STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

BOARD MEETING

Meeting held before the Green Mountain Care Board at the Pavilion Auditorium, 109 State Street, Montpelier, Vermont, on October 24, 2018, beginning at 1 p.m.

BOARD MEMBERS

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

STAFF MEMBERS

Susan Barrett, Esq., Executive Director
E. Sebastian Arduengo, Esquire

CAPITOL COURT REPORTERS, INC.
P.O. BOX 329
BURLINGTON, VERMONT 05402-0329
(802/800) 863-6067
E-mail: info@capitolcourtreporters.com

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1 CHAIR MULLIN: Good afternoon everyone.
2 Welcome to the Green Mountain Care Board meeting.
3 The first item is the Executive Director.
4 MS. BARRETT: I have a very brief
5 Executive Director's report. I want to remind folks
6 that we are going on the road next week. We'll be
7 going down to Mt. Ascutney Hospital. What town are
8 they in? Windsor, right. So we'll be there for our
9 board meeting. We'll also be visiting some community
10 providers in the Upper Valley, so if you're available
11 take a road trip with us.
12 The other thing I would like to announce
13 is if folks could sign in out on the table in the
14 entrance, if you could just make sure you sign in,
15 and that's all I have to report today.
16 CHAIR MULLIN: So before we go to the
17 next item which is the minutes, Mike and Melissa,
18 could you get set up? So the next item are the
19 minutes of October 17th. Is there a motion?
20 MR. PELHAM: So moved.
21 MS. HOLMES: Second.
22 CHAIR MULLIN: It's been moved and
23 seconded to approve the minutes of Wednesday, October
24 17th without any additions, deletions, or
25 corrections. Is there any discussion? Seeing none

1 all in favor signify by saying aye.
2 (All Board Members respond aye.)
3 CHAIR MULLIN: Any opposed? (No verbal
4 response) Okay. Moving right along we're going to
5 turning it over to Mike and Melissa to give us an
6 intro into the OneCare Vermont budget presentation
7 that we're about to participate in.
8 MR. BARBER: For the record my name is
9 Michael Barber, Chief of Health Care Policy for the
10 Green Mountain Care Board, and to my right is Melissa
11 Miles, Health Policy Director for the Board. So
12 we're going to do a fairly brief introduction to the
13 hearing on OneCare Vermont's fiscal year 2019 budget.
14 So this is a schedule for this
15 afternoon. We're going to try to keep our
16 introductory remarks to less than 15 minutes.
17 OneCare will have an hour for their presentation.
18 There's an hour for Board Members to ask questions
19 and for questions potentially from Jackie Lee from
20 Lewis Ellis who hopefully is on the phone. Then the
21 Health Care Advocate will have 30 minutes to ask
22 questions, and, lastly, there will be time for public
23 comment. I would also note that the Board does
24 accept written public comments via its web site at
25 any time. That's up and running currently.

1 So since you are just coming off the
2 hospital budget season we thought it would be good to
3 step back for a second and revisit the Accountable
4 Care Organization model. This slide is trying to
5 show you that the All Payer Model is an attempt to
6 solve a problem, one, that is not unique to Vermont
7 for sure, and the problem is that the cost of health
8 care is increasing at an unsustainable rate and
9 there's room for improvement in both the health of
10 Vermonters and the quality of care that they receive.
11 One strategy for solving this problem is
12 to have providers from across the continuum work
13 together to deliver care in the more integrated and
14 coordinated way, focus more on primary care and
15 prevention, to deliver care in lower cost settings
16 where appropriate, and to reduce duplication of
17 services, to incentivize and facilitate the kinds of
18 changes in the way care is delivered.
19 The other part of the strategy is to
20 change the way to pay for health care, to move away
21 from a fee-for-service payment model which rewards
22 providers for delivering more services and to move
23 towards population based payments where providers
24 accept responsibility for the health of a group of
25 patients in exchange for a set amount of money. The

1 hypothesis is this will be a more predictable and
2 sustainable financial model for payers and providers,
3 will encourage providers to work together in new
4 ways, and will give providers flexibility to make
5 choices in investments that make sense for their
6 payments that might not have made sense -- financial
7 sense at least in the fee-for-service world.
8 The state chose to implement this
9 strategy through a statewide Accountable Care
10 Organization model in which the majority of
11 Vermonters are served under ACO programs that are
12 aligned with one another so that providers have clear
13 and consistent incentives. Under this model ACOs are
14 supposed to be the vehicle for change. They are
15 supposed to help providers succeed in managing this
16 transformation by providing support, data, analytics,
17 and sometimes shifting money to areas that need it
18 most.
19 As you know the All Payer Model
20 agreement signed in 2016 enabled Medicare to
21 participate in this kind of model. We are pretty
22 early in the implementation of the model, 2018 being
23 the first performance year. However, for 2018 we
24 have four fairly well aligned ACO payer programs in
25 place serving approximately 112,000 Vermonters which

1 is a major step, but short of where we are supposed
2 to be under the agreement in terms of scale.
3 This graphic is meant to build on the
4 last slide and just illustrate that the payment
5 reforms really reinforce and enable the
6 transformations and care delivery with the ultimate
7 goal being to achieve improvements in health and
8 slower cost growth. A key concept here is that when
9 you put providers at risk for the cost and quality of
10 care delivered to patients it will spur increased
11 investments and focus on primary care and prevention
12 since there's consensus that a strong primary care
13 foundation with an enhanced focus on preventive
14 services can improve health care quality, improve the
15 health of the population, and keep costs down.
16 The last column here describes the three
17 population health goals that are found in the All
18 Payer Model agreement, and these are the population
19 level outcomes that Vermont is trying to positively
20 impact through the model. This slide is to very
21 briefly remind you of what Vermont is responsible for
22 under the All Payer Model agreement because you can
23 and should consider relevant requirements of the All
24 Payer Model agreement when you're reviewing and
25 approving any budget.

1 The requirements in the agreement
2 generally relate to cost -- cost growth rather,
3 alignment of programs, scale, and quality. With
4 respect to cost the state is responsible for limiting
5 all payer cost growth to below a compound annual
6 growth of 3.5 percent over the five year term of the
7 agreement. They're also responsible for limiting
8 Medicare cost growth to -- well .2 percent below
9 national projections based on what happened last
10 year. The state is responsible for ensuring the
11 alignment of payer programs in certain key areas;
12 specifically attribution -- attribution, services
13 included for determining shared savings or losses,
14 risk arrangements, and quality.
15 The state is also expected to meet
16 fairly aggressive scale targets or targets for the
17 percentages of people that are attributed to the ACO
18 or an ACO participating in the model; and, finally,
19 the state is responsible for meeting 20 different
20 quality measures that are tied to and build up to the
21 three overarching population health goals that you
22 saw on the last slide; improving access to primary
23 care, reducing deaths due to suicide and drug
24 overdose, and reducing prevalence in morbidity and
25 chronic disease.

1 MS. MILES: This slide shows the
2 regulatory levers you have in which to operate at the
3 level of the ACO. Obviously you have responsibility
4 for reviewing ACO budgets and payer programs. You
5 also have the ACO certification responsibility which
6 all fall under Act 113. We did certify OneCare
7 earlier this year and we've asked them to provide us
8 documents so that we can review their continued
9 eligibility for certification. We are in the process
10 of reviewing those, but that is not the subject of
11 today's conversation.
12 So finally you have the ability to work
13 with Medicare on designing an ACO program for 2019
14 and to establish the benchmark for financial targets
15 for the ACO in that program. So we made some
16 decisions on the design of the Medicare program
17 earlier this year and there will be a few more
18 decisions that will be coming back to you within the
19 coming weeks.
20 So the Medicare benchmark and Medicare
21 rate are intertwined with the ACO budget process, and
22 I imagine OneCare will touch on the Medicare rate in
23 their presentation today. This is the budget review
24 criteria as set forth in 18 V.S.A. 9382(b). Many of
25 the criteria relate to the strategy that underlies

1 the All Payer Model, and this is not an exact list,
2 but it gives highlights that we certainly look for
3 when we are reviewing the budgets. So one example is
4 how the ACO is working to prevent duplication of
5 services and integrating with the Blueprint for
6 Health and Communities. Another is how the ACO plans
7 to invest in primary care and community based
8 services and to promote seamless coordination of care
9 and address social determinants of health. We also
10 need to consider how the ACO is supporting improved
11 population health outcomes and also rewarding healthy
12 lifestyle choices, and finally while these are the
13 statutory criteria, as Mike mentioned a few slides
14 back, under the rule you should also consider any
15 relevant requirements of the All Payer Model
16 agreement.
17 I wanted to say on the last slide that
18 the Board is supposed to ensure that an ACO has a
19 financial guarantee sufficient to cover its potential
20 losses. This is actually a requirement of
21 certification, but it's something that we are looking
22 at during the budget process. The way that this is
23 done under Rule 5 is that an ACO has to propose a
24 maximum amount of risk that it wants to accept in the
25 upcoming year and has to provide the Board with a

1 plan for how to manage that risk. Then the Board
2 then approves that maximum risk amount as part of the
3 ACO's budget.
4 I wanted to highlight several of the ACO
5 budget order items that the Board ended up approving
6 on December 21st in 2018 -- sorry, 2017. 2017 for
7 the 2018 budget. These are some of the items, but
8 they are not limited to a maximum downside risk; risk
9 corridors that average about 4 percent among all the
10 payers, a reserve requirement of 2.2 million, an
11 administrative expense ratio that did not exceed 2
12 percent, population health investments that did not
13 go below 3 percent of their total budget and that was
14 an estimated 25 million at the beginning of last year
15 subject to change. The Medicare rate of growth was
16 3.5 for 2018. We also looked at all of the scale
17 target ACO initiatives that they had among the four
18 payers they are contracting with this year.
19 So, finally, this is the timeline that
20 we have been working under. We've been reviewing
21 since October 1st OneCare's budget. Today is our
22 hearing and we are hoping to be able to adhere to
23 this timeline, but as you'll see we do have potential
24 votes for November 28th and December 3rd. We are
25 waiting from -- for some information that has not

1 been finalized at this time from both Medicaid for
2 Lewis & Ellis to be able to complete the Medicaid
3 advisory rate case that is in statute, and there's
4 some unknowns still for OneCare in terms of their
5 self-funded programs for '19 and the commercial QHP
6 program. So we're doing our best to work within this
7 time frame, but we may need to come back to you with
8 an adjustment and that's it.
9 CHAIR MULLIN: Any questions for Mike or
10 Melissa?
11 MS. LUNGE: Just on the timeline my
12 recollection is that the relevant really legal
13 document that would impact any timing issues would be
14 requirements around the Medicare rate, but am I
15 forgetting anything or we have some flexibility
16 there?
17 MR. BARBER: You're remembering
18 correctly. So the all payer ACO model requires that
19 we submit a rate to CMS 30 days prior to the
20 beginning of the performance year. So that would put
21 us at the end of November. We would like to meet
22 that, but we do have some flexibility if we need it.
23 MS. LUNGE: Thank you.
24 CHAIR MULLIN: Last year we waited an
25 extra two weeks for the information, correct?

1 MR. BARBER: That's correct. This year
2 we will be getting the Medicare final information by
3 I believe November 9th so that shouldn't be an issue
4 this year. I think Medicare is on track to give us
5 what we need. We are behind where we thought we
6 would be in terms of getting information from the
7 Medicaid rate case and there's a lot of other
8 uncertainty in the budget that may lead us to try and
9 push this back a little bit.
10 CHAIR MULLIN: Okay. Great. Any other
11 questions? Okay. Thank you very much. Todd and
12 OneCare team, if you can come down. At this point I
13 would ask the court reporter to swear in those who
14 are at the table and, Todd, is there anybody in the
15 audience that you're going to have offer any
16 testimony?
17 MR. MOORE: None that we have planned.
18 (OneCare panel is sworn)
19 MR. MOORE: Thank you. I do want to
20 introduce Kevin Stone is here who is the Chair of the
21 OneCare Board and made the trip up in the audience.
22 So thank you for being here. I just want to, as a
23 way of introduction, say I'm Todd Moore, CEO of
24 OneCare Vermont, and I'm here with team members Tom
25 Moore, Director of Finance; Sarah Barry, Director of

1 Clinical and Quality Improvement; and Karen Lee, our
2 Vice President of Finance. It will be the four of us
3 that will be doing the presentation for you today. A
4 lot of it will be Tom and Sarah doing the bulk of the
5 presentation slides with Karen and I offering more
6 commentary at certain points in response to
7 questions.
8 I do want to just put a couple things in
9 context before we get going which is we're still
10 early in this All Payer Model. It continues to be
11 quite a worthwhile but complex journey to understand
12 how this should work and will work, and the All Payer
13 Model agreement doesn't answer all the questions that
14 get into the details of our budgets and programs or
15 even your regulatory standing over it, but I do want
16 to thank Michael and Melissa, as well as Susan and
17 the rest of the Green Mountain Care Board staff, for
18 really being in the trenches with us trying to figure
19 this out and work our way through how this model
20 should work and it's supposed to work.
21 So I would envision today as it really
22 is a dialogue. There may be some things we need to
23 put in the parking lot for more discussion between us
24 and your staff or with the Board. We're going to do
25 our best to sort of explain the way we were thinking

