. That would be challenging, but the table makes -- doesn't really reflect this additional accountability. So is that just because of the evolution or could you speak to that a little bit?

MR. BORYS: Yeah. I think the complexity of filling that table with all the different providers make it a little tricky to do.

MS. HOLMES: Sure.

MR. BORYS: And we're happy to do that breakdown and show here's the component that primary care has, and I would put it in a couple different buckets; non-hospital primary care, hospital primary care, and then hospital risk bearing entity that serves as the backstop. If that's a perspective that's helpful, I'm happy to submit.

MS. LUNGE: I think that would be helpful because I think it -- because right now it does sort of look like it's just the hospitals taking all the risk, and while certainly this is a small

amount of risk on primary care it would be good to set it up so we can track it up moving forward. So thank you.

So in your -- in the round one questions the staff had asked you about national benchmarks and you had talked about using national quality benchmarks and certainly that the payers are looking at national benchmarks and utilization benchmarks have been a challenge because of cost. So I wonder if you could speak to that a little bit more, what is the cost of that, it sounds like it's prohibitive at this point, are there any publicly available utilization metrics. For example, we had a presentation from Mathmatica where they talked about some hospital specific measures that perhaps aren't exactly the utilization that you would want to look at, but there are some out there. So I wonder if you could speak to that a little bit and get us some more information on it.

MR. BORYS: I'll give it a stab here. It is something that we're interested in doing looking at some national benchmarks to compare our network to other ACOs. Data can be tough to grab because not every ACO is so out in the open in the public space, but it is an area that I'm interested

in exploring. I think to do it really well we probably need to leverage somebody, a firm or something, that has more national experience kind of mining that data and/or those data. I think that would be a good endeavor for us to explore, but right now our focus is so heavily on supporting our providers' evaluation of some of these programs I think that's taking precedent, but I think the point -- the question is very fair. How can we leverage some national trends or benchmarks to either highlight areas of opportunity or areas where Vermont is already pretty great.

MS. LUNGE: Thank you. I only have a couple questions left. My second to the last question is the hundred dollar engagement fee, and certainly I understand discontinuance is primarily financially driven, are you expecting this will impact cost or quality results at all? Would you expect primary care docs or clinicians or offices would still continue to try and reach out and engage with these populations? My recollection is that this fee was really to try and connect with patients who perhaps have not been really firmly engaged in primary care.

MS. LONER: Sure I would be happy to

take that question. I think what we learned through that pilot program is that the financing component really wasn't the incentive. They were doing it because they were receiving data. They got a phone call from somebody else in the community that had a relationship who said hey can we get this individual in to see someone in your office, and so I feel confident that those activities are well established and underway and still spreading, and that's part of the overall care model and the care coordination that's happening, you know, with the community based care team. Beyond that to your point it really was a financial consideration to try to keep those investments in care coordination.

MS. LUNGE: Thank you, and then lastly in your budget submission, which is on page 41 in case you need to look at it, you had talked about connecting with the HSA on examples of high value or low value care, and I'm wondering if you can give us a few examples of the sorts of things that you have reached out to or if this is a future activity and if it is something that you had engaged in already, what trends you might be seeing.

MS. BARRY: So I would want to get back to you with detail as we talk to our team, but just

at a high level I think some of the opportunities that we've focused on are things like bringing some clarity around use of imaging, and so providing that at the level certainly of an organization, but drilling down to individual providers. Certainly we continue to focus on really trying to enhance the use of preventive care and all of the associated services that come along with that and monitoring those activities as an example of high value care, but again I would want to get back to you with more examples after talking with our team.

MS. LUNGE: Great. So, Kevin, the only other questions I have are -- would need to be in an executive session because they are around the commercial contract. So I was sort of assuming you would want to move on to you and Tom and then circle back, but let me know how you would like to proceed.

CHAIR MULLIN: Mike Barber, are you on? Russ McCracken, are you on?

MR. McCRACKEN: Hi Chair Mullin. I'm on.

CHAIR MULLIN: My question, Russ, do you feel there's any benefit to going into executive session now or waiting until all the Board questions have been asked? And as followup to that while

you're thinking about that I would also wonder how we break into the flow with the Health Care Advocate's questions and whether or not the executive session should be after that, and since we are doing that do we really -- should we really go into an executive session just before public comment. So is the most appropriate time after public comment or is the most appropriate time now after we finish with the Board or after the Health Care Advocate?

MR. McCRACKEN: I think you can take either of those options. There might be some advantage to -- and there might be some advantage to considering an executive session after the board questions and prior to the Health Care Advocate's questions. I believe the Health Care Advocate could join the executive session too, and so if those specific questions, they're regarding confidential commercial contract terms, they could ask them at that point.

CHAIR MULLIN: Okay super. So that's what we'll do. Thank you, Robin. Next I'm going to move to Board Member Pelham. Tom.

MR. PELHAM: Thank you. I'm fascinated by this entire conversation. It's -- in the scheme of things it's, you know, the gap money that goes to

OneCare is not as big as some as I've seen, but the level of conversation here is incredibly detailed and thoughtful and I appreciate it.

So my first question has to do with the QHP benefits benchmark plan review that the Legislature passed last session, and basically they assigned to the Department of Financial Regulation to review a plan assessing whether it is appropriately aligned with Vermont's health care reform goals regarding population health and prevention as set forth in the All Payer Model and state health improvement plan. They also kind of included six additional benefits that they wanted this process to look at and the process was open to participation by the Green Mountain Care Board, DVHA, yourself, and so I'm just wondering -- and the report has to be done by January 15, 2022.

So my question is the above legislative initiative is not mentioned in OneCare's 2022 budget given that the QHP population at 31,000 is a considerable segment of OneCare's attributed lives, that OneCare has considerable population health data relative to this population and the funding of population health measures such as prediabetes, which is the one I always use as an example, within the

plan are important to grow and sustain OneCare's mission. What role does OneCare have or see for itself in this benchmark plan review process?

MR. BORYS: I'll take that one. I'm happy to be a contributor in terms of learning what's more in that plan. I've done some research on it. One aspect that I will need to evaluate further is now that we're a 501(c)(3) organization we need to be cautious around anything that would be perceived around lobbying, and because this is a legislative thing I just would need to evaluate it further, the depth of our involvement in something like that. So I'm sorry it's kind of an open-ended thing, but it's a topic that's been on my mind lately to really assess the overall impacts of our 501(c) status.

MR. PELHAM: Well I appreciate that. I just hope you would get to it sooner rather than later because the clock is ticking as we head towards January 15th and, you know, I think for a good segment of your attributed lives population this is going to be important. Keep in mind that the current benchmark goes back to 2014, it precedes you, and so there's probably a lot of areas in the area of prevention, population health, that would be helpful for you to know about in that process and possibly

affect and use the talents of your organization to steer it in the best direction. So's that's one.

