STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

ONECARE VERMONT
FISCAL YEAR 2023 BUDGET SUBMISSION HEARING

November 9, 2022
10:03 a.m.
Montpelier, Vermont

Hearing held before the Green Mountain Care Board at 144 State Street, Montpelier, Vermont, on November 9, 2022, beginning at 10:03 a.m.

P R E S E N T

GREEN MOUNTAIN CARE BOARD:	Owen Foster, Board Chair
	Susan Barrett, Executive Director
	Jessica Holmes, Board Member
	Robin Lunge, Board Member
	David Murman, Board Member
	Thom Walsh, Board Member
	Russ McCracken, Staff Attorney
	Marisa Melamed, Staff
	Sarah Kinsler, Staff
	Michelle Sawyer, Staff
	Michele Degree, Staff
	Jennifer DaPolito, Staff
ONECARE VERMONT:	Vicki Loner, CEO
	Carrie Wulfman, CMO
	Sara Barry, COO
	Tom Borys, VP Finance
OFFICE OF THE HEALTH CARE ADVOCATE:	Michael Fisher, HCA
	Eric Schultheis, HCA
	Charles Becker, HCA
	Sam Peisch, HCA

Montpelier, Vermont
November 9, 2022
10:03 a.m.

P R O C E E D I N G S

MR. FOSTER: Good morning. My name's Owen Foster. I'd like to call to order the Green Mountain Care Board's board meeting of November 9th, 2022. We're here today for a hearing on Accountable Care Organization OneCare Vermont's fiscal year '23 budget. First, I'll turn it to Ms. Barrett for the executive director's report.

MS. BARRETT: Thank you, Chair Foster. I want to just remind folks that there are several ongoing public comments, and I'd refer you to our website. There's a open public comment period. Please check the Green Mountain Care Board website, under public comment. There, you'll see there's several open public comment periods. And just be aware there are dates that comments should be submitted, in order for those comments to be considered by the staff in their recommendations, as well as by the board in their decisions.

I also want to announce that, on November 7th, 2022, the board issued its decision and order approving modifications to the MVP Health Plan

2023 large group HMO rate filing. The decision and order is posted on the Green Mountain Care Board website under "What's New" and also on the filing page on our rate review website.

With that, I will turn it back to you, Mr. Chair.

MR. FOSTER: Thank you.

And I'd like to take up the minutes from November 2nd, 2022. Is there a motion to approve the minutes from November 2nd?

MS. HOLMES: I move approval.

MR. WALSH: Second.

MR. FOSTER: Is there any board discussion?

Those in favor, please say "aye".

IN UNISON: Aye.

MR. FOSTER: The vote is unanimous, and the minutes are approved. I'd like to turn it over briefly to Marisa Melamed.

MS. MELAMED: Good morning, Mr. Chair and members of the board and the public. I'm going to give a quick introduction before we turn it over to OneCare for the hearing.

Can everyone see the slide?

Okay. Good morning, everyone. Are the

slides showing up okay? Yes?

MS. BARRETT: Yes.

MS. MELAMED: So I just want to give a quick introduction and orient us in the process here. I'm not going to go through all the details on each of these five because we've been through them before, most recently on October 12th. This is the budget hearing for OneCare Vermont, ACO.

And as a reminder, all ACOs operating in Vermont are subject to budget review. There's a threshold of 10,000 lives that defines the scope of the review. Also, that OneCare is a multi-paper ACO with contracts with Medicare, Medicaid, and commercial lives. And this budget hearing occurs annually in the fall. We revisit the budget in the spring. And we have monitoring that goes on year-round on budget activities.

The ACO oversight process is governed by the standards of review on this slide -- which, again, we've been through before, but they're available here for your reference -- the statute and the rule, and specific criteria under the rule that the board must consider.

Here's the timeline for the process. So we've made it to November 9th, and that is the hearing

today. The next step in the process is we are revisiting the recommendations for the other ACO under review next week, on the 16th. And we'll be back to discuss OneCare Vermont on December 7th, with staff analysis and preliminary recommendations. The budget is to be voted on by the end of the year. At the moment, we are expecting a potential vote to be December 21st.

The agenda for today -- this is the staff introduction. We have time for the OneCare budget presentation. There will be some staff questions, a break for lunch, which will be at the discussion of the chair, board questions. We can move to executive session, if that were to be necessary, to discuss confidential information. There's time for the health care advocate questions and public comment. And the timing will be sort of set by the board chair as we go, but roughly, it'll be broken up into two components, prior to lunch and after lunch.

And at the end of this slide deck, which is posted online, there are some reference slides, which people on the call might find helpful for their reference. All the materials are posted online that we'll be referring to, and then the criteria under 18 V.S.A 9382 that the board must consider. So you should

be able to find all those materials online.

And if speakers could try to, to the best of their ability, make reference to where information can be found, so that people can follow along.

And that's it. I'll turn it back to you, Mr. Chair. Thank you.

MR. FOSTER: Thank you very much. Participants today have all blocked their full day, so this large, complex budget can be adequately understood, and the board can make informed decisions in fulfilling its obligations to review and determine whether to approve OneCare Vermont's budget.

Vermonters, myself included, want to see OneCare succeed in implementing programs that reform healthcare in ways that lower costs, improve equity, access, and quality of care. Given the immense pressures on our healthcare system and the acute healthcare affordability challenges we face, it's critical that OneCare achieve its mission and improve healthcare for Vermonters and stabilize healthcare costs.

Vermonters have heavily supported OneCare since its inception. Since 2018, OneCare had a full accountability budget of over five billion

dollars, and with this year's budget, nearly 6.5 billion dollars. OneCare has had an entity-level gap budget of over 100 million dollars since 2018, and with this year's budget, is approaching 130 million dollars. And OneCare's operating budget has surpassed 71 million and will be approximately 87 million, if this year's budget is approved.

Vermonters, either through taxpayer-funded healthcare groups, out-of-pocket expenses, copays, or insurance, have borne the bulk of those staggering numbers. And for that, they deserve results. Vermonters need to know what they're getting for their money, and it's this board's job to ask those questions. If OneCare is meeting its mission, Vermonters should know it and should continue to invest and support in it. If OneCare is not, we all need to know that, understand why, and consider any such failings in assessing its budgetary asks.

I read this year's OneCare submissions, the slide presentation, and the transcript from last year's hearing. To my eye, the fiscal year 2022 presentation by OneCare was not particularly well-focused. It was long on process and light on demonstrable results. And as I understand it, the board has made OneCare aware of its keen interest in

understanding whether and by what quantum OneCare is impacting cost, access, and quality.

So I ask OneCare to please concentrate your remarks on objectively showing the impact OneCare has had, not through one-off anecdotes but quantifiable metrics and analysis that tie back to OneCare's work. I'm anticipating today there will be significant staff, board, and healthcare advocate questions and potentially much public comment.

Accordingly, and in light of our efforts to focus your remarks on what we need to evaluate in connection with this year's budget, please keep your presentation under sixty minutes. And forty-five minutes would be even better. If there's material that we need to get to that we weren't able to, we can take it up again after public comment. We're scheduled to go to 4:30, but if we need to, I have no problem staying later today.

As I'm sure you all can understand, you're entrusted with enormous sums of Vermonters' money, and there's huge responsibility that comes with that. You're under oath. Your responses should directly answer the questions, and you should strive for candor. Obfuscation or misleading responses are detrimental to this board's review and the process, and

I'm sure you all recognize that and will avoid it.

And with that, I'll turn it over to Mr. McCracken to swear in the OneCare folks.

And thank you, OneCare, for being here and providing us this information.

MR. MCCRACKEN: Thank you, Mr. Chair.

This is Russ McCracken. I'm a staff attorney with the board.

From the OneCare team, could you just confirm who is going to be speaking today?

MS. LONER: Yes. So Vicki Loner, CEO, OneCare Vermont; Sara Barry, COO, OneCare Vermont; Tom Borys, vice president of ACO finances; and Carrie Wulfman, CMO, OneCare Vermont.

MR. MCCRACKEN: Great. Thanks very much. If you would raise your right hands.

Whereupon,

VICKI LONER, SARA BARRY, TOM BORYS, and CARRIE WULFMAN, witnesses called for examination by counsel for the Green Mountain Care Board, were duly sworn, and were examined and testified as follows:

MR. MCCRACKEN: Great. Thanks very much. You're under oath.

And I will turn it back to you, Mr. Chair, or I can turn it directly to the OneCare team to

start.

MR. FOSTER: Yeah, please -- the OneCare team can go ahead. And thank you guys for the work in putting together your presentation for us today.

MS. LONER: Great. Thank you, Chair Foster.

And thank you, other members of the Green Mountain Care Board.

Amy, could you put up the slides for us, please?

All right. Next slide, Amy.

I'm going to kick off the presentation. My portion of the presentation is going to be very brief, highlighting some of OneCare's successes and accomplishments over the year. And then my team will do a deeper dive, as we go further into the presentation.

At a very high level, the 2023 budget looks to advance our mission by focusing on our core capabilities that were developed as part of our strategic planning process a few years back. That strategic planning was accomplished, and we are looking to have a refresh on our strategic plan and priorities in 2023, for a 2024 start.

I want to start off by talking directly

about the value this budget before you presents to Vermont healthcare providers. And also, on the next slide, I'll talk a little bit more about how it looks to deepen engagement in value-based care, in moving away from a fee-for-service construct that we've been with for decades now.

In terms of value to providers, you'll see throughout this presentation progressively increasing provider network accountability that looks to improve the quality and outcomes, while reducing the administrative burden on our healthcare provider delivery system.

I want to be very clear that these aren't year-over-year changes that you'll see. Population health efforts take time to be able to measure such outcomes. But I believe that, over the years that OneCare has been operating, we have demonstrated significant outcomes in value to both healthcare providers and Vermonters.

This year alone, we are infusing over thirty million dollars directly to healthcare providers to support population health efforts, such as care coordination and quality improvement, with a big focus on primary care. And later on in the presentation, you'll see that the preponderance of these investments

go direct to primary care that they wouldn't otherwise have available, if not for OneCare Vermont.

Another big focus as an ACO is on engaging the full continuum of care. So as you look at our network, OneCare Vermont is more than hospitals. It's more than primary care physicians. It represents a full continuum of healthcare providers, working together as a system. Through these efforts, we've been able to advance care coordination, and we've been able to leverage federal dollars for Blueprint and SASH, care coordination programs, that otherwise would not be available, if not for OneCare Vermont's existence.

I also want to talk later on about many of the innovations in payment and healthcare delivery reform, direct to primary care, such as our comprehensive primary care program. That has more than tripled in numbers since 2018.

Next slide, Amy.

All of these operational and investments that I've talked about on a previous slide has really resulted in a deepening engagement into value-based care. You'll see throughout the presentation that we are returning to pre-pandemic levels of risk and reward, through all of our programs, to the sum of 36.5

million dollars that will be available as risk or could be a reward opportunity for the providers delivering the healthcare to Vermonters.

We have 1.4 billion dollars of eligible healthcare costs and value-based care arrangements anticipated. Remember this is always a forecast because we don't have final numbers from payers until the beginning of next year, collectively. We have maintained a solid statewide network of over 5,000 healthcare providers. That's over 170 distinct organizations that participate in OneCare Vermont and over eighty percent, using Green Mountain Care Board data, of eligible primary care in Vermont.

We've had significant growth in programs such as Medicare and the Comprehensive Payment Reform program over the years, even despite a changing landscape, and our Medicare Advantage. If you compare us nationally, in terms of overall cost in economies of scale, our admin rate is significantly below other ACOs, at about 1.1 percent of total cost of care, compared to the national average, which is about 2 percent. And you'll see a reference point for that number at the bottom of this slide.

Next slide, Amy.

For those of you who have not heard our

budget presentations in the past, OneCare Vermont, through a strategic planning process, really looked at what should our core capabilities be. I think a lot of individuals had different perceptions of what OneCare Vermont should or should not do. And we, as a board and a leadership team, made a decision on what those core capabilities would be.

And so all of our efforts and activities moving forward follow through our core capabilities that were developed as part of our strategic plan. So they're listed here -- network performance management, data and analytics, and payment reform.

Next slide, Amy.

I'm going to highlight, in each of the categories, the work and activities that OneCare Vermont and its network of participating healthcare providers had done over the past year, in these particular categories. Network performance -- when you think of network performance, what you should view in your mind is this is our contracting efforts to really assemble the full continuum of care providers and our population health model and investments.

And remember, our population health model, investments, and activities are carried out by the healthcare providers that take care of you every

day. So they're not done at OneCare Vermont. They're directly supported by the participating providers in OneCare, which are your healthcare providers.

In the care model space, which is our population health model, Dr. Wulfman will talk in detail about the good work that's been done, through leadership committees and our boards, to look at our population health governance structure and really restructure and revitalize that committee and boards, to maximize statewide voice on both ongoing programs, as well as overall strategy, so that people have the ability that are in our network to influence from the ground up.

This group of clinicians has worked really hard over the past year to look at our population health model and to say, how can we push that model to further deepen engagement and accountability in the efforts through OneCare? And at the same time, how do we simplify it, so it's easily understandable to the clinicians that are participating in the programs and to the patients that are being served by these clinicians and these extra activities?

In terms of our network contracting, we hold over 5,000 providers in our network. That's a statewide network, across multiple payers. We're a

very diverse network of provider. We have maintained -- and this shouldn't be understated -- a hundred percent retention of that network, going into 2023. We have fourteen hospitals, eighty-two percent of primary care, and continued growth in programs like Medicare and the comprehensive primary care reform program.

We've maintained about the same level, plus or minus, of attributed lives in the program since 2022 budget year. And this is really quite amazing, considering the changes in the payer landscape, that we've been able to maintain this network.

In terms of outcomes, Sara Barry, our COO, will go into more detail about what we're seeing in terms of benchmarking cross other like ACOs. It's not a -- shouldn't be a surprise that we're a very low-cost Medicare ACO, when compared to national cohorts.

In 2021, we continued to meet and beat the benchmarks that are set by the Medicare payer, in order to be able to send back shared savings direct to our network providers. None of this funding is kept within OneCare Vermont. It goes directly out to those providers delivering care and services, with 2.5 of that savings going direct to primary care practitioners

through our programs, of that 5.5. So just let me be clear. Primary care receives more than 2.5, but they're receiving 2.5 of the 5.5 million.

When looking at our clinical focus areas, we have exceeded most clinical measurements. And in the one area where we have not, we are working directly with healthcare providers who can influence these measures to look at opportunities for improvement.

Next slide, please.

Data and analytics is our next core capability. Our team have been working directly with our participants, our boards, and our committees to understand how we can make improvements in our reporting and our engagement with our network around data and analytics. I'm pleased to report, in terms of reporting and resources, in this year, we had developed a new suite of primary care quality and health disparity report cards for our statewide network.

We had instituted a benchmarking tool to identify strengths and opportunities for Medicare, specifically. And we are in the process of working with our sole member to transition our current analytics platform to an enhanced platform that would enable us, as a system, to be able to have more

standardized reports that are less labor-intensive, for the unique network that OneCare Vermont is.

In addition to reporting, we're also working actively with our network of providers to talk through how we can really work with them to point out areas of opportunity and how we can be supportive in giving them data and analytics, to be able to further improvement. This has resulted in what's called a health service area accountability reporting structure, where our teams work with local communities to point out insights and work with them on how to make improvements in that area.

We've had really nice engagement. Dr. Wulfman will talk about that later. And our hospitals, who, as a reminder, bear the preponderance of financial risk in these programs, have really engaged and are using additional tools and self-service analytics to be able to identify opportunities.

Next slide, Amy.

In terms of payment reform, fixed payment is always a big topic of ours. We have been working actively with the Department of Vermont Health Access or the state Medicaid department to bring about new fixed payments for both the ambulatory surgery center, as well as test sites for hospitals that will

commence later on in 2023.

As you know, as a signatory to the All-Payer Model, Medicare will not be advancing their model. At least, that's what they're highlighting to us. They will continue to reconcile to fee-for-services payment up until a new all-payer model may be reached, as late as 2025. We have been working actively and aggressively with payers. And based on the current negotiations, we do not anticipate that they will move forward in any sort of fixed payments next year.

Next slide, Amy.

Comprehensive Payment Reform program -- this is a program that was developed in 2018, primarily to support our independent primary care practitioners. We've moved from six sites -- that's not six tens, but six actual sites -- in 2018 to nineteen sites as of 2023. When verbally surveyed, the greatest satisfaction in this program has been with the stable fixed payments. They receive a predictable per-member per-month payment across all payers, plus an enhanced incentive for advanced primary care services such as mental health.

If you look at the data in aggregate in 2022, practices earned on average -- and this is an

average -- twenty-three percent more, as compared to if they were just to be in a fee-for-service system, enabling them to really enhance the services that they offer to their patients.

We've been working directly with these payment reform practices to say, how can we do better together? What are further enhancements that could be made in the program? And how do we look to truly evaluate whether or not people are better off because of this program? So that's ongoing work. I believe that you heard, through our primary care panel a couple weeks ago, the value that primary care providers feel that this program brings, and that this is true payment reform.

Next slide.

As I said earlier, primary care supports is really pivotal and front-and-center to the work that OneCare is doing with its provider partners. This chart here shows the actual -- so remember, at the beginning of the years, there was a potential, and then there's an actual -- population health management payments that are made out to our network annually; the percentage that goes to primary care, which, as you can see, is high overall because that has been our focus; and the number of organizations that are participating.

And remember, hospitals would be 110. So all hospital-employed physicians would come in as 110. So if those numbers look low to you, that's why, because this is on a tax ID number. That's 138 million dollars that has gone to primary care providers to support their work since 2018, that would not otherwise be available to them, absent an ACO construct.

Next slide.

I'm going to end here on our core capabilities and talk a little, although this slide doesn't do justice, the work that we've done over the years on diversity, equity, and inclusion. We started at our governance level, working with our boards and committees. At their recommendations and through surveys, we've created a committee that is focused solely on health equity and inclusion.

The group or the membership that's part of this committee is really focused on those who either have had lived experience or worked directly with individuals in underserved areas, so can help us to develop policies, procedures, and programs to address this work.

We actively engage our boards and committees in ongoing training, and we talk at least quarterly, if not more, to our boards about the work

and the plan that we are working in diversity, equity, and inclusion. We have been working with our internal staff to think about recruitment strategies, to be a more inclusive board and committee and workplace. And that of course will happen over time, but we have some good framework put into place for that.

We're working directly with our network to give them data to be able to see where their communities are, in terms of diversity, equity, and inclusion's social determinants of health, in their overall reporting and program design, and how things like food insecurity or housing or poverty might be impacting people's healthcare.

And last but certainly not least, working with our internal staff and employees to first understand where our opportunities lay as an organization in diversity, equity, and inclusion. And from there, we can build an ongoing plan and training around those opportunities to carry through.

That's the end of my presentation. I am going to turn it over to Tom Borys, who is our vice president of ACO finances, who is going to walk through the next section of the presentation. Thank you.

MR. BORYS: All right. Hi, everyone. My name's Tom Borys, vice president of finance for

OneCare Vermont. Thank you so much for the opportunity to present today the 2023 budget for OneCare Vermont. For a little bit of orientation, I structure this presentation into two components. The first will focus on ACO program terms -- things like attribution, total cost of care, and risk. And then we'll shift into more focus on the OneCare Vermont entity itself and its budget for 2023.

Just a reminder to everybody that this is the plan that we developed last summer, with best estimates in mind. The program terms, in particular, are still in active negotiation with the payers, making progress as we proceed towards the end of the calendar year here. And then, as Marisa mentioned earlier on in the presentation today -- that we will be coming back in the spring to share any differences that materialize that represent shifts between what we estimated last summer and what came to bear through these contract negotiations.

Slide, please.

All right. Jumping right in with our value-based care programs, the 2023 budget includes continuation of all the same programs offered in 2022 -- Medicare, Medicaid, and commercial arrangements. A couple quick notes on each -- for

Medicare, we are increasing the risk corridor to three percent. It was two percent in 2022. And we have incorporated the CMS forecast, as dictated by the Vermont All-Payer Model, as the trend rate for that particular program.

For Medicaid, similarly, increasing the risk corridor to three percent for the traditional cohort and two percent for the expanded. The difference between those two groups -- traditional attributes ordinarily through a primary care relationship, and the expanded is a geographic-style attribution model. I'll speak about this a little bit more as the presentation goes on. But we're collaborating on a fixed payment expansion initiative with DVHA, which I'm quite excited about.

And then, in the commercial arrangements, we are planning to increase risk sharing terms, similarly to the public payers. And the trend rates incorporated follow the improved insurance rates and provider increases kind of naturally occurring in the system.

Taking a look at attribution, budget estimates 297,000 lives incorporated. That's very similar to the level that we have in 2022 -- 268,000 expected to qualify for scale. Couple interesting

notes about attribution -- we are expecting a slight increase in Medicare attribution, due to the incorporation of the St. Johnsbury HSA, which is great news.

We do anticipate that Medicare Advantage growth will continue to somewhat offset attribution in this program, as Vermonters may choose to move to a Medicare Advantage product, rather than traditional Medicare. So there's some opposite or opposing forces going on in that particular program.

The most noteworthy item in Medicaid is that we expect redetermination to resume during 2023, where they evaluate who's eligible for Medicaid. This was on pause through the pandemic. What this means is that we expect to see higher than normal attribution attrition throughout the year. We don't think this will affect starting attribution. But throughout the year, we'll see more and more members taper off, as redetermination resumes.

All right. Shifting to total cost of care, we use the attribution estimates to prepare these total cost of care projections. 1.4 billion dollars of healthcare costs in value-based care contracts -- that's very similar to last year, largely because we've maintained the same provider network, same attribution

base, so staying the course.

We do expect -- well, all these target total cost of care estimates here stem from attribution estimates, insurance rate increases, and other payer reimbursement modifications. So we largely are following the industry trends to establish our best estimate of these targets. Ultimately, they're determined through actuarial processes with the payers.

The Medicare column on the left -- you can see that increase due to the addition of St. Johnsbury, as I mentioned previously, and then the ordinary inflationary trend in that program. And then the Medicaid total cost of care -- you'll see it actually is going down. That's an impact of redetermination.

Slide.

Little bit more on the program trend rates. Medicare -- it's a 5.2 percent trend, per the Medicare United States per capita cost forecast that is supplied by CMS every spring, as dictated by the All-Payer Model. Ultimately, that trend rate is at the discretion of the Green Mountain Care Board.

Medicaid -- we based our trend on analyses of prior-year trends, generated through the actuarial rate development process. We have the

benefit of operating this program for a number of years, so we can look back through some historical data, as well as emerging trends in healthcare, to inform the trend rate in this budget. And then commercial programs -- informed by the approved rate filings to develop those trends.

All right. Underneath these total cost of care arrangements, we have some exciting opportunity to do payment reform, where we can change the way providers are paid. Really not a lot of news in the offerings from the payers to OneCare in this provider network. Medicare will continue to be a reconcile to fee-for-service model. Medicaid is an unreconciled model, which is the structure we prefer. And then for commercial -- limited offering, but it is reconciled to fee-for-service.

We put significant energy into commercial fixed payment expansion for 2023. There's a number of limitations that prevented more significant advancement. And we really put a lot of weight behind expanding the offering for the Comprehensive Payment Reform, CPR, program practices, unsuccessfully.

On a more positive note, though, OneCare and Medicaid are in active development of a fixed payment expansion initiative. And one of the

challenges with doing payment reform underneath an ACO model is that the payment reform is limited or contained to the attributed population. There are always unattributed members or beneficiaries in these programs.

So we're working with DVHA to think about, how can we expand the scope of the fixed payment arrangement to not just look at the attributed population but look more broadly at the entire Medicaid population? The impact of this would be that any provider's Medicaid reimbursement would be more in the fixed payment arrangement and less in a fee-for-service arrangement.

And our initial focus is going to be on expanding the lives covered but not the service set underneath the fixed payment. The service set that are covered by the fixed payments is something that we can look at in a subsequent year. But we want to make this really important first step to expand the scope of the population covered by a fixed payment.

Next slide.

Okay. Risk and reward. So under ACO arrangements, there's potential for shared savings or shared losses, another term for risk and reward. The story here is resuming much more material and -- I'll

call it -- normal risk-sharing levels. Prior to the pandemic, you'll see on the left of the chart here forty-two million dollars of risk. This was our pre-COVID budget.

After the pandemic hit, we worked with the payers to modify contract terms to really protect the payers and the providers from high levels of risk in very uncertain times. We lived with risk around sixteen million for the past couple of years. And you'll see, in 2023, this budget escalates risk quite dramatically back to a more, as I said, normal level of risk. It's sizeable -- 36.5 million.

Next slide, please.

Our approach to accountability -- really, two elements to how we install accountability amongst the providers participating in OneCare Vermont. One is shared savings and loss I just spoke to a moment ago. The other is through the population health program accountabilities. This is really a macro and micro concept and trying to keep a common thread throughout.

Starting with the shared savings and loss -- largely remains with the hospitals, due to the magnitude of that thirty-six-million-dollar figure. It gives the hospitals opportunity to offset participation

fees. Hospitals fund OneCare Vermont, so this is an opportunity to get that investment back.