1 about how next year this ought to work and in our
2 budget with your regulatory levers and review
3 criteria in mind. Certainly we're here to answer any
4 questions that you have as we move through this.
5 The other part of the introduction is
6 that a budget is just a plan, and you know I urge you
7 to view this budget the way you might envision a
8 hospital budget, that there's certain parameters that
9 you need to have. You need to understand what our
10 plan is. You do need to ask us to come back next
11 year during the year to say how are we doing against
12 the plan and are we implementing it as we said we
13 would, but a lot of this is very dynamic and we don't
14 know until after the new year who is really the
15 attributed lives and what's in the actuarial models
16 end up being for the actual accountability that we
17 have, and that's just part of what happens here, and
18 certainly the OneCare holds different contracts with
19 -- directly with Medicare, but with a lot of standing
20 by the Board to set those parameters, but also a
21 completely independent contract with Medicaid and
22 with commercial carriers. You know, this regulated
23 but yet individual contracts held by OneCare with
24 different payers and programs, you know, is part of
25 what we're all trying to figure out how do we, you

1 know, build in the appropriate flexibility within a
2 budget to anticipate the fact things do change. So I
3 really appreciate the Board's flexibility and respect
4 last year in getting to a point that we could get
5 this thing launched, and we hope that we have a
6 similar approach heading into this cycle. So with
7 that introduction I think we're ready to get into the
8 information.
9 Okay. Last year I gave you a checkbox
10 list of what was in the budget as the big headlines.
11 I'll do that again this year. I think we have a
12 great story for more progress in the All Payer Model
13 in terms of expanded provider network, expanded
14 payers, expanded attribution, and really fulfilling
15 in our plan what an All Payer Model ought to be which
16 is including populations for Medicare, Medicaid,
17 employer based plans, and insured plans on our
18 qualified health care exchange. You know we're
19 continuing down a pathway of expanding hospital
20 payment reform of the kind we set precedent for and
21 often I think that story gets missed. We're doing
22 the most advanced hospital payment reform -- real
23 payment reform in the country with the fixed
24 prospective payment for Medicare and Medicaid.
25 Continued physician community investment

1 and payment reform. We're building -- we're
2 maintaining and even building on the great models
3 that we've got in place now and you can hear a lot
4 about that story here today. In advancing population
5 health management you'll hear from Sarah Barry how we
6 continue to fulfill the promise of having a plan for
7 every patient as part of this. Yes that's in an
8 effort to do well under the economic model, but it's
9 really the right thing to do to have a more
10 coordinated system and a more proactive system that
11 keeps people healthy rather than only treat them when
12 they are sick. So you're going to hear about all
13 these things here over the next hour from my team.
14 I did include a slide that I have used a
15 couple of times in other presentations for those to
16 explain what's in an ACO budget in Vermont under an
17 All Payer Model with Green Mountain Care Board
18 oversight. This slide oddly enough looks way more
19 complex and busy than it is. I'm usually just the
20 opposite. So really at the end of the day what's in
21 the budget are those two blue boxes which is what is
22 our total cost of care targets for the attributed
23 population that we have and what is our
24 infrastructure and investments and payment reform
25 elements that we're funding outside of that,

1 including the operation of OneCare, and what you're
2 going to hear from Tom is 851 million dollars for our
3 projected spend for the attributed lives next year
4 across all payer programs; 53 million dollars in
5 payment reform, community investment and
6 infrastructure to support the model. You're going to
7 hear about out of the 53 million of that investment
8 that it's about 29 million coming from hospitals and
9 26 million coming from payers in the State of Vermont
10 through a variety of methods; and that is one
11 question I often get asked, and those monies fund the
12 things that are down in the lower right which is some
13 of the great things that maintain the Blueprint
14 payments, support community health teams, do real
15 payment reform for physicians, bring in community
16 based organizations and designated agencies, and
17 support communities and innovations and all the
18 infrastructure to administer it.
19 CHAIR MULLIN: So, Todd, on that you're
20 saying of the 53 million you have got 29 and 26 which
21 adds up to 55. What am I missing?
22 MR. MOORE: Oh good question. What
23 number is wrong, Tom?
24 MR. BORYS: It's probably just a
25 rounding thing. We'll look at it. As we get deeper

1 in we'll have more detail.
2 CHAIR MULLIN: Thanks.
3 MR. MOORE: On the left in the yellow
4 box is the risk and that is the one thing that sort
5 of is this unique factor. Our budget pretty much
6 projects what we think is really going to happen from
7 an actuarial predictability standpoint to our best
8 ability to predict actuary outcomes which isn't that
9 easy. So at the end of the day on top of everything
10 else you will hear about what is our projection
11 against that target, but also what is the maximum
12 risk or reward that we could get under these
13 programs, and that's on total cost of care, and the
14 risk bearing entities in this model again for next
15 year are the hospitals participating in OneCare
16 barring risk for all local attributed lives whether
17 they employ the primary care that attributed those
18 lives or not.
19 For our payment reform the way our
20 programs work is the payers and programs, Medicare,
21 Medicaid, and commercial carriers still pay
22 fee-for-service for most providers whether they are
23 in the network or outside of the network or even
24 outside of Vermont. It's really a short list of
25 providers that we at OneCare actually get access to

1 funds from a premium for us to make the payments to
2 providers, implement the reform, and it's really only
3 two types of providers. One, the hospitals in the
4 network and with the hospital payment reform model of
5 the fixed perspective payment that I talked about a
6 minute ago, and the independent primary care
7 practices who participate in our CPR, comprehensive
8 payment reform, model where they get a monthly
9 blended capitation across payer programs. So we are
10 going to see -- we have three in this CPR program
11 this year. We're going to expand that to I believe
12 five next year, and the hospitals will continue to
13 all be operating from Medicare/Medicaid under the
14 fixed prospective payment program.
15 So that in a nutshell really shows you
16 what you're going to hear about over the next hour.
17 It gives you a feel for how this works.
18 MR. BORYS: All right. So my job today
19 is really just to guide you through the whole OneCare
20 budget model, how it comes together. Hopefully this
21 will work well for doing that. There's a lot of
22 content here. I'm going to try to go through quickly
23 enough to be mindful of our one hour time, but if
24 there's something I'm saying that doesn't compute,
25 just stop me and we'll circle back, but just to start

1 we're going to hit some high level overview points
2 that are really the basis of everything that will
3 follow; and first things first are the payer programs
4 that are included in the 2019 budget model.
5 Starting with Medicare this will be the
6 second year of the Medicare risk program.
7 Interesting note here we're moving from a modified
8 nextgen program in 2018 to a brand new Medicare
9 program called the Vermont Medicare ACO Initiative.
10 Medicare has a number of different program offerings
11 along a spectrum of reform and progression. This is
12 a brand new one that Medicare is offering and we're
13 modeling us as being a N of 1 in this new program.
14 Medicaid. This will be the third year
15 of risk program with Medicaid and it's becoming a
16 very nice stable program for OneCare. Every year
17 that we're in this becomes easier and easier and I
18 can attest to that personally.
19 Also including a Blue Cross/Blue Shield
20 QHP program for risk program for the second year to
21 add that continuity to the network and program
22 offerings, and we also are modeling a continued pilot
23 with University of Vermont Medical Center to include
24 their self-funded plan in our model.
25 The last section here is a self-funded

1 expansion. This is an area of opportunity and growth
2 for OneCare and we're intending to grow in two
3 different ways in the budget. One is to build upon
4 the UVM employer plan model and roll in other
5 employer plans into the programs, and the second
6 approach that we're taking is to work through plan
7 administrators to bring in a larger book of their
8 business under one contract with OneCare. This has
9 some efficiency and we have one relationship with a
10 plan administrator. It can bring in multiple
11 employers with one swoop.
12 The next slide shows our year-to-year
13 network participation growth by community. You'll
14 see in 2017 are our four original Vermont Medicaid
15 nextgen participants and growing substantially in
16 2018 and then continued growth into 2019. The two
17 notes here to make we had two communities that are
18 moving from the Medicaid only on ramp to all three
19 risk programs which is a very positive sign. We're
20 definitely trying to continue to move these
21 communities into all risk programs for scale and for
22 the continuity of care in their community.
23 We also have three brand new communities
24 entering the model in 2019. That is Rutland, St.
25 Johnsbury, and Randolph. They are participating in

1 the Medicaid only option. This is proven to be a
2 successful strategy to on ramp communities, get a
3 little bit of comfort in the Medicaid program, and
4 then transition them to all risk programs in 2020.
5 One other note here is North Country is staying as a
6 Medicaid only HSA for this year and that's due in
7 large part to a recent leadership change.
8 This slide really just shows visually
9 the different provider types that make up our
10 network. We speak a lot about the hospitals, but
11 there's really a wide array of providers that
12 participate in our programs. The first three
13 categories; hospitals, FQHC, independent primary care
14 is really where our attribution comes from, but you
15 can also see from all the remaining columns there's a
16 number of other provider types that don't
17 specifically attribute to the model but are integral
18 to our health systems and important to keep in our
19 model.
20 All right. Attribution estimates. We
21 have this broken down by payer category. Starting
22 with Medicare modeling an anticipated 47,000
23 attributed lives. That's up about 10,000 from the
24 current year starting point. Medicaid we have
25 67,000. A lot of growth in those new communities

1 that are coming on; Rutland, St. Johnsbury, and
2 Randolph HSAs. Blue Cross QHPs anticipating starting
3 the year 22 and a half thousand. We'll see all of
4 these. We'll see where they land when the initial
5 attribution runs when they come through; and
6 self-funded, this is really the biggest area of
7 growth, is up just shy of 36,000 lives, and that
8 includes the expansion of the UVM pilot to other
9 programs and the other model that I spoke about where
10 we're working with a TPA, third party administrator,
11 essentially to bring lives into the program.
12 When I think about the attribution list
13 and what this is for it helps all the calculations
14 downstream. So it's a basis for calculating total
15 cost of care numbers that we'll have, and the PHM,
16 population health management, receipts that we expect
17 from different providers in the network, and
18 ultimately these attribution runs happen in December
19 or into actually 2019 when the final numbers come in,
20 but we use our modeling data and the best available
21 data we have to build our expected attribution
22 numbers.
23 So to run this first section out a
24 little bit we have our network strategy. Really the
25 summer months are when we engage with prospective new

1 participants in this network and develop our idea and
2 strategy for how we get more and more participation
3 and expand this statewide model. Really in this year
4 we focused on the FQHC participation. We focused on
5 getting the HSAs that did not participate in 2018
6 into the model. I'm relatively pleased the way that
7 that all went, and I think our vision looking forward
8 is to round out HSA participation so we have all the
9 Vermont communities in some sort of a program, help
10 to transition HSAs that are Medicaid only path into
11 all three risk programs, four risk programs
12 self-funded, and then also developing our programs to
13 look at how we integrate better, integrate
14 specialists and mental health providers into our
15 clinical models so that we're adding value across the
16 full spectrum of providers.
17 All right. Budget breakdown. My
18 approach to this is going to be to follow the income
19 statement. So for those that have our budget
20 submission, if memory serves me well, it's appendix
21 4.2, and that has really our illustrative income
22 statement for OneCare, different revenue streams that
23 we have, and all these I'll use revenue in quotes
24 I'll explain that a little later and the different
25 expenses that flow through OneCare, and I'm going to

1 go section through section and speak to each about
2 what's our philosophy and approach and how we have
3 come up with the numbers we're presenting today.
4 So the first section is in the revenue
5 block and these are the total cost of care targets.
6 This is going to reference back to the 851 million
7 dollar number that Todd referenced in the beginning
8 of the presentation. These are the targets of
9 accountability. This is the spend expectation for
10 each of these programs and I'll explain how we come
11 up with each of these now.
12 So just to baseline, on the general
13 approach our philosophy is to project the total cost
14 of care targets in a manner that is either and/or
15 actuarially sound using the best data we have and
16 also connects in any ties to contracts and the big
17 example is the Vermont All Payer Model which dictates
18 some of the Medicare components. So we're trying to
19 use a little bit of the best of both or the most
20 appropriate to come up with our best guess for these
21 total cost of care targets. These numbers are
22 important because they ultimately drive what the
23 downside risk or upside potential is for each of the
24 hospitals. So we put a lot of effort into making
25 sure that we're doing the best we can to project

1 these, but I will note that ultimately in particular
2 for the Medicaid and Blue Cross and self-funded
3 programs they are negotiated between OneCare and the
4 payer. Those negotiations are ongoing so the numbers
5 in here are a best estimate of where we think these
6 targets will land.
7 So start with the Medicare. Medicare is
8 an interesting one in that the Vermont All Payer
9 Model really dictates the methodology -- and the
10 Green Mountain Care Board the methodology that is
11 applied to come up with what the 2019 expected
12 benchmark target will be. We are modeling our
13 expected benchmark in a manner that we believe is
14 faithful to the model in the All Payer Model
15 agreement which takes the current year, which is
16 2018, spend and trends that forward using a trend
17 rate for the Vermont All Payer Model that happens to
18 be 3.8 percent in this trend model, and carries
19 forward any expected shared savings from 2018 year
20 into the 2019 year. That's the methodology by which
21 we keep that connection back to year zero of the
22 Vermont All Payer Model.
23 We do have some anticipated shared
24 savings carryover. That is in part due to the
25 conservatism that was built into our 2018 target so