The second one I could probably just almost cast aside completely. Jessica hit it on the head, which happens quite often here, and that's one of my favorite topics the cost shift. So -- but I do have just a couple points to make. In your entire narrative of presentation there was the mention of the cost shift twice and both times it was related to Medicare and the -- your budget incorporates the maximum allowed Medicare USPCC trend rate for Vermont All Payer Model and that you hoped would mitigate the cost shift a little bit because it seemed like a fairly big growth number.

For Medicaid, as I read your narrative, it basically kind of relies on the traditional actuarial approach to setting a trend rate and -- but also in the end basically says that gets -- I'll give you the exact language -- determine a reasonable budget to be used until Medicaid sets the actual total cost of care target. In just this last legislative session, and I'm quoting from a presentation to the Legislature by DVHA, they say that DVHA -- in 2021 DVHA will be level funding rates that do not have a federally mandated rule for

increase such as FQHC services. So the specter of the cost shift is out there and it's a big number, and I kind of tying back to where Jess was in her discussion. I worry that the cost shift is a siphon that if you people are successful through the back door of the cost shift, your success will not be able to be visible, and so in terms of these top side progress measurements if on the fiscal front you have one of your partners, and I know this is a small state and everybody has to get along, but if you have a cost shift that has pulled millions out of the health care system and sends it off to other parts of state government, you're not helping yourselves, and so I would hope that you would have some frank conversations, you know, with DVHA about the cost shift and about how to measure it and how to think about keeping it separate as, for example, in the UVM Network presentation they were very clear about what part of the rate increase they were requesting was cost shift related and what part were cost related, and I think that you might want to kind of think in that same manner about that in order to be able to present the kind of top side overview about your progress over the next two or three years and so that you get credit for what you do, but I don't need to

talk about that any more because it's -- it's pretty clear to me. It's -- to me the cost shift is a chronic disease of our health care system.

My last question goes back to condition 15 from last year's budget, you know, where you were asked to and you did propose some FPP targets, and we're talking about true FPP here, and a strategy for achieving those goals and when I saw your memo I was impressed. You really kind of looked down the road and for 2022 a little bit, but to 2023 and '24, '25 and set some ambitious targets in that regard, and relative to the Medicare target you basically said, you know, you don't have any -- your expectations are zero for 2022, but for 2023 -- let me make sure I've got these right here -- it's up to 53 percent. For commercial the targets are 2.9 percent for 2022 and 22.9 percent and for Medicaid, Medicaid is already quite high in terms of their's. So there's not much change there. There's a little, but what I -- the thing I'm drawn to is having gone through the rate review process this summer and gone through the hospital budget process and thinking about the commercial participation, if you looked at the rate review information that's in our Board decision, it's included in our Board decision, you'll see that the

level of participation of the carriers in fixed prospective payments, the true prospective payments, are down less than 2 percent of the claims they pay. They have these other programs going on, but here we have the largest payer in the state about 1.6 billion and they are only into this at a level of 2 percent; and in the hospital budget process if you look at fixed prospective payments as a part of their NPR, commercial is down at three-tenths of one percent. So there's a lot of work to do there.

Right now I mean despite the cost shift Medicaid seems to be the best person in terms of helping you down the road to fixed prospective payments. Medicare I believe the entire state is working very hard to get CMMI to allow us to end the reconciliation that's in that FPP, but the commercial I don't see a path forward yet. When you have in our rate review hearing one of the carriers testified their problem is there aren't willing partners out there for them to deal with, and when I presented that comment to the UVM Medical Center during the hospital sessions -- I will give you the quote -- Dr. Brumsted said well I'll just say that we would be the first up if any commercial payer wants to come forward with actuarially derived cost of care targets

and are willing to allow us to have the portion of the premium that would flow through the ACO to support care management. Be first in line he said.

So to me there's a gap there and, you know, I've listened to the, you know, the representations from the carriers that they are all in on health care reform, but when you follow the money there's a pittance, and so I'm just wondering what is it -- well my first question is if we get approval from Medicare in 2022 to move to a full fixed prospective payment what -- what do you folks have to do because I don't think you can just click a switch. So what kind of timeline do you need in fiscal '22 so that program could be available in fiscal '23?

MS. LONER: I can speak to that.

MS. BARRY: I was just going to address the timeline component. Any of these conversations and the work would need to take place in the first four and a half to five months of calendar year 2022 so that by June OneCare's board can be voting on policies that then are incorporated into contracts with our network that take place over the months of July and August. So that's just the practical piece that you were asking about.

MR. PELHAM: So we don't have the full '22 to wait.

MS. BARRY: No. We have five months.

MR. PELHAM: Okay. That's helpful to understand. So what thoughts do you have about trying to bring Mr. Brumsted and the carriers closer together so that they can shake hands and bring the carriers into health care reform in a more robust manner?

MS. LONER: I would say that I think the major disconnect is probably in our terminology and how we describe a fixed payment. It is true that Blue Cross Blue Shield offers a fixed payment, but it's a reconciled fixed payment. That is not something that any of our providers are interested in. It's an added administrative burden. It's unpredictable. It doesn't do what we're trying to do with health care going forward and that is to encourage investments upfront and know those investments will be there. So I think that's the major disconnect when we just use terminology.

It is true that the carriers are offering -- or Blue Cross Blue Shield is offering a fixed payment for a select portion of their business, but it is not a true fixed payment. So I think what

we need to do is get to a space that a couple of things have to happen. There has to be a willingness to offer a true fixed payment and then there has to be an ability to operationalize a true fixed payment, and that has to come through from the payer as well.

Thirdly, which we've experienced and then, you know, plagued with problems by different payers every single year, so not to put it on one player, is delivering claims data that is reliable on a consistent basis that will enable our provider network to take true financial risk. So all those things have to come together before you can shake hands and say this is the way that we're going to operate moving forward.

MR. PELHAM: So in your condition 15 response I think that you had a very low expectation in 2023 for commercial payer FPP, but you start to ramp up in 2024 or maybe it was '23. Did you think that -- so that's a fairly near -- near timeline. Do you think that this bridge can be gapped between the -- with Blue Cross Blue Shield and MVP, et cetera, so that -- because I worry that as time goes by, if you don't develop those relationships, I think that would be a big hole in your portfolio not to have the commercial folks engaged in this.

MS. LONER: I think it's totally within the realm of possibility as long as all parties are able to dedicate the time and resources needed to that. I'll also say that you want to be careful on how you roll out those type of payment changes because as we saw with Medicare even in the beginning the rollout was less than smooth, and so you don't want to further disrupt your health care system unnecessarily. So that has to be part of the process and making sure that you can be able to do this -- all parties can do this in a very competent manner that doesn't further stress our system.