We pool savings and loss by HSA with HSA-level performance factors, as we've done in the past. And the accountability pool incorporates primary care into the risk model across the network -- all types of primary care, but at a moderated level that's more aligned with their revenue and the other population health management payments they receive from OneCare Vermont.

Moving to the micro side, we have a PHM program, which I'll speak to a little bit more in this presentation, that incorporates provider-specific performance-based components. And we heard loud and clear from our provider network that they want their measurements to be things that they can directly control and affect.

So having specific measures that give providers meeting or exceeding targets the opportunity to earn more, relative to their peers, is really the essence of value-based healthcare. Doing this also enables the financial accountability to align with the size of the investments, in that we're not overburdening primary care with risk of large payback at the end of the year or a very sizeable payment even.

Next slide, please.

A couple risk management notes for the board. The accountability pool components are expected to apply universally. In the past couple of years, we've only had provider risk for the Medicare and Medicaid programs. And so we expand provider risk more broadly to all program offerings. The accountability pool will go with it. We still offer the deferral option for providers electing that particular pathway.

We are offering a risk mitigation arrangement for NVRH and the St. Johnsbury HSA, as they enter the Medicare program for the first time. We've done this many times, as we've grown the OneCare network. So we are limiting the St. Johnsbury HSA to one-percent Medicare risk corridor. And OneCare Vermont is the counterparty to this arrangement, meaning that any losses beyond one percent are owed by OneCare Vermont, and any savings beyond one percent are payable to OneCare. If we did have to pay on behalf of St. Johnsbury, OneCare reserves will be used to fund that obligation.

Next, we've made a couple unique accommodations to grow the CPR program. It's been a successful endeavor, and we want to make sure we can get as much participation as we can. We have not

budgeted a reinsurance or reinsurance-like arrangement for 2023. And the Medicare financial guarantee of one percent, we plan to facilitate through the same line-of-credit arrangement we've used in the past.

All right. That section was a high-level overview of just some of the ACO program terms. Now we're shifting into OneCare Vermont as an entity. This is my perception of OneCare, a 45.1-million-dollar organization with two main components -- 29.9 million in population health management investments. These are payments facilitated by OneCare directly to the providers, to support our shared goals of high-quality healthcare and managed healthcare costs.

And then 15.2 million dollar in OneCare shared infrastructure. We call it shared infrastructure because we are welcoming to all participants and providers who would like to be a part of these value-based care programs.

Couple of notes. It's a balanced budget -- no profit or loss, and no additional contribution to OneCare Reserves, Incorporated. And the two key elements that I'll speak to in a few moments -- transition to the new population health management program financial model and work

reconfiguration. We've reduced office space, to align with our primarily remote work model, and redesigned analytics support.

Looking at revenue notes, I'm pleased to say there's not a lot here, which is a good sign, if you ask me. Budget includes consistent reform investments through payer contracts. Often, there's a PMPM per attributed life paid to OneCare that we can then use to invest in the providers or provide incentives. The revenue levels float with attribution, but we expect the models in place in 2022 to largely remain the same and just flow into 2023.

A little bit of nuance to the next one -- there's a potential incorporation of a two-million-dollar Medicaid value-based incentive funding pool. In 2022, Medicaid is making available to providers two million dollars for the value-based incentive fund, but it's paid directly from Medicaid to the providers. In other words, it does not flow through OneCare's business entity.

When this budget was being developed, we weren't certain whether that model would stay in place or if the funds would actually begin to flow through OneCare, so that we can align payments more seamlessly to the providers. What we chose to do here is

incorporate a two-million-dollar unsecured revenue line. And that means we could then show, on the expense side, the full boat of population health management payments that we intend to provide to the providers.

A potential that exists is that Medicaid will retain that two-million-dollar pool and pay those providers directly. If that were to occur, we would simply remove the two-million-dollar unsecured revenue line, and in a corresponding and balanced way, remove two million dollars of population health management expense, as that will be paid directly by Medicare and outside of OneCare Vermont.

Either case is net neutral to the OneCare bottom line. It just reflects the way in which the funds will flow.

And then the last bullet here, a 205,000 or one-percent increase in hospital participation fees -- again, the hospitals fund OneCare Vermont, so we're always very mindful of the impact that the OneCare budget has on those hospitals.

Here's the numbers for the revenue. You can see the payer program support going up by 1.6 million. Part of that is the two million dollars in unsecured revenue. So if those funds do not flow

through OneCare, we'd simply back that two million out. You can see next the shared savings to fund the Blueprint. The 472,000-dollar change reflects the inflationary impact, applying that 5.2 percent to the advanced shared savings line in our budget.

And then the other notable number, other revenues -- you'll see a pretty sharp decrease of 1.4 million. This reflects use of deferred funds, largely in 2022, that we don't expect to use again in 2023. The pool of deferred funding grew through the pandemic, as priorities shifted. And in 2022's business, we've committed to pushing a lot of those funds out to the providers.

All right. Shifting to the expense side, I've broken this down into two components, as well, the first being population health management. The big change that we had to incorporate in this year's budget was the evolution of the new population health management program. It was designed to be a consolidation, where we took the historical 3.25 PMPMs paid to primary care, care coordination funding, and value-based incentive funding into the new model.

When we did this, we really put a lot of emphasis on sustaining base payments to providers right now. That was important to keep some consistency and

regular cash flow to the participating organizations. And then we also wanted to incorporate, universally, bonus potential based on quality and outcome. So this is where any individual provider can earn this bonus payment, based on achieving pre-set benchmarks.

This also gives us the ability to enhance accountability in future years. There's a proportion of base payments to bonus payments. That's a split that we can move over time, to put more emphasis and focus on achieving those quality and cost outcomes that we'd all like to see.

Continuing with the CPR program, five-dollar PMPM incorporated, we've done some work with the CPR clinical advisory group to establish clear accountabilities. I'll speak more about CPR in a few moments. And then Blueprint -- as I mentioned before, budgeted at the All-Payer Model trend of 5.2 percent. And this decision ultimately lies with the Green Mountain Care Board.

So to speak to the population health management program in a little bit more detail, this first slide focuses on the primary care component. And in a moment, I'll speak about the designated agencies, home health, and AAAs. We break these two apart because of attribution. Primary care attributes

providers directly, so we can do PMPM payments, whereas the other provider types don't attribute in the traditional sense, so we have slightly different arrangements to fit their structure.

So you can see, in the base payment section of the chart in the middle of the page, combining the historical 3.25 PMPM and the $1.50 PMPM for care coordination into a single blended PHM base payment of 4.75. So designed to be net neutral and even for the providers.

Then, for the bonus opportunity component, we looked at historical care coordination bonus earnings and VBIF earnings -- again, both for primary care -- and we rounded it up to a nice clean number of one-dollar PMPM for the bonus. One of the reasons we could round up, without increasing hospital dues, for example, or participation fees, is that not every participant will maximize that one-dollar PMPM of bonus. We estimated that about eighty percent will earn the bonus payment. But we're going to learn a lot during 2023 about the rate that these providers meet those targets.

Next slide.

So focusing on the DAs, area agencies on aging, and home health agencies, same concept,

really -- consolidating prior care coordination and value-based incentive payments into one stream. In alignment with the primary care model, eighty-five percent of the pool will be paid as base, fifteen percent as bonus opportunity. That's the same proportion that exists in 2022 and largely the same measures as 2022, so that there's consistency throughout these years.

A little less finalized at this point, but before the budget was submitted, DVHA expressed interest in the mental health and substance use disorder areas. And we agreed to put a 500,000-dollar expense component for this important topic. We're still working on the specific nature of the initiative, but happy that we have some funds in the budget to invest in this area.

All right. CPR program. CPR program is the Comprehensive Payment Reform program. This is a payer blended, fixed payment model that OneCare can offer to independent primary care. We've been offering this program since 2018. And as Vicki said earlier in the presentation, it's grown substantially, and we now have nineteen sites participating in 2023.

The change that we've incorporated this year is to link primary care reimbursement through the

CPR program to the total cost of care. The purpose of this is to have primary care reimbursement more closely tied with macro-level healthcare cost growth trends. What we've seen in the past is that healthcare costs, at the top level, continue to go up, and primary care reimbursement has not kept pace.

So this is an opportunity to maintain a linkage so that, if the total cost of care grows substantially or even modestly over time, primary care reimbursement will follow along, so that they are receiving a similar portion of the pie that you see on the right. This also helps us establish a baseline. We can really evaluate where are we now, relative to the total cost of care in Vermont, as a starting point, and then build towards a level that we find is appropriate, into the future.

There are a couple challenges with this arrangement, as well, that would be important to share. First, the total cost of care is variable. So we're making primary care reimbursement linked to the total cost of care, and we do not know what next year's level will be, or the year after. So there's a level of this uncertainty that comes with that.

And then, second is that the percentage of total cost of care for primary care works cleanly

when you're looking at it through one payer. And you can look at Medicaid, for example, and say, in Medicaid, primary care receives X percent of the total cost of care. And you can do the same in Medicare and the same in commercial.

Where it gets challenging, though, is when you start to blend across payer lines. And this is a payer blended model, where there's a singular fixed payment across all their population. So we've had to put a lot of thought into how to make this fair and balanced for any provider, regardless of their payer mix -- so if they're a Medicare-heavy practice or a pediatric practice, for example, that the arrangement that we built works fairly for all different types.

Accountabilities -- we're still working on the details, but we're getting quite close. But our vision is that providers can reach different tiers of reimbursement, based on actions and outcomes. While not finalized, we think that some sort of a mental health integration into primary care is likely to be a component of this that would allow a practice to reach a different tier or strata of reimbursement. And then, importantly, participation in ongoing program evaluation -- putting a lot of emphasis here is an important element, as well.

Opportunities for this program to continue to grow and be successful -- expand payer participation with unreconciled fixed payments. I mentioned earlier around some challenges in that space. Expansion to other types of primary care -- we have done a lot of work on potentially applying this to FQHCs, and we're actively looking at whether this could be installed over hospital-employed primary care sites. It's a little bit challenging in that space because of the way the billing works, but I do think that there is some opportunity to do that.

Continued refinement of accountabilities will be important as we move forward and then, again, program evaluation an important element.

Next two slides are largely just for reference here. We take the just shy of thirty million dollars in population health management investments and break them down into two different ways. This first slide looks at the investment area or program, if you will. So you can see the top two rows -- the population health management program base payments and then the population health management program bonus payments.

And if we shift to the next slide, same numbers, except it's broken down by provider type, so

you can see which organizational type is receiving these funds and through which programs.

All right. Another transition point, shifting off of the population health management expenses and onto the operations. This is really the OneCare Vermont entity that makes all of this possible. The two notable changes that I referenced earlier was redesign of analytics support. This is in partnership with the UVM Health Network, to make sure we have a high-quality and efficient analytics engine to support this work.

It's a phased approach. And what we've done is designed this to be net neutral to OneCare Vermont in 2023, so it neither costs more nor less to us. But we will evaluate continuously, as this transition rolls out. And for the 2024 budget, hopefully, we start to see some of the efficiencies or economies of scale that we can gain through this transition.

Next, work reconfiguration -- we've reduced our office space to reflect a primarily remote work configuration. Took us a little bit to get there through the pandemic, but we committed to this new structure and reduced our footprint accordingly.

And then other expenses have been

reduced to align with this remote work model. Through the pandemic, we weren't sure if we'd come back to being in person largely or remain remote. But now we're more committed to this remote model and have made adjustments accordingly.

To show the numbers, 248,000-dollar expense reduction for OneCare Vermont, about 1.6 percent. You'll see, in the table above, many categorical shifts. This is largely from the restructuring of analytics support with the UVM Health Network.

For example, you see salaries, payroll, and fringe going down. But that's offset by an increase in the purchased service. It's replaced, dollar for dollar, with a services contract from the UVM Health Network. So a lot of juggling between the different buckets, but most of it is related to this analytics transition.

Not a discrete row in the table above, but reducing our office space saved 373,000 in rent and utilities. The chart on the left shows operating cost over time. You can see pretty aggressive growth between 2018, '19, and the 2020 pre-COVID budget. This is when OneCare was exploding with growth.

We reduced quite drastically after the

pandemic hit, right around this fifteen-million-dollar level, and have maintained this level largely to avoid having more costs borne by the hospitals. There's always more we can do at OneCare, but again, being thoughtful of the cost placed on Vermont hospitals.

A couple quick notes on staffing. The most significant change is on the rightmost bars of the table here. It's a value-based care category. This combines some historical groupings that we showed in the past. Analytics, prevention, care coordination, and quality are now kind of merging under one org on our org chart.

The reduction to that area reflects the analytics transition -- those staffing moving from OneCare Vermont to the UVM Health Network. Outside of that change, there really aren't a lot of other substantive changes. There's a couple of shifts that -- they're more organic. Somebody's role has evolved a little bit or moving to a different department. But not a lot of change overall to the staffing model within OneCare Vermont.

I like to show this one every year, too. This is the OneCare operating cost as a percentage of the total cost of care. Continues to decline. This to me just shows the economies of scale that are achieved

through this singular model, where we can just bring more providers in, more attributed lives, onto the same platform and chassis of expense.

Next slide.

Very simple income statement for OneCare Vermont here. You can see on the revenue side, if you will, the total cost of care targets -- 1.4 billion. It's not OneCare revenue. Those are existing healthcare dollars that are now in a value-based care arrangement. Next, payer contract revenue -- about twelve million. Other revenue is 3.6. And hospital participation fees of 19.8.

On the expense side, you have the health services -- 1.4 billion again. Note the difference between that number and the number under the total cost of care targets is the Blueprint advance shared savings component. Population health management investments -- 29.9 million. And then operating costs of 15.2. And a gain or a loss of zero dollars.

The pie on the right shows that, in this budget, 96.9 percent existing healthcare dollars paid either directly to providers or through a fixed payment, so no real change in the industry or system in that part. But then supplemented by 2.1 percent in population health management investments and then 1

percent in the OneCare operation itself.

Last slide for me. I know it's tiny. Apologize. But wanted to put in a more robust income statement and balance sheet and just use this as a backdrop to say there are lots of Excel files on the Green Mountain Care Board website for the public to review, in many different perspectives, in depth. So I invite everybody to go there and take a deeper look, if you're interested and curious.

And that concludes my section, so on to Carrie.

MR. FOSTER: Let me just interrupt real quick. Thank you. And I think the pace picked up a little bit, but just watching the time, it's been about fifty minutes. And if we need to go a little bit into lunch and spill over past an hour, we can. But we've been at it about fifty minutes so far. Thank you.

DR. WULFMAN: Hi. Good morning. I'm going to make comments on budget section 7, ACO quality, population health, model of care, and community integration.

Next slide, please.

Last year, we committed to the goals that you see here, many of which have already been mentioned by Vicki or Tom, so I won't read through

them. We'll talk about them in the next few slides.

Let's go ahead, please.

So as we committed last year, we developed a new committee structure this year. And it aligns with our three core capabilities that we identified in our 2021 strategic plan -- and just to restate those -- network performance management, data and analytics, and payment reform. If you see the row with the three turquoise boxes here, those represent these three core capabilities.

And then, moving on down in this diagram, we show you the work groups that we have developed. We wanted more input from our provider network in foundational creative and tactical thought processing, so we invited them to participate in these work groups that you see here. And we got a lot of work done by doing this. We gained a lot of input across our network, as well. We have ACO-wide participation and engagement over the year, with ongoing attention to diversity and inclusion across all groups.

Subcommittees and work groups have charters, and all but a couple of these groups that you saw on the last slide -- yes, go ahead, please -- have met at least once this year. And as a result, we've

made rapid progress on important developments and decisions, such as this list here -- quality measure selection, disparities scorecard development, clinical prevention topics, care coordination activities, and CPR developments, which you just heard about from Tom.

We strive to be all-inclusive in membership, and this includes seeking participation from our patient and family advisory council, which meets once a month. And members from that council are invited to participate in all of these groups. We now are seeing interest from a variety of organizational members, who have actually been asking us if they can participate in one of these groups.

Next slide.

We are committed to continuously increasing our engagement and relationships with our network. This year, we wanted a fresh approach and reformatted our health service area consultations. And Vicki told you something about that already. The new template that we developed aims to deliver both data and insights for direction and then also to invite dialogue about key findings, in an effort to stimulate and support action.

These sessions have increased attendance and conversation and are followed by coaching and

support at the local HSA population health level, with the teams there, to work on quality improvement projects, which are identified throughout this process. And we develop a mutual plan and have touchpoint sessions with the HSAs at the local level, on a regular basis.

HSA teams have been and will continue to be invited to our board of managers meetings, to show off their work and get feedback. The Bennington HSA and also an independent primary care team presented this year so far, in the public sessions of two different board meetings. This helps foster transparency, awareness, and engagement.

Next slide.

As you already heard, we are advancing our population health model framework, moving from an individual PHM program type of structure, with some accountabilities, into a blended model with advancing accountabilities throughout '23 to '25.

Next slide, please.

This new model drives us forward into evolving value-based payments and requiring care coordination and collaboration across the HSA care continuum to unlock funds, and it also pushes quality improvement. This program will gradually shift away

from base payments and towards increasing accountability-related payments. We purposefully chose metrics for '23 that are claims-based rather than manual abstraction metrics, and therefore can include the entire attributed population.

Next slide.

Our 2021 quality results show that we are doing well in diabetes control, reaching or maintaining the ninetieth percentile for that metric across all payers. We also show strengths in follow-up after ED discharge for both mental health, as well as alcohol and other drug dependence. And also, we show strengths on an ongoing basis in the area of child and adolescent well care.

We have opportunities in areas of hypertension control, depression screening and follow-up, and the initiation and engagement of alcohol and other drug dependence treatment. We are using these results to set goals for our 2023 PHM and to continue to raise the bar on value.

We promote a mindset that care coordination and prevention are common threads throughout our network's clinical work, and they impact our success in all areas. Care Navigator, a software platform used to document shared care plans, will

sunset at the end of 2022 and no longer be required for documentation by our members.

We continue now -- and will for 2023 -- to support and hold our members accountable for care managing high- and very high-risk patients and patients in areas of focus, such as high social and medical risk, high ED and inpatient utilizers, and those with high total cost of care. We are requiring our members to have triannual reporting for care coordination and to review with our oversight team what they are doing, at regular intervals.

We did a survey in 2021 of those patients across our network who were care-managed and got positive responses about the care coordination they received. They were pleased with their engagement in their shared care plans, with communication, and with having lead coordinators.

We are incentivizing HSA-wide care coordination teamwork via our 2023 population health model, as you already heard. The population health model also incentivizes prevention by setting quality targets for preventive visits, timely follow-up and control of chronic disease, and health screenings, as well.

Our data and analytics team has

developed and is deploying a health disparities scorecard, using data-driven gap analysis that shows great promise for supporting local communities and focusing on the intersections between medical risk, healthcare access, and social determinants of health. So that is in an iterative state, and we're very excited about how that's going to aid us, going forward.

Next slide, please.

This diagram we just developed to depict how all of the work that I just described is interrelated and brings us closer to our primary outcome goals of improved population health and lower healthcare cost. Each gear wheel shown keeps the other turning, and it takes the various cogs to make it all work together. As all partners in the care continuum implement change at different points of care, we can move towards our goals.

We believe that our organization remains a valuable catalyst in helping transform the healthcare delivery system in Vermont. Thank you. And I will pass it over to Sara, our COO, to talk about evaluation and performance benchmarking.

MS. BARRY: Good morning.

And thank you, Dr. Wulfman.

So I'll be quite brief and just want to start by noting that the Green Mountain Care Board has invited OneCare and payers involved in ACO activities to a session later in November, to review and discuss in detail our quality and financial performance. So we've not repeated that information here.

If you could advance the slide, please.

So briefly, I wanted to highlight some of the evaluation activities that we are focusing on this year, some of the initial results and findings that we're seeing, and then I'll end by speaking about some of the areas that we need to focus on in the year to come.

So at a high level, you've heard a theme throughout this presentation of evolving our population health model. And that really began with some key inputs, as Dr. Wulfman mentioned, looking at our quality opportunities but also our care coordination program, and some of the findings that we were seeing and some of the challenges that people were telling us about, from our network. So we used those as a platform to really think about how to evolve that program and ultimately to inform the selection of the specific quality metrics that will be incentivized for payment in the year to come.

In addition, at the beginning of 2022, we embarked on two large endeavors. The first was a contract that we initiated with the University of Vermont Health Services Research team, to help us scan the literature and identify evidence-based measures out there that we could consider as an ACO, to inform a set of key performance indicators across a variety of domains, including cost and utilization, looking at outcomes, engagement, et cetera.

And that process has resulted in a set of measures that will be going through OneCare's governance committees later in December. And ultimately, our goal is to align them with the Medicare benchmarking analysis that I'll speak of in just a moment.

The second thing that we asked for assistance with from this Health Services Research team was, again, scanning the national environment and helping us to identify whether there was a provider satisfaction survey that could help us understand the expectations and performance of OneCare, from the lens of our network participants.

And through that process, unfortunately, there was not a known instrument that could be identified that would address some of those key

questions, and so the UVM HSR team actually developed an instrument. It focused on really understanding the perceived usefulness and ease of use of some of the tools and supports that OneCare provides to our network, as well as providers' knowledge and understanding about OneCare and overall healthcare reform and their experiences thus far.

Because this was a new instrument, it was determined that the appropriate next step was actually to pilot it with a small group. And so over the last couple of months, we've deployed that survey to primary care providers in a sample, and we have responses now across the state, from our fourteen health service areas, with just about eighty primary care providers. And I'll speak in a moment to a couple of the early indications that are coming out from that survey.

And then, in response to the Green Mountain Care Board's budget order to OneCare for 2022, OneCare embarked on finding a vendor and working very diligently to create a Medicare benchmarking analysis platform that would really bring together key cost utilization and quality metrics. And in doing so, the vendor pulled a hundred percent of the Medicare population fee-for-service national data set that

initially included over 500 ACOs.

They developed an algorithm to identify a peer group of ACOs on a set of robust criteria that meant that we were comparing apples to apples, so things like ACOs that were in two-sided risk programs for the Medicare program. And the result from that is a cohort of about twenty ACOs nationally that OneCare can be benchmarked against, to understand current performance, both strengths and opportunities.

It is important to note that, in using that data set, there was a tremendous amount of work that needed to be done to risk-adjust and adjust the unit cost and normalize that data, so that it actually makes sense and can be applied in the State of Vermont and in our context.

And then, finally, I won't go into detail now, but it's been noted that, within our CPR program, some qualitative evaluation work has begun. And more quantitative work is planned in the months to come.

Next slide, please.

So this could go on for hours, both in terms of strengths and opportunities. But I pulled just a couple of key highlights that I think are worth noting, from some of the efforts I just mentioned. And

to start at the top, with the new Medicare benchmarking analysis, we have been able to see consistently that OneCare is lower cost than other peer ACOs nationally. And while that varies a little bit from year to year, from the years 2019 to 2021, it ranges from nine- to fourteen-percent lower cost overall.

Similarly, preference-sensitive conditions -- these are things like somebody choosing to have a knee or hip replacement, spinal fusion, or a coronary artery bypass graft. Those are often choices driven by consumer preference. And OneCare, as a statewide ACO, demonstrates results that generally are twenty to eighty percent lower than the national ACO peer cohort. That's not to say that there aren't opportunities for improvement, and I'll get to those in just a moment.

In the pilot survey data that I was discussing a moment ago, one of the interesting early findings is that, from independent primary care providers responding, they indicated that they understood how OneCare supports critical aspects of the work that they're conducting with their patients; that their work would be more difficult without OneCare and its support; and that, ultimately, the quality of care they're delivering has improved through their

participation in OneCare.

It is interesting for us to note that it stands out that that comes from the voice of independent primary care providers, who are most likely more aligned with our CPR program and some of the advancements there, and that there is some work to be done to help our colleagues in other primary care sectors to continue to understand and advance some of the value proposition that then, through OneCare, they're able to deliver to their patients.

And finally, through CPR, again, flexibility, predictability, and enhanced payments are themes that we heard through that qualitative evaluation.

With respect to opportunities, again, reverting back to the benchmarking data, we saw some pretty significantly higher use of the emergency department than other national peer ACOs. And we also saw opportunities to continue to maximize the role of primary care; that some of those services were lower utilized than in other parts of the country and in other similar ACOs.

Similarly, there's some pretty complex data emerging around post-acute care transitions, where we're seeing some higher lengths of stays, some higher

costs, and higher admissions. But interestingly, we're also seeing lower use of inpatient rehab, better use of home health.

And so there are some exploratory conversations going on around whether, in Vermont, perhaps there is a better use of appropriate care settings, based on patient need and desire. So more work to be done to really evaluate and understand that data further and to continue to work on transitions of care, particularly from inpatient to outpatient settings.

And then, finally, in the context of that survey, advancing provider education to improve general understanding and ultimately to reduce some of the complexity that is involved in Vermont's healthcare reform efforts and in advancing some of the payments and care delivery transformations.

Next slide, please.

So finally, these are really early days, when it comes to some of the evaluation and data and findings. And so there's much more work for OneCare and the team to expand upon, as we move into 2023. Some of the areas are highlighted here, and I spoke to them a moment ago.