1 that we can continue funding some of the Blueprint
2 programs in the state. As we look at the trend chart
3 here I do want to point out some interesting things.
4 Early on the green line that you'll see is our actual
5 spend, and just as a note here this is going to be a
6 mix of shared savings results and a mix of All Payer
7 Model results with some slightly different networks.
8 So there's some noise in it, but I think the
9 messaging is still important. The shared savings
10 calculations of benchmark never really worked that
11 well for our state. They are both national and
12 regional adjusters that resulted in benchmarks that
13 were well below what we expected to see for spend.
14 The Vermont All Payer Model provides a
15 much better basis for setting a benchmark. It uses a
16 much more current base. Shared savings actually
17 looked all the way back to 2014, whereas, the Vermont
18 All Payer Model uses the previous year and is based
19 on our actual network and their actual spend. So the
20 basis upon which the target is built is much more
21 relevant to our economics, and you can see that
22 increase in the gray line from '17 to '18 and then
23 '18 to '19 has been much more reflective of our
24 expected spend in the state. Without some of these
25 modifications it's questionable whether or not we

1 could reasonably and justifiably enter into a risk
2 program with Medicare.
3 MR. MOORE: So the '17 and '18 includes
4 both the 3.5 percent floor growth rate and the
5 Blueprint conservatism. So that wasn't included in
6 the base in '17 on this particular graph. So that
7 was the basis of the -- of that big increase there.
8 MR. BORYS: All right. Next we have
9 Medicaid. Again Medicaid is a negotiated program and
10 we really have a more stable base of data upon which
11 to build these targets which adds confidence
12 certainly to our model, and we're using the '17 spend
13 and very conservative trends that are yet to be
14 negotiated with DHVA to come up with what we think
15 the expected 2019 benchmark will be. Right now we
16 are using half a percent for that from the 2018 and
17 19 mark. We do incorporate -- because we've been in
18 this program for a couple years we do incorporate our
19 actual current year performance. That's relevant
20 important data. We also get modeling data from
21 Medicaid and we do our best to blend these and come
22 up with targets that are as reasonable as we can get
23 them to be. This program, just like the Medicare
24 program, includes the 0.2 percent discount factor
25 built in.

1 Next we have our Blue Cross/Blue Shield
2 of Vermont QHP total cost of care target. We are
3 generating this target by using the 2017 spend.
4 We're doing this all based on allowed amount and
5 projecting that forward using trend rates per the
6 Blue Cross Green Mountain Care Board approved filing,
7 and that is how we get from our 2017 spend number up
8 to the 2019 projection. We're in negotiations with
9 Blue Cross to really finalize both the methodology
10 and what the real number will be. This right here
11 represents our best estimate of a fair approach to
12 get to a '19 benchmark and ultimately will be
13 determined in collaboration with Blue Cross.
14 Just to go into the Blue Cross trend
15 rate a little bit deeper, it's an interesting one and
16 a little bit more nuanced perhaps than some of the
17 others is we build the trend off of the Green
18 Mountain Care Board approved rate filings, but really
19 are zeroing in on the factors that affect claims
20 cost, and some of the factors that affect premiums
21 don't necessarily translate directly down to the
22 expected claims trend so we try to zero in the best
23 we can on the factors that really would affect
24 fee-for-service equivalent value of the care for our
25 attributed lives.

1 One factor that we do have built in here
2 is a 2.3 percent adjustment for the AHP, association
3 health plan, transition that came up in the
4 negotiation -- or the trend rate filing with Blue
5 Cross. We deemed it to be reasonable, and that type
6 of migration of healthier patients from the QHP
7 market to an association health plan market can
8 increase the costs on a PMPM basis, and these are the
9 type of factors we're looking at when determining
10 what's a fair benchmark for the ACO. We're excluding
11 any factors in the trend rate filing that are related
12 to non-claims components such as administrative costs
13 or building of reserves for Blue Cross or any other
14 Blue Cross tax or fee impact adjustments.
15 Next we have our self-funded total cost
16 of care data are limited for this programming. We're
17 building this model largely based on the current
18 self-funded model that we have, but we will be
19 hopefully bringing in new plans and also a plan with
20 a third party administrator that will affect these,
21 but just to put in a placeholder of what the expected
22 spend might be showing some trends here. Really
23 there's a lot of opportunity in terms of scale to
24 grab more and more self-funded. It's an area we
25 focus on a lot and want to continue to work on it

1 more and find more employer plans and more plan
2 administrators that want to participate with us in
3 these models.
4 All right. Slide 20. For those on the
5 phone, Jackie, if you want, we have the estimated
6 total cost of care targets in aggregate. This slide
7 isn't intended to show trend rates, but really the
8 scope of claims cost that is now within our
9 accountability as OneCare. We're moving from a
10 projected total cost of care. I say projection
11 because it is based on attribution and attrition that
12 we may experience, but expected 2018 total cost of
13 care 635 million moving to 851 million. So that's an
14 additional 34 percent accountability in the OneCare
15 model or 215,000. It's a substantial increase
16 certainly in my view to the spend for our Vermont
17 attributed lives that is now in the program.
18 All right. So we just talked about
19 gross dollars 34 percent increase. Now this slide is
20 intended to boil that down into a blended trend rate.
21 So one of the interesting nuances when looking at our
22 numbers for this year is we have a change in the
23 payer mix. We're seeing more growth in the Medicaid
24 programs since we brought in new communities in a
25 Medicaid only arena, and Medicaid happens to have the

1 lowest PMPM. So on a pure total dollars standpoint
2 on a PMPM basis our blended rate actually went down.
3 That's actually not the case, but it appears that way
4 when you add in more Medicaid lives as opposed to
5 more Medicare lives.
6 This exhibit quiets the payer mix noise.
7 It takes the PMPMs from '17, '18, and '19 and applies
8 the payer mix attribution mix by payer that we have
9 in 2019 and applies that backwards so that mix in
10 payer is not affecting the overall PMPM that we're
11 seeing here. When we do that and take our 2017, '18,
12 '19 PMPMs with this standardized payer mix we're
13 seeing a 1.9 percent blended increase from 2018 to
14 2019. This is encouraging to us in that based on
15 this methodology we're living within the 3.5 percent
16 target asset by the All Payer Model.
17 Out of curiosity we also took the
18 statewide payer mix and applied our PMPM rates from
19 2018 and 2019 just to see if that yielded a different
20 result. When we did that it came up to 3.0 percent
21 blended trend rate from '18 to '19. So even if our
22 PMPM were applied statewide, every life was in a
23 OneCare program, this model would have us living
24 within our 3.5 percent trend rate goal.
25 All right. Next section of the budget

1 will speak about the other revenues that OneCare has.
2 So the total cost of care targets are really our
3 benchmarks. These other revenues are what help us
4 sustain operations at OneCare. So this next section
5 of the income statement -- so really three different
6 buckets of revenue sources. We have our payer
7 partners who contribute, we have the State of Vermont
8 who contributes as well, and then the hospitals. The
9 payer partners contribute in the form of PMPMs. So
10 for every attributed life there's a cash in-flow to
11 the OneCare network that helps us fund our population
12 management programming and operations in some cases.
13 The State of Vermont supplies funding for the
14 advanced care coordination program, the health
15 information technology platform, and primary
16 prevention programs, and then lastly, certainly not
17 leastly, is the hospitals whose participation fees
18 round out the revenue needed by OneCare to really
19 facilitate these programs and the reforms.
20 So that was the revenue section of the
21 income statement. So this next component will shift
22 into the expense section, and I'm going to start with
23 the health services spending. So before we were
24 projecting what are the total cost of care targets or
25 benchmarks going to be. Now we're trying to project

1 what's the spend going to be. In some cases those
2 are the same. For the Blue Cross and Medicaid and
3 self-funded we're expecting whatever we negotiate
4 those payers to be our best guess of what the actual
5 spending will be. Medicare is a little bit different
6 in that some of the terms of the alt payer model mean
7 that the target could be different than our expected
8 spending, but our general approach in calculating the
9 expected spend is really a HSA model where we take a
10 HSA base year PMPM and everything is built on a PMPM
11 model. We apply the program trend rate. This is the
12 trend that we expect to see this next year to come up
13 with the 2019 expected HSA PMPM that is multiplied by
14 attribution -- expected attribution and that is
15 really the HSA total cost of care. We do this
16 collectively for each HSA. This is important to do
17 it this way because the base PMPM HSA is not the
18 same. We have one global target. Might be $250 per
19 member per month for the total program, but some HSAs
20 are higher or lower depending on the risk of their
21 population, the efficiency of the care delivery. So
22 we build it from that HSA level to come to a total
23 cost of care.
24 When doing that we aggregate up to this
25 slide here which is the total expected spend. This

1 then we break that down to a combined PMPM for each
2 payer program. So this is where the differences in
3 each payer program PMPM becomes quite evident.
4 Medicaid is 249 is modeled here. Medicare 841
5 dollars. So you add all the Medicaid lives that's
6 why the blended PMPM will just go down in the absence
7 of any payer mix adjustment. So really again a big
8 number in terms of the total spend that we're
9 expecting for our attributed lives for '19.
10 When we think about the spend at least
11 at the ACO we start to break it down a little bit
12 into a couple different views and perspectives. You
13 just -- HSA has a total spend number, but that spend
14 happens in various settings and various proportions.
15 So this next slide here shows in the dark green for
16 the locally attributed lives, lives attributed to
17 each of the HSAs how much of the care is delivered at
18 their home hospital under the fixed payment model,
19 how much is delivered at a different OneCare hospital
20 under fixed payments. This could be a referral to a
21 different hospital. The gray section is a non-fixed
22 payment hospital but within our network. So that
23 could be Copley or Grace Cottage or Dartmouth is a
24 fee-for-service payer, and the last is remaining
25 fee-for-service that is basically anything else, but

1 it could be a local primary care doctor that's
2 accepting a fee-for-service mechanism. It could be a
3 FQHC. It could be an out-of-state provider that is a
4 fee-for-service basis. As we think about the long
5 term evolution of this no two HSAs are identical.
6 Some have a lot more care that's delivered locally at
7 home, some refer out more, and we need to be mindful
8 of that as we develop our risk models going
9 downstream.
10 This next slide takes a slightly
11 different view and really looks at hospital spending
12 across our network on a PMPM basis. I think it's an
13 interesting way to start looking at some of the
14 hospital spending numbers, but we're taking the
15 hospital spend and dividing it up by our total
16 OneCare attribution to come up with a -- just a
17 relative amount of hospital care that each of these
18 providers are delivering. I think that this will be
19 an interesting one to look at over time, some
20 year-to-year trending to see were there any movements
21 in these PMPMs, and it also is broken down the top
22 section here into two different categories. One is
23 for the hospital care that they deliver for the
24 localized. The green is for lives that are referred
25 into their hospital from a different attributed

1 community. The bottom graph here is stacked bars
2 that shows the proportion of spend related to their
3 local lives versus those being referred in. There's
4 some pretty interesting trends to this. I find that
5 geography often affects this quite a bit. For
6 example, Southwestern Vermont Medical Center down in
7 Bennington really doesn't refer to a lot of other
8 Vermont hospitals very often just because of their
9 geography and capacity down there in Bennington.
10 So this naturally segues into the fixed
11 payment model. This is also a part of that section
12 of the income statement of health services spending.
13 The fixed payments represent the more chipped away
14 from fee-for-service, really start thinking about
15 health care delivery in a different way, capitated
16 way, and the 2019 budget model incorporates fixed
17 payments for the Medicaid and Medicare program. So
18 the same fixed payment approach that we have in 2018.
19 These fixed payments work a little bit
20 differently. The Medicaid fixed payment is viewed as
21 the true total cost of care. That fixed payment is
22 what we're agreeing to with Medicaid is the actual
23 spend amount for these attributed lives and is not
24 subject to any reconciliation at year-end. Medicare
25 works a little bit differently. They view the fixed

1 payment as really a cash advance and the network
2 earns that back as they do provide care to the
3 attributed patients and have a zero pay. Shadow
4 claims we call them. That really is reconciled at
5 the end of the year so if Medicare were to overpay us
6 for the fixed payments, we owe that back to them. If
7 they underpay us, then they would actually make good
8 on that. That is really a subcomponent under the
9 program and the full settlement. The settlement is
10 still based on the benchmark that we have for
11 Medicare and the fee-for-service equivalent of all
12 care underneath it. So they will take those value --
13 those zero paid claims plus actual fee-for-service
14 paid to do the settlement. So just a nuance that I
15 think is important to understand for the fixed
16 payment model.
17 Another important note actually really
18 quickly the amount any hospital receives is the
19 payment to cover care for not only their localized
20 but any of their referrals in. So that's a component
21 that we look at; how much of the fixed payment was
22 for their local population, how much was referred in
23 from other communities. In 2018 we reconciled that
24 latter piece to protect against any market shifts
25 that we might experience.