MR. PELHAM: Well I thank you for that. I'm just -- these next two years to me seem critical. I do worry about the cost shift kind of being a back door to your organization as it is to many of the providers, and I worry about the carriers staying on the sideline and so hopefully we can all work together to remedy those two.

MS. LONER: Perhaps there's some opportunity, if there is to be a next All Payer Model waiver for the next five years, to think about those things in advance of that.

MR. PELHAM: I agree. So I'll send it back to the Chair. Thank you very much for your

time.

CHAIR MULLIN: Thank you, Tom.

MS. LUNGE: Kevin, I have one quick followup on that.

CHAIR MULLIN: I had a question for you as well, if you could just tell me how much time you think the executive session will take?

MS. LUNGE: I think -- well I would say I have about half a dozen questions. So maybe half an hour.

CHAIR MULLIN: Okay. Go ahead and ask your followup question.

MS. LUNGE: Yeah it's really more of a comment. I just wanted to make the comment on Medicare implementation timelines. In the last negotiation when we were talking with Medicare about their implementation timelines it takes them a year to 18 months to change their claims processing system. So I think just to set realistic expectations out there, you know, Medicare's ability to change their payment is not on a dime. So it will take some time on their end, and to Vicki's point even with that implementation timeline there was some snafus. So I think that quite frankly on the Medicare side will be the driving time factor for

implementation of a different payment model.

MS. LONER: That's a great point.

MS. LUNGE: So if -- are we ready for executive session, Kevin, or did you have some questions?

CHAIR MULLIN: Not quite. Not quite.

MS. LUNGE: Okay.

CHAIR MULLIN: And I'm going to limit myself to one question. There's quite a good volume of a written record and there's a few discrepancies and the staff will follow up with you on those, but my one question has been asked kind of already today and it's been asked in years past, and so I'm going to try to phrase this a little bit differently and see if we can try to flush out some enthusiasm here. So, Vicki, if you could pick one thing that OneCare Vermont has accomplished in the past that you stand back and say wow we did that, what would that be? In looking forward what's the one thing that if you accomplish it this year you would be jumping up and down and saying yes we did that?

MS. LONER: All right. I'm going to try to muster up a lot of enthusiasm for you, Chair Mullin, on this one. You know as I reflect on OneCare's accomplishments I have said throughout this

presentation we have brought together over 5,000 providers who are committing to value based care over 160 organizations all sitting together and agreeing to be in value based programs and committing not only time, energy, resources, and money to that cause. Whenever I talk to other ACOs around the country they cannot believe the size, breadth, and depth of the participants that we have in our model, and we should be rejoicing in that because it really is unheard of across the country. You know it has a lot of opportunities when you had that many different provider organizations, and it also has many challenges as we've spoken about in that not one size will fit every single one of those organizations, and so that you have to be able to listen, that's why God gave you two ears and one mouth, and be able to respond in a way that meets the needs of the collective whole.

So I would say that's the one thing that I am most proud of. I have -- I've been with this operation for about nine years. I will tell you when we first brought together OneCare I would not call it the coalition of the willing. It was the coalition of we better just get into this to see what the heck is going on with health care reform and we want a

seat at the table. Now you had a good group of individuals who were really willing and wanting because they see that this is the direction that health care reform is going into.

If I were to state the one thing that I believe will really be able to help us move forward and that is around our comprehensive payment reform program, and we are working internally, as Board Member Holmes kind of talked and touched on earlier, to think through what is our three to five year version for that program, how do we want to move it, how will we define its success, and really what I want for the organization is to be able to provide all primary care regardless of employment, attachment point, this program so that they can have predictable, flexible patients, to take better care of the patients that they serve everyday, and I think that is going to give us kind of the biggest bang for our buck in health care reform is really moving into a model that supports primary care and we're well on that path.

This is a model that we had within Vermont that has been developed and executed solely by OneCare Vermont. It's not a model that exists elsewhere and, you know, I think it is showing some

promising results. Know there's been a lot of noise and interruption so we can't tell you perfectly how it's working, but it's got a ton of support from those 16 provider organizations that are part of it, and if you talk to them privately, they will tell you that that program is the only real reform effort that they have ever seen in Vermont that is truly supporting primary care. That's what I got.

CHAIR MULLIN: So, Robin, I assume you have the specific motions and who should be there.

MS. LUNGE: I do. So in order to go into executive session it will take a couple of motions. So the first motion I would make is that I move that we find that premature general public knowledge of the information identified by OneCare as confidential in its budget submission would clearly place OneCare at a substantial disadvantage with respect to its negotiations of contracts with commercial payers, and that is because I have some questions related to the confidential material that they submitted.

CHAIR MULLIN: Is there a second?

MR. PELHAM: Second.

CHAIR MULLIN: It's been moved and seconded. Is there any further discussion? All

those in favor signify by saying aye.

(All Board Members respond aye.)

CHAIR MULLIN: Any opposed signify by saying nay.

(No response.)

CHAIR MULLIN: And the second motion, Robin.

MS. LUNGE: The second motion is that I move that we go into executive session under 1 V.S.A. 313(a)(1) to consider OneCare's contracts, specifically aspects of its contracts identified as confidential in the budget submission, and also to consider portions of their budget submission that are exempt from access to public records provisions in the Public Records Act.

CHAIR MULLIN: Is there a second?

MS. HOLMES: Second.

CHAIR MULLIN: Robin, I didn't hear the players in there.

MS. LUNGE: I don't believe I have to say the players in the motion.

CHAIR MULLIN: I just want to make sure that everybody that should be there is there.

MS. LUNGE: Yes. So typically so the attendance in the executive session is limited to the

Board, and at our discretion our staff, legal counsel, OneCare because they are the obviously answering the questions, and then of course the HCA because they are party to the proceeding.

CHAIR MULLIN: Okay. So was there a second to that motion? I think there was, but I can't remember.

MS. HOLMES: Yes.

CHAIR MULLIN: Thank you, Jess. Is there any further discussion?

MR. McCRACKEN: Just to help us with logistics about how we manage this please --

CHAIR MULLIN: So, Mike, you should have been sent a Team's invite to a separate meeting for an executive session. Hopefully you have that. Mike Fisher, do you not have that?

MR. FISHER: We do not yet have that.

CHAIR MULLIN: You do not. Abigail and Cara, can you make sure Mike Fisher, Eric Schultheis, Sam, and --

MS. CONNOLLY: (Inaudible)

CHAIR MULLIN: What's that? Marisa, what did you say?

MS. CONNOLLY: Sorry. On this end there's a separate executive session link that should

be sent. If it hasn't been sent to you yet, we can send it to Kaili and Mike and they can forward it to those additional folks.

CHAIR MULLIN: Okay. That would be great. Thank you. Appreciate it and does the OneCare team all have it? Tom, are you all set?