And it encompasses lining our key

performance indicators with those benchmarking reports and pushing that information out deeply into our network, so that they understand performance opportunities and have systems and supports to help facilitate improvements in those areas; continuing to advance our provider survey, our CPR evaluation; and as Vicki said at the top of this session, to really use all of the data that we are finding here to inform our strategic plan refresh in the next quarter of 2023.

And all of this work will be supported through the one new hire that we've planned as a program evaluator, that we are hoping to move forward with early in 2023.

So with that brief overview of some of our evaluation activities, I'll now turn it back to Vicki to provide some final remarks.

MS. LONER: And thanks, Sara.

I'll just close by wrapping up and saying our 2023 budget, at the start of the hour, was really to focus on our mission as an ACO, and with a keen laser focus on what our board and our leadership has determined to be our core capabilities. And those are the things that OneCare can really execute on, in terms of the contracting, the data and analytics, and the payment reform mechanisms.

And we, with our provider partners, who are the ones who can really do the delivery system reform aspects -- we can install the payment reforms -- our participating providers are the ones that can really impact the care delivery part -- really are working together as a system, to support patients with the best care, the right time, the right place. Thank you.

MR. FOSTER: Thank you, all. And really wonderful graphics on your slides.

I'll turn it over now to our staff and Ms. Melamed, for their staff questions. Thank you.

MS. MELAMED: Thank you, Mr. Chair.

And thank you to the OneCare team for the presentation. I'm going to kick it off with some questions from the staff. So our first question is around OneCare's risk model. It's going to be in reference to slide 20, and you're talking about the 36.5 million dollars' worth of risk.

So in OneCare's model, the longstanding risk model has been to delegate the risk out to the provider organization. And this we view as the ACO, as an entity, is taking only the -- OneCare as an entity is taking on only minimal risk. So you mentioned some risk mitigation for some hospitals, I think at about

800,000 dollars or something this year. It's varied over the years.

OneCare is making the choice to delegate all the risk and pass on all the settlement to its participant hospitals. Does OneCare continue to believe that delegating all the risk to hospitals is the best strategy? And then please explain why -- just as opposed to holding more of it as an entity.

MR. BORYS: I could answer that. Marisa, you characterized it correctly that we do delegate or pass through the risk to providers. Every once in a while, we discuss or talk about whether or not it would make sense for OneCare to hold more risk. But ultimately, it's the healthcare providers that are the ones that will help generate these savings.

I mean, OneCare tries to install the framework, use data effectively, implement payment reforms to help them in that endeavor. But at the end of the day, it's their hard work delivering the healthcare that should be rewarded. And that tends to be the concept or theme that takes the most hold to it.

It also adds some stability for us, in that we have the hospital participation fee model, where OneCare's effectively funded, and there's no kind of organizational risk that we wouldn't earn shared

savings in a year and all of a sudden find OneCare as a business entity in a tough financial predicament.

MS. MELAMED: Okay, thank you. I have a couple questions now on the payer contracts and network. Can you provide any insight as to why Mt. Ascutney left the Blue Cross Blue Shield Vermont program for '23?

MS. BARRY: I can take that question. This is Sara Barry. My understanding is that there are several exceptions that the board approved, related to complete participation in programs. And by and large, the reason had to do with electronic health record conversions or other large operational changes that were happening within the hospital system, that were making it difficult for them to continue to accurately identify specific cohorts and take increasing risk.

And so in each conversation that the board had in managing those requests, they considered kind of for how long this request might go on and were there indications that there would be an endpoint in sight. And the intention is that there is, although it varies from one organization to the next.

MS. MELAMED: Okay, thank you. The Green Mountain Care Board requires actuarial certifications to be submitted by OneCare for each

commercial benchmark, stating that the benchmark is adequate but not excessive. Actuarial certifications are required because the financial targets for commercial ACO programs are typically not finalized until after the board issues the budget order.

In prior years, the Green Mountain Care Board approved budgets reflecting yet to be negotiated commercial targets, provided targets met certain requirements, including that the targets be certified by an actuary as adequate but not excessive. We understand from your responses that OneCare's position is that it is not the proper entity to supply this certification.

The OneCare FY '23 budget includes a return to more traditional risk sharing models for commercial programs, as you stated, so adequate target setting methodology is even more relevant. So my question about these certifications is, what data does the consulting actuary receive? And explain why it is or is not sufficient to provide an actuarial certification, from your perspective.

MR. BORYS: That varies by payer program. Some payers offer us modeling data sets that we can use, and we rely upon our consulting actuaries to evaluate the sufficiency of the target, using the

modeling data.

In other cases -- most cases -- we actually don't receive that modeling data set. So what our actuaries opine on is the model itself -- is there bias, is there anything that is unfair to either party, frankly, in it. And at the end of the day, if the target is set by a payer, they typically have -- well, often, if not always, have vastly more data than we do.

So it's always a little bit of a leap of faith when OneCare enters into an arrangement. But we do it very thoroughly and deliberately with the actuaries, to ensure that we think the target is fairly set.

MS. MELAMED: And has the ACO reviewed this budget order requirement and gone to this actuarial review with the commercial insurers? Like, have you shared what your process is with them and discussed this requirement with them?

MR. BORYS: Yeah. I mean, they've supplied certifications for us in the past. It's always a tricky conversation with our actuaries because, again, they don't have the data. So a little bit difficult for them to certify, specifically, the target.

But they do certify the model itself --

do they think that the target will be excessive -- and then they also look at the nature of the risk arrangement, to determine whether or not there's any risk on the solvency of OneCare Vermont.

MS. MELAMED: Okay, thank you. I'm going to move onto a couple of questions about the analytic transition and the relationship with the University of Vermont Health Network. My first question is probably in reference to slide 34 from your presentation. But the question is, can you tell us what the total value of OneCare's contract with UVM for analytic services is?

MS. BARRY: We cannot release that in the public, but we're happy to share it privately with the Green Mountain Care Board and Health Care Advocate.

MS. MELAMED: Okay, thank you. Because we were trying to track the transition, and from the income statement, there's a two-million-dollar change in contracted purchased services. But the decrease in software line is about 800k. So I'm sure there's -- these don't line up, and it's unclear to us what the total value of that is.

MS. LONER: We can say it generally.

MS. MELAMED: And you stated that there's --

MS. LONER: I was going to say, Marisa, we can say generally to you, because this was something that our board of managers required as part of this transition, that it is budget neutral for OneCare Vermont and is not representing a cost increase, to be able to transition to this system, which is very impressive, considering we're having to operate two dual systems right now, as we transition to a new software.

MS. MELAMED: Okay.

MS. LONER: But any other detail --

MS. MELAMED: Perfect. Yeah, that was my follow-up question -- if there were added costs, and it sounds like the answer is --

MS. LONER: There are not added costs.

MS. MELAMED: -- it's during a transition period, and it's -- okay. So we just might need some help tracking how the line items moved from one line to the next and then the total value of that contract, when it's available.

So the second part of the question then is, the Green Mountain Care Board has requested a copy of the agreement with the University of Vermont Health Network to provide these services within five business days, if executed. Has this contract been executed

yet, and when do you expect to provide it to the board?

MS. BARRY: Thank you for the question. Yes, the contracts have been executed, and I am waiting for redacted versions to come out of our legal office, which should be any day. And we will get those to you immediately.

MS. MELAMED: Okay, thank you. Then another follow-up on this, around the responses to the written questions. So you described some of the data security measures that OneCare and the University of Vermont Health Network will take, as OneCare data and analytics move to the University of Vermont Health Network.

We had an additional question, if you could please further discuss how OneCare and the Network will prevent any anticompetitive conduct and handle any conflicts of interest that could arise from UVM managing data from providers that compete with UVM and payers competing with UVM and the MVP Medicare Advantage plan.

MS. BARRY: Sure. I can take that at a high level. And then, once we've shared the contract, if there are additional questions that arise from some of those details, we'd be happy to answer those, as well. Globally, as we've structured this agreement,

OneCare is responsible to our payers, to our network, through our data use agreements, to ensure the appropriate segmentation and use of any data.

And through that, OneCare has established a set of policies that span compliance, data use, privacy, et cetera. So all of OneCare's policies will continue to control the arrangement with the UVM Health Network as a vendor supporting these activities. OneCare staff -- so someone remaining on the OneCare team -- will vet all of those data requests, ensure that they are compliant with those terms, and then move a data request forward through the system, to actually have it operationalized.

In terms of data storage and protection, we have required the UVM Health Network to establish some additional policies and procedures. Those are -- some of them -- still in process right now. But again, we would be happy to share those appropriately as soon as they're available. And those are things that are, for example, maintaining user accessing the system. So user permission(ing) systems where OneCare has control of who has that access and what level that access will be determined at.

Partitioning data. The staff that are transitioning from OneCare to the data management

office at the UVM Health Network will work solely on OneCare data, so they will not be conflicted in the sense that they might be asked to perform analyses for the UVM Health Network and their business plans while also being asked to participate in OneCare analyses. Those things will be completely segmented. If there are additional questions, again, I'm happy to attempt to answer them now, and we will follow up with more detail.

MS. LONER: Sara, the only thing I'd add --

MS. MELAMED: Thank you. That's -- oh. Sorry. Go -- go ahead.

MS. LONER: So Sara, the only thing I'd add to that -- and for Marisa to know -- is that we've outlined at a high level the governance policies and procedures and processes overall that are being used to protect data, and that has been provided to our network at large, as well as the healthcare advocates and other interested parties. So that is a publicly available document right now.

MS. MELAMED: It's available on your website or -- how is it publicly available?

MS. LONER: It's available on our portal for all of our participants right now. And we've made

it available upon request to any other entity and anticipated those that might be interested.

MS. MELAMED: Okay. Thank you. That is helpful. I'm going to move on to some questions around staffing and compensation. The budget guidance asked for the amounts of both projected base pay and projected variable compensation for OneCare management positions in 2022. So projected 20- -- 2022 compensation. OneCare only provided one amount for each position. That's in tab 6.7 of the Budget Guidance Workbook. Are these amounts base pay or base pay plus variable compensation?

MR. BORYS: They would be both. And if you'd like that segmentation, we'd happily supply it.

MS. MELAMED: Okay. Yes, please. So if -- so if there are assumptions in those projections around variable compensation, what are those -- I assume that that isn't final. What are those assumptions based on?

MR. BORYS: Based on past performance or earning potential under the goal structure that we have for our leaders.

MS. MELAMED: So from the 2022 to 2023 budget, total FTEs decreased overall by more than ten, which you showed on your slide thirty-five. And total

salaries and benefits decreased from 9.4 million to 8.7 million. It's a seven percent decrease or 664,000 dollars, approximately. However, executive leadership compensation appears to increase by twenty to thirty percent between the FY '22 submitted budget and the FY '22 projections that are included in this year's submission. So we compared what you submitted on tab 6.7 for last year to the same tab for this year. And if you could please explain this differential -- we don't see it, in the variance analysis -- any explanation of the change in salaries.

MR. BORYS: I'd have to see the data in a little bit more depth. But my initial instinct is that it probably has some sort of an impact related to when certain leaders were onboarded into OneCare, and last year's projection may have had partial years for some who were not on the team for the entire year. But I'm happy to look at that as well.

MS. MELAMED: Okay. I'll send over the comparison, and we can talk it through. Does OneCare have a policy that formally outlines how variable compensation is applied to a policy that's been formally adopted through your committees and board?

MS. LONER: So we're -- our comp -- Marisa, this is Vicki Loner, for the record -- that all

OneCare employees are actually UVM Medical Center employees, and our compensation plan follows the UVM Medical Center Compensation Plan.

MS. MELAMED: So including the variable compensation metrics that you have described to the board in compliance with our guidance on executive compensation?

MS. LONER: The process, yes. The goals, of course, are different because we perform different functions.

MS. MELAMED: Okay. Thank you. And then looking at the FY '23 budget, again, we did ask you to provide projected '22 salaries. Are executive and leadership salary increases included in the FY '23 budget? Are there any increases budgeted?

MR. BORYS: There are kind of typical cost-of-living increases incorporated into the budget, which, again, I can give you the exact figures, but it's a little bit complicated because we're all UVM Medical Center employees on the UVM fiscal year, and we operate on the OneCare fiscal year. But they're roughly in the three percent range as incorporated into the budget.

MS. MELAMED: And is there similar adjustments in compensation for OneCare employees below

the executive and management level?

MR. BORYS: Yep. We apply the budget increase kind of uniformly across all the employees.

MS. MELAMED: Thank you. And a couple questions, now, on the benchmarking and evaluation information. The first one is in regards to a condition that's been in the OneCare budget order for several years -- I think back to 2019. The budget order has included the condition that states, "Over the duration of the all-payer model agreement, OneCare's administrative expenses must be less than the healthcare savings, including an estimate of cost avoidance and the value of improved health projected to be generated through the model". What steps has OneCare taken to measure the value of healthcare savings and return on investment of its programs through improved health and outcomes over the duration of the all-payer model agreement so far, so from 2018 through 2022?

MR. BORYS: Well --

MS. LONER: Oh, go ahead, Tom. You go, and then I'll go.

MR. BORYS: Well -- sure. I mean, there's one reference point. We can look at the shared savings earned by the providers. But again, that's

a -- the providers have earned those funds, in my opinion. We've had challenges with this conceptual question, because I think there are a lot of benefits to having value-based care programs available to Vermont providers. And quantifying that benefit broadly to us as a state, to all of our residents is really challenging. And also isolating it to a period of time is challenging, as well, as we hope, that what we're doing here by installing value-based care programs, really trying to turn healthcare into a high-functioning system, that the real value will materialize in ten years or twenty years and that we have a much more effective healthcare system as the state ages. So it's been a really tough question for us to wrestle with, frankly.

MS. LONER: Marisa, I was just going to --

MS. MELAMED: Would consider --

MS. LONER: I -- I was just going --

MS. MELAMED: I'm sorry. Go ahead.

MS. LONER: Sorry, Marisa. This is Vicki again. I was going to add to that that through the all-payer model program -- which OneCare Vermont is really the only ACO in the state that is participating in that program -- the federal government has hired an

independent evaluator, NORC, through the University of Chicago, to provide a qualitative and quantitative analysis of those findings. We all did receive a report showing promising signs in the first two years. I understand that the next report will be coming out shortly as well, and that does include findings of OneCare and its network for the duration of the all-payer model. So I would also say that that is a point of reference for the value of ACOs in Vermont largely, but not the same as the all-payer model, which is really a state-led agreement.

MS. MELAMED: Okay. Thank you. I'll pause longer before I move on to my next question to make sure that you all have been able to get your responses in.

As we consider this -- I'll just make a comment here -- as we consider this particular condition, which has been longstanding, we are, as people know, coming to the end of the original agreement, so we have to consider how to interpret that condition if we are looking for that measurement to come at the end of this year or if we want to extend that. But we need to reconsider that condition for this year's review.

The next couple of questions are around

the new OneCare Medicare program performance benchmarking report that came out of last year's budget order and review that Sara Barry touched on during your presentation. So in order to be able to rely on that report for performance assessment, the Green Mountain Care Board needs to understand the limitations and potential biases of the comparison cohort. You stated that the broad comparison cohort includes twenty out of over 500 ACOs in the Medicare ACO dataset and approximately 700,000 attributed beneficiaries total with an average ACO size of about 33,000, based on the average member months divided by the twenty ACOs. So that would be 33,000 Medicare lives. Do the selection criteria that your vendor went with -- or that you worked out with your vendor include other ACOs with multi-payer contracts? Or are the comparison ACOs Medicare only?

MS. BARRY: Marisa, I would want to confirm with our vendor, but based on the discussions that we've had, it would be any ACO that had a Medicare contract. And then, per the criteria that we outlined in our summary memo, they, the vendor, independently identified five criteria for the purposes of matching and finding like ACOs just at a high level. It included narrowing it down to those involved in two-

sided risk programs, those that were considered to be high-revenue ACOs, which was really defined as those that had an ACO network that included hospital-based services -- not only, say, SNF or only primary care.

They looked at an urban/rural distribution because they felt that an entirely urban, for example, ACO would not be a like-to-like comparison. They looked fairly grossly at the specialty network composition. And then, finally, they looked at the proportion of duly enrolled Medicare and Medicaid beneficiaries represented in the ACO. If there are additional questions that the board or the staff would like to ask, we're happy to facilitate that process. But that's pretty much the limit of what we know and understand about how that matching criteria was constructed by the vendor.

MS. MELAMED: Yeah. Yeah. I understand you've provided those criteria to us. So we appreciate it. We just had some, sort of, additional questions about how that was done, and we may take you up on talking about that further. But I had another just question around those lines, which, again, your answer might be the same, but I'll state it anyway for the record. So Vermont obviously is a small state, but OneCare as a statewide ACO is large relative to ACOs

nationally with over 250,000 lives attributed statewide. And that includes over 60,000 Medicare lives, which is, if you were to do a rough average, maybe twice the size as the comparison cohort potentially. Did the vendor -- do you know -- and you can defer if you're not sure -- but did they consider size as an attributed population as part of the selection criteria?

MS. BARRY: I'm not aware that they did, but we can certainly follow up and ask them explicitly.

MS. MELAMED: Okay. And one more along that line is does the comparison group include any similar-sized ACOs? So did it look at other ones with similar Medicare population, similar size overall?

MS. BARRY: Again, I don't know, but happy to ask.

MS. MELAMED: Okay. The next one is probably going to be the same answer, I would imagine. We're also wondering if you can provide for us a step-down diagram of the number of ACOs that were excluded after each criterion was applied? So how you started at 500 and got to twenty?

MS. BARRY: We don't have that. We can ask our vendor for it. They may request confidentiality regarding their algorithm, but I would

assume that we would be able to get that information to you. And I also --

MS. MELAMED: Okay.

MS. BARRY: -- just to say -- I don't know the order in which those steps were applied, so we can find that out as well.

MS. MELAMED: Great. One more along those lines. We'll also be looking for a side-by-side of demographic factors like age, gender. You just mentioned urban/rural acuity between OneCare's Medicare align beneficiaries to the national average from the comparison group. This may also include risk scores. And again, we can talk with you outside the hearing about how to get some of this information.

MS. BARRY: Yeah. I think if you could provide us with a list of what you'd like to see, we can certainly go back to the vendor and ask what's available and what the timeline would be.

MS. MELAMED: Okay. Thank you. Finally, on this -- still in the comparison cohort -- OneCare and its vendor have elected to include, in the benchmark report, a ninetieth percentile benchmark that selects two ACOs with overall success controlling costs rather than identifying the high performance or ninetieth percentile for each measure included in the

measure set. This means that for some of the measures, the results are percented as the ninetieth percentile -- I'm sorry -- presented as the ninetieth percentile are, in fact, lower than the median performers. So it fails to give OneCare and others an accurate sense of the potential ceiling for high performance. Do you know why OneCare and its vendor made this choice? And does OneCare believe that having just two ACOs as the benchmark group is -- gives it enough sort of power in comparison?

MS. BARRY: So just to be clear, we, OneCare, did not independently ask for the ninetieth percentile. We felt that that was a part of the budget order and was requested specifically by the Green Mountain Care Board, which is why that was produced. We did not have any input into the methodology that the vendor used to develop that. It was presented to us as a strategy. And as it was discussed with us in the overall template, the vendor noted some concerns about that ninetieth percentile. Not so much for the reasons that you were describing about the individual measures, but because inherent in the fact that that represents the average of two ACOs, it becomes more volatile to your point. It also doesn't necessarily respect the differences in the markets in which the ACOs are

performing, the availability of services, the types of services, consumer preference, and utilization patterns. So it gets pretty complicated pretty quickly.

Ultimately, our vendor recommended to us at OneCare that the most appropriate benchmark comparison is to use the national peer group. And so while we've only had this data a very short time, that's what we're focusing on right now to better understand and dig into some of the variation we see there, both positive and negative.

MS. MELAMED: Okay. Does OneCare have a timeframe to analyze, distribute, discuss, and develop action plans to address the areas that you outlined that represent greatest areas of improvement? Are there resources allocated in the 2023 budget to address these improvements? The broad question here is sort of what is your next steps for this report and its findings?

MS. BARRY: Thank you for that question. It's a little bit of a challenge, as so many things are, where we are handling performance results from 2021 just arriving while, right around the corner, we will be planning 2024, so managing multiple years at a time. Having said that, we did just receive the data

in the last couple of weeks. We are still working internally to understand it, but our next steps will be to certainly ask follow-up questions of the vendor to more deeply understand the information. And then in December and into the new year, to be bringing it out through our governance processes, for example, the committee structure that Dr. Wulfman described, bringing it to our board in the context of strategic planning and also incorporating the key information into those HSA consultations that Dr. Wulfman described. So I think that's really the first round of dissemination of information.

Then the next step for us is, really, as we start the planning process for the Population Health Model Accountabilities Advancement for 2024 -- which for us begins at the beginning of 2023 -- all of that information will be incorporated. And so for example, some of the measures -- focused measures or incentive measures might change. Some of the investments that get discussed with our board that might go into our 2024 budget would be considered over the first six months of next year. It's a long process. We're trying to move a dial for a whole state, and so it's going to take us some time. I think the exciting opportunity in this is to really dig deeper and think

about our entire network, not only specific segments, and how we can bring them together to understand where some of the gaps are and where we want to focus our energy so that we can do really well as a system and not really have fragmented or kind of sporadic focus areas that don't get us the ultimate outcomes that we're looking to see over the next few years.

MS. MELAMED: Okay. Thank you. We're excited to look at this report and start digging into it, and we look forward to talking with you about it more. I just have one final question.

Shifting gears, has OneCare provided to the Green Mountain Care Board all information on actions, investigations, or findings involving the ACO or its agent or employees?

MS. LONER: Yes, we have.

MS. MELAMED: So with that, I'm just going to look to the staff to see if there's any additional questions that came up during the course of the hearing as people were listening to the information. I don't see any, but I'll just pause for a minute for any hands.

And, seeing none, I turn it back to you, Mr. Chair.

MR. FOSTER: Thank you, Ms. Melamed.

And thank you, all, for your responses to Ms. Melamed's questions. With that, we'll turn it to board questions, and we'll try and take our break on time at 12:15.

I'm new to this role in this field to a large extent. So I appreciate you guys explaining all of this. I have heard the phrase mission-oriented organization. What does that mean? And do you guys consider yourself a mission-oriented organization?

MS. LONER: I'll answer. This is Vicki Loner. Yes, indeed, we do consider ourself a mission-oriented organization. We serve our providers to enable them to transform the way that healthcare is delivered by providing them all the things we talked about in our core capabilities, through payment reforms that enable them to change the way that care is delivered, through waivers, through contracts that tie them together. So the short answer is, yes, we do.

MR. FOSTER: And can you explain what OneCare Vermont's mission is?

MS. LONER: Yeah. I think I actually just did that, but I'll reiterate it for you. So we, as an ACO, are working in partnership with our healthcare providers to transform the way that healthcare is paid for and delivered. We do that by

helping to support providers and focusing on their healthcare goals and promoting activities through the ACO, like actionable data and innovative payments that serve better outcomes. And our full mission and vision -- so that's just a summary of it, not a word-by-word -- can be found on our website and was recently revisited through our strategic planning process in 2021 and came up with that mission, vision, and values through stakeholder, board, and staff input.

MR. FOSTER: In your view, does OneCare have a role or responsibility to assist or curb healthcare costs in Vermont and improve quality and outcomes? And if so, what do you see that role as?

MS. LONER: Yes, we do. And our role, as we talked through as part of our strategic plan, is to really provide those three core capabilities that will enable the care delivery transformation that's needed to be undertaken by the healthcare delivery system. So we provide the infrastructure, shared resources, the contracting, the data analytics to really enter into value-based care services. And if you look at where the federal government is going through their CMMI strategic refresh, it's not if people will be -- or if providers will be in accountable care relationships. CMS is very serious

about having providers get paid differently in accountable care relationships into the future. So this is a need that the delivery system has. We offer a venue to be able to leverage those resources without every community having to have their own ACO, which would be way more expensive.

MR. FOSTER: In your view, is OneCare accountable for curbing healthcare costs in Vermont?

MS. LONER: Yes, we are an accountable care organization.

MR. FOSTER: And in your view, are healthcare costs in Vermont too high?

MS. LONER: I would say that nationally healthcare costs are rising, and we also have a lot of challenges in our healthcare system right now in terms of access to care, workforce issues, and others that really complicate the picture.

MR. FOSTER: So would you or would you not characterize healthcare costs in Vermont as too high?

MS. LONER: I would say that affordability is a challenge for many Vermonters.

MR. FOSTER: Your website says, "Healthcare costs are too high". Do you disagree with that?

MS. LONER: No. I --

MR. FOSTER: How do you think OneCare Vermont is doing at achieving a goal of curbing healthcare costs in Vermont?

MS. LONER: I would say, if you looked at our record year over year in the Medicare program, we have exceeded the benchmarks that are being set.

MR. FOSTER: And to what do you attribute that?

MS. LONER: We attribute that to the data and supports that we provide our healthcare providers, to have them deliver care differently through value-based care arrangements, making them accountable.

MR. FOSTER: And what do you think is OneCare Vermont's most cost-effective tactic to reduce healthcare costs in Vermont?