1 Slide 30 provides a breakdown of the
2 fixed payments in terms of the Medicare and Medicaid
3 programs gross dollars just to get a feel for how
4 much money there actually is falling through OneCare
5 to the hospitals and breaks it also down by PMPMs.
6 Two different methodologies. One is based on total
7 attribution. One is based on HSA attribution.
8 Really the number that I think is important to note
9 is 25 percent of the total cost of care is flowing
10 through a fixed payment model, which is a good solid
11 number but one that we would like to see increase
12 downstream.
13 Funds flow is a question that we
14 received often and really it remains unchanged from
15 2018, but to make sure that's understood there's
16 really two avenues here. At the top we have the
17 payers. So this is Medicaid, Medicare, Blue Cross
18 Blue Shield of Vermont, and the self-funded plans,
19 and there's an early split that is either paid
20 fee-for-service claims, this is for a non-hospital
21 provider or a non-comprehensive payment reform pilot,
22 independent primary care employer where the provider
23 submits a claim and the payer pays that claim
24 according to their own fee schedule and their own
25 adjudication process. OneCare never actually touches

1 those dollars. That's the case for FQHCs, any
2 non-CPR primary care, and the other continuing care
3 providers whether they are in network or out of
4 network.
5 The other way in which funds flow is
6 that payers pay OneCare monthly for the fixed payment
7 allocations, the amount that we've agreed upon with
8 the payer to cover the hospital fixed payments and
9 CPR fixed payments and then any of the payer
10 investments in population health management. From
11 there every month OneCare makes payments to the
12 participating network providers and pays out
13 according to those three boxes in our payment
14 approaches. For the left-most box the hospitals and
15 CPR is going to include their fixed payments, any
16 other population health management payments that they
17 are eligible to receive, care coordination payments,
18 the value based incentives fund payment which happens
19 at the conclusion of the plan year, and then any
20 other payments related to reform efforts such as our
21 specialist reform pilot program that we're working on
22 now.
23 The other attributing practices receive
24 basically all the same with the exception of the
25 fixed payments, and then the non-attributing

1 practices are really zeroing in on the care
2 coordination funds and their participation in that
3 program, the value based incentive fund, and if they
4 have any involvement in specialists, for example,
5 they would be eligible to receive any funds for that
6 program.
7 So next we're going to get into our
8 population health management spending and because
9 this is really all of our clinical initiatives and
10 the investments we're making in the community I'll
11 have Sarah speak to those.
12 MS. BARRY: Good afternoon. So I'm
13 going to walk you through the 37 million dollars
14 worth of investments that we're looking to make in
15 our communities over the course of 2019 and describe
16 some of the programs and their expansion as well as
17 some new programs that we're looking to implement.
18 So as we look to the programs that
19 really were set in the foundational year with
20 Medicaid in 2017, in 2018 we've been expanding those
21 to our other programs as well. With our population
22 health management program we are currently funding
23 $3.25 per member per month into all of our primary
24 care practices based on their attribution. What
25 we've been revising and really updating in this

1 program over the course of the summer months is to
2 clarify the expectations and the accountabilities
3 associated with ongoing receipt of that funding, and
4 so each of our practices over the course of the last
5 three months has gone through an attestation process
6 to make sure that we are all clear on the key
7 criteria for these funds and how they are applied,
8 and you can see in a synopsis level those criteria on
9 the screen. They include making sure that you're
10 using data effectively to evaluate the care that
11 you're providing, having activities in place to
12 address care, working on the accuracy of the coding
13 to make sure that we understand the risk profiles of
14 the population panels that you're caring for, as well
15 as maintaining and continuation to advance the team
16 based care concepts that the Blueprint has done so
17 much to put in place over the last decade.
18 In the second investment we are
19 continuing to expand our complex care coordination
20 program. In 2019 we are anticipating this to be in
21 the range of 9 million dollars. The entirety of that
22 funding comes through OneCare and is sent out into
23 our network to support our person centered community
24 based approach to care coordination. One of the new
25 things that we're anticipating being able to support

1 in our care coordination program in 2019 is a
2 partnership with the Health Department and some local
3 parent child centers in a program called DULCE which
4 is really looking at how we can address social
5 determinants of health and early childhood
6 development to create strength based programs and
7 really advance care for that potentially vulnerable
8 time in a young child's life.
9 In the third area we have continued to
10 expand our value based incentive fund. So this was a
11 pilot program for communities in 2017 that has
12 advanced in all our payer programs in 2018, and we're
13 anticipating not only continuing that in 2019, but
14 we've also been working through a primary care work
15 route to implement and test over the course of 2019
16 some variable models for how the funds would actually
17 be allocated based on what is earned at the level of
18 the ACO. So we're looking forward to the opportunity
19 to evaluate that and continue to refine it in 2019.
20 Tom spoke just a moment ago about our
21 comprehensive payment reform program. This program
22 was a pilot in 2018 with three independent primary
23 care organizations, and we're very excited that is
24 expanding on a voluntary basis to nine organizations
25 over the course of 2019. As part of that they are

1 receiving funding in a new and different way,
2 something that they need to get used to, and they are
3 also investing time and energy and resources and
4 really thinking about how care can be provided in
5 different and new ways. We've been obtaining
6 tremendous feedback from providers and continuing to
7 reform that program as we look toward 2019.
8 In the area of specialists we are very
9 committed to implementing a pilot program in 2019 and
10 are really looking at two key drivers; the first
11 around improving access to care and the second around
12 quality of care, and so looking for the right levers
13 and opportunities both from payment and care delivery
14 to think about how we can better align and support
15 the integration of primary care and specialty care
16 providers to make sure that the patients that are
17 sickest or most vulnerable are able to access
18 specialty care services in a timely manner and return
19 back to their primary care providers as appropriate.
20 In the area of primary prevention we
21 continue to support the RiseVT initiative which has
22 been tremendously successful in getting off the
23 ground in 20 communities over the course of 2018 and
24 we're anticipating that will expand to an additional
25 14 communities over the course of 2019. That program

1 has had a tremendous local success in engaging
2 program coordinators in at least six of the health
3 service areas to be able to identify what the areas
4 of opportunity are and address programs that with
5 small funding and creativity and community engagement
6 really can make a difference in promoting health and
7 well being.
8 In order to support our programs and
9 really make sure that we are able to learn from the
10 local variation, as well as the wonderful work that
11 is happening from one end of the state to the other,
12 OneCare invests funding in regional clinical
13 representatives. These are individuals that provide
14 really peer-to-peer coaching. They serve as local
15 champions for the work that's happening. They share
16 data and information from OneCare centrally into
17 their community as well as bring information back
18 about successes and lessons learned, and so all of
19 those regional clinical representatives also serve on
20 our clinical and quality advisory committee providing
21 that bi-directional communication that we're finding
22 to be so effective.
23 One of the brand new areas that I'm
24 particularly excited about for 2019 is an innovation
25 fund, and OneCare is looking to invest a million

1 dollars in 2019 in local communities to be able to
2 test and evaluate innovative projects that have the
3 potential from day one to be scalable to other
4 communities and statewide, and so this is a program
5 that we anticipate running through our population
6 health strategy committee which is quite a diverse
7 group of providers, continuum of care
8 representatives, and individuals that are very much
9 dedicated to helping make sure that OneCare is able
10 to advance its mission towards accomplishing the
11 triple aim.
12 These next three programs and
13 investments are really about continuing the Blueprint
14 for Health investments from the Medicare program. So
15 regarding the patient centered medical home payments
16 as well as the community health team payments, we are
17 anticipating and we are actively working with
18 Blueprint staff right now to refresh the Medicare
19 attribution which has been held constant for quite a
20 period of time, and what we are anticipating in that
21 process is there actually will be an increase in the
22 Blueprint Medicare attribution that we will want to
23 account for.
24 For the SASH payments we are
25 anticipating a direct contract between OneCare and

1 SASH to help support the alignment with our overall
2 care model and are looking forward to continuing that
3 partnership. We are anticipating fully funding all
4 of the existing SASH panels as well as continuing the
5 contributions for both ACO and non-ACO participating
6 practices and community health teams.
7 MR. BORYS: All right. So next we're on
8 to the operating costs, the last section of the
9 income statement for OneCare. This slide shows a
10 summary of the 2018 budget to 2019 budget and the
11 change areas that we're seeing. So we're moving from
12 12 and a half million up to just shy of 16 million.
13 The bigger changes happen in the staffing area. I'll
14 speak to those in a minute. Contracted services is
15 going up, and actually just to back up one step
16 further one of the reasons we're experiencing some
17 operating cost increases is that RiseVT is truly
18 on-ramping into OneCare operations. Last year it was
19 viewed as a population health investment and all of
20 the costs were in that PHM category. They are
21 becoming such an integral part of OneCare their
22 salaries and a lot of the expenses that they have as
23 an organization are now rolling into our OneCare
24 operating costs. So that's one of the reasons for
25 the changes. So that's going to be a contributing

1 factor for the salaries, for the contracted services.
2 The investments that they make to build that RiseVT
3 program and expand it statewide are included in that
4 contracted services line. We're also seeing
5 increased costs in the categories of actuarial
6 services and legal as we expand our network and have
7 more need to do data analysis and expand payer
8 programs that all require analysis and growth there
9 as well.
10 The other expense category that's
11 showing some increase is travel. As we have a more
12 statewide network we're going to have to spend more
13 time on the road, and then the other expenses is
14 growing in large part to the Green Mountain Care
15 Board bill back.
16 On the staffing changes really it's kind
17 of a widespread small incremental growth approach.
18 We did put a lot of time and energy into looking at
19 the staffing model we had, reacting to the needs of
20 the network, and making sure we had the right people
21 in the right positions to meet the needs of our
22 network. The -- so there's really 7.1 FTEs that are
23 related to OneCare operations. The bottom section
24 here is four of those RiseVT positions that are now
25 on-ramping into OneCare, and then there are two

1 positions that are in the budget to do specific work
2 on mental health and opiate use disorder projects.
3 All right. Reserves, and this happens
4 to be the answer to the very first question we were
5 asked by Chair Mullin which is what was the
6 difference between those two numbers in the first
7 sheet. The answer is the reserve calculation. So
8 the 2019 budget model has a 2.8 million dollar
9 operating gain. This is the means by which OneCare
10 can develop reserves. As a reminder there are --
11 there's a budget order in the 2018 program year 2.2
12 million dollars in reserve built by the end of this
13 year. We intend in this budget model to add 2.8 to
14 that to have a 5 million dollar reserve. These
15 reserves are becoming an important component for
16 OneCare. It's taken some thought to get to this
17 point, but one of the findings -- results of our
18 network development strategy this year is that the
19 downside risk is a big deal for some of the smaller
20 hospitals and their balance sheets. Having some
21 reserves at OneCare can be a useful strategy to help
22 bring more in, especially when we start getting into
23 the Medicare program. So that's one reason for
24 having some resources that OneCare makes sense for
25 our network development.

1 One of the concerns raised last year was
2 the issue of default risk; if a hospital were just to
3 not pay a downside risk payment, how would OneCare
4 protect itself and its solvency, and an answer to
5 that is having some reasonable reserves. The other
6 is just regular cash flow. We're a growing business
7 and the amount of dollars that flow through OneCare
8 are growing as our network grows, our programs grow,
9 and having some -- having a balance sheet to rely
10 upon to cover timing issues with any payments that
11 come from the payers or from the network is an
12 important aspect, and the last point we make here is
13 that we would like to see this scale proportionally
14 with our overall network growth.
15 The one other note I'll add is that any
16 reserves that OneCare builds or intends to build
17 should be considered in context of other payer
18 program requirements. Medicare, for example, has a
19 reserve requirement that comes along with being in
20 the nextgen or Vermont ACO initiative. That was a
21 substantial amount of money, about 4.2 million
22 dollars that had to be secured to meet the program
23 requirements of Medicare. So really any reserve
24 request we would ask be considered in the context of
25 other reserve requirements that are in place.