MS. LONER: I'm good. Thank you. Appreciate it.

CHAIR MULLIN: Okay. So any further discussion on the motion? Hearing none all those in favor signify by saying aye.

(All Board Members respond aye.)

CHAIR MULLIN: Any opposed signify by saying nay.

(No response.)

CHAIR MULLIN: Okay. For members of the public we estimate that we will be in executive session for approximately a half hour, but I'm going to ask Cara and Abigail just to put up a sign saying that we'll be back at 2:40 and we'll get back as soon as we finish in executive session.

MS. LUNGE: And, Kevin, just for the public's understanding no formal or binding action is taken in executive session. It's simply information gathering and also the court reporter will be

present. So my apologies for leaving her out.

CHAIR MULLIN: Okay. For the public we'll be back soon and for everybody else I'll see you in executive session.

(Public hearing is in recess at 2:14 p.m.)

[Public session continues at 2:45 p.m.]

CHAIR MULLIN: At this point I'm going to turn the meeting over to the Health Care Advocate for questions. Michael Fisher.

MR. FISHER: Thank you, Mr. Chair, thank you Board, and thank you OneCare for the presentation, and also thank you OneCare for a couple of meetings I want to mention. I think it is good that we have a pattern of meeting before this meeting to answer some questions, that does help out, and then I also want to recognize that we did also meet with your patient and family advisory committee which is a good meeting, and in line with I think the Board -- do we have a sound problem?

CHAIR MULLIN: Carrie Wulfman, if you can put yourself on mute we're getting feedback from your line. Okay, Mike.

MR. FISHER: So we do have a few questions. Sam is going to ask a question or two, and then I have a few questions. So why don't you go ahead, Sam.

MR. PEISCH: Thanks very much, Mike. I have a few questions and then I'll pass it back to Mike. As we know racial disparities in health existed in Vermont prior to COVID-19 and they only

worsened during the pandemic. So this is a three-part question, but the first one is OneCare measuring these disparities as a part of its ongoing data and analytics works, and does it share this data; and, if so, does it share this data with its provider network? Thanks.

MS. BARRY: Thank you, Sam. We're very interested in this topic. I'll start by saying that we are limited in the type of information that comes through in the claims data sets that allow us to identify different types of populations such as by race. Where we have that we have used it and been able to look at things like variation in the mammography usage by zip code, for example, and we've seen certainly some variation there, been able to share it within the local communities, and work with them on what are some strategies where they might be able to think differently about either outreach or locating services or communicating with primary care to encourage some of those activities to happen.

Having said that, we're also talking with payers about where there could be opportunities to access data points that we don't currently receive that could help us do more in that area.

MR. PEISCH: Thanks. Are there any

interventions that OneCare is doing or planning to do to address disparities?

MS. BARRY: I think in terms of interventions it depends which level of the system that we're thinking about. Certainly at the individual patient level it would be in the areas I was just referring to with that mammography example. Coming out of our strategic planning process, and Vicki may want to speak more to this, the board really prioritized a focus on looking at our governance structures and processes and where we could learn more and do better when it comes to diversity, equity, and inclusion, and so we are in the process right now of working to conduct some focus groups with different populations and bringing that back. I believe the plan is in December this year it will be going to our board and then they will be working on some recommendations for where we can make some changes.

MS. LONER: Sarah, I can add a little bit more context for you as well, Sam. We started probably three or four months ago doing surveys of all our boards and committees to do an environmental landscape to say where decisions and policies are being informed, what's our makeup, and are we really

representing the full spectrum of Vermonters and their individual needs, and what we found out from that study was that really for individuals living with disabilities and individuals with people of color was really lacking on our committees and boards, and so as a part of an intervention what we did was we reached out to many organizations that represent people of color and people living with disabilities to form some paid focus groups of which we have had three, and OneCare management has been there to open up, talk about this process; and then we left it with our consultant so that people felt like they had a safe space to provide feedback, and we're in the midst of compiling all that information, giving some very specific recommendations back to our board of managers, and looking at what the appropriate next step would be, and if and when we were to form a diversity, equity, and inclusion work group as part of the board of managers how would that tie in, in very cohesive ways to make sure that things that were identified were really acted upon and people felt like their voices were truly heard because I think that's one of the things that we're hearing is people want to have a voice and they want to make sure that their voice results in some

meaningful changes within the system.

MR. PEISCH: Thanks for that. That's encouraging. Last question from me is we have heard a couple times today about patient satisfaction survey. Just a clarification. Is this survey the consumer assessment of health care provider surveyor? Is it a different survey?

MS. BARRY: You're correct it is the CAP survey.

MR. PEISCH: Okay. Are you using like demographic data from that data evaluation of satisfaction? Just kind of curious how you use the data that you get from that.

MS. BARRY: Sam, I think that would be a great conversation for us to be able to give you some followup information on. To my knowledge we have not used the patient experience survey data set to look at disparities in that way. We've been more using our claims data, but I can certainly check back with the team and let you know.

MR. PEISCH: Okay. Thanks. Over to you, Mike.

MR. FISHER: Thanks. On slide 5 I saw your very high level positive take away from the NORC evaluation, and I listened to the NORC presentation

and read it as closely as I could and saw a much more nuanced description and on a couple different fronts, but the one front I'll just mention here and the reason I'll mention it is -- well your friends and mine have been working on community health teams for years and years and I think -- I fear that without a recognition that today's health care reform efforts are built upon the efforts that have come before us and impacted by the efforts that go before us that we're not giving them recognition. So I just want to give you an opportunity to recognize that dynamic.

MS. LONER: I think it's very true and part of the NORC evaluation that Vermont has been very progressive in its health care reform efforts and that the ACO and the All Payer Model builds upon previous efforts, and so to really isolate and find out, you know, which impacted what is really hard to disentangle, and at the same time I think that NORC did a really nice job at doing some comparable analysis against other states and similar health care reform efforts and trends that they are seeing. So what we take from it our results in Vermont are very promising and that we need to continue to do this work and refine our efforts on this work and learn from our mistakes and rectify them as quickly as we

can and move forward.

MR. FISHER: Thanks. I heard your very clear statement that care coordination is -- I think it was Dr. Wulfman's statement -- is that is the center of success, and I would agree that care coordination is a key part of the effort here, and I also saw on slide 13 a slide that -- a graph that showed -- it appears to show increase in care coordination, and I wonder how that compared -- I'm just having a hard time putting that together with a statement on page 10 of your narrative that recognized a 7 percent reduction in care coordination. Can you help me understand those?