MS. LONER: I think that's challenging to say specifically, but I would go back, again, to our core capabilities, the network contracting, the data and analytics, and the payment reforms are our tactics.

MR. FOSTER: I understand your tactics. Do you have any sort of hierarchy or basis to opine on which are the most effective at curbing costs?

MS. LONER: I don't know that I could

answer that question.

MR. FOSTER: Do other ACOs assess the cost effectiveness of their strategies?

MS. LONER: I'm sure they have a way of doing that. Every ACO is different. I would say that, overall, we're looking at right care, right place, right time, and total cost of care and the quality metrics. I mean, that's the ACO framework. The federal government has sent out a framework for how you measure success in ACO programs, and we follow that framework.

MR. FOSTER: So how does OneCare evaluate and assess the various functions to determine how to allocate resources?

MS. LONER: We do that through our boards and committees.

MR. FOSTER: And what do you look at to make that determination?

MS. LONER: We bring all these through our clinical committees and population health committees and look at the investments that the providers feel will have the biggest opportunity. And we also leverage our data as part of that.

MR. FOSTER: Is there any sort of cost-benefit analysis that's done in connection with

evaluating how to deploy your resources?

MS. LONER: They have not.

MR. FOSTER: So how do you verify that where you're putting the money is the right place to put the money?

MS. LONER: So we're looking at overall controlling utilization, increasing care coordination of services, and the primary focus being on primary care.

MR. FOSTER: So how do you determine what's the most cost-effective way to curb healthcare costs and deploy resources to that? And what I'm getting at is, you have --

MS. LONER: Yeah --

MR. FOSTER: I've looked at all your budgets. There's 15,000,000 for population health management base, 2.5, I think it is, for bonus, 1.5 -- a very small amount of money for CPR -- and I'm trying to understand if that's the right mix of where you're putting your money and how you determine that.

MS. LONER: Yeah. I recall that CPR is a component of the overall primary care, so you can't just look at that as a separate line item. It would be better to look at our overall investments in primary care. That was on one of the slides that we showed to

the group.

MR. FOSTER: Yeah. Thanks. My question was, how do you know that the mix you have of the funds and where you're putting them is the right mix?

MS. LONER: Well, we do have limited funds, because, recall, that our funding is purely through hospitals and the contracts that we have with payers that fund a portion, but not all, of those investments. So we have to look at the amount of available revenues that we have coming in compared to our shared savings opportunity to be able to provide enough investments for providers to be able to do the work while recognizing that there's not endless revenues coming in from other sources to the ACO.

MR. FOSTER: You're hiring a program evaluator in 2023?

MS. LONER: Correct.

MR. FOSTER: Is that right? And what are they to do?

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

MS. BARRY: Sure. So we are looking to basically become more sophisticated in the structure and type of evaluations that we can perform on individual programs and investments. We have tried,

over the past few years, a variety of analytic approaches and frankly to varying effect, in part because of the complexity of the actual work that we're doing, the numbers of interventions there happening simultaneously, the numbers of organizations that impact them in different ways. And so we don't expect perfection from this individual, but we're really hoping for some advanced guidance to help us think in new ways about how to answer some of those crucial questions.

MR. FOSTER: And have you had a program evaluator previously?

MS. BARRY: No, we have not.

MR. FOSTER: Is it typical of high-performing ACOs to have program evaluators?

MS. BARRY: I don't have an answer to that question.

MR. FOSTER: Why had you not employed a program evaluator previously?

MS. BARRY: I would say that it had not coalesced into a clear and apparent need. In some of the prior years, we were doing -- making lots of adjustments, particularly early in the pandemic. We had, coming into -- just prior to the pandemic, a pretty intense focus on new investments and

innovations. And we learned a lot of lessons through that process about the difference between, I think, good-stated intentions by our network on what we could evaluate and then some of the practical limitations of data availability, the complexity, et cetera. And so all of those things started to point us in the direction of wanting to expand some of the expertise that we already had in house.

MR. FOSTER: In connection with the prior efforts that you said were challenging to do this type of work, did you speak with any consultants or other ACOs as to how they do this?

MS. BARRY: We certainly, through the National Association of ACOs, had some awareness and had access to case studies about how others have investigated certain aspects. Frankly, one of the biggest challenges we've seen any time we try to have those conversations with other ACOs is that, by and large, although not exclusively, those ACOs work within a single, clinically integrated network, which means they have one EHR data source. They have direct impact on interventions. They can kind of put some parameters around those evaluative activities to make them cleaner and clearer. For us as a statewide network with the roughly 170 organizations that Vicki described earlier,

it adds many, many layers of complexity. The number of EHRs alone has been incredibly challenging across the state -- not only OneCare, but the entire healthcare delivery system is really at times stymied by the lack of ability for data sharing and integration that would optimize patient care and streamline some of these efforts.

MR. FOSTER: I think it was slide 10 you had a figure of 138 million on population health innovations since 2018. Is that the right amount of money?

MS. LONER: I think that there's much more opportunity to make investments in primary care and population health services and that cannot be bore directly and solely from the providers who are trying to make those changes.

MR. FOSTER: So my question is whether or not you think the 138.4 million dollars invested in population health since 2018 is the right amount of money?

MS. LONER: No. I think that the state and federal government could be investing more money in population health and helping those healthcare providers to make that transition away from fee-for-service to value-based care.

MR. FOSTER: And in terms of shifting people to value-based care, it looks like only one payer is actually doing unreconciled fixed-perspective payment. Is that right?

MS. LONER: That is correct.

MR. FOSTER: So how would investing more in population health increase that output?

MS. LONER: So I think of the two things as very different. You're talking about fixed, predictable payments. So those are a means for providers to be able to deliver care differently and with more flexibility. That is, indeed, only being offered by one payer, Medicaid, right now. The state doesn't have a means to force commercial payers to enter into fixed arrangements. And through the agreement with the state, Medicare has signaled to the state through that agreement that they will not offer fixed prospective payments.

MR. FOSTER: In terms of the population health program -- the bonus, which I think was about 2.3-ish million dollars -- those payments are tied to whether providers achieve certain specific outcomes; is that right?

MS. BARRY: Yes. There are a set of six different measures for primary care, one focused

measure for each part of our continuum of care. And then there are targets and stretch goals set either through national benchmarks or, where those don't exist, through our governance committees. And so then performance is measured against those and payments made.

MR. FOSTER: Do we here, at the care board, have the numerators and the denominators for these metrics, as in what you need to hit to achieve?

MS. BARRY: I don't know if you do or not. I guess I would ask your staff. I believe you do have the measures themselves. And to the extent you don't, that's something we can provide. It's something we're in the process of communicating out with our network right now.

MR. FOSTER: Okay. Yeah. I'll check with the staff and then we'll get back to you if we need them. They struck me as a good idea, and like, it really could impact change, right? I mean, you're looking at hypertension follow-up, wellness visits, diabetes control, avoidable ED visits. Those are all salutary, positive things. How are you finding measuring these and providing payments for achieving them in terms of if it's working?

MS. BARRY: So I think we have some very

positive early signals. Recognizing that the PHM program and those six measures will be new starting in January, we have basically built and evolved the programs based on what we've been doing in 2021 and 2022. So specifically, we have right now a value-based incentive fund program, which works very similarly -- a set of quality measures, target and stretch goals. Those payments we make quarterly, whereas we'll be making them more frequently under the new model.

But ultimately, I think it is working quite well in terms of dealing with one of the biggest challenges that our network had really brought to our attention in the past, which is that if you move the incentive too far away from the expectation for performance, it can become a disincentive or it can water things down. So I think that has improved tremendously. I think the focus of the specific measures and being very clear and crisp on what the gaps are and what the expectations are has been very helpful as well. One of the significant challenges that remains that I think will be a theme over the next few years is that you have to have measures that occur sufficiently frequently at the organizational level so as to be measured and meaningfully able to improve. And you have to have a data source that you can access

at large scale. So that really means that we need to do our utmost to rely on claims-based measures, things where we have a large volume of information. In the 2021 and 2022 program, some of the measures selected through our governance process required OneCare to use manual staff time to continue to gather information from all of these disparate electronic health records. And while ultimately, there are times that is important because of the gap, say, in performance, it's very resource intensive. And so we take that into consideration as we're thinking about what are the priorities and what does the network really need to improve on in the future.

MR. FOSTER: And would you agree with me that this is a good tactic? I mean, to me, it seems like the incentive is closely tethered to results, and it strikes me as a good tactic. Do you agree with that?

MS. BARRY: Yes, I do. We're very excited about it.

MR. FOSTER: How did you determine that 2.8 million is the right amount of -- it's 2.3 or 2.5, 2.8 -- whatever it was -- how is that the right amount of money for this tactic?

MS. BARRY: Yeah. I think there are a

couple of realities to look at. First of all, we did not want to have a cliff for providers in our network and move from a program where they had a certain amount of money that they were expecting to receive from OneCare and the calendar flips to the new year and all of a sudden it goes to zero and they have to earn everything immediately based on incentive. Because we knew that that would have impacts on workforce staffing, their own prioritization of projects and investments. So we decided that we needed a tapered approach. And so we arrived at that eighty-five percent in the base in year one and fifteen percent in the incentive as a reasonable threshold. And we have socialized, through that process and through our governance committees, an intention to keep changing that ratio from year to year. The amount of that change has not been predetermined; that will be evaluated each year based on what we're seeing in terms of advancements. But ultimately, the intention is to shift more and more of it into that incentive payment, therefore, really turning the dial up on making sure that people are being rewarded for achieving those higher outcomes.

MR. FOSTER: So there's no table or projections or anything you've communicated about how

you see that evolving over time at this point?

MS. BARRY: Tom, are you aware of anything that we've communicated out?

MR. BORYS: We've communicated to our board and committees kind of a visual that over time the opportunity for the bonus increases and then the base payment kind of decreases in a corresponding way. And another element being considered is, if there is a different integration into the shared savings and shared loss model, that would actually supplement this even further. And, over time, I think it's important that we continue to put more emphasis on these actual data-driven, data-measured outcomes, and there are fewer dollars in the base payments.

MR. FOSTER: Why don't we stop there. We're two minutes over. So we'll take our break now, and we'll come back at -- I think it's 1 p.m., unless you guys want to shorten it. What's your preference over on your side at OneCare?

MS. BARRY: I don't think we have one, Chair Foster.

(Indiscernible, simultaneous speech)

MR. FOSTER: Great. Okay. Well, we'll stick to the schedule. Come back at 1. Thank you very much.

(Recess at 12:17 p.m., until 1:01 p.m.)

MR. FOSTER: All right. Thank you, everyone. You're still sworn. I hope you all had a nice little lunch break. I understand you're transitioning data analytics arm to UVM. What UVM entity is receiving that data?

MS. BARRY: So this is Sara Barry. We have a contract with the University of Vermont Health Network. The specific entity underneath managing the data is called the Data Management Office.

MR. FOSTER: And how did UVM win the bid to take that work from OneCare?

MS. BARRY: There was a strategic planning process initiated by our board that Vicki Loner has described earlier in the day. And from that, there was a strategy to look for efficiencies and cost savings as well as to advance our analytics overall. Through that process, the UVM Health Network was also looking to build out its performance under value-based care contracts. And we saw an opportunity to look at joining them in the process that they were running to look at different vendors. So it was really through that process.

MR. FOSTER: Was there a bid process?

MS. BARRY: They had an RFP process.

They would have to speak to it directly in more detail. OneCare staff participated in seeing different vendor solutions in setting specifications about what we would need to meet our current expectations of our network. And then it moved forward from there.

MR. FOSTER: You said "they had an RFP process". Who's "they"?

MS. BARRY: The UVM Health Network.

MR. FOSTER: But it's the data that OneCare possesses and is responsible for. Did you have an RFP process to select from potential vendors?

MS. BARRY: No. There's two things happening at the same time back when this was all occurring. So coming out of the strategic planning process, OneCare found a need to look for alternatives. UVM Health Network independently was going to have its own process. We saw opportunities for synergy in that and explored whether the needs that we had as a network overlapped or aligned with their needs from that. Those criteria were provided out to selected vendors, and there was an RFP process. We then were able to watch demonstrations and to indicate where we thought that the solution the vendor could best meet the needs for OneCare's network.

MR. FOSTER: The vendor being UVM?

MS. BARRY: No. The vendor being a company called Arcadia.

MR. FOSTER: All right. How many entities did OneCare consider in providing this data to?

MS. BARRY: OneCare considered all of the entities that the UVM Health Network was looking at for a vendor, but the vendor --

MR. FOSTER: Hang on. Let me interrupt. Hang on. I'm getting at did you consider anyone other than UVM? Did you, OneCare, when you were giving out your data, consider anyone other than UVM?

MS. BARRY: No, we did not. We did not see a need.

MR. FOSTER: Why not?

MS. BARRY: Because there were two strategies involved here. Ultimately, there's a new data platform. That is a vendor. There is also the question that you asked me a moment ago about where -- which entity under the UVM Health Network -- that is, the Data Management Office -- will be managing the data. Those two things came together for us in an overall strategy to meet the requirements of our board.

MR. FOSTER: And how could you evaluate whether or not UVM should take Vermonters' personal

health information as opposed to anyone else if you didn't consider other options?

MS. LONER: I think there's some confusion. It's not UVM; it is Arcadia that is the vendor.

MR. FOSTER: I understand the vendor. But you're doing this work with UVM, right?

MS. LONER: UVM Health Network is our sole parent organization. As part of our strategic planning process, our board directed us to look for options to advance our analytics that would not be duplicative and would not be more expensive than current --

MR. FOSTER: So why not --

MS. LONER: -- offerings.

MR. FOSTER: Yeah. All right.

MS. LONER: Us doing this alone would cost Vermonters more money, and we would have had dueling data analytics with our largest healthcare provider and our sole member organization. That's not cost effective.

MR. FOSTER: And you have about 300,000 attributed lives; is that right?

MS. BARRY: Correct. Just a little less.

MR. BORYS: Yes, that's correct.

MR. FOSTER: And prior to this transition, did UVM Health Network have the PHI of those 300,000 people? Or were there some they did and some they didn't?

MS. BARRY: UVM Health Network or UVMMC has a existing arrangement with OneCare Vermont that's been there since our inception, where they provide supports and services, as Vicki described earlier, in terms of employment points, et cetera. Through that, we've always received IT support and had appropriate protections in place. This effort that we're moving forward with advances that work, because OneCare currently has a separate data vendor for a data platform. That platform will now be aligned through this agreement with the health network.

MS. LONER: OneCare still owns the data and is still responsible for the data as the accountable care organization. We still have all the business associate agreements in place with all of the payers, so if there is ever any breaches of data, ineffective use of the data, OneCare is ultimately responsible for that use. Thereby, we need to hold agreements with UVM Health Network to make sure that data is adequately protected.

MR. FOSTER: And UVM didn't have all of this data before this change; is that right?

MS. LONER: Sara, I'm going to put that over to you.

MS. BARRY: We used servers through the UVM Medical Center/Health Network. That does not mean that they have the type of access that would be envisioned in this new arrangement as staff are moving over in that direction.

MR. FOSTER: So previously, this data -- OneCare used UVM services to house the data, but there is limitations, and now, those limitations are altered through this arrangement. Is that fair?

MS. BARRY: That is correct.

MR. FOSTER: Okay. And is UVM operating as a covered entity or a BA in this arrangement?

MS. BARRY: I can check and get you that answer. I can't answer it off the top of my head.

MR. FOSTER: Did OneCare provide notice and receive authorization from the 300,000 Vermonters whose PHI was provided to UVM?

MS. LONER: We annually have to do data opt-in and opt-out processes on new members. So that's part of the ACO requirements. There's not a requirement for us to -- once we transition vendors --

to get reauthorization for that, as long as we have all the appropriate safeguards in place.

MR. FOSTER: So there's a safeguards rule, a privacy rule -- and I'm trying to understand what was the mechanism through which this information could be shared with UVM. So under the privacy rule, you have opt-in authorizations being provided. People say you can share this information with UVM for these purposes. And then there are certain permitted uses. And what I'm trying to understand is what was the legal authority to provide you -- OneCare -- the right to give this information to UVM.

MS. BARRY: So Chair Foster, my understanding is that everything that we are doing is under the allowance for payment and operations under HIPAA. And in this case, what we're talking about is UVM Health Network acting as a subcontractor -- a vendor of OneCare for the purpose of those payment and operations.

MR. FOSTER: Great. Thank you very much, Ms. Barry. That's helpful. And what did OneCare do to ensure that that permitted use -- the healthcare operations use -- is the only use by which UVM has access to?

MS. BARRY: Thank you for that question.

So that's why this process has taken us quite a number of months to put the contractual obligations in place. We hired additional outside legal counsel to advise the process and ultimately have very recently entered into contractual arrangements. There is some remaining work to be done before any data are shared under the new arrangement, and that involves ensuring that the final policies and procedures that dictate at the granular level the detail around how data are handled are well spelled out, and we have a written process in that contract to make sure that OneCare's compliance and legal officers review and approve those procedures before we move forward and actually share any data.

MR. FOSTER: So if it's -- if you can -- we'd certainly like to see those. And we'd also like to see the diligence that was done on UVM's security prior to entering this contract -- or agreeing to enter the contract. And one of the questions I have is what role or impact, if any, did UVM's 2020 cybersecurity breach have on your decision to give UVM access to all this information?

MS. BARRY: So starting with the beginning, we can certainly provide you with the additional information. I would say that there was not a direct impact, from my lens, of the cybersecurity

attack and their response on the process that we went through. We did, at the time that that occurred, provide all of the required notices. We did the extra evaluative work that was required reported to our payers to ensure that there really, ultimately, was not any detriment to any of the information that they held on behalf of OneCare.

MR. FOSTER: Sorry. So are you saying OneCare's data was previously exposed in UVM's prior breach?

MS. BARRY: No. It was -- in the end, it was not exposed.

MS. LONER: It was not.

MR. FOSTER: Got it. But it could've been. But it wasn't. Is that right?

MS. BARRY: Correct.

MR. FOSTER: Okay. And then my question was, what role -- how did you evaluate their response and hopefully enhance privacy protections in determining to give them more access to this information?

MS. BARRY: Can you ask the question again, please?

MR. FOSTER: So UVM had a very large breach, which caused a lot of issues. And certainly,

when entities go through this, you hope that they take significant remedial steps to prevent it from happening again. And I want to know what OneCare's evaluation was of that in determining to give them this information.

MS. BARRY: So we could certainly work with our internal team to get you some more information. What I can speak to directly is that, not long after that time, we did some pretty extensive auditing work with them regarding the certification levels and the protections of data. Ultimately, they were found to be very well protected. And, as in any situation, there are obviously opportunities to continue to refine and enhance some of their procedures, and they put a work plan in place associated with that. So we did not have any findings that suggested that there were concerns that would lead to hesitation as we moved forward.

MR. FOSTER: And you diligence(d) that prior to giving them this information in connection with shifting your analytics to them?

MS. BARRY: That process that I'm referring to was complete before we moved forward with this. And just to be clear, we have yet to give them any new information under this arrangement.

MR. FOSTER: And you all are UVMMC employees?

MS. BARRY: Yes.

MS. LONER: Correct.

MS. BARRY: Our employment attachment is UVMMC.

MR. FOSTER: Do they set your salaries?

MS. LONER: Yes. We use the UVMMC compensation policy, but the board, for me, ultimately sets the CEO salary using the information gleaned from national standards.

MR. FOSTER: I want to be respectful of my fellow board members' time and the healthcare advocate and the public. Just, I think, two little areas. Real quick, the benchmarking report, is that a final report that we received?

MS. BARRY: The vendor has listed it as a preliminary report but agreed to allow it to be shared with the Green Mountain Care Board.

MR. FOSTER: Do you think it's accurate and can be relied upon for you to make decisions as to your practices and for the care board to make its decisions with regard to your budget?

MS. BARRY: To the best of our knowledge, it's accurate at this time. I think that

the reservation is that it is brand-new information, and we at OneCare continue to need to spend time looking at it and asking follow-up questions.

MR. FOSTER: In terms of the payment reform, shared risk -- it's set at, I think, 36 million dollars in the '23 budget. How did you come up with that amount, and why is that the right amount to incentivize the behaviors that you're trying to incentivize?

MR. BORYS: I can take that one. So the -- generally, the way that the risk and reward amounts are determined is through what's called a risk corridor, which is a percentage above and below the benchmark set by payers. And those can -- it can be anything you want. It could be a one percent corridor. It could be a fifteen percent corridor. I would say that standard ACO arrangements tend to revolve around the five percent range. There's certainly ACOs that take on much greater corridors, limits of up to fifteen percent. We have largely -- we negotiate those amounts with payers in order to find the balance between what type of risk we're willing to take on as the provider network and what type of risk or amount of risk the payer thinks will generate the right attention under these programs and, again, through the pandemic, reduce

that amount. And the amounts that we have in the budget that ultimately determine the 36-million-dollar figure represent increases up closer to what we had prior to the pandemic, but in some cases a little bit lower. And the slight reductions relative to the pre-pandemic years really reflect the fragility of Vermont's healthcare system. It's an important --

MR. FOSTER: Let me pause you there just so I can -- I got to focus, because I think I asked the --

MR. BORYS: Sure.

MR. FOSTER: -- question poorly. Why is it 36 million and not 100 million dollars?

MS. BARRY: We negotiate the terms with the total cost of care as set by the payer might be, you know, 500 milliom dollars, and then there's a risk corridor applied to that. And that determines the dollar figure -- the maximum loss or the maximum savings that providers can receive.

MR. FOSTER: So would a greater number provide a more significant incentive to achieve the -- your goals of aligning conduct with curbing costs?

MS. BARRY: It would, but it would also present a concern in the sense that some providers might say the amount of risk I carry is too great for

my organization, and they might opt to not participate. So there is a balance to be struck.

MR. FOSTER: And how do you see the -- I guess the word is fragility these days -- of the hospital's finances impacting the temperature in terms of taking on risk?

MS. BARRY: Very significant challenge. When we started with these programs at the beginning of the all-payer model, the landscape was quite different from a financial perspective. The pandemic has caused a lot of challenges. You guys heard it all through the hospital budget process. So like I said, I'm going to go back to the word balance and say that we want to resume more material risk-sharing terms, because it does get attention, and it needs to be done very thoughtfully with a careful eye towards the financial health of our system.

MR. FOSTER: But if hospitals or providers have control over the outcomes, which I think is the intent, and they could achieve and make more money through this, wouldn't that be a good thing for them to do given the financial challenges they're facing, right? Like, if you give me an opportunity to make more money and I need money, I think I want it so long as I have an ability to impact it. Why is that

not what's happening?

MS. BARRY: I agree with you. But the factor that I think is important underneath it is what's the stability -- the underlying stability of the organizations? And even as individuals, we might place a bet on something, but I wouldn't recommend placing a bet on a very fragile foundation.

MR. FOSTER: Thank you. That's a fair point. If there are losses -- let's say they owe back 5 million dollars as opposed to 5 million they saved, where would that money come from? Who would pay that? It's the hospitals, right?

MS. BARRY: Largely, the hospitals, correct.

MR. FOSTER: And how would the hospitals fund that? Would that be through Medicaid, Medicare, co-pays -- all the various revenue streams they have?

MS. BARRY: Basically, would come off of their balance sheets, essentially.

MR. FOSTER: So would any executives or individuals who are responsible for that loss have actually any skin in the game?

MS. BARRY: That's a good question. We really put the organizations rather than the individuals at risk in this. And one of the challenges

to bringing this provider network together is getting the governance structure for each of these hospitals to agree to the terms. So I think -- without speaking for them -- I think executives would feel some responsibility to their boards in the sense that if they had to make a large-share loss payment, their boards are going to consider that when evaluating management.

MR. FOSTER: Would that number, that there was a loss, come back through in our budget process here at the board?

MR. BORYS: It would actually. Through the hospital budgets, it must go through OneCare because we have a fully delegated or passed-through shared savings and lost model. So essentially you could see a circumstance in which a hospital comes and said, boy, we had a rough year and these ACO programs and had to pay a 5 million-dollar share loss payment.

MR. FOSTER: So if the hospitals ultimately as an organization would foot the bill, is it fair to say that by and large Vermonters are paying that, given that's the source of the revenue stream, other than the fed chair, of course, which, you know, we're part of?

MR. BORYS: I think through extension

there's some truth to that. But I will also add that the complexity of healthcare funding is huge. And if the general belief is that every dollar that funds health care comes from individual people, which is probably fair, then I'd say the answer is yes.

MR. FOSTER: So how would that actually change provider behavior or hospital executive behavior if they're not on the hook for any of it?

MR. BORYS: Every provider is really trying their best to sustain operations for their community, especially these hospitals, at least in my experience. And there's a balance to be struck between the activities that generate revenue under fee for service and doing the right thing for individual patients. And what we're trying to do here is align these two factors so that, when providers do the right thing for the patients, they're also rewarded financially. That's what makes us successful.

MR. FOSTER: Thank you for that answer. Looked like the commercial insurers are not doing fixed prospective payments. Why is that? I think there is a thing it said low marketability, technical limitations, risk tolerance. I think it's slide 19. Is that why the commercial insurers are not participating in that?