1 All right. Next I want to talk about
2 what this really means for the network and their
3 commitment to this accountable care approach. So
4 really OneCare, as most of you know, is a network of
5 providers and we're all coming together to further
6 the components of the triple aim. This really is a
7 big task that takes both clinical and financial
8 reforms working together to achieve these results. I
9 think if we just were to do financial reform and not
10 have any clinical investment, we probably wouldn't
11 achieve great results, and in many cases the clinical
12 reforms can't take place without changes to the
13 financial incentives that are put in place in the
14 financial model. So it's a very connected model.
15 To do this, to pull this off, takes
16 really two things. One is accepting downside risk
17 which is the financial reform that flips the
18 incentives structure so that a well population
19 doesn't damage the delivery system, and it takes
20 investment in our programs and those investments come
21 from a number of places. The payers contribute some
22 other revenue streams, but the hospitals are also
23 major players in investing in the model so that we
24 can sustain and do well in the financial paradigm.
25 So with that in mind a little bit on

1 risk and what's included in the budget model. This
2 is -- bearing that risk is a -- really a requirement
3 of the accountable care models, and as in -- just
4 like in 2018 each hospital will be supplied a maximum
5 risk limit calculation that takes their HSA spend,
6 spend for their HSA lives, and applies the program
7 risk terms, the corridor, and the sharing that may be
8 in place to their HSA spend to come up with a maximum
9 risk limit.
10 Technically all of these programs settle
11 at the ACO level. So one HSA could drive the entire
12 risk corridor for the ACO. We don't want that to
13 happen because that could jeopardize the solvency of
14 any one HSA. So we applied these maximum risk limits
15 and rules about how any risk or reward above that
16 limit is handled in the network as a real protection
17 for all of the HSAs and the hospitals bearing the
18 risk. What we have in here for risk corridor terms,
19 and these are subject to negotiation or -- and/or in
20 some cases decision by the OneCare Board, Medicare
21 will remain at the 5 percent in this corridor but
22 transitioning from a 80 percent share to a 100
23 percent share. This decision is supported by the
24 fact that we anticipate having some shared savings
25 because of the conservatism in the 2018 target for

1 the Blueprint. So essentially if we were to hit our
2 actuarial claims target right on the head in 2018,
3 we're going to owe back 20 percent of the
4 conservatism that was given for Blueprint. After the
5 results that we're experiencing thus far, we think it
6 is right to go away with the 80 percent sharing and
7 make sure that we can carry forward as much shared
8 savings as we can earn into the future years.
9 Medicaid moving from a 3 percent in this
10 corridor to a 4 percent in this corridor is
11 consistent with the program evolution of Medicaid and
12 taking measured steps to move it forward and
13 accountability under the model. Blue Cross
14 maintained the same risk model, which is a 6 percent
15 corridor and 50 percent sharing within the corridor,
16 and then self-funded -- this is very premature, but
17 we're exploring some downside risk elements of the
18 program which would have a 6 percent corridor but a
19 30 percent share. That 30 percent is meant to ensure
20 that the loss of the attribute would qualify for
21 scale targets under the All Payer Model.
22 So this next slide builds upon
23 everything discussed thus far; the estimated
24 attribution, the estimated total cost of care, model
25 risk terms, and boils it down into estimated hospital

1 risk. It's a big number. There's 34.8 million
2 dollars of downside risk or upside potential for
3 these programs. Ultimately the actual upside and
4 downside risk is dependent on final attribution that
5 we receive, actual total cost of care targets that we
6 negotiate and finalize with the payers. This is
7 meant to represent our best estimate of all of that
8 and how hospitals make decisions and the boards make
9 decisions about whether or not to participate and
10 whether or not a year in which they had to pay up to
11 the maximum risk limit would be harmful to their
12 organization.
13 One other note on here. There are some
14 risk mitigation solutions that OneCare has developed.
15 There's a risk mitigation model for the Medicare
16 program and there are some risk mitigation
17 arrangements for hospitals. These are not factored
18 into these numbers. It's just gross risk numbers and
19 essentially the check OneCare would have to write
20 back to these payers if we completely maxed out our
21 downside.
22 All right. So next we have our hospital
23 participation costs. These are really -- the amount
24 here, this 29 million, is the amount that we need
25 from the hospitals to fulfill the OneCare budget

1 model here, and we collect those either through fixed
2 payment deduction when we're able for the Medicaid
3 and Medicare programs or quarterly invoice to the
4 hospitals. I really want to break this number down
5 in a couple different components. We have a gross
6 deduction amount of 29 million. That's the amount
7 that the hospitals are paying in monthly and
8 quarterly installments to OneCare. That really funds
9 two different components. One is the investment and
10 population health management programs that comes
11 right back to the hospitals. So they are
12 contributing to OneCare programs, but they are also
13 recipients of those funds. So one could view the
14 expected PHM receipts column 14 million as really a
15 cash flow function. We're withholding the dollars at
16 OneCare so we can operate the programs that are
17 ultimately paid right back to the hospital network.
18 The amount remaining is really the net cost to the
19 hospitals of OneCare, and this would be the amount
20 that would essentially go away if they didn't make
21 the payment at all. So that's 14.6 million. That
22 can be broken down into three categories here. One
23 is community investments. These are investments
24 where the hospitals are paying in to help fund
25 OneCare initiatives and payments are being made to

1 other community providers, agencies, independent
2 primary care, FQHCs, et cetera, and really investing
3 in population health for the other community entities
4 that are in our network.
5 We also have that contribution to
6 reserves number here, that's the 2.8 million I
7 referenced before, and the last is contribution to
8 OneCare operations. 7.8 million is really the amount
9 that OneCare needs after factoring in all other
10 revenue streams that we can use to help fund our
11 regular operating costs.
12 MS. BARRY: So now I would like to walk
13 you through a couple of highlights related to our
14 clinical and quality outcomes. We have spent
15 tremendous time in the last couple of years talking
16 to providers across our network as well as working
17 with the Green Mountain Care Board staff and the
18 Heath Care Advocate and really looking at the
19 opportunities to align quality measures under the All
20 Payer Model. The latest work collaboratively in that
21 has been around aligning the Medicare quality
22 measures that will go into effect for 2019, and the
23 accomplishment there collectively is that over the
24 course of the last two years we've really been able
25 to take a disparate set of more than 40 quality

1 measures, many measures which do not align across
2 more than one program, and bring them into alignment,
3 and so you'll see here a set of 15 quality measures.
4 Usually about 13 measures for any one payer program.
5 The intense focus of these measures and
6 the alignment under the All Payer Model really means
7 a couple of things for us. It looks at effectively
8 being able to reduce the administrative burden on
9 primary care from having to develop systems and
10 processes for oftentimes measures that had slightly
11 different definitions and became very frustrating to
12 try and figure out how best to track, but also it's
13 really looking at measures that are clinically
14 important. They are important to the overall health
15 and well being of Vermonters, and our providers feel
16 very strongly these represent a diverse set of
17 measures that really allow them to set targets and
18 goals.
19 Looking at our 2017 quality measure,
20 performance results became available recently. In
21 our Medicaid program, again the four pilot community,
22 we achieved a 85 percent quality score overall. This
23 was using a brand new set of measures for us, and one
24 of the key determinations related to our ability to
25 reinvest in quality is that our population health

1 strategy committee and our board of managers approved
2 and worked collaboratively with the DHVA on a
3 reinvestment strategy for the components of the value
4 based incentive fund that was not successfully
5 earned. So this was the 15 percent that we did not
6 achieve by the quality score that we obtained, and so
7 the plan that we have in place now and will be
8 operationalizing over the next few weeks is to be
9 able to send those funds out into the local
10 communities in those four health service areas
11 through the function of their community
12 collaborative, also known as their accountable
13 community for health, with some guidelines from
14 OneCare about areas of opportunity that align with
15 gaps in care, and then for us to work with them
16 around how to design specific programs and projects
17 to address those gaps in care over the course of the
18 next year.
19 Within our Blue Cross Blue Shield
20 program in 2017 this was a shared savings program and
21 you can see that we were able to achieve 73 percent
22 as our quality score and really maintain the overall
23 quality across those measures.
24 For Medicare we achieved an 88 percent
25 quality score, and one of the things that really was

1 changing for us in that shared savings program year
2 is that six different quality measures that had been
3 reporting measures became payment measures and that
4 did have an impact on our overall quality score as
5 well as the quality scores for other ACOs around the
6 country, and so as you'll see in this next slide this
7 is an opportunity for us to look at under the
8 Medicare shared savings program how does OneCare
9 compare to all of the other ACOs on two dimensions;
10 across the x axis we're looking at cost per
11 beneficiary per year and on the y axis we're looking
12 at that overall quality score, and if your eyes can
13 search it out, in that top left quadrant you will see
14 a green dot and that represents OneCare's performance
15 relative to all of the other ACOs. We pay tremendous
16 attention to this and this for us is the high value
17 quadrant. We always want to see we are able to
18 function and support Vermont and health care reform
19 by really leveraging high quality care and
20 controlling that cost growth.
21 This is just a quick example of some of
22 the types of activities that when we take a
23 longitudinal view of our quality measures that we're
24 able to see some growth and some impact, and so this
25 is a measure around adolescent welfare. Looking in

1 the left-hand chart at the Blue Cross qualified
2 health program and the -- on the right the Medicaid
3 program, the very colored lines are really showing
4 you the benchmarks by year and the bars are showing
5 what our actual quality performance is, and so you
6 can see we're making incremental and steady progress,
7 the most dramatic of which has really been in the
8 last year in the Medicaid program as we are able to
9 really advance towards that 75 percentile. It's
10 interesting to note that this quality measure
11 nationally has stagnated for a long time. It's a
12 very hard measure to move.
13 I often spend quite a bit of time
14 talking about our care coordination program, and so
15 rather than walk you through the fundamentals of the
16 model I thought I would take a couple minutes to
17 highlight some of the early results and then share
18 with you a case study, a real life example of the way
19 care is changing in our communities.
20 So in this chart what we're really
21 displaying here is that for all of our payer
22 programs, so regardless of which program a
23 participant is in, if they were successfully engaged
24 in our care coordination program between one or six
25 months, we're looking here at the utilization of

1 emergency room visits and what we're seeing is that
2 with the beginning of the 2018 calendar year and the
3 transition to these risk based programs that we're
4 actually seeing a trend showing some decline in those
5 emergency room visits. This is still an early
6 signal. We have many other metrics that we're paying
7 attention to and we would be happy to describe, but
8 these are the types of information that we're sharing
9 across our communities as we start to look at the
10 impact of this community based care coordination
11 program.
12 So in this case study I would like to
13 share with you we're looking at a Medicaid member who
14 was determined through our risk stratification
15 program to be at very high risk. She's in her late
16 50's, she has an extraordinary medical complexity,
17 and so for the purpose of this case study I'm going
18 to call her Sally. Sally over the course of the last
19 12 months had a risk score about 14 which is
20 extraordinarily high when you look at our population.
21 Her spending was above $120,000 in the last year.
22 She was admitted to the hospital seven times. Four
23 of those times the cause of her readmission was
24 related to the initial diagnosis that she had had,
25 and she visited the emergency room six times. Sally

1 has diabetes, she has COPD, she has congestive heart
2 failure, she's obese. In total we captured 28
3 different health conditions that put Sally at
4 increased risk. Unfortunately Sally's pattern was to
5 spend one week at home followed by roughly three
6 weeks in the hospital and that pattern was repeating
7 itself over and over again. In August Sally was
8 identified as someone who could potentially benefit
9 from enhanced care coordination services. She was
10 outreached to from her primary care practice and
11 selected a nurse in that practice to serve as her
12 lead care coordinator.
13 Sally described herself as depressed,
14 fearful, exhausted by her many admissions and all of
15 the transfers, the documentation, the details that
16 she had to track. She was able to articulate that
17 her goal primarily was to stay at home, but that the
18 complexity of her illnesses made this particularly
19 challenging, and it was recognized that without
20 strong coordination across a number of service
21 providers that that was unlikely to happen. Because
22 of Sally's underlying conditions as she was
23 discharged in that last visit in August she could not
24 be admitted to a skilled facility because they didn't
25 have the services available to supply the advanced

1 needs she had for IV medication. So her hospital
2 case management team worked to stabilize Sally. They
3 actually inserted a line to help her be able to get
4 her medications, and they strove to really figure out
5 how they could get home health to support her.
6 The initial plan was that she could be
7 at home but she would have to travel to the hospital
8 everyday for her IV medications, and that in order to
9 do that someone would need to help arrange for
10 specialty van transportation back and forth each day,
11 and for a whole variety of reasons that was a process
12 that was likely to not result in the type of care
13 that Sally really needed in order to be able to break
14 the cycle of hospitalizations.
15 So the local and the referral hospitals
16 collaborated. They worked together through pharmacy
17 and supply chain, they identified all of the
18 equipment and the surgical supplies that Sally
19 needed, her lead care coordinator worked across all
20 those systems, addressed her needs for specific
21 prescriptions, identified barriers related to her
22 out-of-pocket expenses, and helped support her to try
23 to be able to obtain those medications. The care
24 team identified medication complexity as a barrier
25 and arranged for bubble packs, so somebody to

1 actually count and aggregate medications so there
2 could be a process, a standardization about which
3 medications, what time to take them, how to take
4 them. That care team held multiple care conferences
5 both by home and -- excuse me, by phone and in the
6 patient's home. It involved home health, the Choices
7 for Care program, her nurse care coordinators, her
8 neighbors, a diabetes educator, her husband, and
9 pharmacy technicians.
10 The lead care coordinator organized the
11 team to care for the husband, also a patient in that
12 practice but one who is not attributed to the ACO.
13 The husband was significantly older than Sally and
14 was experiencing other social and economic challenges
15 and was asking for help. The lead care coordinator
16 ID'd existing social supports, many from her local
17 neighborhood, as well as arranged for a plan for
18 those neighbors to come in and support Sally and her
19 husband cooking, caregiving, checking on them to make
20 sure that they were okay on a daily basis. All
21 together providing a more stable home and emotional
22 environment.
23 The early signs indicate a significant
24 reduction in Sally's utilization. She's now been at
25 home for 11 weeks. She has not had any admissions or

1 emergency room visits. She's successfully managing
2 her complexity. She's weighing herself. She
3 managing her conditions. She's actually successfully
4 completed several of the goals in her care plan and
5 has now set new goals for herself.
6 So I share this case study for you as an
7 example of the type of transformative care that
8 OneCare is really trying to support and facilitate as
9 we're aligning the care delivery system at the local
10 level, as we're bringing together talented
11 professionals across many organizations, and working
12 to break down the barriers, often systemic barriers,
13 to providing optimal care.
14 Before I finish up I would like to just
15 touch briefly on our patient benefit enhancement
16 waivers. You have heard me speak about these before,
17 but two important notes that I wanted to bring
18 forward today is that as we spent time meeting with
19 both our current network participants as well as
20 those that were considering joining us over the
21 course of the summer for 2019 one of the surprising
22 things that I learned was that it was actually these
23 patient benefit enhancement waivers that were a
24 driver in the decision making at the local level
25 about the potential impact and the way it can be felt