MS. BARRY: Sure. I think it's a timing issue as much as anything. One of the challenges for us is that we need to wait until the new contract cycle data arrives. So it usually takes until about April for that new cohort that was defined by the contract that went into effect in January. So when we look at kind of defining a new cohort for examining care coordination it usually starts in April not January of the year. So at that point we see a dip because some individuals for whatever reason are either no longer a part of the ACO program or they might have changed insurers or moved out of

state, something else has occurred, and so at that point we are cleaning that data out. There's a drop, and then what we've been monitoring this year as well as last because really in light of the pandemic what are some of the differences in how people engage in care coordination and how do they connect in a virtual environment say. So in those regards what we're seeing then after that dip is kind of a slow and steady increase. That mirrors what we saw last year as well, and I think it will take us a little bit longer to understand is that going to be a bit of a natural cycle due to the way of data flows or are we actually going to smooth that out as we continue to get deeper into this program.

MR. FISHER: And now maybe I'm even more confused. Are you projecting a 7 percent reduction in care coordination for 2022?

MS. BARRY: Not at the end of the year. So this I would have to go back and look at that particular data point, but when we prepare these budget submissions they take us months to prepare so we pull data at one point in time and so that would have been the data point at the time in which we pulled the data.

MR. FISHER: Okay. I'm interested in

that and I'll just add the perspective, and I think we've expressed this year over year, we have generally been concerned about whether OneCare is doing enough care coordination to have the kind of effect that we're trying to have on the health care system, but I'll leave that topic.

Population health investments. So for a number of years we have all heard your description, your highlight, and support for RiseVT. A notable change this year about Rise. I'm curious about sort of what led to your decisions about Rise this year. Was it purely a financial decision or was there some measure of effectiveness?

MS. LONER: Sarah, I can start. I'll just echo what Sarah had said. When we looked at our strategic plan and gathered input from all of our stakeholders to really refine our goals and responsibilities the area of prevention is one that's always top of mind, and so from our stakeholders' perspective and board of managers, as Sarah said, there's numerous providers out there that do this work really well, and what we need to do really well as an ACO is that clinical prevention and getting closer to the primary care medical home.

So what we have been asked to do is to

look at our prevention model and really get closer to that clinical prevention angle, and I know that Sarah and Amy Bodette, who I believe is on the call, have been working very closely with the RiseVT communities to think about how do we take this next six months to really think about how we evolve that model and what some of the tangible outcomes would be. This isn't all because the model isn't effective. It's just a point in time, and of course financial resources always play a role in all of these decisions and you're right, Mike Fisher, there's never enough resources and finances to really do all that we would like to do on this front, but the investment has to come from somewhere, but, Sarah, do you want to hit more of the details on that?

MS. BARRY: Yeah just to add a little bit. So structurally the way that some of the investments in RiseVT have worked in the last couple of years is that we've done some matching. So in the local community they put up a portion of funding to help support part of a position and OneCare matches that. It's been interesting to us to note over the last few years that the source of those matching funds 9 out of 10 of the positions are funded through the hospital locally. One is in a FQHC, and so when

we were having conversations the issue of simplification also came up in the conversations, and a lot of the hospital leaders continued to recognize and support the value of the activities, but said that it aligned through a lot of their community health needs assessment work and some of the teaming that was already happening, and so rather than see it pushed through dues and then back it was just a little bit less of moving dollars around for them to be able to ingest and continue some of that work; and so we're actively working and that's part of what we need to be doing over the next six months, but we're looking at how those activities can be sustained and at what level in local communities.

MR. FISHER: So stepping away from Rise for a moment you know I think I'm understanding that, and please correct me if I'm wrong, that last year's budget had 30.6 million population health investments and this year's budget has 28.9, and so I'll make very much the same comment I made about population care coordination. We continue to feel concerned not enough investment is happening here, but I'll go on to express a little bit of concern, make a statement and welcome a response from you.

I was troubled to hear today about the

change towards a clinical focus for population health investments. One of the promises of this effort that's been highlighted for me for many years is the potential to recognize and invest in promising community efforts that build -- that build on the protective factors. I'm a social worker so I'm going to say it that way, and it's not at all surprising to me that a group of providers would say oh no we should put our money into clinical investments. That's troubling to me. I'm happy to hear a response.

MS. LONER: I'll just say, Mike, we really had to sit down and think about where we were going -- the place where we were going to start from and not necessarily the place that we wanted to end up being, and so this is a place we really needed to start from as an ACO in order to be able to show our outcomes and really hone in on what our core capabilities were at present and not to say that they won't be there in the future.

MR. FISHER: Okay. Now just a couple of odds and ends. A friend of mine sent me a copy of her mother's bill from a Medicare statement and on it at the bottom it had the following text: Your Vermont all payer ACO provided this service. If many

of your visits are with your ACO providers, you may be eligible for a cash reward. Call 1-800 Medicare or ask your doctor about your ACO.

This is news to me. I've never heard such a thing. Is it news to you? I would be happy to send you a copy of it.

MS. BARRY: Please send a copy right away.

MS. LONER: We don't know about this.

CHAIR MULLIN: News to the Board as well, Mike.

MS. LONER: Correct me if I'm wrong, I think for any of these type of incentives that are available through Medicare that we as an ACO would have to opt into these incentives and we would have to be able to track it in some manner. There used to be an incentive to receive primary care I believe from an ACO primary care provider that Medicare was offering.

MR. FISHER: I fully recognize this is maybe a national thing that doesn't really play out here in Vermont, but it did say your Vermont ACO provider so I --

CHAIR MULLIN: So I wonder if -- and I don't want to get into specifics, but there's one

practice in Vermont that is working with an ACO that is Medicare only and it could possibly be that. So it will be curious to see what this really is.

MR. BORYS: And for that exact reason we should be very mindful of HIPPA laws in putting out that information. So very open to exploring that, but just want to put that out there.

MR. FISHER: Have no fear I will not send any protected information.

MS. LONER: It's a good point, Chair Mullin, that we do have another ACO that's doing Medicare only. So that might be where that applies.

MR. FISHER: It was in Chittenden County. Okay. So then my last comment is sort of what you would expect from me at every one of these. We're spending a great deal of time focusing on the impacts of medical debt on people's medical decision making, and we've been out talking to people in a proactive way trying to understand, you know, the numbers that come before your desk, the Green Mountain Care Board desk, about bad debt, you know the 85ish million bad debt in Vermont's system, what does that mean in Vermont families and how does that play out, and the story we have heard really powerfully people saying I'm not getting the care my

providers are recommending because I'm afraid of medical debt or because I can't get more.

Now I fully understand your answer to this question might be that's not in our wheelhouse, that's outside of our effect to do anything about, but I would be remiss if I didn't say clearly that we see the impacts of medical debt as pushing in exactly the opposite direction of the work you're engaged in.

MS. LONER: Agree with that statement.

MR. FISHER: Okay. Thank you, Mr. Chair.