MR. BORYS: I'll speak on behalf of the

commercial insurers, and we may want to get into an executive session to discuss this in more depth as we are in active negotiations with them. I think it's about shared alignment largely in terms of what we're trying to achieve through OneCare Vermont and what their goals are. And I'll leave it there, so I don't step into some territory I shouldn't in public.

MR. FOSTER: Well, is there anything that's not confidential that you can share as to why you think, from your perspective, the commercial insurers are not participating in this?

MR. BORYS: Again, I don't want to speak on behalf of the commercial insurers. So I'll --

MR. FOSTER: I'm asking --

MR. BORYS: -- I'll just leave it --

MR. FOSTER: -- I'm asking for your perspective, not speaking for them, your perspective.

MR. BORYS: My perspective -- I think it's the alignment issue that I mentioned before. We're trying to install true fixed payments for providers that establish here's how much you should get paid for the work to care for this population. And I think some of the challenges that naturally come up are how do savings that the providers generate get back to the rate payers, for example. That comes up as an

interesting dynamic. And I think it's a valid point but one that represents a misalignment between what we're trying to achieve with the provider system, how the system is funded and paid for versus what the commercial insurers see as their value proposition with their members.

MR. FOSTER: Okay. Thank you. The CEO compensation is projected to be 491,000 dollars in fiscal year '23. And I understood from the responses to the staff that that includes bonus. Does it also include retirement benefits, any sort of severance package, or any other financial benefits? And then corollary, are there any other financial components to the comp that are not included here?

MR. BORYS: The table that we supplied was designed to be -- it's a projection, but designed to be like what an individual's taxable income would be along the lines of what is reported on a 990. It's a little difficult to project that, frankly, but that was the intent when we supplied that table.

MR. FOSTER: Thank you.

To the CEO, do you think you're adequately compensated?

MS. LONER: Yes. UVMC goes through a very rigorous process to benchmark the CEO salary

against other CEOs in like organizations. And the board reviews that and makes a determination on my annual salary.

MR. FOSTER: And do you think if you were compensated more generously you would be greater incentivized to achieve outcomes for a Vermonter or it would not make a difference?

MS. LONER: I think I'd like you to restate the question.

MR. FOSTER: Do you think additional compensation to you would provide an additional incentive for you to perform OneCare's mission on behalf of Vermonters?

MS. LONER: No. From a personal one, and I'm just going to speak on a personal basis because every CEO is different, I think that you need to be reimbursed based on fair market value and that individuals will make decisions based on what they hold important to them. And for me, it's the mission of OneCare Vermont that brought me to OneCare from the state, and that's how I continue to be passionate about that work.

MR. FOSTER: Well, what was your salary your first year as CEO?

MS. LONER: I do not recall. I could

get that for you, but --

MR. FOSTER: What year --

MS. LONER: -- not --

MR. FOSTER: -- what year did you become the CEO?

MS. LONER: I've been the CEO for about three years now, so I think it was in 2019, August of 2019.

MR. FOSTER: The 990 from 2020 indicates the salary was 377,000 and now it's projected to be 491. What are the performance metrics that went into determining that increase?

MS. LONER: So remember, in certain years -- and we can get you those details -- all the executives took a pay reduction due to the pandemic and forfeited any of their variable pay as a part of that. So that -- those factors would have to be taken into consideration.

MR. FOSTER: So the -- not the 2020 990 -- at 377, you're saying is depressed because there were variable comp not received?

MS. LONER: Correct.

MR. FOSTER: I see. And in terms of the 491 projected compensation, how much of that is tied to incentive-based compensation?

MR. BORYS: Actually, just received an email from the staff team and we'll supply a breakdown accordingly with the base versus incentive opportunity.

MR. FOSTER: Could you provide to me now?

MR. BORYS: I needed to have somebody on my team pull those data. I can try and get it during this meeting, but it'll take a little bit of work to break it apart.

MR. FOSTER: What about last year? What percentage -- and you can give me a ballpark -- was the compensation for the CEO incentive based?

MR. BORYS: I don't know.

Vicki, you recall?

I can try and -- let me try and look it up. Hang on.

MS. LONER: I don't recall. So it all follows UVMC's policy of variable compensation, which the Green Mountain Care Board does have copies of. So at maximum, the CEO can obtain twenty-five percent of their base pay through variable compensation. And VPs have a different rate, and then directors have a different rate as well. That's set year over year, and that is assuming they pay out a variable compensation, which they do not in every year, and it's determined on

whether or not we meet our corporate goals.

MR. FOSTER: And that's what I'm trying to understand is how the comp is tied to the corporate goals and what the metrics are that are being evaluated in determining what the comp should be.

MS. LONER: Yeah, you do have a copy of our corporate goals year over year, so you would be able to look at those to see exactly what those corporate goals were.

MR. FOSTER: Well, what I'm getting at is, like, I want to see how that translates in the evaluation, like, to determine the CEO-level compensation. Like, I get what the corporate goals are, but are those actually scored? Are those -- how are those evaluated in connection with determining compensation?

MS. LONER: Those are scored initially by our executive committee. Our executive committee of the Board of Managers makes a recommendation to the full board, and the full board ultimately decides on whether or not there is a payout; if so, what is that percentage of that payout; and that's done on an annual basis.

MR. FOSTER: And do we have that; do you know?

MS. LONER: I don't know that you have individual employee evaluations. I would not think you'd have that information.

MR. FOSTER: And from your perspective, does the executive -- the CEO and the other executives' compensation comply with Rule 5.203(a)?

MS. LONER: You'll have to tell me what that rule is. I don't have it in front of me.

MR. FOSTER: I can generally say what I think it is. I don't know if I have the language, but it's that the ACO structures executive comp to achieve specific and measurable goals, supporting the ACO's efforts to reduce costs and improve quality of care.

MS. LONER: Yes.

MR. FOSTER: Your comp is tied to those factors, great. And would you serve as OneCare's CEO if you received less compensation?

UNIDENTIFIED SPEAKER: I'm making more coffee, just so you know.

UNIDENTIFIED SPEAKER: Oh, okay.

UNIDENTIFIED SPEAKER: It's brewing.

MR. FOSTER: Sorry, I think there's another mic on.

My question is would you continue to serve as OneCare CEO if you received lower

compensation?

MS. LONER: I think it would be dependent on what that compensation was and whether or not it was within fair market value for my services.

MR. FOSTER: All right. Thank you all for answering my questions. I appreciate it very much. And with that, I'll turn it over to Jessica Holmes. Thank you.

MS. HOLMES: Okay. Thank you.

So first of all, thank you for the efforts that you've gone into preparing the submissions. Appreciate that.

I have some questions. Some questions have already been asked by other staff or Chair Foster, but I will go through the questions that I have remaining. And some of your comments actually created new questions for me. So one was -- my first question was around the -- how many -- let's just say you have 5,128 providers. How many of those deliver primary care? About, just roughly. Just trying to get a sense of how many of your providers in your network are primary care providers.

MS. LONER: We have fifty-four tax ID numbers. We'd have to do the math for you on how many providers, because remember, UVM Medical Center's one

tax ID number. They have hundreds of primary care providers.

MS. HOLMES: Okay. I mean, I guess part of my question revolves around you had seventy-eight respondents in your primary care engagement survey. So I'm trying to get a sense of whether you've assessed whether those providers are representative of all the primary care providers in your network. Seventy-eight seems low to me, particularly now that you said there's hundreds within UVM alone. So have you done an assessment to see whether they are representative of your primary care network?

MS. BARRY: We've not done that assessment, but we don't dispute the concern that you have about the number seventy-eight being low. It's actually quite a grave concern for us as well. And one of the key learnings that our staff are reflecting on right now to try to think about how to do better is is there a better or different mechanism to get the survey out to encourage engagement.

So we tried to use kind of a networked approach where it went out to key people at the sites and then from them to the providers within their organization. And what we learned is that did not work very well despite multiple reminders and outreach. So

part of what we need to do is, A, be careful that we don't overstate the value of those preliminary pilot survey results, but yet we use them because I think there are some interesting signals that we start to see, and second, that we figure out how we change our strategy to better engage and get higher response rates for primary care but also as we think about the other segments of our network that we want to survey.

MS. HOLMES: Yeah, and did the survey instrument include questions that gather specific examples of how one carries -- investments, data analytics, and payment incentives have fundamentally shifted -- how those providers actually deliver care? Like, is it -- is there evidence in that survey being collected about meaningful and measurable delivery system transformation that's directly linked to OneCare-specific efforts?

MS. BARRY: So if I'm understanding your question correctly, that it's really assessing like is this survey assessing change in behavior and outcomes, the answer would --

MS. HOLMES: Yes.

MS. BARRY: -- be no. The survey was designed to actually look at people's understanding of healthcare reform, the ease of use, or the difficulty

of use of some of OneCare's systems and tools, their knowledge and understanding. So it was framed quite differently than what you're suggesting.

MS. HOLMES: Let me put in a pitch for as you roll out the next version of this survey and hopefully have a greater response rate. I think it'll be really helpful and I think a lot of the questions that we've asked over the years around evaluation are trying to understand how do OneCare Vermont-specific policies, programs, investments change the delivery system and change outcomes for patients? And so asking specifically, you've got a provider survey out in the field. That's a good way to assess how things that OneCare is doing are actually changing the delivery system. So I will put in a pitch for that hopefully that you'll consider.

Happy to see that you're hiring an evaluator. Again, you know this is something I've been pushing for years, trying to get more evaluation. Something that's weighed on me for the past year is that we've been celebrating our relatively low total cost of care for Medicare, and perhaps we should, but I want to ask you about our wait times. So our wait times are excessive in Vermont, particularly for specialty care, which is disproportionately used by

seniors. So how does, like for example, the Medicare benchmarking report or OneCare Vermont assess the role that wait times and access challenges might play in OneCare's Medicare cost performance?

MS. BARRY: I'll let Dr. Wulfman address some of this, but just to start in terms of the Medicare benchmarking report, I think one of the early things that we are very interested in and concerned about is that in those reports our ED utilization is particularly high, and we have concerns that that is a signal that it is high perhaps because of access or wait-time issues. So that's one of the things we're looking at.

We are digging in more deeply, as I mentioned earlier, specifically to the transitions-of-care issues. And I know that that the board is well aware of these as well. They're in the news. But really understanding how patients not being able to leave the hospital to get to, say, a skilled nursing facility or back to home with appropriate supports is definitely having an impact on their quality of care that -- their desire for the place and services that they want to receive. So I think what we're trying to do through this new lever is shine a different light on that and use the national-benchmarking approach to

really indicate that there's some need -- it's a very specific need -- to look at certain parts of the system and try to address that.

Now, I think it's premature to answer the question "what are we as an ACO going to do about it?" because, as I mentioned, we haven't even disseminated all of this information yet, but it's critical ultimately to the health of the healthcare system.

MS. WULFMAN: I agree with what Sara said. And I'll just add I think we have a wait-time problem for all areas of health care. It's not just specialty care. It's getting out of the hospital to go to SNF or rehab; it's for primary care; it's for -- you name it. ER wait times are horrible, we know. So it's everywhere we look, and I think we cannot underestimate the impact of staffing issues that are huge in all those areas.

I definitely think that we have the need to educate the patients more about where to go for their care. And I don't want us to underplay the responsibility of the patients in helping with solving these problems. So if a patient of mine thinks they have a mole that needs checking and they don't get to see me on the day they want at the time they want, they

might go to the ER. That has happened. And many other examples, I can give you. So I think we're working on this together with our providers and in all kinds of different ways but remains a heavy burden.

MS. HOLMES: Well, let me ask you a follow-up question about the budget, then, and thinking about where in the budget are -- would we find resources allocated to address some of these opportunities that have been identified in the Medicare benchmarking report for improvement, specifically the lower than expected primary care usage, the higher than expected ED utilization that you mentioned. So where in the budget will we see resources specifically allocated? I know you may not have action steps identified, but are there resources already allocated to address opportunities for improvement?

MS. BARRY: I think there's two parts to the answer to that question. The first is we just received the data and the budget was developed months prior. So there's a cycle that we have to go through to make some of those broader adjustments. Having said that, kind of knowing the broader landscape, I think you could look specifically to the enhanced support for the CPR program and the flexibilities that that provides for allocating funds within those sites for

staffing and to meet some of those needs. And the second is a line item for specialty care, which we're still working on some of the details, but Dr. Wulfman is leading some efforts with the states and with others around some of the problems in skilled nursing facilities right now. And so you'll hear more from us as that emerges over the next couple of months. But those would be two examples.

MS. HOLMES: And just as a follow-up, then -- I recognize the budget was produced before this benchmarking report came out. Is there any appetite for shifting some of those resources now that you know a little bit more about the benchmarking report? Would you -- if you could submit your budget now, would it be the same budget?

MS. LONER: I think our budget is built and approved by our board based on the amount of revenues that we have coming in from the hospitals and the payers. I don't think there's an appetite from the payers to give us more money for these services, but you could certainly ask them to.

MS. HOLMES: No, I wasn't thinking that you would have to add more, but you might shift resources within the same dollar amount, right? So you might just shift programmatically allocation of

resources given the data that you're receiving from the Medicare benchmarking report.

MS. LONER: I think the only challenge would be is that providers like primary care sign up based on the population health payment programs that we're supporting. And if you change that, you've changed the contractual agreement that we've made with those providers who have signed on. So you could suffer a loss if you did that in your provider participants.

MS. HOLMES: Okay.

MS. WULFMAN: Could I add a couple of clinical comments? We are --

MS. HOLMES: Sure.

MS. WULFMAN: -- also, through our population health model, incentivizing some of this work. So the two care-coordination outcome measures that we have built into the population health model for '23 are follow up after two avoidable -- potentially avoidable ED visits. So getting people in. If they've had two ED visits in the last ninety days, incentivize people to get them in within the next sixty days so that they don't have a third one. And working together on that across the care continuum.

And then also hypertension follow-up is

a process improvement that we are requesting as our care coordination, one of our two metrics, for the population health model. So if somebody has a diagnosis of hypertension, going forward we're not just saying, oh yeah, this year again it isn't controlled. We're saying get them in within a certain time frame in order to get credit so that they have adequate follow-up. So I think those are very important metrics that we are adopting for '23, and we will measure that. They will --- we will measure the outcome of those two incentives.

MS. HOLMES: Okay. My next area you cite a few challenges to success, and I just wanted to probe a few that you mentioned. One was you cite as one challenge the expansion of enrollment in Medicare Advantage plans and highlight that this needs to be addressed in future visioning. I think those are exactly the words that were used in the submission. So I'm wondering what is the path forward to achieve meaningful scale? And specifically, what role does the new collaboration between UVM Health Network and MVP play in the ACO's scale success and future visioning?

MS. LONER: I can speak to that. So as we discussed earlier, our initial strategic planning process started in 2021. The plan was at the time to

roll that process through 2024 because we thought at that time there would be only a one-year extension to the all-payer model agreement, and instead we've gotten a two-year extension. We have been highly focused this last year, trying to understand if there will be any adjustments made in the current model, which we're being told are not.

And so next year, as part of our strategic planning process, we're going to have to understand what are other options that are available to us as an ACO that we can enter into directly with CMS, CMMI, the state, perhaps certain payer partners if another all-payer model agreement is not beneficial to our provider network. So that needs to be the process from which we build on and our strategic planning kind of refresh next year to look at what are those paths that would be viable to us as an ACO in Vermont. So that will be taken up as part of that strategic planning process.

MS. HOLMES: Okay. With respect to the challenge that you cite about the absence of Medicare in commercial unreconciled fixed payments, I'll leave the Medicare aside for now and focus only on the commercial -- and I know Chair Foster asked you this question, and I recognize that some of it may have to

be relegated for an executive session if we go in there, but perhaps I can ask it slightly differently that doesn't reveal confidences -- you referenced these three barriers: technological limitations, low marketable value, and low risk tolerance from fee for service as the commercial barriers. So I'm wondering how you were able to successfully overcome those barriers in the CPR program and in the SVMC Hospital pilot program and why those strategies can't be scaled up.

MR. BORYS: Well, I'm not sure that we have solved it. We have a -- I'll call it a kind of a Band-Aid approach to make CPR work because it's been a priority area of ours. And by that, I mean at the end of the year, we do have reconciliations between OneCare and the payers that require a reconciled payment. We just don't charge into the CPR practices; it gets put into the hospital settlement. That is not my ideal scenario for this, and it is a barrier to making this a bigger and broader program and -- so in short, I think we've made it work but not in the ideal state.

MS. HOLMES: And the SVMC program similarly?

MR. BORYS: Yeah, I would say it's similar, and credit to SVMC is that they offered to be

a pilot site to help us test this out as a new initiative, and they've largely stuck with it, I think, partially in hope that it would move to a truly unreconciled model.

MS. HOLMES: If we could -- I don't know if you have your submission in front of you, but I wanted to talk to you about tables 6.1 to 6.3, the variance analysis, and this is looking at the revised fiscal year '22 to fiscal year '23 variation. And you list a twenty-six percent increase in revenues coming from the Blue Cross Blue Shield QHP program. And in the table, the tremendous growth in revenue is attributed to approved QHP filings. So can you help me understand how that -- where that twenty-six percent growth rate comes from? Premiums didn't rise by twenty-six percent, and according to slide 14, attribution to the Blue Cross Blue Shield QHP program is projected to fall. So I'm really just trying to understand that growth rate --

MR. BORYS: Great question.

MS. HOLMES: -- in that table.

MR. BORYS: I can probably answer that better if I have a little bit more time with the numbers, but my initial thinking is that it's against what the numbers reference. So what is the twenty-six

percent referenced against? If it was last year's budget, then that could be twenty-six percent. In other words, if last year's budget was lower than we anticipated or reflective or relative to what we're experiencing in the market now, it could look like there was a bigger increase. But the way in which the target was set was we looked at emerging 2022 span data and built on top of that, if memory serves me, a six percent increase, which is identified as the medical expense component of the insurance rate trend. So that was pretty clean and straightforward. But if the twenty-six percent is referenced against a prior year budget, there could be another variable to consider there.

MS. HOLMES: Well, maybe if you could follow up, that'd be helpful. This is -- in the variance table it's the revised budget, so it's not the original budget, but it's the revised budget so presumably --

MR. BORYS: Okay.

MS. HOLMES: -- you would have more up to date than the original '22 budget. So it would be helpful to us to understand --

MR. BORYS: I will --

MS. HOLMES: -- how that --

MR. BORYS: -- do that.

MS. HOLMES: -- rather large -- and it's a pretty significant amount of money as well, not only percentagewise, but also just dollars. Also, you budgeted 1.87 million dollars for software. And I'm wondering if you can just give us some more details on that. I know you're a sunsetting Care Navigator. Data analytics are being outsourced to UVM Health Network now under contracted services, so what remains in that bucket of 1.8 million dollars for software?

MR. BORYS: Good question. So this is a transition period where OneCare largely has to maintain its ability to deliver analytics, support to its network while the Arcadia system is being built up. So there are some software tools, including the current data warehouse tool, that we still are paying for through this transition period. What we expect to see in future years is that we can start to sunset some of these software expenses as the new platform is up and running and ready to deliver supports to the OneCare Network.

MS. HOLMES: So in a follow-up, would you be willing to supply a breakdown of that software and then what you anticipate will be sunsetted in future years so we can understand what the ongoing

software costs will be and what you're maintaining in duplication this year?

MR. BORYS: I think we could supply something like that, as long as -- always careful about disclosing software -- or vendor pricing information. But if we can do it in a kind of a generalized way, I'm happy to do that.

MS. HOLMES: That would be terrific. You can work with our legal team in terms of what's confidential and what would be allowable.

My other question in terms of the budget is around salaries plus purchase and contracted services. So I'm adding the two together because I recognize there's been movement, particularly this year, between the two with the new UVM Health Network data contract. So I'm going to call this a human capital bucket, if you will, and that's hovered around 9 to 10 million dollars since 2018. When I look at that bucket between '22 and '23 I see about a twelve percent jump. And I'm trying to figure that out because the number of employees is lower, salaries are only rising by three percent on a smaller number of employees, and the UVM Health Network contract is supposed to be net neutral. So I'm trying to figure out where the twelve -- you go from, in 2022, I think I

have 10.7 million dollars collectively in that bucket, and then in 2023, it's about 12 million dollars. So can you help me understand that combined growth in what I'm deeming the human capital bucket?

MR. BORYS: One moving part to mention is as part of the transition to the UVM Health Network analytics model, the vital contract is now in that purchase services arrangement. So that's kind of a nonhuman capital component. The other that I'll mention that has grown over time is legal expense. That's been a pretty significant growth area for us over time. And more closely, it's also where our actuarial expenses live, which has been a growing expense as well. And audit -- audit has grown from an expense base also.

MS. HOLMES: I think probably what'll be really helpful is for us to understand some of that, if there's a way to deeper dive into that, because it's not clear from what you submitted where all those -- the changes in those dollars. So I think particularly if you go from '22 to '23, it would be helpful for us to understand those moving parts with fewer employees, salaries rising only by three percent. If you add up the contracted and purchased services, it's hard for us to offset what is UVM and what is some of the other

buckets of services that you're providing. So if you could just help us do that walkthrough, I think that would be helpful.

MR. BORYS: Sure thing.

MS. HOLMES: Thank you. All right. My last actual question is around -- then I want to -- because I'm also trying to be cognizant of there's many other people that have to go after me. You submitted some data in Appendix 7.4 that illustrates the proportion of patients in the high-risk groups whose care is managed and coordinated. And to be honest, I was surprised by the proportion of high-risk patients whose care is actually being managed is quite low. Only five percent of patients in the very, very high-risk level report being or -- are reportedly being managed and only six percent of high-cost members. So I'm wondering if -- and maybe this is a question for Dr. Wulfman -- did those reported percentages surprise you given all the efforts that OneCare is taking to manage the care of the folks in that fourth quadrant? And how do we interpret those numbers? And I recognize -- I read all the footnotes there, and we can't compare '21 to '22, although I would like to, but I recognize we can't because it's a different collection mechanism, but given the data in 2022, those

numbers seem surprisingly low to me for that high-risk category.

MS. WULFMAN: I agree they are lower than we would like. I can't give you all the reasons why. We are always driving towards maximizing that. I can look into it further. It does differ across payers, and it differs from HAS to HAS, so there are a lot of factors that impact that. But obviously, our goal is to keep moving that up. There is a little bit due also to switching from Care Navigator for recordkeeping to our new methods, and that's settling out still. So we're still in transition, and so the rates may actually be higher than what we were able to report.

MS. HOLMES: Do you have -- I guess I'm thinking, assuming your new population health management payment strategy and bonus incentive systems work, these numbers should rise next year. So could you submit -- and if you don't have them today, understandable -- but could you submit your target levels for what you're anticipating the percentage of patients in each of those categories to be managed for next year so that we can get a sense of how well you're tracking progress towards those goals, given that you're changing your payment mechanism to try and

maximize care management?

MS. WULFMAN: Absolutely.

MS. HOLMES: That'd be great. Thank you.

I think I'm going to kick it back over to you, Chair Foster, given how much time we have.

MR. FOSTER: I think you're fine if you'd like a little more. If you're all set, we can come back to it if you'd like. Do you have more or you --

MS. HOLMES: All right. Well, let me --

MR. FOSTER: Go ahead.

MS. HOLMES: -- go ahead and I -- yeah, I have a couple of questions, but I can -- I'll see if others have those similar questions. Then I can come back.

MR. FOSTER: Okay.

MS. HOLMES: Thank you.

MR. FOSTER: Yeah. I sort of budgeted thirty to forty-five minutes per member. And if people go over or under, that's totally fine.

So next, we'll go to Dr. Murman.

MR. MURMAN: Hi. Dave Murman, new on the board. Nice to meet most of you for the first time, a few of you in the past. And I have a lot of

questions for you. I'll try to trim it down. They keep growing through each hour.

So I guess I just want to start with, like, an introductory remark, which is to say thanks for your budget submission and presentation and all of this overview. As you can understand, I'm sure that coming to try to understand all of the intricacies in the last six weeks has been a bit of a lift for me as my preconceptions of what an ACO and OneCare is have been completely flipped, and I hope that I understand this well. So I may have some redundancy in some of my questions of what things that you've covered elsewhere, and I apologize for that.

I just want to be clear that you guys understand that our perspective on this from the care board is that we are tasked with -- we're a regulatory agency, the task improving the health and population of Vermonters, reducing the per-capita growth and expenditures for health services in Vermont across all payers. Although, I think we're particularly concerned about ones that affect Vermont commercial payers and Medicaid while ensuring access to care and quality and is not compromised, enhancing patient and health care, professional experience of care, and recruiting and retaining and achieving administrative simplification.

So each component of that healthcare delivery system shares many of these goals that are often not entirely aligned by different market forces, incentives, and other priorities. So just understand that our questions and my questions today come from this perspective, which is -- and these aims are just to drive a system-wide improvement in access, affordability, and quality in health care to improve the health of Vermonters.