1 on a personal level basis for transforming care.
2 As we've implemented these waivers -- I
3 just was getting an update today for the skilled
4 nursing facility waiver that allows an individual on
5 Medicare to waive the three overnight stay before
6 being able to be transferred to a skilled nursing
7 facility. That was first piloted in the Middlebury
8 health service area and they have now successfully
9 admitted 18 patients through that waiver. It spread
10 into the St. Albans health service area. They have
11 had their first several patients now admitted through
12 that waiver. It's active as well down in Brattleboro
13 with their first patient.
14 We've been continuing to train the
15 communities, and I think one of the biggest
16 challenges that we're facing with this waiver is not
17 whether patients are interested, it's not whether
18 this results in better care, it's about making sure
19 that we have the skilled nursing facilities that have
20 a quality level that allows us to be able to bring
21 them into the network and utilize this waiver, and so
22 really helping to support that program moving forward
23 will be a next task for us.
24 In terms of the two other waivers they
25 are in early stages of implementation. We are

1 underway with SASH in a pilot program for the
2 telehealth waiver for residents in some of their
3 settings and connections to their primary care
4 providers, and then for the post acute home discharge
5 waiver we're hoping to implement the first pilot
6 program in November. We have been challenged by some
7 of the legal and contractual requirements that are
8 necessary to be able to fully deploy this waiver and
9 the way it works for our network. In other ACOs
10 around the country it's tended to be done in a
11 centralized fashion maybe through a clinically
12 integrated network, but we're really looking to build
13 that parnership more strongly between our providers
14 and our home health agencies. So just working
15 through the details of how to make that happen has
16 taken us a little longer than we anticipated.
17 Before I end I wanted to touch briefly
18 on our population health management platform. This
19 is really the sophisticated set of tools that we
20 bring together and brand as work bench one. Work
21 bench one allows us to integrate data from multiple
22 sources. We bring together our claims data, our
23 clinical data feeds, both from our electronic medical
24 records and our health information exchange. We
25 bring in event notification data, something new to us

1 in 2018, as well as our care management data, and all
2 of this data come together and are accessed by an
3 extraordinarily talented team of analysts and
4 programmers who take that data, really the raw
5 output, and are able to bring it together turning
6 that data into information that's actionable for both
7 our monitoring as well as for driving change and
8 improvement, whether that be at a statewide system
9 level or the local care delivery level.
10 We also use this analytics platform to
11 support our payer reporting and our regulatory
12 requirements. We feed data to our clinical
13 governance committees as well as specific local and
14 statewide change efforts. So that might be a
15 learning collaborative at the local level, a
16 statewide one that we are offering such as our
17 diabetes and prediabetes management learning
18 collaborative, and we support local effort be that at
19 the individual site level or across accountable
20 community for health.
21 MR. MOORE: Thank you, Tom and Sarah.
22 All right. So as we conclude our formal presentation
23 just a couple thoughts to put this year's budget in
24 context for where this is going in All Payer Model.
25 I think we started something really good here in

1 Vermont. People are really interested nationally to
2 see how this is going to work and, you know, we are
3 all working really hard to make the model right, but
4 thoughts of ensuring success for the rest of the
5 model after this year I just want to take a couple
6 minutes.
7 I would encourage you to focus on
8 affordability as having a true north which is the All
9 Payer Model growth rate of 3.5 percent, and, you
10 know, the way you got to think about this is on a
11 statewide level having a model for what you think the
12 different categories are going to grow at and then
13 understanding what is OneCare's unique payer mix and
14 is the population even within a payer that we
15 attribute higher or lower risk than the statewide
16 average. That really gets complex, but it's really
17 going to be essential for us to agree on how we
18 measure that growth rate and what OneCare's subset of
19 the state's accountability that we have, and you know
20 that's when you certainly have me and my team's
21 strongest dedication to work on.
22 I know we all worry about affordability
23 and a lot of times that ends up just being focused on
24 the commercial insured. This is an All Payer Model
25 and we do have a definition of affordability at the

1 3.5 percent growth rate level. We believe in our
2 best ability to calculate it that if the entire state
3 was in OneCare, we would be proposing a growth rate
4 from 2018 to 2019 of 3.0 percent. So it does even
5 leave a little room and margin for error for the
6 non-attributed lives and for models and targets, but
7 I really urge you in your regulatory models for the
8 ACO under All Payer Model to use that 3.5 percent as
9 your true north and regulatory guidance parameter.
10 The regulatory oversight levers, and
11 this is one we have talked about together for years
12 which is, you know, the U.S. regulatory body are
13 unique nationally in having a dialogue around
14 hospital budgets, the largest chunk of the spend in
15 the health care delivery system in the total cost of
16 care. You have a traditional insurance department
17 role in fully insured rate regulation under the same
18 hat, and then we've added the middle layer of
19 accountable care organization risk model taking risk
20 from payers and then paying providers and delegating
21 that accountability to live within our spending
22 pattern.
23 You know one of the things that I think
24 for the first time this year that there's going to be
25 some real conversations in terms of if we have

1 something in our budget that we think is consistent
2 with the 3.5 percent growth rate and our expectations
3 from the payers and we negotiate that, but yet the
4 payers or the state budget for Medicaid can't align
5 with our .5 percent growth rate or what our PMPM, we
6 might say we think is a fair target for a commercial
7 program. If that money isn't there or is misaligned
8 somehow, you know, how we close that gap is going to
9 be important, and you got to remember that as an ACO
10 we don't have reserves. We don't have an adverse
11 risk adjustor to pay us next year if we end up with a
12 riskier population than we set course for. It's a
13 voluntary model meaning that I have got to bring
14 before we sign contracts to a board of providers that
15 are at risk a proposal and our best projection on
16 whether we think we're going to do well under the
17 model, and the higher probability that we bring them
18 a target that we think might be what we call
19 underwater from month one meaning we really, really
20 are not going to have a chance at earning shared
21 savings. We certainly have shared losses. That's a
22 real thing that we need to protect against and really
23 the one thing that you need to work with us on if you
24 really do care for the All Payer Model and its
25 sustainability and success.

1 Committed payer partners. Certainly
2 trying to get this into the vision of the All Payer
3 Model. These are aligned models in terms of levels
4 of risk and the ways we can pay providers differently
5 underneath the population targets, and the fact that
6 there are expenses in implementing reform that were
7 originally intended to be under a lot of funding from
8 the delivery system reform program that hasn't really
9 fully materialized. You know we need payer partners
10 so when we're doing something to invest in it even
11 further, especially as we scale, and then finally
12 especially for hospitals, you know, I gave you this
13 information last year, the hospitals are really
14 stepping forward in this model. We're going to have
15 12 of the 14 in Vermont, and the other two were very
16 interested, but just -- for a variety of reasons just
17 weren't in a financial position to assume the risk,
18 but we have 12 hospitals in this model in Vermont.
19 We still have the original founding partner of
20 OneCare Dartmouth-Hitchcock as a very dedicated
21 partner in this thing. Between funding, you know,
22 about half of the transformation of the hospital
23 dollars, accepting payment reform for what happens in
24 their own four walls, taking a fixed payment monthly
25 to cover any services that they got to provide to our

1 attributed lives, and in addition taking the total
2 cost of care risk which includes for the first time
3 against a hospital balance sheet. Under this program
4 in Vermont hospitals are taking accountability for
5 claims spending for things that could happen a
6 thousand miles away, and that's a brand new risk on
7 hospital balance sheets that never existed before.
8 It's one thing to say we're flipping the axis for
9 your services that we are to reward high volume in
10 your hospital and now we're going to reward high
11 value in your hospital, but on top of that taking
12 that extra risk on the total cost of care that's
13 embedded in ACO models is a big deal, and especially
14 as we scale the model, if you really believe that
15 we're going to keep making progress and scale targets
16 and need to make progress on scale targets, I think
17 the hospitals are about tapped out under the existing
18 models in what their balance sheets can bear. The 34
19 million dollars total risk that Tom talked about is
20 getting to be such a substantial number that from
21 here in 2020 if we're successful in additional scale
22 we have to have a really serious conversation in
23 terms of do we want to build additional reserves at
24 OneCare so that we can limit the 34 million maybe in
25 a flat year-to-year basis. Do you want to allow

1 hospitals that are taking that risk to have extra
2 hospital budget accommodations to build reserves so
3 that I can give them more than 34 million dollars
4 worth of risk and not have it be safe risk and funded
5 risk. That's going to be the really most important
6 discussion we're going to have as we get into the
7 second half in year three of this All Payer Model,
8 and those are the thoughts I want to leave you with,
9 and at this point I think we're done with our formal
10 presentation and are glad to move on with the
11 questions.
12 CHAIR MULLIN: Super. Thank you very
13 much. It was a great presentation. I'll start off
14 with some of the questions. If you go back to the
15 slides, the network participation, so we know it's a
16 joint collaborative with Dartmouth and UVM and it
17 appears that at least Dartmouth has told us that they
18 can't participate on the Medicare population of
19 Vermonters because they are participating in the
20 nextgen project in New Hampshire and that federal
21 rules preclude them from participating in Vermont,
22 I'm wondering if you have quantified the number of
23 Medicare lives from Vermont that comes up to and if
24 there's any plan to try to figure out some way around
25 the federal regulation?

1 MR. MOORE: I don't know the answer to
2 how many Vermont Medicare beneficiaries receive their
3 primary care in an attributed relationship with New
4 Hampshire based Dartmouth-Hitchcock providers. I do
5 not know the answer to that question.
6 CHAIR MULLIN: I'm just concerned about
7 that knowing that we have that benchmark of 90
8 percent Medicare participation by 2022 and so I raise
9 that question.
10 On the slide that has initial
11 attribution estimates, under the self fund how many
12 different insurance companies are we talking about?
13 MR. MOORE: Yes. So that really is
14 projecting a four hospital cohort doing a model
15 similar but adding two-sided risk, but similar to
16 what we're doing this year, pilot with the Medical
17 Center. So really we're anticipating and budgeting
18 three additional hospitals joining that cohort under
19 a single program as a bit of a pilot innovation model
20 with multiple payers with direct contracts to OneCare
21 on top of whatever carrier they otherwise would have.
22 In addition in the self-funded we're
23 currently working on one contract with a carrier that
24 does have quite a few lives in Vermont. We're
25 working on a model that does qualify for scaled

1 targets in a way that would allow them to bring all
2 attributed lives for all their self-funded clients in
3 Vermont into a single performance pool for us. We
4 are currently under a non-disclosure agreement as we
5 work through the negotiations. So I'm not at liberty
6 to give you more details of that program than I just
7 said.
8 CHAIR MULLIN: I'm also feeling a little
9 bit of the displeasure on the QHP category knowing
10 that MVP has increased their lives in the QHP
11 program, but it doesn't appear that they are a
12 participant again this year. So just stating some
13 dissatisfaction there. That's all.
14 On the slide for fixed payments under
15 the Medicaid per member per month total attribution
16 column is there an equation that we could have so
17 that we could figure out how these numbers have been
18 achieved?
19 MR. BORYS: The fix -- the fixed payment
20 amounts are some that we model and we really -- this
21 is probably the one example where we model from the
22 gross number down to PMPM. We're looking at spend
23 within -- for the attributable lives, and where it's
24 occurring across our network we have these grids that
25 we produce that show contributing HSA and where the

1 lives receive the care. So that could be at their
2 local hospital, another hospital in network, fixed
3 payment all the way out to fee-for-service
4 categories. We use those historical spending
5 distributions to estimate how much care will be
6 delivered by one of these hospitals in the next year.
7 These are good models. When we get revised data for
8 the actual population and incorporate that with the
9 experience we're seeing in this current year that
10 will ultimately determine how much each of the
11 hospitals receive in their fixed payment, but it's
12 really our modeled best estimate how much care these
13 hospitals will provide to any OneCare life in the
14 plan.
15 CHAIR MULLIN: So you -- Sarah, you did
16 a great analysis with I believe it was Sally.
17 MS. BARRY: Yes.
18 CHAIR MULLIN: And what I was trying to
19 figure out we've known that hospitals have done the
20 equivalent of a look at frequent fliers for a number
21 of years, huddling up once a week and trying to
22 discuss those most frequent users of the services and
23 trying to figure out a plan to get them in a better
24 place. What is different about your care
25 coordination that is an improvement over what had

1 been occurring in the past?

2 MS. BARRY: I think there are a couple

3 of factors. The first is certainly scale. So when I

4 have spent the last couple years traveling and

5 talking in local communities about some of those

6 collaborative efforts to address those frequent

7 fliers it's often five or ten or maybe twenty

8 individuals that they are able to prioritize, and so

9 what we're really trying to do is we take this

10 holistic view and make sure we have a care

11 coordination program that is aligned across all of

12 our payers is to add the capacity to make sure that

13 we are talking about hundreds, if not thousands, of

14 patients in local communities and making sure that

15 we're proactively assessing their needs. So I think

16 that's one component.