CHAIR MULLIN: Thank you, Mike. So at this point we're going to move to public comment. Is there any member of the public who wishes to comment on OneCare Vermont's proposed budget? I do see a hand, let me get there, and I don't have a last name, but I do have Patrick.

MR. FLOOD: That's me, Chairman Mullin. Can you hear me?

CHAIR MULLIN: Yes. So for the record that is Patrick Flood.

MR. FLOOD: For some reason my camera is slow coming on. Is it on now?

CHAIR MULLIN: Yes we can see most of you.

MR. FLOOD: Hopefully you can see the important parts. I just have two questions that I think are germane to the budget presentation. In order to comment -- make public comment on the budget I would like to ask basically I think the Board two questions. The first question is where can I find the financial outcomes -- the financial results for OneCare Vermont from 2020? I've looked on your web site and I don't pretend to be an expert at finding things, but I can't find any 2020 financial results. So if you could just tell me where to look, I would appreciate that.

CHAIR MULLIN: So I'm the last person to ask. I'm going to defer to Marisa or Sarah if they could help me out.

MS. KINSLER: Hi. Thank you, Mr. Chair. Can you all hear me?

CHAIR MULLIN: We can.

MS. KINSLER: That's on the Board's agenda for the 22nd of November. We'll have a panel of all payers from 2020 and results. At this time this is typically the time of year when those results become available both the financial and the quality results. So we usually do a panel between October and December.

MR. FLOOD: All right. So there are no results available yet. They will be available on November 22nd. Is that what I'm hearing?

MS. KINSLER: Correct. We make it a priority to ensure those are available and before making any recommendations to the Board or asking the Board to vote on that.

MR. FLOOD: Okay. All right because I think it's important to be able to look at success or failure in terms of commenting on the budget for the next year. It's kind of late in the process not to have those financial results, but I'll let that go. Wait until the 22nd.

The other question I have, Chairman Mullin, and you're aware of this because I already submitted a FOIA request for this relative to the agreement, I believe there has to be a written agreement between OneCare Vermont and UVM Health Network when OneCare Vermont joined the Network. I assume there has to be a written agreement somewhere and I asked your staff for it. What I got was I was directed to the ACO certification document which is, you know, which I reviewed. That's not really what I'm looking for. I'm -- I think it's a really key development this year that the ACO became part of the

UVM Health Network and I'm trying to understand that relationship. So I would really like to see the written agreement. So I guess I'm asking you today do you know if there is such a written agreement and does the State have possession of it?

CHAIR MULLIN: So I don't see Laura on this call. Marisa, did you work with Laura on that FOIA request?

MS. KINSLER: I'm going to have to check. Can you hang on?

CHAIR MULLIN: Yes.

MR. FLOOD: I don't want to hold up the process, Chairman Mullin. So assuming you let me jump in later you can continue with public comment.

CHAIR MULLIN: Well unfortunately there's no other hands raised right now so --

MR. FLOOD: So it's on me. All right. Well that's okay. I can wait.

MS. KINSLER: Are you just looking for the operating agreement, Patrick?

MR. FLOOD: Well I'm not sure exactly what it would be called. I just assume there is a written agreement in which OneCare and UVM Health Network agree on terms and responsibilities and I think that that's very germane to this process. The

question came up earlier today, you know, what are the details of that process. So I don't know what you would call it.

CHAIR MULLIN: So, Vicki, is there something other than the operating agreement that you have that details the relationship?

MS. LONER: No because I think there's confusion about what it is. So OneCare Vermont did not join the UVM Health Network. We're not an affiliate. We're not owned by the UVM Health Network. UVM Health Network is a parent of OneCare Vermont. That's reflected in our operating agreements.

MR. FLOOD: If I might, Chairman Mullin, and I don't think we want to get into a back and forth here, but what does it mean then to be the parent organization of the ACO, and I ask this question because obviously over a billion dollars in state and federal money is passing through the ACO. You know what I'm really curious about is what is the relationship of that pass through of those funds to any decision making process at the Health Network. So what does it mean to be a parent? Why did OneCare join or become whatever they have become? That's got to be spelled out somewhere in writing. Was there

not an agreement that UVM Health Network could provide some services to OneCare?

CHAIR MULLIN: So, Vicki, if you're able to answer that.

MS. LONER: All of that is outlined in our operating agreement. You can find that all there.

MR. FLOOD: All right. Chairman Mullin, I won't belabor the point, but I don't -- yeah I will follow up.

CHAIR MULLIN: Okay. Thank you, Patrick. Did you have other questions, Patrick?

MR. FLOOD: No that's enough. Thank you very much.

CHAIR MULLIN: Okay.

MS. KINSLER: Mr. Chair, if I might, I just wanted to say, Patrick, Green Mountain Care Board staff will share the link to the operating agreement on our web site with you as well as staff that the Medicare 2020 settlement is posted to our web site and we will send that as well.

MR. FLOOD: Thank you very much.

CHAIR MULLIN: Okay. Next I'm going to call on Susan Aranoff.

MS. ARANOFF: Good afternoon. I think I

just emailed you and a couple members of the Board the most global commitment statement and I sent this because I know I have to ask my questions through you so I wanted you to see in front of you the document I was looking at, and this is a document that the Agency of Human Services has to release like quarterly, and it talks about where certain Medicaid funds are going, and I call your attention to the last three lines on page 1 where it's talking about the special terms and conditions, that's what TS383 stands for, and these are the DSR investments. You'll see three of them that went to OneCare. Of note --

CHAIR MULLIN: One is basically the cover page. Page two is a list of the global commitment investment expenditures.

MS. ARANOFF: That's what I want to call your attention to. So the very last three lines of page two, and if you see the date on the cover page, you will see it's very recent. Like October 2021.

CHAIR MULLIN: Okay.

MS. ARANOFF: So the last three lines the first refer specifically to the DSR funds that we have heard about, and just as an historical note these were funds that were supposed to be made

available to the community based non-profits like the designated agencies and home health that provide Medicaid funded services entities, and Al Gobeille, who used to have your role, when he moved over to Agency of Human Services he made a decision to give that Medicaid money to OneCare and OneCare only, and the question I'm leading up to --

CHAIR MULLIN: To be clear, though, Susan, the original agreement envisioned the possibility of many, many, many millions of dollars that could have been accessed if the state put up their share from the federal government. That didn't happen. So there was --

MS. ARANOFF: Well that agreement we can talk about if it was envisioned or fantasized, but yes the documents that supported the agreement show that there would be millions and millions of delivery system or investment dollars available. Nevertheless those are the only ones. The ones that did materialize the only direct beneficiary recipient of those Medicaid dollars from our Agency of Human Services has been OneCare, and as you may know I and others have tried to track doggedly how much from our Medicaid money over the years and our HIT money included over the years have gone to OneCare, and the

only information I can find on the public record is these dollars right here.