So with that sort of background, I guess the first question that I have in reading through all this and listening to all this is that clearly you are people that think a lot about health care: healthcare delivery, health of the patients, the population of Vermont. And so my first question is -- and I'd love to hear from any of you -- is what you think as a state, as a society, what are the things that we can do from here to improve the health of Vermonters? Not necessarily OneCare or ACOs, but what are some of the things that we could do? And I guess, then, if there are some things that OneCare can address, then that's, I guess, the ones that are most exciting to me.

MS. BARRY: Well, I can start at a very high level. I mean, what comes to mind for me is that I think we need to grow a broader understanding of true

population health and we need to be putting more resources and intentionality around preventive-based activities. And I think that the healthcare system in the United States is kind of perverse in that sense, that we're really focused on treating acute care and illness and not enough up front. And that's one of the issues that I will say we, at OneCare, grapple with, but it's an issue that we hear from providers across the state as we have conversation.

MR. BORYS: I can add to that a couple of different perspectives as well -- or additional perspectives, let's say. First is having a healthy care-delivery system. And I mean that broadly in that it's not just financial health of organizations, but there's provider satisfaction and they are ready, willing, and able to care for patients. So that's something I think about a lot in these programs is, under CPR, the Comprehensive Payment Reform Program, for example, our providers are actually more satisfied in this type of arrangement and therefore can deliver better health care. Their focus is more on the health care. So I do think about how do we make the healthcare system itself as high functioning as it can be and then that should, in my view, lead to better health outcomes for patients.

The other thing that's really in OneCare's wheelhouse but not exclusively is the use of data. I think the data that we have sheds light on opportunities that are otherwise invisible in our system, and we can really do a lot with these data in terms of identifying opportunities for specific interventions, specific improvement areas, so that we can collectively raise the bar and that every diabetic patient is well controlled now, and we know exactly where we stand, we can make measurable improvements over time.

MS. LONER: Yeah, Tom, I would just agree with what you said and add on in terms of workforce and having a happy and satisfied workforce. And I think part of that that could be better reviewed or looked at, and maybe something that the care board could take a look at is what are those administrative burdens that are being placed on healthcare providers right now, and is there a way to be able to streamline and simplify some of those burdens, because what you're trying to do is create a better mousetrap in value-based care. And you have to always have regulation, and smart regulation is good regulation, but you can't put additional administrative burden on your already-fragile system unless you have a real reason for doing

it and making sure that the reason you're doing it is that people are going to be better off at the end of the day. And people that's like all Vermonters, like that's what we're trying to get at, is are people better off because of this new system approach or not?

MR. MURMAN: It's interesting, all three of you kind of spoke to things that I have furthering questions.

So Vicki, if I could start with you, which is, I'd actually cross this question out, but what has one -- as OneCare describes that they do in the budget submission that there is a reduction in administrative burden, and I was wondering if there's a one -- is there a way that OneCare measures that reduction in administrative burden, or at least from a survey standpoint, if we know what reductions are occurring, if that could be quantified in some way as a decreased impact on those providers? I mean, we all know that primary care providers are burning out with pre-authorizations and complying with certain documentation and regulations. But what has OneCare done and how do they quantify it to reduce administrative burden?

MS. LONER: We haven't surveyed, right, to get an exact percentage on how we've done this, but

I can tell you a few of the ways. So through our contract with Medicaid, the providers that are part of OneCare had administrative relief of prior authorizations for select services because they are agreeing to be accountable financially and clinically for certain measures. So that provides a measure of relief for all Medicaid individuals that are in the program -- and their providers as part of that.

We have done things internally to be able to reduce administrative burden back to the providers, as Carrie mentioned. Through our population health model, we used to have care-coordination metrics, value-based incentive metrics, population health metrics. It was all in support of caring for the person and what better outcome; so why don't we blend those all together, take a more holistic approach, and get down to a few measures that are meaningful to providers. That's easier -- it's not easy to do, right? Because all payers have their requirements that they'd like to see and things they'd like to measure. You as the Green Mountain Care Board have things that you would like us to measure. And so this is really trying to get at what are those measures that the clinicians believe are valuable to measure and patients are better off because of it. So those are

two concrete examples of things OneCare has done to be able to reduce the administrative burden on healthcare providers.

And the payment reform alone provides a lot of flexibility in terms of the way care is delivered to Vermonters and not having to be tied to certain CPT and ICD 9 codes in order to build for those services. So more flexibility in the way that care is delivered is what I would say.

MR. MURMAN: Sara, I want to just follow up on your thing with prevention. I think one of the things that we struggle conceptually with -- I think you're a pediatrician or were a pediatrician or a pediatrician or once maybe worked in --

MS. BARRY: No, just worked with them for a long time --

MR. MURMAN: Worked with them --

MS. BARRY: -- not one, though.

MR. MURMAN: -- because pediatric is really the place where prevention is occurring and -- for primary prevention, and then we're sort of stuck with secondary prevention and the -- for the bulk of our years. And then a lot of the metrics that we're using to evaluate the quality of health in Vermont are A1C scores, hypertension, depression, screening. I

don't know, I guess from my perspective, I feel like we're just sort of scratching the surface of what really health care's value is when we're talking about those things and that prevention really is almost -- precedes the delivery of health care. But with that in mind, are you -- do you feel that these metrics that we're following like A1C less than 9 -- I think -- I couldn't figure it all out -- is A1C less than 9, diastolic pressure less than 140? Depression screenings, are these -- do we know -- do you have any understanding whether or not this is -- I mean, a lot of these are really long-term things, but in the short term, do you have any data or signals maybe that this is reducing cost, reducing disease, reducing hospitalizations?

MS. BARRY: You're asking a wonderful million-bazillion-dollar question, really. And so I think there's multiple components to it. I spent many years working with pediatricians and family practice physicians and, from that process, learned that really a multi-generational approach to thinking about and integrating medical need and social need is incredibly complex and quite necessary to be thinking about the primary prevention strategies.

And so OneCare has a couple of things

that we're working on. With respect to the quality measures, you're absolutely right. We look at chronic disease management, and that's an important component to controlling costs and improving outcomes. But we also look at proxies for preventive care. So for children and for adults, we look at the use of wellness visits, age-appropriate wellness visits, screenings -- developmental screening for kids, being a good example -- depression screening for adolescents and older adults. And that's just the start.

We also really try to think about where there's space for innovation. So you'll see OneCare and it's budget continues to invest in a program called DULCE, which is a partnership between local pediatricians' offices, parent-child centers, and legal aid to really support new parents, so parents of newborns and young children, to identify some of those social stressors, environmental needs, and provide immediate referral and linkage to services to really try to get in front of and make a generational impact on some of those challenges that have existed. So that's -- it's small. And one of the challenges we've had, frankly, is how do you expand that model statewide when the birthrate is declining and we might not see in each practice enough newborns to actually make that

model work? But we continue to think about what are the strategies and what's the right place for those strategies? Is it in the patient center medical home; is it in the community; is it partnering in a different way?

MR. MURMAN: I think one of the things that I'm struggling with when I'm trying to understand what the potential impact of an ACO is within preventative care is this charge of the care board, which is trying to reduce the per-capita growth rate of expenditures in health care, and it seems that we can throw so much at prevention, but the gains of that are five, ten, twenty, thirty years out. And we've got this sort of confluence of crises going on right now where hospitals' budgets are really struggling, insurance rates are going through the roof, inflation, staffing, and whatnot. So I guess to follow up on that question, I guess, when you all as OneCare or as individuals think about cost drivers in health care and what those are, are there cost drivers in health care that you think that OneCare -- I guess actually is OneCare -- can OneCare augment these things that are driving up the cost of health care; and if so, how?

MS. BARRY: Well, I think OneCare tries to --

MR. MURMAN: In the short --

MS. BARRY: -- augment it --

MR. MURMAN: -- in the shorter term is I guess --

MS. BARRY: Yeah.

MR. MURMAN: -- what I'm trying to say.

UNIDENTIFIED SPEAKER: Yeah.

MR. MURMAN: Yeah.

MS. HOLMES: That's the difficult challenge right there, is the timeline. And so I think what we continue to struggle with and have conversations through all levels of our governance is how do you manage these one-year payer-contract cycles and performance expectations with mid- and long-term outcomes that our clinicians remind us all the time it's going to take years, decades, generations to address. And so I don't know of a secret formula that says here's exactly how much we should be investing in in prevention specifically versus chronic disease management. I think we're continuing to refine that.

But one of the most important messages that we as the staff at OneCare try to convey all the time to our provider network is that, using the data, not everything needs to go down. Like costs may need to go up in primary care. We might need to actually

incentivize more visits for people who are very fragile or have needs. And that's okay and good. That just needs to be offset with a broader vision of where are the avoidable areas of utilization and how do we address those all.

MR. MURMAN: I guess, how do you address the avoidable areas of utilization? And I think the big expensive utilizers are -- or the big expensive cost centers are going to be hospital-based procedures, admissions, visits. How does OneCare incentivize people to get care in other locations or in less expensive hospitals, EDs, places to get procedures?

MS. BARRY: I think there's multiple strategies. But as Dr. Wulfman spoke about a moment ago, certainly our care-coordination program is a large part of it. And the work that we've done in the last couple of years to get more precise in sharing information, not just about a large swath of individuals that might benefit from generalized care coordination, but specifically looking at those who are showing back up at the emergency department.

MR. MURMAN: Does OneCare have, like, any specific programs to try to encourage hospitals? Well, I mean, it's such a tricky time right now. So like, hospitals are still struggling. The budgets are

complicated. The labor costs are through the roof. I think you know I work in the emergency department. Our volumes are super high. The census of the hospital is super high. The census at the SNFs is super high. Access is super low. It's a really complicated time to work. But at the same time, boom, I mean, costs are just going up super -- very quickly in health care year over year. Are there programs that OneCare has to work specifically with hospitals to try to reduce costs within hospitals or push hospitals to encourage hospitals to move to -- say, to outpatient surgery centers or other lower cost areas to deliver care?

MS. BARRY: Tom --

MR. BORYS: I'll put --

MS. BARRY: -- do you want to speak? Yeah.

MR. BORYS: I'll put a plug here for payment reform. And that if we can change the way that these high-expense areas of the healthcare system are paid and one that's more of a -- I'll call it a capacity-based model rather than a volume-based model, it does help to stabilize overall costs. And the challenges it places on those facilities and organizations is to live within those means of here's your Medicaid fixed payment for the year; you need to

run your organization in a way that lives within that budget amount.

And then on top of that, you layer in the potential for shared savings or loss; that's another factor. So what I hope happens to these programs and all of a sudden the hospitals see, all right, my budget for Medicaid is paid, and now if I do extra, which is move care to lower cost settings to do better work with prevention, I can also earn some shared savings. And then I think the system starts to work better and is more focused --

MR. MURMAN: But for Medicaid --

MR. BORYS: -- on the health outcomes.

MR. MURMAN: So Medicaid with fixed prospective payments has some of that now, would you say, that the fixed prospective payments going to hospitals would incentivize hospitals to try to figure out how to be more cost effective while maintaining quality in their care?

MR. BORYS: Yes, I would agree.

MR. MURMAN: And then what are the quality metrics, then, for hospitals within that?

MR. BORYS: That's a good question. We're starting to discuss that with DVHA around this Medicaid fixed-payment expansion initiative. But

largely, it's been the same quality measures that we're accountable for broadly under these ACO arrangements. But I expect there to be some more facility-specific quality factors looked at in the future.

MR. MURMAN: I think -- one question. I'm kind of scattering around my questions here, but I appreciate your guys' comments. But one question I had that I -- when I was reading through the budget submission, which I think was kind of an anecdote regarding a potential cost savings in the Burlington HSA, was how the -- I was going to bring up by example of how OneCare's improving care -- and it's discussed in the Burlington HSA -- reductions in the increase in admission rate growth. And that there's this observation that the Burlington HSA limited the increase in admissions from, I think it was 2021 to 2022, from like seven percent to one percent increases in growth. And that was thought to be -- it's listed as a quality improvement. And I guess, how can you observe that this decrease in emissions is a quality improvement due to OneCare?

MS. BARRY: I think ultimately we're very cautious about questions of causality, because as I talked about earlier, there are so many different interventions, so many organizations that are involved

in these things. What we focus on is trying to provide the data, the resources, the information. And when we see best practices, that we try to serve as a vehicle to disseminate what is happening in the Northeast Kingdom that maybe the southwest of the state would want to know about or vice versa.

And more recently, one of the mechanisms we've just started using to help facilitate that is by inviting some of our network to present at public sessions of our board meeting to really highlight some of those success stories. And we'd like to see more of that happen.

MR. MURMAN: Yeah, I think this specific thing what concerned me was like is this increased quality or is this decreased access? And are we seeing the impact of difficulties of getting inpatient beds in the Burlington HSA and that's why admissions are down, and I know that patients board often for a long time at hospital in the Burlington HSA and that they subsequently don't get admitted. So I sometimes get nervous with some of these, as you mentioned, sort of causative-sounding things that really are observational.

Let me just flip to one other -- oh, I wanted to bring up another issue that I think -- and

I'll try to -- I have my sort of drawn-out case stories in emergency physicians seeing elderly patients who are near the end of their lives. But basically, it gets to the point that I think a lot of my patients really want -- struggle with having really intimate conversations with their providers. And they're focused on diabetes management, hypertension management when really, like, they're trying to figure out how to manage the later years in their lives, which gets into the question of goals of care. And often in the emergency department, we'll see patients, who don't really have well-established goals of care, that are critically ill. And we spend -- we're happy to connect with these patients, and it's really incredible work. But it often feels like we're doing a lot of really expensive testing, interventions, unnecessary testing, hospitalizations, when it really kind of turns out over a period of time that really this is not consistent with what this person would want in their life.

And so I guess my question is, is what is OneCare looking at trying to incentivize providers to have goals-of-care conversations, palliative-care-type conversations, end-of-life care conversations with patients in sort of -- in a way that is universal?

MS. WULFMAN: I'd love to answer that.

Hi, Dr. Murman. I'm a family doctor in Brandon where I've worked for twenty-four years and I still see patients. And I couldn't agree with you more on that topic. It isn't solving it quickly, but we are convening a work group to work on that kind of topic. I'm a big believer in planning for appropriate care in the primary care home and being willing to have those discussions in a timely fashion. So if a patient doesn't really want to be in the ER and run up a huge bill with expensive testing, then that doesn't happen. Or if they do, let's talk about why. So we're going to have a work group called Living Fully Supported (ph.), and it will include topics like that and palliative care and SNF challenges, et cetera.

MR. MURMAN: Thanks.

MS. WULFMAN: Um-hum.

MR. MURMAN: I think it's just incredibly important work. I know you work as a family doc, and I'm sure that's a daily patient's interaction is trying to figure those things out.

I have a few more questions, which is also -- is OneCare able to do anything to try to improve the complex issues relating to SNFs and rehab facility access, staffing? Is there any levers in your guys' wheelhouse that you can move to try to improve

the ability to move patients from inpatient to longer term care?

MS. WULFMAN: I'm happy to answer that also, if that's okay. We have been having discussions with the state and with the UVM Health Network medical group administrators and with a lot of different providers as well as the medical directors throughout the state who oversees SNFs about this problem. And we are moving the needle forward slowly. I have a meeting tomorrow again about this. But OneCare has put aside some funds and is willing to help with a pilot and some initiatives in this area. We haven't firmed up the whole plan yet, but more to come, and we are focused in on helping with this issue.

MR. MURMAN: Because when I think of cost drivers in our system right now, I guess I feel like the challenges of moving people out of the highest cost settings into lower cost settings who don't need that level of care is probably a pretty significant cost driver.

MS. WULFMAN: Very much agree.

MR. MURMAN: So I have a few questions that came up while we were talking here today. Oh, I have one -- here, I have a few prior questions. So regarding the Medicaid total cost of care, so I see it

is on page 22 of the budget submissions, 306 million dollars, but only 171 million's unreconciled. Is that difference due to the non-attributed Medicaid patients or is there another reason why the rest of that is not unreconciled?

MR. BORYS: Great question. So the way that total cost of care is determined is we take the attributed population, which is around 100,000 roughly for Medicaid, and project the total cost of care for those patients. And that is really the total cost of care. It's healthcare expenditures regardless of where it's delivered, whether locally, down in Massachusetts, and Florida. The subset in the fixed payment represents just that portion of care at the providers accepting a fixed payment, so just at the Vermont hospitals who are under the fixed-payment arrangement. For the other care, it is paid by Medicaid on a fee-for-service basis and they bill a client, Medicaid, pays it, but it's part of our accountability and ultimately determines whether or not shared savings are earned or shared losses are owed.

MR. MURMAN: Okay. Thank you. That's super helpful. So -- and then to pivot to the whole OneCare-UVM relationship, which I must admit is something that I don't think I quite understood before

today. So I guess, first of all -- so is OneCare a subsidiary of UVMMC or UVMHN, or is it a separate organization?

MS. LONER: We -- we are a separate LLC 501(c)(3) organization whose sole parent or sole member is UVM Health Network. Our members used to be UVMMC and Dartmouth-Hitchcock Health. That changed about a year and a half ago to UVM Health Network being our sole member.

I would say the difference between what you might see with other UVM Health Network affiliates is that our board of managers is fully responsible in charge of our budget: personnel, strategy, expenses. And UVM Health Network does have members on that board.

MR. MURMAN: Do you, Vicki, have a reporting structure within the UVM Health Network other than the board?

MS. LONER: I do not.

MR. MURMAN: Or not -- not the board, the board of OneCare.

MS. LONER: I do not. My direct reporting structure is up to the board of managers. So only the board of managers can hire and fire the CEO or the officers of the board, me being one of them.

MR. MURMAN: Okay. And then given that

the DMO is now going to be managing all this data, which my -- my understanding of UVM health network is the DMO is under the CFO's reporting structure. Is Rick -- is Rick Vincent going to have any -- is -- what's his relationship to the data that then is going to be held by OneCare? Is this -- is this -- is -- how does that work?

MS. LONER: To kind of simplify it, think of UVM Health Network as OneCare's vendor, providing data and analytics. So it's a purely contractual agreement between OneCare and UVM Health Network.

MR. MURMAN: So -- and to get back to one of Owen's questions, the -- why would -- why can't OneCare just contract with Arcadia? What's the intervening step that the DMO does that -- that -- that they need to do?

MS. LONER: So OneCare could hold its very own contract distinctly with Arcadia. In terms of economies of scale, that might mean that we have a lesser -- like, we have to pay more of a PMPM to hold that payment directly with Arcadia. So that --

MR. MURMAN: Does UVM have other contracts with Arcadia? Is that the --

MS. LONER: No, I'm just saying, for us

to have our own separate and distinct contract with Arcadia versus buying a whole kind of suite of both tools and personnel would come at an increased cost for OneCare.

MR. MURMAN: So what's -- what's the DMO doing -- what's the intervening step that the DMO does between OneCare and Arcadia then? That -- that -- you said you have the suite -- the suite. I assume the suite is the DMO part?

MS. LONER: It's the tool and the people.

MR. MURMAN: So Arcadia --

MS. LONER: So think --

MR. MURMAN: It -- and it -- you couldn't just independently contract with Arcadia without having another layer of data-management people at OneCare; is that what you're saying?

MS. LONER: Right. Correct.

MR. MURMAN: But then there's people leaving OneCare to go to the DMO to do this job?

MS. LONER: Yeah, so remem --

MS. BARRY: Yes, that's correct.

MS. LONER: Yes. Remember we're all UVMMC employees. But now it moves at -- all from our financials as a direct FTE to a contracting service.

MS. BARRY: So maybe two -- two points I could add. One is that the general philosophy behind how the agreement is structured is that it's focused on the deliverables and the expectations not on a count of the number of people. So that's important because it's our board that's -- at OneCare that's really saying, we want better analytics; we want them to be more customized for specific audiences; we want more flexibility around them.

And then the other reality just in terms of software in this field in general, not speaking of any one specifically, is that a lot of their payment structures or their fee structures are based on volume. So the more lives you bring in, the lower a PMPM or a PMPY might be for those costs. So ultimately, we can leverage more buying power in any of these analytic services when we think about that combination of the lives that are not part of OneCare, sitting in one place, OneCare lives being under this sort of master agreement.

MR. MURMAN: I -- I guess the reason why I bring this up, and I think we're all kind of hung up on it, is the optics of this are kind of -- kind of awkward and challenging. I mean, I think that if you -- if you put yourself in the shoes of someone

who's not -- who's a competitor of UVM, say for instance, or a patient who sees a competitor of UVM for their healthcare, now more consolidation of OneCare within UVM kind -- kind of creates a little bit of a concern or an image -- potentially an optical image of a concern that UVM and OneCare are, you know, working together to sort of -- to potentially benefit UVM.

I think what you're saying is that there are firewalls and protections and organizational structures to prevent that, but I -- I would imagine you could -- you could see that without this clear hearing or a clear idea that that is -- on the surface, it's UVM employees taking UVM and data services under the CFO's management to -- to aggregate quality and operational data throughout the whole state. It just has a -- it has some challenges to it, I think. But I -- I don't want to --

MS. LONER: Yeah.

MR. MURMAN: Just optically.

MS. LONER: I -- I get that. I totally agree with you that there's always going to be optical challenges. And then there's the practicality of the fact that we've put in safeguards to be able to protect against that. And we could spend all day talking about what those safeguards are.

There's also -- the reality is that if OneCare Vermont went out and tried to do all of this on our own without the support of our sole member organization, we'd have to hire our own HR team; we'd have to hire our own payroll team; we'd have to hire our own IT and security. So we'd be bringing forward a budget to you that is way more than the current one that we're bringing right now.

So by aligning and sharing and not duplicating resources, actually enables us to bring in a budget that's lower than would otherwise be if we weren't sharing these resources. Which would mean that our participating hospitals that are not UVM Health Network would be paying more for the services than they are right now because our budget would be even higher.

So there's the optics, and then there's the organizational business of making sure that we're keeping our operational costs as low as we can so that we're good stewards of the State.

MR. MURMAN: I guess, the -- the one other thing that you bring up with that too is that organizational costs, you have this really nice graph of them declining over time as a percentage. Do you have a similar graph showing the -- the -- the shared savings by your -- your attribution as well, if that's

changed over time or if that sort of offsets -- if that's related to the -- to the attribution?

MR. BORYS: In the submitted materials, there's shared savings earned year over year. Happy to consolidate it if that would be helpful, but is that kind of what you're asking?

MR. MURMAN: Yeah, I guess I -- the -- the graph that you showed is really, really helpful to see is there. And I was just -- and I haven't -- I did look at the shared savings, but I didn't look at as -- as a percent of the total attributed lives or a percent of the total budget like you do with --

MS. LONER: Okay.

MR. MURMAN: -- a graph of the -- of the total budget. And I think that would be a kind of a helpful visual to understand how successful you guys have been at sort of working with the various, you know, provider networks towards shared savings.

MR. BORYS: Yeah, I -- I think -- I think I understand what you're saying, yeah.

MR. MURMAN: I guess that's all I have for right now. I -- thank you so much. I will pass it back to Owen.

MR. FOSTER: Thank you. Just -- let's take a -- Cassidy, how long of a break would you like?

THE COURT REPORTER: Oh, five minutes would be great.

MR. FOSTER: Okay. We'll come back at 2:36.

THE COURT REPORTER: Okay.

MR. FOSTER: Thank you.

THE COURT REPORTER: Thank you. Off the record.

(Recess at 2:31 p.m., until 2:36 p.m.)

MR. FOSTER: And we'll turn it over to Thom Walsh for his questions. Thank you.

MR. WALSH: Thank you, Chair, and thank you, Cassidy, for your help today. Thank you for -- OneCare members for joining us and spending a long day of answering questions. I want to turn to outcomes and process improvement, if you don't mind. What is the outcome measure that you believe best demonstrates the value that OneCare provides to Vermonters?

MS. LONER: Sorry. I can't get myself from mute. So --

MR. WALSH: I have that trouble too.

MS. LONER: I -- I would say that the federal government has created a national framework through the Medicare program to evaluate ACOs' success in quality-of-care programs that follow care

coordination, patient safety and experience, and overall chronic disease management. They also have a framework for looking at savings and losses per ACO. So at an overarching level, Vermont is no different in that we follow the framework that was very carefully selected by the federal government in evaluating the success of our programs year over year. And we do that across payers.

MR. WALSH: Yeah. I -- I appreciate that. I'm -- I'm familiar with the framework. I don't know that Vermonters are. And there's -- there are concerns that the organization, the accountable care organization, is -- is costly. But it's hard to identify the benefit. And I -- I'm just trying to -- to help with that a little bit. And so from that framework, what's the biggest -- the best outcome?

MS. LONER: I think if you asked 1,000 clinicians, you'd probably get 1,000 different answers on what is the best outcome because they're all different in looking --

MR. WALSH: I'm asking -- I'm asking OneCare leadership.

MR. BORYS: I can take a stab at this. I think there's a lot of -- of different ways value can be measured, but to suggest, for a number, I'll give

two --

MR. WALSH: But what do you think is best?

MR. BORYS: The two numbers that I think of, first and foremost, are 296,000 lives and 1.4 billion dollars. And I say that because what OneCare has done is put the care for those lives into accountable relationships, meaning that the providers that care for these individuals are now accountable to quality --

MR. WALSH: I appreciate -- I appreciate that. I appreciate that, Tom. And I -- I don't need to have ACOs described to me. What's the outcome that you believe has had the biggest impact for Vermonters?