17 Another is that I see the work that

18 we're doing as really expanding that care team. So

19 there's been tremendous successful work in looking at

20 team based care models in primary care as an example,

21 and they are highly effective, but as I travel around

22 the state I don't always see that they are thinking

23 more broadly or more inclusively about all of the

24 continuum of care partners, but also human service

25 agency partners and professionals who are actively

1 supporting the needs of individuals, and so it's
2 really deep transformative system level work that
3 needs to happen. It's much more complicated than we
4 might have initially anticipated and it's really
5 driven by work load development, trying new things
6 out, figuring out what works for one individual and
7 seeing whether that can work for more and doing that
8 at scale.
9 CHAIR MULLIN: It's exciting. Hopefully
10 this is the heart of what better outcomes and cost
11 containment can be.
12 MR. MOORE: We're adding more tools to
13 the toolbox, right, and we really were just trying to
14 empower communities and those providers and even the
15 hospitals as anchor providers in those communities to
16 do what they wanted to do and not really had all the
17 tools in the toolbox, but you bring some of our
18 waivers that Sarah talked about, our relationships
19 that we built in the community collaboratives with
20 the community based organizations and home health and
21 other programs and tools to make sure that we have a
22 game plan for all these patients that make sense and
23 has a higher chance of working.
24 MS. BARRY: If I could just add to that,
25 I did bring one new statistic along with me which is

1 that over the last nine months as we think separately
2 from our software implementation around care
3 navigator, but we really look at the tools,
4 knowledge, language, skills around care coordination
5 we have successfully trained 586 individuals in
6 either the core competencies or in advanced skills,
7 and that to me really speaks to our ability to reach
8 to all corners of the state regardless of direct ACO
9 participation or not, but to get communities ready to
10 be able to join our network and to have that -- those
11 tools and the facility and the knowledge around how
12 to support true transformation.
13 CHAIR MULLIN: Great. One of the
14 complaints that we hear occasionally is that the
15 approach to care coordination by OneCare is a
16 decentralized approach, and some national research
17 has shown that a centralized approach works better,
18 and yet when you think about the history of Vermont
19 with the Blueprint for Health and the successes that
20 were reached on a decentralalized approach quite
21 frankly I don't know how you would ever get
22 participation without having a decentralized
23 approach. I just want to know if somebody can
24 address the controversy of the centralized versus
25 decentralized.

1 MS. BARRY: I spend a lot of time
2 thinking about that because certainly as I travel and
3 talk with other ACO partners around the country they
4 do have centralized models. At most they might have
5 embedded models of ACO staff in certain locations.
6 So what Vermont is doing is unique, but Vermont is
7 often unique and in the forefront, and I think you're
8 absolutely right. We do well in local models that
9 really take into account the local conditions, the
10 understanding of those partnerships, and so the
11 challenge that I see is finding the line between
12 making sure that we have standard measures that we
13 have the data, the accountability, the tools to be
14 able to support the education, the knowledge, the
15 communication, but that we provide the flexibility
16 for the local decision making for the local work
17 flows for how communities collaborate together, and
18 it is challenging. It takes time. It takes honesty,
19 tough conversations, and a lot of transparency so
20 people are willing to share not only within their
21 community but across communities what's working and
22 what's not. I do feel very confident that we're on
23 the right path and that we'll see tremendous scale
24 and growth over the course of 2019.
25 CHAIR MULLIN: So you just mentioned the

1 word data and that brings up a public comment that we
2 received, and I felt the best way since you were
3 going to be here today was just bring it up directly
4 with you so that we can get an answer, but the public
5 comment is from a person in Johnson and it basically
6 says could OneCare Vermont please comment on its
7 decision to eliminate the director of analytics role
8 from the organizational chart, also the decision to
9 add the manager analytics role to the quality manager
10 who has no formal analytics education, and they go on
11 to say with ACOs fundamentally being an analytic
12 revolution how can there be -- how could there not be
13 a qualified senior leadership overseeing the
14 analytics at the heart of the OneCare's request for
15 nearly one billion.
16 MR. MOORE: Some of the publicly
17 submitted input on analytics approach are a bit of
18 headscratchers. Not really sure what the source of
19 information is, but basically our informatics isn't
20 existing for informatics sake. It's to transform
21 care and it's to transform the payment model from
22 value to volume, and so in that it really needs to
23 support those two major functions we did decide to
24 put a little bit more accountability for the
25 informatics under finance and under Sarah's

1 leadership and clinical quality improvement. The
2 individual that's actually overseen that team on a
3 day-to-day basis does also have some responsibility
4 for our quality measurement team which is in high
5 alignment and included in what we do in an
6 informatics standpoint, but also had substantial
7 experience in a military role in large data
8 informatics and so highly qualified. When we did
9 have some turnover among our leadership over the
10 informatics team he oversaw the team on an interim
11 basis under Sarah's interim directorship, and it
12 worked so well that we decided to make that our
13 permanent model. So to the degree that we want to be
14 transparent and have dialogues in our decisions
15 around the best way to oversee our functions I think
16 should be within our purview to make those decisions.
17 CHAIR MULLIN: My last question before I
18 turn it over to the next board members it looks like
19 you're looking to add 2.8 million to reserves in
20 addition to the 2.2 -- 2.8 million looks like it's in
21 your margin. In a doomsday scenario where OneCare
22 ceases to do business what would happen with those
23 dollars?
24 MR. BORYS: That's a great question and
25 we're actually working through that collectively with

1 our founders and our board. It's a really good
2 question that needs to be answered actually before
3 the 2018 year ends up. It's one that has
4 intersection between our operating agreement with the
5 founders which are the governing documents that guide
6 OneCare operations and there's some accounting
7 treatment and tax treatment considerations.
8 I think it's safe to say without
9 speaking on behalf of our founders, the board, that
10 we're looking for a model that is reasonable and fair
11 and reflects the source of the reserves, and in the
12 event of a company liquidation we treat those in a
13 manner that's fair and agreed upon by the
14 participants on the board.
15 CHAIR MULLIN: Who would like to go
16 next? Everybody's hand was up. I'll start with Jess
17 and work my way down.
18 MS. HOLMES: Thought you were looking
19 for volunteers, but we had lots of volunteers. Okay.
20 So, first of all, thank you for the presentation and,
21 Todd, I really appreciated your opening remarks about
22 this is the beginning of a process, and to the extent
23 that my comments that follow -- I understand that you
24 are working. This is, you know, the start of a long
25 -- hopefully long model that is going to require some

1 work and some foundational building.

2 So -- but when I think about budgets I

3 think of it as forward looking documents based on

4 strategies to achieve some goals, and the goals I

5 think about here are scale goals, payment reform

6 goals, and delivery reform goals all if achieved will

7 bend the cost curve and improve quality of care for

8 Vermonters. So when I think about, first of all,

9 scale goals I was struck a little bit by there's a

10 commentary in here about how OneCare has not set

11 numerical goals for provider participation and

12 attributed lives by HSA and hasn't done an assessment

13 of penetration rate by HSA. So I'm wondering if you

14 could speak a little bit to that why there are no

15 goals on the scale in particular by HSA and

16 penetration rates and provider goals. Seems like we

17 should have some goals and goalpost.

18 MR. MOORE: I'm not sure I disagree with

19 that, but you're right we haven't really thought

20 about that, and as you know with your long service

21 here on the board that this is meant to be a

22 voluntary model. So we spend most of our time and

23 energy trying to make it look like a great idea to

24 say yes to providers and payers that participate in

25 the model as our approach to scale and hope for the

1 best.

2 We do -- we believe OneCare and the

3 scale targets that were really designed to say the

4 greatest transformation is going to come when the

5 majority of patients in Vermont and percentage of

6 revenue if you want to think about that for providers

7 or percentage of handles, if you're a primary care

8 doc, are aligned. Common incentive model. So I

9 really do believe based on my entire career, plus

10 this All Payer Model, that this scale target is

11 trying to get to that tipping point of more than half

12 and hopefully toward that 70 percent make a lot of

13 sense. These first couple years it was could we

14 attract enough and see where we are. I think that

15 this will be the cycle into year three where we're

16 going to get more serious in terms of where can we

17 make additional large strides toward the scale

18 targets. One of the big ones is going to be we need

19 to get people into the Medicare program. So the

20 Medicare risk scares some of the risk bearing

21 hospitals. The high spend per beneficiary. The

22 number of Medicare beneficiaries we have in Vermont

23 growing with the aging of the population, and the

24 risk corridors even at that minimum five percent on

25 Medicare makes the maximum risk number for being in

1 the Medicare program a scary number even when we
2 actuarially convince them you have a really good
3 chance of beating the target, and so that's one as we
4 sort of need to crack that nut, how do we get
5 hospitals in for all programs including Medicare, and
6 that's one of those relations to the hospital
7 budgets. So I think we're going to turn our
8 attention to be much more proactive in terms of what
9 are the large levers, how many lives will they bring
10 in a more meaningful way. So I appreciate the input
11 and the question.
12 MS. HOLMES: Okay and just let me --
13 quick question. Actually you answered my Medicare
14 question. I was going to ask you about why Medicare
15 is so scary, but you answered that, but back to one
16 of your slides, participating provider, you had a
17 decrease among independents, slight decrease among
18 primary care, one practice but five specialty
19 practices, and I'm just wondering is there anything
20 we should learn, worry, be concerned about?
21 Everything else is moving into a positive direction
22 except for the independents. I am just wondering if
23 there's something you can share about that.
24 MR. BORYS: Yeah. Independent primary
25 care was one practice that didn't renew. The

1 specialist one is one that jumped off the page to me
2 as well. I think it's reflective of the initial
3 programming that OneCare has developed hasn't really
4 zeroed in on specialists and that's why it's a core
5 component of our 2019 model is to start integrating
6 them in, especially independents, into our reforms
7 into our health system and more clearly show that the
8 value that the ACO adds to them and offers them. So
9 I think there's a number of practices that just said
10 I'm not seeing so much out of OneCare yet and I'm
11 thankful for the 25 that stuck around and think that
12 we can continue to grow this with more targeted
13 programming.
14 MR. MOORE: I think the one practice
15 that did exit, an independent primary care, was a
16 pediatric practice and with our focus starting on
17 high risk patients' care coordination, you know, the
18 pediatric population isn't the multi-chronically ill
19 population and probably it's almost benign neglect.
20 There's not much in it for them currently and I think
21 the same for independent specialists. Part of the
22 reason why we're adding a specialist physician
23 payment reform model for next year is to start to
24 engage them more in the population management. They
25 can be really important in the rising risk quadrant

1 we want to sharpen our approaches on. I think you
2 will see the independent specialist cohort grow as
3 they see this pilot we're going to implement in next
4 year's budget.
5 MS. HOLMES: So that second bucket of
6 goals revolves around payment reform and I think, if
7 I understand correctly, about 25 percent of the total
8 cost of care spend right now is in fixed payment, the
9 remainder from what I understand is still in
10 fee-for-service; is that right?
11 MR. BORYS: Yes.
12 MS. HOLMES: Do you have goals regarding
13 that like moving for -- what are your goals for the
14 next couple of years in moving money out of
15 fee-for-service toward fixed payment?
16 MR. MOORE: Well we do want to work with
17 our commercial insurers to sell them on the
18 attractiveness and help them be able to
19 operationalize the fixed payment model for the
20 hospitals because we really do believe that provides
21 the sharpest clear incentive for hospitals for value
22 over volume. So one reason it's 25 percent is that
23 we don't have any commercial payers in the fixed
24 payment model program. We can simulate it against --
25 behind the scenes against a retroactive settlement

1 against fee-for-service, but that is, you know, slow,
2 after the fact, and not as sharp of an incentive. So
3 we do have a goal to get more of the attributed
4 population in the fixed payment model.
5 MS. HOLMES: So that's -- my followup
6 question actually related to that, is I was struck a
7 little bit also by the comment here, I think it's on
8 page 15, of scale strategy three which said currently
9 we're experiencing limits to the commercial payers'
10 willingness to align the business models of the All
11 Payer Model and the program parameters payment reform
12 and population health management set forth under the
13 Medicaid, Medicare, nextgen program. So I'm
14 wondering if you could speak a little bit to getting
15 more commercial payment into fixed payment and
16 getting on board to the extent you can speak to it.
17 MS. LEE: So I've done a lot of work on
18 the commercial side of things as I know you know.
19 We're really running into -- you talked about
20 disappointment in MVP, pick on that for a second, but
21 they come from New York. They don't have a huge
22 population here. They have a different model in that
23 state. Changing -- they are not able to implement
24 fixed prospective payment. Doing something for the
25 small group of members that they have here is really

1 difficult for them.
2 So while we have had extensive
3 conversations we're so far apart on the models that
4 it just doesn't make sense at this point in time to
5 contract, but if anything from believing in the
6 model, understanding the model, sharing risk, sharing
7 claims payment data, that's something that we're
8 hitting significant resistance on with the new payers
9 we've talked to.
10 Quality metrics. One of the other
11 commercial payers we talked to they have contracts
12 already in place with employers that have very
13 specific quality metrics and incentives for them. In
14 order for them to share those dollars with us we have
15 to align to their model not they align to our model,
16 and so I think it's going to be while we have had
17 great conversation and I think we've done a lot of
18 educating for new payers coming into the market or
19 entering into the All Payer Model, I'm hopeful that
20 maybe in another year we can really get there with
21 more conversation. It's just we didn't include a lot
22 of detail or numbers in our budget because we're not
23 sure we're going to get there for some of the payers
24 for 2019. We're hopeful for 2020.
25 MR. MOORE: And that's a great answer

1 which allows me to make the point of from a provider
2 standpoint we want aligned population models, right.
3 So we can think of all the patients we touch in a
4 similar way based on their needs and what we need to
5 do to keep them healthy. From a payer perspective
6 they want sort of all their provider network accounts
7 to follow a similar model. They like to use their
8 value based purchasing as a differentiator in the
9 marketplace, and both positions can be right and so
10 you sort of end up trying to find something that
11 meets in the middle, and we've got at least one payer
12 we've traditionally contracted with that we think has
13 been on the side of it works, right? MVP didn't
14 quite get to that middle layer and sort of was a
15 little bit too much toward a model that didn't make
16 sense for us, and so this is going to be a bit of an
17 ongoing evolution on this model. We're struggling
18 with this issue as they try to do all payer models or
19 multi-payer line models for accountable providers.
20 MS. HOLMES: I'm glad to hear there's
21 optimism. Related to that I noticed
22 Dartmouth-Hitchcock is not in fixed payment. So is
23 there any or -- Medicaid or commercial. So how does
24 the partnership with Dartmouth-Hitchcock and the
25 movement towards getting them on fixed payment like

1 the other hospitals --

2 MR. MOORE: Yeah I mean Vermont with its

3 really focus on local hospital autonomy, leadership,

4 and accountability, the Vermont culture really lent

5 itself to local communities want to be responsible

6 for the total cost of care for their local community

7 members wherever they get their care, and so really

8 we had a long discussion in terms of what does that

9 mean when they end up at Dartmouth-Hitchcock, and,

10 you know, both the local hospitals and

11 Dartmouth-Hitchcock both thought it would be better

12 to leave that spending accountability at the local

13 community because we did believe it was a danger that

14 local communities might start sending more types of

15 care than needed the level of care at

16 Dartmouth-Hitchcock tertiary center could provide if

17 they didn't have that accountability. Focus on the

18 ability.