So my question to you, to OneCare through you, Mr. Chair, is are there other monies that this OneCare has received during the period reflected in this document that are not included here? Are there other either DSR investments or HIT investments or other just Medicaid dollars that have gone to OneCare that are not included in the analysis?

CHAIR MULLIN: I don't think OneCare has it in front of them, but what I have in front of me that was sent to me by Susan is a list and on that list are three DSR investments made by AHS. In '21 it was 3.9 million. In '20 it looks like it netted out about 1.75 million. In '19 it looks like 4.6 million. In '18 it looks like 1. -- a little bit less than 1.8 million.

MS. ARANOFF: Just a clarification, Mr. Chair. The reason I'm asking OneCare to state whether or not the amounts they received are different from this is because in last year's budget documents and other budget documents they have indicated in writing that the amount they received through DSR was more than what is reflected on this

form.

CHAIR MULLIN: Was that through the HIT fund?

MS. ARANOFF: DSR -- actually no. Good point, Mr. Chair. Because some of OneCare slides they don't distinguish and they will just say state Medicaid 10 million and then in parentheses something like DSR. So good question. Really good question. I think a very good question, Mr. Chair, would be -- and you're in a position to ask it -- how much public money, HIT and DSR, have gone to OneCare since we have begun the All Payer Model? I have been trying to find the answer to that and I just can't.

CHAIR MULLIN: So I'll ask Sarah and Marisa to work with OneCare to create a timeline of when the dollars came in and posted to our web site. Is that okay, Susan?

MS. ARANOFF: That would be great because really what is in the public record is what you're looking at; those global commitment reports which are great as far as they go.

CHAIR MULLIN: I think that each year when they come in they have talked about the DSR dollars. So I think there's more than that in the public record, but I would agree with you that it

would take an herculean effort to figure it out. So let me make it easy for you and ask my staff to work with Tom at OneCare to make an easy document that will -- that we can post.

MS. LUNGE: Mr. Chair, I would just note the HIT fund also has a report that goes to the Legislature every September. So the OneCare investments from the HIT fund are in that report, at least the one I just found on the internet.

CHAIR MULLIN: That's what I would have assumed, Robin. So thank you for that. Again we'll make it very clear by getting out a quick Excel sheet that could be posted. Is there other public comment?

MS. WASSERMAN: Chair Mullin, this is Julie Wasserman. I tried to raise my hand multiple times, but for some reason it doesn't go.

CHAIR MULLIN: I can hear you so go ahead.

MS. WASSERMAN: For some reason there's a disconnect there. I have a couple questions. My first question is about OneCare's attributed lives that are actually scale qualifying, and as we all know in order to be attributed lives and be officially counted in the All Payer Model they need to be -- they need to meet the definition of scale,

and the most important aspect of scale is that at a minimum risk must be borne. So as you know this is one of the fundamental underpinnings of the All Payer Model. This issue of risk is especially relevant for commercial lives as Board Member Pelham mentioned earlier.

I've asked the Green Mountain Care Board staff for the preliminary number of scale commercial lives for 2021 and was told it would be available at this budget hearing. Preliminary numbers for scale were established last spring when contracts were signed between the ACO and the commercials. OneCare reports that Blue Cross Blue Shield bore zero risk in 2021. So given that Blue Cross Blue Shield is bearing no risk my question for OneCare, in particular Tom Borys, is this; how can you count any of Blue Cross Blue Shield's attributed lives as scale qualifying since there is no risk being borne this year?

MR. BORYS: Chair Mullin, I assume you would like me to respond to that.

CHAIR MULLIN: Yes please, Tom.

MR. BORYS: First I can't speak about active commercial contracts being negotiated so that limits my answer. Also say OneCare is not the

arbiter of which programs result in scale target qualifying lives. After we execute a contract we share that contract with the Green Mountain Care Board. They do an evaluation of the program terms and ultimately determine whether or not those lives qualify for scale. Through our budget we merely estimate which programs we believe will qualify.

MS. WASSERMAN: So that I guess my question is for the Green Mountain Care Board staff instead of OneCare.

CHAIR MULLIN: Do you know who on the staff promised you the information would be there today?

MS. WASSERMAN: Well I have had multiple emails over the last three or four months with Alena Berube, Sarah Kinsler, and Marisa Melamed, and the implication was that I could get the information today, but not -- it wasn't forthcoming prior to today.

CHAIR MULLIN: So Marisa.

MS. MELAMED: Hi Julie. I think I can take a stab at that and Sarah can. Like Tom said you know they are still in the contract negotiation so they give an estimation of the scale lives --

MS. WASSERMAN: No. I'm talking about

-- just to be clear we're talking 2021 the year we're currently in. Those contracts were signed back in the spring. I'm not talking about 2022.

MS. MELAMED: Okay. I'm sorry. I was thinking about the submitted budget. I think then what we meant is that we were going to try to have an assessment of the lives in our staff presentation not the presentation today from OneCare. We were hoping to focus on the 2022 budget.

CHAIR MULLIN: Go ahead, Sarah.

MS. KINSLER: Thank you. Julie, I thank you for your question and I want to point out something that I think has been getting lost in translation here. It is not required by the agreement that an initiative must include risk to be scale qualifying. It is required that there is -- that at least shared savings is available, and if the Vermont ACO is also at risk for shared losses, the shared losses have to be a certain, you know, at minimum a certain percentage, and I was kind of likely quoting from the agreement there. You know you can see page 9 of the current agreement, but I do not believe that ACO contract has to be -- has to include shared risk in order to qualify for scale.

MS. WASSERMAN: Well my understanding is

-- go ahead.

MS. KINSLER: There does have to be a tie to quality and those savings and losses do have to be kind of a minimum sharing percentage within whatever the corridor is, and I would invite Green Mountain Care Board legal staff to jump on if I'm misinterpreting or misspeaking at all, but I did want to clarify.

I also want to point out there was a question that got to this point that was in our staff written questions to OneCare, and OneCare's response does identify by program starting numbers for each program and that is also on our web site and I will make -- we will make sure that our staff presentation on December 8th also includes a clear chart and reporting in a more consistent format going forward.

MS. WASSERMAN: So a couple thoughts. The information that -- so I read page 9 of the agreement as well and I would be interested in a legal interpretation because it says at a minimum and it lists four different items, and so I -- so my sense was that risk was a piece of that, and I'm hoping that when the 2021 numbers for the current year are given that it does not include Blue Cross Blue Shield non-risk because it seems to me that's

clearly not scale. Those are not scale lives. So -- but a followup question for the Green Mountain Care Board is that can you help me understand then why state employees are included as scale in 2021. They opted out of a risk arrangement with Blue Cross Blue Shield and OneCare and so how are they included as scale, and that would be helpful to understand.