MR. BORYS: Well, that's the one that I believe.

MS. LONER: I -- I think that's what Tom is --

MR. WALSH: Don't -- so let me just -- let me follow up with Tom, please. You believe that the number of lives covered is the best outcome?

MR. BORYS: What I was saying is that I believe having the care for these lives in value-based arrangements is a very positive outcome. And absent OneCare offering these arrangements and programs, the

way I see it is that everybody just goes back to their own corners of the health care system and -- and does things the way they've been done for decades.

MR. WALSH: Okay. So what -- what I'm struggling for, right, is -- is to find an outcome that would be meaningful to Vermonters. And you may be able to say something like reduced ED visits. And then I could follow up and say, is that the same across all hospital service areas? And you might be able to say no, we have some that are underperforming, some that are performing well, and we're trying to learn from each other. I could ask reduced ED visits, is that the same for white and nonwhite patients? Those are outcome measures that matter to patients, and I can't find them.

What I find on page 6 of your executive summary are things like, we've made measurable progress, including modifying coordination programs, engaging stakeholders, redesigning committees, testing models, and developing a plan. That's not really what I have in mind when I think of measurable progress. All right. And it's -- like -- like Chair Foster said at the beginning, I think we need to change a lot about the way health care gets done across the country and here in Vermont. The Vermonters deserve better. All

right. I want OneCare to succeed, so please keep that in mind as I work through these questions.

Outcomes are first mentioned on page 49 of the submission -- the narrative submission you sent to us, and you outlined four categories of -- that you've put patients into: healthy, stable, rising risk, complex. All right. Earlier, there was a question, and it was less than ten percent of the patients in the complex bucket receive coordinated care. Somebody is defining that and saying it's coordinated care.

Now, that didn't surprise me at all. All right. I don't think that that's underperformance necessarily because they could be in the complex bucket because they're not getting coordinated care. They're hard to get ahold of, to coordinate care with, or they have a hard time accessing services in our -- in our delivery system. All right. But I don't see what's happened to that number since 2016. I don't see any outcomes stratified by those groups.

I see a CMS report card for Medicaid ACO work. And the overall grade on the report card is around sixty-nine percent. What's the corrective action you're planning to take to improve that score?

MS. LONER: Carrie, I can probably let

you speak to this, but a lot of the questions that you had surround providers' ability to impact care and to change care delivery.

MR. WALSH: That's right.

MS. LONER: Right? And so --

MR. WALSH: Is not one of your aims to improve the coordination of care --

MS. LONER: Right. And so --

MR. WALSH: -- and to help them to do that?

MS. LONER: Our job at the ACO is to provide them the data, the analytics, the supports, the insights, and the payment reforms to enable them to do that. That's what OneCare does, and that's what we should be evaluated on. The outcomes are --

MR. WALSH: And so --

MS. LONER: -- provider -- let me finish.

MR. WALSH: I will.

MS. LONER: The outcomes are driven by our care delivery system, which are frontline providers who are hurting from a workforce perspective, hurting from a financial perspective. So I would ask, what is the system in totality doing to help clinicians deliver care, just deliver care on a day-to-day basis? So what

we're doing is a small part in helping them in value-based care arrangements.

MR. WALSH: I -- I appreciate that. And if OneCare's role was to support through data analytics, maybe training some other things, over time, wouldn't there be improvements that we could point to? Right. If we looked year over year, and it's been going on for five or six years, wouldn't there be improvements that we could point to, even if it's just a little piece?

MS. LONER: And I think Carrie was showing some of those improvements that we've had in select measures. And you also have to remember that we've been living in a pandemic for the last three years, and so really evaluating while we've been living during a pandemic and care delivery has had to radically turn itself on its head just to deliver basic care for our patients, I think that's an unfair expectations to put on our providers during a time that they've been struggling to take care of patients.

But Carrie, I don't know if you'd like to say more about that as a frontline provider of care.

MS. WULFMAN: Sure. I agree with the last comment you just made there, Vicki.

And Thom, my answer to your question

about outcomes: I -- when I think about what patients, their families, and caregivers want, I believe we want wellness, first of all. And after that, we would like access to care. And granted, not everybody wants the same kind of access.

We touched on that earlier, but I do believe that most people want primary care access. I think most people know that's where they're going to get the best care and help -- education and help staying well or being treated when they're sick. I don't think people want to go to the ER necessarily or be in the hospital.

So I think people want more primary care. They want their basic needs met, which is why we're studying social determinants of health and finding out where that intersects with the quality metrics that we are working on. And I think people want their care coordinated. That's very different in my book than needing a care manager, although that's a section of it. But we all want our care coordinated. We don't want confusion. We want communication. If we have a mammogram and it's abnormal, I don't want to know that next week. I want it today. I want it tomorrow at least or as soon as possible.

So I think those are the basics that we

want. And I think that the support -- the data and the sport -- supports that we're giving our members are pushing in that direction.

We have been in a pandemic. Primary care access has crashed. You know, it's -- it's been a mess. People go to the ER or they stay away from their primary care on purpose because they don't want to be exposed, et cetera. So it has been a hard time to measure this.

But going forward, what we're pushing are these very things: getting access in the right location, being accessible, providing coordinated care, and also, I think for primary care to move in the direction of team-based care is a big piece of this as well so that we have, in the primary care home, the components that our patients need access to. They may need a behavioral therapist, they may need a dietitian. And when that's all more centralized, I think we can provide better preventive care and better sick care as well.

MR. WALSH: I -- I appreciate that too. And -- and I understand that we've been in a pandemic, and it's disrupted everything. It's disrupted everybody's lives. And most of us have family members that have been severely affected. It's no small thing.

All right. I get it.

If there was a mature service organization following outcomes and working to improve processes, we'd see tables and charts of where things were at the beginning, what's the -- the current system performance, what interventions have we utilized, and what's the performance now? Right. What impact we've had. Then we could say, oh, we had a small impact, but there was a pandemic.

I -- I don't see things like that in your submission. I see a lot of different grass from a lot of different places and a lot of reference to federal government things. But when we're trying to assess the budget of OneCare in being able to meet our charge the way that Dave outlined, we need to be able to assess the outcomes and the improvements that the organization is meeting to justify the budget. And I want to see those things, but I don't.

MS. LONER: I think what you're asking for, Thom, would require that we were in a stable state every single year. So for instance, our network and our attribution and our patients were different in 2017 than they were in 2018 than they were in 2019, and so on and so forth. So it's not a straight line that we can be able to measure year over year, because year

over year we look very different from a composition point of view in terms of both providers, practitioners, and payers that attribute.

So what you get from us is an annual evaluation on the current state of affairs. And what you're getting with a NORC evaluation is a more comprehensive qualitative and quantitative analysis of how the system is working.

MR. WALSH: That's --

MS. LONER: And that's what they're being paid to do.

MR. WALSH: Yeah, I -- I read through that carefully. They do a good job, and there were some promising things that were happening in the first couple years, for sure. Right. They kind of flip around a little bit. They -- they talk -- NORC talked about some reductions in ED visit utilization. Some more recent things looks like ED visits are -- are higher, right? So there's conflicting aspects, but we can at least try to follow it and talk about it when we have those outcome measures. Right.

And it's -- I understand, the -- the composition of the participating providers changes. That's not unique to Vermont. Before I did this job, my other work was working -- some of it involved

working with ACOs who are trying to form or trying to improve. That problem isn't unique, but they can generate outcomes, and they can show process improvement and change in outcomes as a result.

You -- you started to talk about key performance indicators in -- in the submission. What are your top three key performance indicators?

MS. LONER: So we're working right now through the process I described with the UVM HSR team. They did the research. We have a set of ten or twelve KPIs, and they are going to our board to be reviewed. And in particular, we want to look at them in terms of their alignment with the Medicare benchmarking report. I would say globally there's pretty good alignment, but I don't want to be in front of our governance process in saying what those final measures are. We'd be happy to follow up with you as soon as that conversation happens though.

MR. WALSH: It -- it'd be great, right? You're -- you're here before us, and we're reviewing the -- the budget. And it would -- and this isn't the first year you've been doing it. And it would be part of preparing for this to -- here's our performance indicators. Here's how they've changed over time. Here's our strategy and tactics going forward.

In the submission to us, we had things -- the key framing questions about the KPIs were, what's in our sphere of influence and what will best demonstrate our value or potential value? Those seem very relevant to OneCare, but not particularly relevant to Vermonters.

Meanwhile, right, we're -- we're talking about six years in, figuring out KPIs and whether they're in our -- your influence or not or whether they'll demonstrate how good we're doing or not. Suicides are at a all-time high in Vermont. Right. We've got ED visits, according to the latest data, that are twenty-nine to thirty-seven percent above those of comparison ACOs.

Many of those suicide attempts or depression, anxiety, people seeking care for that. It's very difficult to get in to see a primary care provider or a psychologist. Oftentimes you need to use telemedicine and go out of state to have access to those. Given the high rate of ED visits, given the difficulties with mental health and substance use disorder, does OneCare have an action plan to address those needs?

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

MS. WULFMAN: We have an action plan to address avoidable ED visits built into our population health model, and I already described that briefly. We can come back around when we meet with you later on our whole quality update and give you more information about that. And we don't have our own personal organizational project, if you will, on reducing suicide, but we have had many discussions, and some of the leaders are working together with other efforts that are going on in the state that we want to support.

We don't want to start something new. There are efforts going on with the Department of Health, with the Howard Center, et cetera. We are in conversations with those groups and plan to join and provide our support there. In -- in a very -- in a very, you know, real way, not just -- not just giving you lip service.

MR. WALSH: I appreciate that. And I'm -- I'm glad. We'll be able to follow up more about -- about quality. And I'm looking forward to that.

The ED visits, the wait time issues, part of -- of OneCare's mission as outlined at the beginning of -- of this meeting was addressing care coordination. What -- what role do you all see as

one -- that OneCare has in addressing the wait times issue in Vermont?

MS. WULFMAN: There are, as we talked about earlier, wait times at all locations. So are you talking about all those locations or just ER wait times right now?

MR. WALSH: I'm -- I'm wondering if OneCare sees itself as having a role in helping address the issue of wait times across the state?

MS. WULFMAN: Absolutely.

MR. WALSH: Can you describe the role, please?

MS. WULFMAN: I think the role is multifaceted, depending on the care setting. So -- and I believe that they've all been touched on, at least briefly today. So working with a consortium on providing some physician coverage for the sniffs (ph.), because they're in a crisis with not enough physician care. Therefore, throughput from the hospital to sniffs is -- has a roadblock. So we're working on that.

We are incentivizing wellness visits in our population health model that requires people opening up access in the primary care home and getting their patients in for wellness visits. That's child,

adolescent, and adult age forty and up. So those are some of the examples, but definitely top of mind in -- in all of our clinical work.

MR. WALSH: I appreciate you helping me understand more about it.

MS. WULFMAN: Um-hum.

MR. WALSH: Here -- you talk about data analytics to support providers. And in the narrative that you submitted, you write that in the -- you're in the process of developing a survey for primary care providers. And at this point, the work in progress is to explore the practical implications of deploying the survey and increasing the response rate. Could you explain what exploring practical implications of deploying the survey means?

MS. WULFMAN: Yes, I'm happy to do that. I took the survey, and I helped to deploy the survey. So we worked with the research group at UVM on this. And there are -- we learned a lot, a lot of lessons learned. First time to do it.

We sent the survey link to leaders in health care throughout the state and asked them to ask their primary care force to take the survey. So instead of sending out an email to the whole list, we used other local healthcare leaders to see if they

couldn't get their primary care providers to answer the survey. We thought that would be more effective.

MR. WALSH: I was hoping for (indiscernible) all of that.

MS. WULFMAN: I think it was more personal. That's why we did it. It was not effective. People are busy. I took the survey. It took maybe ten minutes, but people -- several people started it and stopped. They either didn't like it or they got interrupted.

So there are multiple reasons why we didn't have more success or as much success as we wanted. Eighty responses throughout the state. Like Jessica's mentioned earlier, that's not a very high response, but we had to kind of do some extra calling to get that many people to respond. So you know, I sent some emails later to the leaders reminding them, please ask your people to take the survey.

So many reasons why getting this off the ground wasn't exactly what we wanted. But again, we're learning from it. And there were questions in the survey about, what does OneCare do for you; what does OneCare not do for you? We didn't ask for written answers. They were more agree, disagree, strongly agree. You know, a line up of responses, multiple

choice.

So that also has its limits. We would have liked to ask for some written responses, but we thought this year let's just get a survey off the ground and get some responses going and learn from that. So that's what we did. And --

MR. WALSH: I appreciate the explanation. What -- what -- what was the response rate at this -- at this point?

MS. WULFMAN: Yes, the survey has only been partially analyzed, so I don't have all the final. We can share that with you later. But as Sara shared in her report out, it did differ between -- at least so far in what we've analyzed, it differed between independent primary care providers and those who are employed. And I think you can probably figure out why.

MR. WALSH: Yes. But what was the -- what were the rates?

MS. WULFMAN: I -- I don't have those off the top of my head. The rates of -- of response or the rates of like versus not like, et cetera? We can --

MR. WALSH: Just -- just the --

MS. WULFMAN: -- prepare that for you later.

MR. WALSH: The -- yeah, the response rates would be great.

MS. WULFMAN: Um-hum.

MR. WALSH: And you must know, like, how many you sent out and how many you got back.

MS. WULFMAN: Oh, oh, yeah. I don't know the total we sent out. But as -- as we said, we got eighty completed and a few more partially completed. So I believe there are about eighty being analyzed.

MR. WALSH: Okay. Thank you.

MS. WULFMAN: Um-hum.

MR. WALSH: So I guess what I -- what I'd like to -- to be able to do, looking at the budget is to -- to move beyond a simple assessment of the dollars. Health care is expensive. If we were -- in our country, we were getting -- we all felt confident that we were getting great service, our lives were healthier, we were living longer because of the health care we were receiving, we'd probably be pretty happy spending a lot on health care. And we spend tens of billions of dollars a year on pet food. Right? We don't -- we're a pretty wealthy country overall. We -- that -- that seems a reasonable place to spend money is on health care.

But in our health care system, as you all know, and you're probably motivated to do what you do because you know some of this information, our outcomes are mediocre at best, but we spend more than twice as much per citizen as any other country. And so we need to move beyond just the dollar amount to look at the outcomes that the work we're doing is producing.

And -- and six years in, right, I'd like to be able to look at a budget for an organization and see, here's where we were when we started; here are the things that we've been doing; here's where we are now; here's what we're going to do next. And none of those numbers are ever going to be perfect. There's going to be limitations and problems with all of them each of the time, and we can have a discussion about that. But we want to be able to see what's happening because of all that's being spent. And that's very difficult to see with the material that you're providing to us.

I want you to succeed. I want health care transformation, but we -- I need to see more of it. All right. Like, what are -- here are the outcomes that matter. Here are our priorities. Here's our impact. Here's what we've been doing to address the systematic issues facing the state's health care system.

And these things can be rather simple when you break it down. We -- you -- you could be asking, right, what proportion of covered lives of patients have diabetes? What proportion of the patients with diabetes have an A1C level greater than nine? That's already being done, right? You've got those numbers.

The next step is to say, what proportion of those patients have not been seen in the last six months? Of the patients who have not been seen, what number of those end up in the ED or end up admitted Over time for any -- for the whole care system and for any HSA within it, the goal would be zero admissions and zero ED visits, and the number of patients with an A1C level greater than nine should shrink. You don't need to benchmark to anybody else, just show that those numbers are declining and getting closer to zero. We need some type of -- of measurement like that.

The final question. This came up from listening today. Sara, I didn't quite get it all, so I'm hoping that you'll -- you'll help me out. Says OneCare is unique. It's a statewide entity. Most other ACOs, I think she said, are more clinically integrated? How -- how --

MS. BARRY: Yeah, so Thom, the point I

was trying to make is that when you look around the country, ACOs vary tremendously in size. Many of them are aligned with a specific health system and work within that health system. So there's much more interoperability of data and information.

And the point I was trying to make is that one of the ways OneCare is complex is that we have this statewide network, lots of different organization types. They all have their own EHRs. They, you know, define things differently. They calculate them differently. They have their own governance boards that they're all accountable to.

So the layers of complexity, and therefore sometimes the slowness of bringing people along in effectuating the type of change that we all want to see, I guess, takes more time. And that's what I was trying to get at.

MR. WALSH: Okay. Yeah, and -- and some of -- some of the data regarding successful ACOs across the country, right, that -- that fits with those. They tend to be smaller. They tend to be physician-led. Right. And so I'm wondering if -- I know this would be a difficult question for any of you to answer on -- on the spot. And so I'm not going to ask anybody for an answer, but I'm left to wonder, would Vermonters be

better served with more smaller, physician-led ACOs?

And with that, I'll turn it back to you, Chair Foster.

MR. FOSTER: Thank you very much, Thom. And the last board member with questions would -- and certainly, far from least, is Ms. Lunge. Thanks, Robin.

MS. LUNGE: Thanks, Owen. Hi, everyone. Good afternoon. So I had a couple of questions about the CPR program development that you spoke to briefly earlier in the hearing and in your materials. So specifically, your materials mentioned -- and in response to the staff questions, you mentioned that you're exploring how to expand the CPR program to hospital-employed, primary care, and FQHCs. So could you give a bit more detailed status update on where that initiative is at and sort of your timetable of -- of how you would see that developing?

MR. BORYS: Sure thing. So for FQHCs, we did a pretty deep dive with them. Actually, it was leading up to last year's budget process and sounded like timing wasn't quite right for the FQHC group, and they -- they didn't opt to take it up. I think it would be relatively easy to apply over FQHCs. Some adjustments would be necessary because they're paid a

little bit differently than independent primary care, but I think the concept would actually hold true quite nicely. So if FQHCs are willing to be a participant or a pilot, say, I'd take it up in a -- in a heartbeat.

For hospital-employed, one of the challenges that we ran into with this was the way that the primary care billing happens within a hospital, and they have a separation of facility charges from the professional charges that just makes capturing the actual primary care claims much more challenging. It's even different between critical access hospitals and PPS hospitals. I don't think it's insurmountable, but I do think that we needed to do a little bit more diligence in terms of understanding those dynamics to get it right.

And I think what I'd like to do during 2023 is some sort of a conceptual or shadow year with a few hospital-employed sites, because I think it would be great to really incorporate hospital-employed CPR sites into our array.

MS. LUNGE: Thanks. Sorry. I'm going to -- it's going to take me a minute to get to my questions. They're embedded in my binder. So we have had quite a bit of discussion about the commercial ACO programs and movement there in terms of what I will

call a misalignment of priorities between the provider network and the commercial payers. I'm wondering if you have ideas or thoughts around how to build alignment as a state, not necessarily just for OneCare, but as a state.

MR. BORYS: Good question. I think it's really getting every component of the state, the providers, insurance companies, et cetera, on the same page in terms of what we're trying to achieve collectively. And I actually -- even though we haven't really succeeded yet in getting these unreconciled (indiscernible) paid with commercial insurers, there's more universal interest in doing it, which I think is really good. And now it's more in the space of let's figure out the details of it. And that's where we've been hung up a little bit.

And so I think there's some positive movement in this space, and we intend to keep working with -- with both of our contractors and commercial insurers to try and figure this out for next year. We even talked about maybe if there's a midyear arrangement that we could have -- think about rolling out during 2023.

So I think there's positive movement, but we really had to get target models ironed out with

them. And then I think we do need to spend some time collectively on shared purpose, shared value of having fixed-payment arrangements for providers.

MS. LUNGE: Thanks. So I wanted to ask you a little bit about -- for more discussion about the Blueprint for health and particularly around your new standard reports. I may be out of date on what the Blueprint is doing, but they used to do standard reports to practices. That was discontinued, and I think now their standard reports are annual.

But I'm wondering if you could talk a little bit about your standard reports and how they either complement or not, the Blueprint for health data analytics that are provided, since one of the statutory criteria is ensuring that there's not duplication between the ACO and the Blueprint for health.

MS. BARRY: I'm happy to start with that question. The -- the Blueprint reports, as you mentioned, have evolved over time as has OneCare. So, you know, lots of movement, which I think is both very positive because it's responding to the requests and the needs of the network, but can also cause confusion, right, as documents are changing. And -- and you know, people need to know who to expect it from and when.

So as we testified about last year and

have since implemented, we've really been focused on some new reports related to our quality measurement. So our VBIF reporting and our primary care panel management reporting, getting those out into the field in a timely manner to inform kind of current performance and -- and incentivize the -- the behavior change we want to see.

I think where we still have opportunities is that OneCare is a contracted network. We have the ability to share data within that network. And where there is alignment and overlap, in a good way, with the Blueprint, it makes it much easier.

So for example, if a community health team administrative entity is a hospital, and that hospital is in our network and there's a mutuality to the purpose of seeing the data, that makes it easier to translate that information and use it for multiple purposes. Where there are distinctions, that creates some challenges. And we have not been able to independently solve those yet, although we keep working on it and -- and trying to evolve within the limits of our data-use agreements.

So in that sense, I feel like what we're seeing in the community level is more timely information. Certainly the HSA consults that Dr.

Wulfman has described and has been evolving are a really key, central location for dissemination of particularly actionable information. So what are we seeing in your community that is different, worse, potentially, than somewhere else, and what -- what can you do about it?

And then we're supplementing that in some new ways with coaching between those sessions to really say, okay, you committed to do A, B, and C. What progress have you made in that arena? And what we're trying to do is really make sure that we're doing that in a complementary fashion with the Blueprint, with the priorities that are already established on the ground that we're trying not to kind of come in on top of those.

And I think that's more and more vital as we're all talking about workforce challenges, right, and -- and the need for reducing burden and better coordination. One of the recognitions that we've had, and what we've tried to leverage in our partnership with the Blueprint, is really around the quality improvement support. So the Blueprint has quite a number of quality improvement facilitators deployed throughout the state. OneCare has two. One in -- kind of focused in the north, and one in the south to work

collaboratively through that process, not duplicatively.

So those are some of the tangible things that I've been seeing. I'd have to get back to you if you have more specific questions about specific data reports.

MS. LUNGE: No, thanks. I just wanted to get a sense of how that was going, because quite frankly, the lack of Blueprint data, I think, has been a problem in general for the primary care medical homes.

In terms of the benchmark report, I'll just make a comment that I would -- when you have developed your more in-depth analysis and key takeaways from that report, I'd be very interested in learning more about that. Some of the data was not intuitive to me that certain things were high and other things were low in terms of utilization versus cost. So having a deeper understanding of what's behind that would, I think, be very interesting and helpful in general.

MS. BARRY: We had some of the same observations, which is why we're digging in.

MS. LUNGE: Yeah, great. Let's see. In terms of DULCE, in your submission you mentioned that OneCare is declining its contribution, and the

Department of Health I think is replacing that. Could you speak a little bit more about how that came about and the driving forces behind there?

MS. BARRY: Sure. We're really implementing a planned kind of progression that has been negotiated in place for a couple of years now. And it came about really because OneCare, when we first started the DULCE program, it was kind of when we were in a phase and a mindset around short-term investments in innovative ideas that needed to be sustained by, you know, local community and providers. And so that was the initial approach.

We certainly learned through DULCE that they had some great outcomes and that the system is fairly complex. So meaning, I -- I think I spoke to this a little bit earlier. It's not just something that you could cookie cutter move into all settings of care, and yet everybody believes that it's something that has value in those communities that it's serving.

So we started some conversations, now a couple years ago, with the director of Maternal and Child Health at the Health Department and really explored how that aligns with the MCH goals of the Title V grant, and then what we could envision for a longer term. And so with that last year, we stepped

down the first phase, and then this year -- or for 2023, we plan to do that again.

But all of that said, I think, you know, in parallel, we continue to learn more and continue to engage around our SCOH (ph.) data to really think about the -- the overarching system of care and what are some of the opportunities that OneCare can best influence.

MS. LUNGE: Thanks. So it's a long-term goal, then, that DULCE funding would essentially move to the -- to VDH at some point? Or would you consider that to continue to be a collaborative venture?

MS. BARRY: Right now, I think we consider it to be collaborative. We don't have a date lined up with them that it goes to zero, but it's something that we do need to continue exploring.

MS. LUNGE: Okay. Great. I think actually the rest of my topics have been thoroughly explored, which is one of the benefits of going last. So I'm all set, and I'll turn it back to you, Chair Foster.

MR. FOSTER: Thank you. I have two brief follow-ups based on my fellow board members' questions. On the benchmarking study, has there been any effort, or will there be any effort to normalize Vermont's results for the fact that we are a low-cost

Medicare state, in fact, the lowest-cost Medicare state in the country?

MS. BARRY: So the data have already been normalized through risk adjustment and unit cost analysis. The concept that OneCare is a low-cost ACO relative to the others is foundational to the findings of the model. And so no, there is not a plan to readjust those numbers.

MR. FOSTER: And I think it's to Dr. Murman's point, you know, what we are trying to sus out is, is this because of the ACO and the ACO's work, or is this because Vermont is generally considered the healthiest state in the country and because we have severe wait times and access issues? I mean, obviously, if you can't get into the doctor at the volume you want, the costs are going to be lower, particularly if you're a healthy state. So I think ensuring that data reflects those macro demographics of the state would be particularly valuable for us to evaluate it.