MS. KINSLER: From my understanding, and other staff can correct me if I'm wrong here, we do not have access to information about the specific employer groups that have opted in or out, but I see that current -- the current scale reporting and that includes the preliminary 2021 scale that we reported in June does not include Blue Cross Blue Shield non-risk lives.

MS. WASSERMAN: My question was specific to the state employees. The CMS report that was most recently submitted by the Green Mountain Care Board on scale did say -- actually it was number 4 on the cover letter state employees are not counted for scale. So my -- I was curious how that would be given that the state employees opted out of a risk arrangement with both Blue Cross Blue Shield and OneCare.

MS. KINSLER: That's a great question,

Julie, and I'll double-check on that.

MS. WASSERMAN: Thank you.

MS. KINSLER: I'll add it to the report.

MS. WASSERMAN: Okay great. I have another question about the way in which OneCare describes their payment to providers. It's important to distinguish between OneCare's true fixed prospective payments that are actually capitation and OneCare's monthly advance provider payments. So there's a big difference between the two. One is true capitation and the other is advance payments that are reconciled at the end of the year, but OneCare has blurred the distinction between those two types of payments in some of their presentations. Perfect example is OneCare considers all Medicare payments be fixed prospective payments, capitation, but instead these payments are actually monthly advance payments reconciled for fee for service at the end of the year; and by the way the NORC report confirms that the Medicare payments are not fixed prospective payments. The NORC researchers describe the ACOs Medicare hospital payments as fee for service. So my question for OneCare is can you provide the actual amount of true capitated fixed prospective payments for Medicare, Medicaid, and the

commercials and this would be for both 2021 and 2022.

CHAIR MULLIN: Before the answer I think in fairness to them that this is something that everyone has recognized that they wish Washington would do differently and so I don't know if anybody from the OneCare team wants to elaborate on that.

MS. LONER: I would just say that I think Tom Borys was very clear in his presentation that the fixed prospective payment is indeed through Medicare considered an all inclusive population based payment, and he did point out it was reconciled at the end. So there was no obscuring about whether or not that was a reconciled payment. None of these are true capitated payments. I want to be clear again on terminology. So just for the record I would say that I think we were very clear in our explanation.

MS. WASSERMAN: Well --

MS. KINSLER: If I can add to that, I'll just note that staff have been working to develop a clearer reporting template. Our federal partners have been very clear with us that they consider the Medicare next generation ACO payment model would be also population based option to fit into the LAN category 4B population based payments. The fact that it's reconciled is not, we understand, to be the

preference of OneCare and its network, but nonetheless our federal partners consider it in that category. So we are trying to develop a reporting template that will get us more granular reporting there.

MS. WASSERMAN: That would be great and would it also apply to the percent of hospital budgets that are fixed prospective payments because the 14 and a half percent for 2021 of fixed prospective payments in the hospitals is that all capitated or is some of that include the Medicare advance monthly payments? And I'm not asking you to answer that question because you probably aren't prepared to do that, but it would be nice to know for 2020 and 20 -- I'm sorry, for 2021 and 2022 since we already know and have approved the hospital budgets what percent is actually capitated and what percent is not, and the clarity in definitions will be very helpful. Thank you and I have one last comment.

The key findings from the NORC study it is true that the ACO had gross Medicare savings. Unfortunately it had no net Medicare savings and net savings are the true and most accurate measure of savings because they remove items such as CMS's pass through payments for the Blueprint. So we want to

look at net savings as the most accurate measure, and it is noteworthy that NORC found net Medicare savings with the state level group which it was a significant finding and that means that the state level group outperformed the ACO. If the state level group produced net Medicare savings but the ACO did not, then we need to question, you know, how effective the ACO is in that venue.

CHAIR MULLIN: Thank you, Julie. Is there other public comment, and if anyone is having the same problem with having to get their hand up -- I do see a LH.

MR. HOFFMAN: Hi can you hear me?

CHAIR MULLIN: Yes. Can you identify yourself for the record?

MR. HOFFMAN: Rob Hofmann. Just some clarifications for two of the commenters. You can easily find the rollup of DSR and HIT funds -- Tom Borys actually does a decent job on his pro forma year over year showing what those investments were. It's roughly 16 million. If you add in the SIM grant for 2017 that set up the VPN for VITL to OneCare, it's 18 million. It's worth noting, however, that in OneCare's own representations year over year they have lacked access to VITL data that they can use in

critical decision making. They have acknowledged they can only report out on certain measures once annually after manual extraction. So the roughly 4 million invested in VITL -- well 6 million including the SIM grant, you know, state stakeholders should really be asking what was the value of that investment. The balance of that two-thirds would have gone to mostly Care Navigator and Health Catalyst. Care Navigator is being retired. So again people around the state should be asking what was the value return on investment of that, and the ACO has been relatively mum and why they are putting less into Health Catalyst. Most people believe that they are going to be switching to Epic in the near future. So again it's worth asking what was the return on investment for Health Catalyst, and then to Miss Wasserman's question Miss Kinsler does a great job of splitting hairs in terms of legalese. The reality is the APM is preferenced downside risk. SEAC came into 2018 budget process easily with much better results both in terms of quality and savings, and we're precluded from participating going forward because they didn't want to take downside risk. An amazing group of community health providers, FQHCs were prevented from participating in this ambitious model

because they wouldn't perform downside risk in the way that we're now allowing tens of thousands of attributed lives to opt out of downside risk. So those are some important qualifications to make for the two comments that were made.

CHAIR MULLIN: Thank you, Robert. Is there other public comment? Is there other public comment? (No response.) Hearing none I wish to thank everyone for their patience today. It's been a long day with a lot of numbers and there's been a lot of submissions that have had to be poured over and studied, and I know that I really want to thank my Board Members who I know that's how they spent their weekend. So thank you very much, and at this time is there any old business to come before the Green Mountain Care Board? (No response.) Hearing none is there any new business to come before the Green Mountain Care Board? (No response.) Hearing none is there a motion to adjourn?

MR. PELHAM: So moved.

MS. HOLMES: Second.

CHAIR MULLIN: Couldn't wait for you, Robin.

MS. LUNGE: That's okay.

CHAIR MULLIN: All those in favor of the

motion signify by saying aye.

(All Board Members respond aye.)

CHAIR MULLIN: Any opposed signify by saying nay.

(No response.)

CHAIR MULLIN: Thank you everyone. Have great rest of the day.

(Adjourned at 3:40 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: FY2022 OneCare Vermont Budget via Microsoft Teams on November 10, 2021, beginning at 9 a.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting, and the foregoing 226 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 13th day of November, 2021.

_____

JoAnn Q. Carson
Registered Merit Reporter
Certified Real Time Reporter