MS. BARRY: I think we can certainly look at some of those extra demographics that you're interested in. I would also just mention that contextually there are a tremendous number of environmental factors that we should probably consider

if we want to think that we're comparing apples to apples. So the amount of competition, the number of urgent care centers, you know, how many sniff beds (ph.) per capita there are.

There are lots and lots of factors out there, which is why I think ultimately this provides some interesting and helpful information to us to see, you know, maybe where we are performing well and we are we're performing significantly worse and perhaps should put some energy in. But ultimately the interventions that align with those areas of opportunity have to be thought about in the context of Vermont's health care resources and environment.

MR. FOSTER: Yeah, totally. I mean, most reports you receive from an expert would have some sort of, you know, risk analysis based on the environmental factors for which you can't actually, you know, determine causation. So I think a good report would have that kind of information for us to consider how strongly we should be, you know, evaluating what -- what -- what's in the report.

The only other question I had real quick is I think -- I think the CEO said something about the ACO provides data to enable providers to do things and that the ACO is a small part in helping them. And this

isn't, you know -- OneCare can't fix all of Vermont's problems with its health care challenges, right? Neither can the Care Board, neither can PCPs, neither can UVM. There's a huge universe of insurance companies that have to figure this out together.

And from that perspective, what I want to get a sense from your view is, who is the most accountable? If you do a hierarchy, you have patients, you have PCPs, you have nurses, you have RNs, you have PAs, you have doctors, hospitals, ACOs. Who -- who should be accountable for results? If you were to do a hierarchy, who has the best opportunity to make an impact on what we're all trying to fix? And I want to pay that person.

MS. BARRY: Yeah. I don't know if you're asking a question or making a statement, so I guess that would be helpful.

MR. FOSTER: What my -- it's a -- it's a question. What's your perspective on where we should be deploying our resources to the people that are most accountable for improving care and costs?

MS. BARRY: I think it all starts at the state and federal levels in terms of policies and procedures and how payments are made to providers. I mean, that's at the top level. It's your governance

for your state and federal government.

MR. FOSTER: But how -- right. I want your perspective from your work on where the federal government or the state government should be deploying its resources at the level that makes the most impact.

MS. BARRY: Well, long term, that's prevention.

MR. FOSTER: And so the money would be -- if you want prevention, should be deployed, you know -- obviously, this is rough, but it should be deployed to the patients themselves and to their primary care providers?

MS. BARRY: It could be. It also could be to the communities directly for providing things like, you know, sidewalks, infrastructure in the community, better benefits so everybody has food and housing security. Like, it's all those upstream, social determinants of health, yet we don't invest in them as a country because they don't have those annual return on investments that everybody is looking to be able to measure year over year. So until we as a country start looking at those upstream, really upstream variables, we won't be better off.

MR. FOSTER: That's -- that's very helpful. I appreciate that. Thank you for sharing

that -- that view. I -- that's helpful.

Does anyone else have any views on this question? Okay. Great. Thank you all for -- for addressing the Board's questions. We -- and the staff's. We really appreciate that. And with that, I'll turn it over to the health care advocate.

MR. FISHER: Thank you, Mr. Chair. Mike Fisher here, health care advocate. I'm -- I'm going to ask a few questions, and then Sam will have a few questions. Thank you, everyone, for spending -- spending the day together and providing a lot of -- a lot of answers to a lot of questions. Getting to go last also, I think, shortens our questions. And maybe some of our questions become follow-ups to discussions that have already happened.

Let me start with a recognition of some positives. We -- you know, again, thank you for your presentation. We -- we really want to acknowledge and support OCV's commitment to DEI work within your governance structure and the development of the disparities scorecards. I think this is important work. It's a step in the right direction.

We also want to recognize -- or I want to recognize that we had a -- we had a nice meeting with the -- your patient-family advisory committee.

Look forward to that every year. You have indeed assembled a group of consumers that have a lot of questions about how to make the world a better place.

I want to -- in a follow up, maybe, to Marisa's point about the contract, the contract between UVM and OneCare, I -- I -- you know, I -- I heard the question. I heard your answers. I know this is complicated stuff, and it takes a while to develop. I think I heard you say that it was signed up on November 1st. But I do want to express frustration that we don't have that in front of us today. I think we should have that in front of us today. So just wanted to express that. It would make it easier. It would help a great deal.

So I have a few questions about IT systems. We at the Health Care Advocate's office are concerned about the amount of money that flows into health care IT systems. This concern is not just about OneCare Vermont. This is a much broader concern, but because we have OneCare in front of us today, there's a few examples.

So with regard to Care Navigator, we asked a question about how much Care Navigator has cost, and you provided the answer in your written answer to us that in 2021 you spent 387.5, 387,500

dollars on Care Navigator. Our question was -- well, I'm trying to back into how much was spent altogether on Care Navigator. How many years was Care Navigator invested in by OneCare, and is that 387,000-some a good proxy for how much was spent per year?

MS. BARRY: Mike, this is Sara. I don't know the -- the number off the top of my head that was spent overall. Frankly, we'd have to pull lots and lots of accounting records to figure that out. But I do think that that number we provided you for 2021 is a very fair proxy for what the annualized expenses were for the system and the customizations that we were adding year after year to try to make this work for our provider network.

MR. FISHER: So -- and thank you. I'm not asking for a specific audited number by any means. I'm asking for a sensitive. So -- so what -- to get a proxy, about how much was invested in Care Navigator? And would we multiply that by six?

MS. BARRY: Wait. I'm going to count on my hand here, so. Yeah, six, that makes sense.

MR. FISHER: Okay. So there have been quite a lot of questions about OneCare's new contract with UVM. And so I want to try and fly a little bit high on this, but we do have a few questions about it.

Our non-UVM Health Network OneCare participation fee is being used to fund the analytic work that OneCare contracts with UVM Health Network for?

MS. LONER: Yeah. So Mike, our model is that the hospital participants pay for our operational budget. So anything that the ACO supplies is universally purchased at differing rates across hospital systems. And you know, the smaller hospitals, with their net-patient revenue, obviously, pay less than -- than the larger hospitals do. But they paid that before. This isn't a new cost to them. In fact, this is the same cost to them as it was in the past. And we're looking to get a better analytics tool out of this in the future.

MR. FISHER: Okay. There's been a lot of questions about the firewalls, the data firewalls. I'm not going to ask that question again. I appreciate the -- the high-level description that you provided. But I think we're all interested, or the Healthcare Advocate's Office is interested in the much more detail about the separation of -- about the firewall. But about what you just spoke to, Vicki, can you say a little bit about what motivated you to move away from Health Catalyst?

MS. LONER: Yeah. So as we worked

through our strategic planning process, it was unanimous that we needed to elevate our data and have access to better data analytics that wasn't so manual, right, that we weren't creating from our staff, right, having to gather data to be able to push out answers for our provider network. Because remember, again, we had -- we don't just have one organization network trying to take in data for. We had about 170 organizations that we're trying to take in data for. And so at the same time, we were told by our board, we cannot raise dues. So we want a better-enhanced system. And we don't want to pay more for it. And we -- because we can't pay more for it.

And so at that point in time, UVM Health Network was exploring a population health tool, because remember, OneCare is just one value-based care arrangement that UVM Health Network has across its enterprise. So they were exploring some opportunities specific to value-based care contracts. And so our board said to us at that time, why don't you explore whether or not there is opportunities to work with UVM Health Network, use as there were talked about previously, you know, how large they are as a system and the pricing that would be available to them to get a enhanced tool for the ACO that would better support

our growing data and analytic needs within the same, you know, cost construct. Because as you've seen, our costs haven't gone up year over year. In fact, we've taken a precipitous decline in how much our operations costs are, yet the accountabilities and the payment reforms that we have to manage and the provider network we had has been growing since we started. So we need some pretty sophisticated tools to be able to manage that tension.

MR. FISHER: So for today and for a number of years, OneCare has talked about its data and analytics as -- as one of its core functions. And in fact, I think, I think, I've heard you say this is what you do well and something that you get to do that smaller hospitals really can't do for themselves. I can't help but wonder whether -- I guess, I end up with something of a similar question that I asked about Care Navigator, but now about Health Catalyst. There's something about what you were getting at -- at Health Catalyst for however many years you've been working with them that wasn't sufficient to do the work that you thought was right. And so I --

MS. BARRY: Mike?

MR. FISHER: -- and so I have the question about the money that's been expended and

whether -- whether that was reasonable?

MS. BARRY: Yeah.

MS. LONER: Yeah. I wanted to get the details, Sara. But I would say, yes, it was reasonable, our number of technology has advanced since we first purchased Health Catalyst. And so ACOs have come more mainstream. And then, there's been data and analytic services that have grown around ACOs, right? So it's always good you shouldn't just use the same vendor year over year. You should look for vendors that maybe are more specific to the work that you do as an -- as an ACO.

But Sara, you --you worked through the process of the RFP. You probably have a more detailed description than I do.

MS. BARRY: Yeah. I don't need to go into tons of detail. I would just add that our current system is not broken. It's inefficient. And it requires a lot of manual staff work to maintain and manipulate that information. And it's, in part, because that particular vendor has chosen to focus on other priorities, not so much in the ACO population health analytic space, to date. In contrast, this other vendor, Arcadia, built that up quite a bit over the last four or five years, and now has standard

reports that has the data organized in ways that can, we think, can be more efficient and effective over time. It is going to take us some time to realize that. So the focus that we've had is on making sure the costs are neutral. Meaning, that we don't duplicate payments as we're starting to transition those. And then, ultimately, we think that there will be some greater efficiencies. We can't quantify them yet in the sense of, like, reduced staff effort to manually load data or to customize things to actually be able to use it. That will come over time. But I think we do have a pretty strong belief that it's going to be easier and better in terms of how we serve our network.

So just to give you a really practical example, right now, we have somebody who has to program some standard reports that we want to push out every month. And then, we have to have a staff member manually load them to a secure place. Where then, we have to notify providers to remember to go get them. In the new system, there will be security in place that will allow non-PHI, who contain data, to be reported directly into the email box of people who are provisioned to have that level of access. So they'll get their summary report. And then, based on their

user access, they'll be able to click on a link to go get more information to help them close care gaps, manage populations, et cetera. So that's just one example of where we want to be heading to keep up with technology and its evolution.

MR. FISHER: Okay. Just one more data question, then. Whenever -- whenever you do a transition to a different data system and you have to interface with existing data systems, there's hiccups, right? Do you expect there to be transition stresses for -- from hospitals around their transition to this new -- new data platform?

MS. BARRY: The only stressor that I think is in evitable is the time it takes people to learn new reports. And obviously, it's our job to help support that. But we are making sure that the reporting that they currently get will continue until the new reporting is ready and that people have had a chance to learn it and transition over. And that was a fundamental concept that our board kind of set out as a guardrail.

So yes, there will be bumps to your point. It's inevitable. I think, you know, one of the chronic bumps that we're always dealing with are data files that come in from payers that are not formatted

correctly per the contract specs. And we'd have to go back, and you know, over and over again have those conversations. That's going to happen to a certain extent, regardless of the -- the platform. It's really about how we manage those things and how we continue to work on in improving them.

MR. FISHER: All right. I'll leave this topic of data systems with a statement that, from the Healthcare Advocates perspective, we have serious concern about how much money -- how much healthcare dollars go into data systems, and continue to wonder whether -- we're not in any way opposed to data and the analytics, but continue to wonder about -- about just how much money flows into them, and have concerns.

So with respect to Medicare and the increased population of people, the -- the uptick in Medicare Advantage, it was -- we read in your -- in your budget narrative, sort of, that dynamic of the number of -- the increased number of people moving into Advantage and it's impact on you. We also noted in your answer to, I think, it was a Board question, a recognition that, I think, you said, OneCare data suggests that the population leaving traditional Medicare for Medicare Advantage has lower costs on average. FYI, that is a very similar finding to a

description in a large insurer's medigap filing, that the population moving to Medicare Advantage have -- has a lower morbidity.

So this leads to the question -- and I know that we've asked this question before, but we continue wonder, from OneCare's perspective whether the uptick -- whether this movement, this movement of relatively healthier lives out of traditional Medicare, and therefore, out of your attribution, is a good thing or a bad thing for the -- for the All-Payer effort and for OneCare's goals?

MS. LONER: I think you kind of have to separate that a little bit, because I always hate to -- there's the All-Payer Model, which the, you know, the State is a signatory to. And they have very specific goals and accountabilities under that. And then, there's the ACOs. Currently, OneCare is the only ACO that has agreed to participate in the State's APM reform. And I would say, we need to look to the next agreement. I don't think this is something that OneCare has the bandwidth to look at the Medicare Advantage over the next two years as we transition out of this current All-Payer Model agreement, into whatever comes next. But it has to become part of our strategy at the ACO level to look at what programs make

sense for us to be in, and not necessarily what programs fit the State's goals and responsibilities for scale targets, if there are even scale targets that come into play in the next All-Payer Model agreement.

MR. FISHER: I apologize. I did not manage to say one -- one thing in my original question that I just think is important to say out loud, sort of, in recognition of full transparency here. OCV, as a part of UVM, is part of an entity that's offering a Medicare Advantage plan. And I just think it's important to recognize that. And I also appreciate that it's not within your bandwidth overall and maybe not at 3:42 after a long day to think about. But I think it's something -- it is indeed something affecting the Vermont landscape, and I think, also affecting OneCare.

I'm going to turn it over to Sam to ask a few questions. Thank you.

MR. PEISCH: Thanks, Mike. Sam Peisch, health policy analyst with the HCA.

I want to turn to page 18 of the narrative where you talked about the effectiveness of Population Health Management activities. This will be assessed, and I quote, "Over the next three to five years". I wanted to ask you to consider this from the

perspective of a Vermont family that makes a typical median income, that has a 15,000 dollar deductible, with real healthcare needs in their family, and how you justify this event?

MS. LONER: I think, as we've talked before, Sam, and been recognized by this committee, affordability is not just the accountability of OneCare Vermont. We have a small section of the population. We are but one cog in the wheel. And yes, there are other tools that can have more immediate effects. We're charged with population health, management, quality, and total cost of care. And so I totally hear what you're saying. And I don't disagree with you. In fact, I -- I agree with you. But I think that you have to look to the system and the other entities on how you make some more immediate changes.

MR. PEISCH: Okay. Thank you for that. I mean, I -- this goes into our next question, which is, over the -- over the -- in the past, we've heard you talk a lot about bending the cost curve and even reducing the per cap -- per capita cost of care. And it's notable that this seems to have been significantly downplayed, and discussion of it really arose mostly upon questioning from Chair Foster today. And we heard the OneCare performs better, compared to national

benchmarks on reducing costs. But I want to point out that these benchmarks don't require these costs to decrease. And they only refer to system costs, not public costs, or like, the Vermonters, like, all of us. Do Vermonters receive any of these shared savings from these models, or does it all simply flow to this being providers, or are there any plans for these savings to flow to Vermonters in the future?

MS. LONER: It all flows to participating providers. That's the ACO model and the way that it's set up. There are additional incentives that can be provided to patients that are part of the ACO. And I think those do occur, because you're allowed to provide incentives that you otherwise wouldn't as being part of an ACO that don't look at anti-stark and kickback rules and things of that nature. So there are certainly benefits that are accruing to individuals that are part of the ACO, but it's not through shared savings.

MR. BORYS: I can add a little bit to that. For the commercial programs where there's the most direct linkage between a patient's payment and the insurance coverage, what we have actually seen in the past is, that if OneCare Vermont owes a shared-losses payment, for example, back to the insurer, that that

payment back to the insurer becomes part of their rate filing for the next year. So other words, it offsets some of the increase that you'd expect in the following years. So I was very glad when I saw that that actually occurred. And I would think that's an -- an important thing that -- important dynamic in place with these commercial arrangements.

MR. PEISCH: Thank you for that. That's -- that's helpful. I know some of the questions today have focused a bit on evaluating causal impacts, so this is in that realm. In your -- in responses to our questions, you wrote, "Due to the complex healthcare reform landscape, OneCare does not maintain a goal determining definitive causality of its programs". And I think we've heard today that, you know, the health system is complex. I think we can all agree on that.

But so -- but I want to point out that this doesn't necessarily mean the causal analyst in this area is impossible, or that it hasn't been done already, or there aren't methods to do this. I mean, I think we can point to Directly (sic) Acyclic Graphs, Graves' methodology, difference-in-difference, which NORC used, among others. So I'm wondering why none of these methods appear to have been utilized by OneCare

in the past, or if there's a plan to use these methods in the future to evaluate the impact of these taxpayer-funded approaches to population health?

MS. BARRY: Sam, thanks for the question. I think the future's unknown. But we're hoping that through hiring this particular new FTE, that we'll be able to have some guidance to help us in that arena. Speaking to the past and kind of the present, we have a fantastic group of analysts who are really focused on understanding claims data and clinical data and being able to turn that around into actionable insights for on-the-ground performance. We did not hire them, you know, at the various points in time to be able to do some of those particular types of analyses. That's not to say that we can't, you know, advance or change things in the future. But we've really been focused on trying to ingest all of this complex information, make sense of it, and get it out to folks. We have, I think, more to do as we've tested various methods, frankly, to mixed results in terms of what methodology makes the most sense to evaluate specific programs, or even, you know, long-term investments.

MR. PEISCH: Thank you. That's -- that's helpful. Just a follow-up, a bit of a comment

on the causality piece, not to harp on it too much. But one concern that we wanted to raise is, one of the guiding questions for the KPI, key performance indicator, work that Member Walsh asked questions about, though, I think we're all keen learn more about, was what metrics best demonstrate value or potential value of OneCare? And this, I think, strikes very clearly as a leading question, that presupposes the existence of something that should be asked. So I just want to make that point in the hope that future causal work proceeds from a more of a null hypothesis-style question.

But our last question, on page 23 of the narrative, it reads, "From the healthcare provider side, commitment to payment reform remains strong. But there are concerns related to the magnitude of hospital commercial rate charge requests. Insuring the approved hospital commercial-rate charges are incorporated in the fixed-payment amounts is essential for sustainability." I'm wondering how OneCare reconciles these, it appears to be conflicting messages, very high, large commercial charts requests, and then, hospital claims that these charges are needed for sustainability?

MR. BORYS: Yeah, good question there.

So what I was conveying in that clause there was that every provider accepting a fixed payment will view fee-for-service as a reference point, whether we like it or not. And sometimes it's good. And sometimes it's detrimental. So to make sure that these payment reforms are effective and sustainable, we do need to make sure that their approved rate increases are incorporated. Otherwise, you know, any hospital with this being a voluntary model would just say, wait a second, I can do a lot better in fee-for-service. So making sure that there was a connection point there is very important. And at the same time, this attention is not putting too much weight on variation from fee-for-service, I think, is something that will make true payment reform more sustainable over time.

MR. PEISCH: Thank you, appreciate it.

Turning back to you, Chair Foster.

MR. FOSTER: Thank you for those excellent questions from the Healthcare Advocate's Office. I appreciate that, and the responses.

It is 3:51. And we still have public comment and a little Board business.

Cassidy, how you holding up?

THE COURT REPORTER: I'm doing really well.

If I could just ask, quickly, Mr. Peisch, what did you just say there? You said the cycling-pass methods? At the end, you were talking about that NORC uses?

MR. PEISCH: Oh. Yeah. So there's -- so NORC, a caption, an acronym, but I can look it up. But it's difference-in-difference, I believe, is what I was talking about.

THE COURT REPORTER: What did you say exactly? You used two different, it sounded like nouns for two different methods?

MR. PEISCH: Sure. There's Directly (sic) Acyclic Graphs, which I believe I had mentioned and Sufficient-Component Cause Model.

THE COURT REPORTER: Okay. Thank you.

MR. PEISCH: And then, difference-in-difference modeling.

THE COURT REPORTER: Okay. Perfect. That's all I needed.

Yes, I will need to recall my backup recorder at about 5:15 today, Mr. Foster. But other than that, I'm doing great.

MR. FOSTER: All right. Well, we certainly hope to wrap it up before then.

THE COURT REPORTER: Thank you, sir.

MR. FOSTER: So I'll turn it over to public comment. And for public comment, please use the "Raise Your Hand" function. And I'll endeavor to call on folks in the order in which their hands are raised. Is there any public comment?

Yeah. I'm sorry. Let me -- let me take a pause. I actually need five minutes, because I think I might have a technical problem with seeing -- there's a lot of people. Why don't we go off the record. And we can just come back at 3:58. And I apologize. Off the record.

(Recess at 3:53 p.m., until 3:58 p.m.)

MR. FOSTER: I had one more that I forgot to ask. And I apologize for chiming in with more. I'm looking at -- it's tab W in the binder, appendix 6.1, balance sheet. And there's a line that says, "Due to UVM MC, 2022, 4.25; 2023, 3.797". I just wanted to understand what that was.

MR. BORYS: Sure. I can take that one. So we mentioned before that we're all UVM Medical Center employees. So this particular line is the way in which we reimburse -- OneCare reimburses UVM Medical Center for the salary expense and any other expenses that UVM pays on our behalf. So for example, when UVM cuts payroll for all the staff, we then pay UVM back

through this "Due to" from account.

MR. FOSTER: Great. Thank you very much. I'm sorry to interrupt the flow. And with that, I'll turn it to public comment. I think I've got this figured out. If you can -- if you're on the phone, please identify yourself. The first hand is Ham Davis.

Please go ahead, Mr. Davis.

MR. DAVIS: Thank you, Mr. Chairman. I've just got a couple comments on this. I've been to these meetings -- started going to this type of meeting in 1983. And this is the most unusual one I've seen over that whole period. It's -- I'm struck by what looks to me like a huge air of unreality that hangs over the whole thing. OneCare Vermont is assumed to be the per -- the agency that's supposed to -- to control the costs in the system. That is impossible. They have no power to do that, no power whatsoever. What they can do is, and what they do do is, is they can give you a fixed-price contract, which is the way you get to capitation, which is the way the Federal Government and the health policy industry understand as a way to get the real cost containment.

They can't -- the -- the people that can -- the people who have the power to actual change costs, is the Green Mountain Care Board itself.

They've got, for the last year, they've had in their website all kinds of data about problems that with -- with -- especially with the nonnetwork systems, the nonhealth -- Vermont Health and the -- the non-UVM network segment of the -- of the -- of the system. The cost in the -- in the UVM system on a cost per capita basis are the lowest. And the quality is lower -- is better than the rest of the system by a factor of two or three. And so what I'm curious -- and -- and this -- the -- we've just gone through the Board, not under this particular chairman, but just went through the whole budget cycle, and not one single element of all that data that's been sitting there for a year was even mentioned.

So I -- I just don't get it. I mean, the reality is, OneCare Vermont -- OneCare Vermont can -- can get, you know, about 35 million dollars a year to each of the 700 or so primary care doctors in the State. They will deliver, they can per -- they can construct a contract, a fixed-price contract, with any payer who's willing to do it. But they have no power, none whatsoever to actually force any payer to do that. The only people that have power in this system are the Board itself. Thank you.

MR. FOSTER: Thank you very much, Mr.

Davis, for your -- for your insights and your comment and for participating in meetings like this for such a long duration. It's really important. And thank you.

Is there any other public comment? I see no other public comment, which means, I had anticipated there would be much. And like a lot of my experience in this job, I'm pretty bad at anticipating what happens and what will -- what will come forward next.

So with that, I do want to thank the OneCare team. You guys were incredibly patient and thoughtful in your responses to a wide variety and assortment of questions. I thought you did a really nice job of being candid. And I appreciate that and recognize this. So thank you for doing that. I think it informs the Board a lot more of where we are and how we can help. And hopefully, it was a valuable process for you all as well. Your presentation, I'm sure, took immense time and effort to -- to put together, and have a lot of detail in the binder. It was very helpful for me. So I want to recognize that effort that you all put in and thank you for it.

And internally, I don't think people recognize the amount of work the staff does to get the Board ready and under -- explain all this to us. I can

tell you there's a lot of late nights by a lot of staff members, a lot of it because of me and others. But I want to thank them publicly and acknowledge the kind of effort and work they put into this. It's really, really, really impressive. So thank you, staff.

And with that, I think we can conclude the OneCare portion of today's meeting. And thank you all.

Is there any old business to come before the Board? Any new business? And is there a motion to adjourn?

MS. LUNGE: So moved.

UNIDENTIFIED MEMBER: Second.

MR. FOSTER: All in favor, please say, aye.

UNIDENTIFIED MEMBERS: Aye.

MR. FOSTER: Aye. And it sounds like there's none opposed. And so the motion carries. Thank you, all. And the meeting is adjourned.

And thank you, Cassidy. Have a good night.

THE COURT REPORTER: All right. Thank you. Could I just get a few spellings?

(Whereupon, the proceeding was adjourned at 4:04 p.m.)

C E R T I F I C A T E

BE IT KNOWN that the foregoing proceedings were reported by Hannah Stowe, and reduced to written form under my direction; that the foregoing 231 pages constitute a full, true, and accurate transcript; all done to the best of my skill and ability.

DATED this 16th day of November, 2022.

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HANNAH STOWE

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