19 So I know it sounds weird

20 Dartmouth-Hitchcock is largely a fee-for-service

21 provider for our population, but no organization

22 nationally has had a longer dedication of population

23 health management and trying to take these

24 accountability models and make them successful. So

25 they are not just another fee-for-service member of

1 the network. They are a highly collaborative one at
2 the table working with us looking at data to try to
3 understand that. So --
4 MS. HOLMES: It's not a worry for you.
5 MR. MOORE: It's not a worry for me.
6 Dartmouth-Hitchcock when they do attribute lives in
7 the program they participate in take the risk like
8 any other hospital, but from a payment model
9 perspective even within the State of Vermont,
10 University of Vermont Health Network, even though
11 they get paid prospectively on a payment model when
12 they serve people from another community that goes on
13 that other community's dime and we settle that up
14 behind the scenes against those fixed payments. So
15 they are really no different than University of
16 Vermont Medical Center is when people come from other
17 communities.
18 MR. BORYS: I have one other nuts and
19 bolts thing to add on this.
20 MR. MOORE: That wasn't nuts and bolts
21 enough.
22 MR. BORYS: Well -- so with our fixed
23 payment reconciliation model we keep the home
24 hospital spend for local lives a true fixed payment
25 concept. For the referrals in and out that is

1 subject to reconciliation and Dartmouth does so much
2 care when they are referred from other HSAs that so
3 much of the spend would end up being reconciled at
4 year end that it's just operationally easier to keep
5 it fee-for-service payer. So we haven't pushed on
6 this too much. So that --
7 MS. HOLMES: Great. Thank you. The
8 last is obviously delivery reform, and so one of the
9 areas that I wanted to ask some questions about were
10 -- involved the care navigator uptake and the care
11 plans and the lead care coordinator. Some of the
12 percentages of uptake and percentages of high risk
13 patients that have a lead care coordinator have a
14 care management plan seemed low to me, but I
15 recognize this is the beginning of a process, but I
16 wanted to hear again what your goals are to get
17 higher engagement.
18 MS. BARRY: Sure. So we had a goal that
19 we've articulated to our network around patient
20 engagement in care coordination for each of the payer
21 programs and that is to achieve 15 percent
22 engagement. Sounds like a small number, but in our
23 research it's actually quite an aggressive number.
24 We are on track heading in that direction. I don't
25 know that we'll meet that target in 2018, but I think

1 that we'll be a good position to be able to achieve
2 that in 2019.
3 On top of that we're really starting to
4 pay more attention to some of the outcome measures
5 that we want to see. So looking at those reductions
6 in utilization of admissions, readmissions, ED
7 utilization, increases in preventive care, and those
8 are things we are really monitoring on a very close
9 basis not only internally to look at the
10 effectiveness of the program, but being very
11 transparent and sharing that variation from one
12 community to the next trying to understand why we're
13 seeing some of that.
14 At the same time certainly we hear
15 feedback as well about care navigator as a software
16 tool. I think there have been some very significant
17 steps forward in the last year. A couple of the key
18 things that we've heard very positive feedback around
19 are the introduction of event notification. So
20 bringing in the ADT feeds, the admission, discharge,
21 and transfers information in realtime through VITL as
22 well as through our patient contract, and that has
23 provided value that all of a sudden there's a care
24 team member saying I really want -- I want access, I
25 want to make sure I'm on the care team that I get

1 those alerts. It's also driving the need for network
2 development; so five people get the alert, who's on
3 first, who takes the ball and really runs with it.
4 The other thing we've been working very
5 aggressively on we've heard some feedback about how
6 challenging it can be to be at a central computer to
7 log into a software system to be able to access those
8 latest updates, and so we've worked really hard with
9 our software vendor and we're in the process of
10 rolling out a mobile app. Something that's designed
11 very differently. So just like we might download
12 something from the Android store or the Apple store
13 and kind of intuitively know how to use it, that's
14 the approach that we've really taken with the first
15 phase of that mobile app, and we're pilot testing it
16 right now with our users to get some feedback and
17 have plans for really advancing that during the
18 course of the next months.
19 MS. HOLMES: Thank you very much. I
20 appreciate it.
21 CHAIR MULLIN: Maureen.
22 MS. USIFER: I also want to second, you
23 know, you guys have really put together a great
24 presentation taking some complex things and trying to
25 simplify it somewhat. A couple questions I have.

1 First on attribution and there's some numbers that
2 differ throughout the slides, so I guess the first
3 question is for 2018 some of the backup I think you
4 had attribution around 105,000, 106,000.
5 MR. BORYS: Yes. That's correct.
6 MS. USIFER: And then on your slide that
7 shows 177,000 in attribution. That's like a 70
8 percent increase, and in your backup between your
9 backup slides where you actually do some of the math
10 it's about 144,000. So you may want to reconcile.
11 The other reason I say that is because your total
12 dollars is going up about 35 percent.
13 MR. BORYS: Yes. So this is actually a
14 good answer. The total attribution estimate of
15 177,000 includes lives that we're anticipating under
16 one of these new self-funded arrangements. We don't
17 have any spend data for those so I wanted to show
18 really the upside number; here's what we could get to
19 if we could get to yes with the self-funded models.
20 When I'm doing more of the breakdowns of PMPM spend
21 and things of that nature I have to exclude those
22 lives, otherwise, the PMPMs will be way out of whack.
23 So a little bit of inconsistency throughout the
24 presentation, but my intent is to really show what
25 the top end attribution number could be if we get

1 this program.

2 MR. MOORE: Because a lot of expenses in

3 programs scale based on the lives we -- that is one

4 thing we are committed to is some of the add-on

5 payment models being applied to every life if we're

6 going to do the same population.

7 MS. USIFER: Perfect. That helps

8 explain that, and then when we also talk about scale

9 and some of the goals -- I think where Jess was going

10 a little bit -- we have 8 hospitals participating all

11 in, right, and we have 4 hospitals partially

12 participating in, and only 2 that aren't. Yet when

13 we look at the total lives right now we're about

14 145,000 out of 600,000 lives in the state. So we're

15 making progress for sure. It's just how do we get

16 that -- that more ties to their primary care, right,

17 or to commercial, but to get those primary care

18 tapped in so one of the things on your chart maybe

19 when you talk about where DHVA -- maybe the goals of

20 how many are in that set because you know the

21 hospitals there are 14. I don't know how many

22 independent primary care. Where is the gap to show

23 how you grow.

24 MR. BORYS: I think that's great and

25 really the network development that we experienced

1 over the last summer at least at this point in the
2 ACO evolution is so hospital focused because we need
3 them in to bring in the rest of the HSA, and it was
4 really all hands on deck let's try to get all the
5 communities in and then secondarily perhaps maybe
6 entangled with this other piece get them into all
7 three programs, and then I think there is a very
8 targeted let's look at each HSA, different providers
9 that are there, who is not in, and do some targeted
10 outreach in that way.
11 The other piece of that scale is there's
12 a lot of self-funded lives and self-funded employers
13 in this state, and one of the strategies that we have
14 is to work through those plan administrators to try
15 to bring in a number of payers in one shot
16 essentially so we don't have to have individual
17 contracts with every single employer.
18 MS. USIFER: And then when we talk about
19 the total cost of care for Medicare and then the
20 total cost of care in total and where we're trying to
21 -- it looks like 2018 -- so when you go to your slide
22 total cost of care and we talk about 3.8 percent
23 increase, slide 15, yet when you go over the
24 year-to-year it's only a little under one percent and
25 I think that's because in 2018 it's inflated by the

1 shared savings carry forward.
2 MR. BORYS: Yes. This is another good
3 question. So the way 2019 is built is 2018 expected
4 spend plus the trend rate plus estimated carried
5 forward shared savings. The amount that we're able
6 to carry forward is limited by a couple factors. One
7 is the 80 percent sharing. So essentially we're
8 giving away that 20 percent that we would have been
9 able to carry forward and maintain that link back to
10 the 3.8 percent total trend. The other is the risk
11 corridor limitation, and the initial results in
12 Medicare, and it is early, are favorable and between
13 the conservatism that we had in the target plus some
14 just good performance it seemed by the network it's
15 looking like we might actually leave some dollars on
16 the table on top of the 80 percent share issue. So
17 really what that all means is that we're not able to
18 carry forward enough through the carry forward shared
19 savings to get us back up to that full 3.8 percent.
20 Otherwise, we would be there.
21 MS. USIFER: Where I think that also is
22 important is on slide 21 when you came up with your
23 calculation of the 1.9 percent year over year I get
24 the math that that works, but if I did a weighted
25 average of the 3.8 percent and then the 5.5 percent

1 for commercial and the self-funded rate, it would be
2 more like a 3.3 percent, and you know I just want to
3 make sure we're cognitive of that because we're kind
4 of starting at a high point for 18.
5 MR. MOORE: Yeah and that's why I said
6 some of our work together between the Board and
7 OneCare is to agree on how we're going to do those
8 measurements. Maybe there's even a couple different
9 flavors of growth measurements we can say we know
10 what we're talking about, and even weighted average
11 do you weight it just based on the number of lives or
12 do you weight it on the lives and the spend per
13 beneficiary knowing that that is what generates the
14 total dollars.
15 The other thing that gets a little
16 tricky in this is in the All Payer Model any shared
17 savings paid or shared losses absorbed go against the
18 trend rate, right, and so on a pure fee-for-service
19 basis you look at the green lines for Medicare it's
20 really flat since '16. A great story that it's
21 really flat, but we will earn some shared savings
22 against those targets, and that's the reason why they
23 need to be rolled forward and should go against the
24 growth rates; and so if a big part of the payments
25 for Medicare is going to be the shared savings both

1 between the Blueprint conservatism which we didn't
2 earn all of it back, plus additional savings to get
3 us all the way up to our maximum corridor, that's
4 what generates that 10,413 to 10,526 in our mind from
5 the All Payer Model being the way Medicare measures
6 what the growth rate that they actually saw was which
7 is really 1.1 percent.
8 MS. USIFER: And then just on the fixed
9 payment calculation, for the fixed payment my first
10 question on -- just so I can understand the concept,
11 if you're a hospital like UVM and you have your
12 attributed lives and you have fixed payment for those
13 attributed lives that live in your HSA and then you
14 get a lot other payments from people who come to UVM
15 that are attributed lives but not to you, is that
16 based on fixed payment or is there any reconciliation
17 to the hospital that would be at risk for those
18 people on a fee-for-service true-up?
19 MR. BORYS: So the fixed payment that
20 each hospital receives includes both components and
21 we show it to them in that way in some of the reports
22 that we produce each month. The piece that is for
23 their local lives, so if it's UVM Medical Center, the
24 attributed lives that's treated as a true fixed
25 payment not subject to any reconciliation. The

1 amount that's referred in to UVM we do look at that
2 through the lens of let's true this up at the end of
3 the year using whatever available dollars we have to
4 do so. That second piece is really independent of
5 any risk for UVM. Those dollars -- the risk belongs
6 to the community that attributes the life. So that
7 spend, even though it's happening at UVM, it's under
8 UVM's fixed payment, is part of the accountability of
9 whichever HSA attributed the patient. So that nuance
10 between what the fixed payment is, is really hospital
11 care versus the risk model which is HSA based is an
12 interesting one when we do the reports.
13 MR. MOORE: So there is this sort of
14 balance of trade calculation for each HSA that's
15 based on services they provide to others that come to
16 their community is that higher or lower, what is
17 estimated in the fixed payment, and then vice versa
18 when people leave their community to go elsewhere to
19 a fixed payment hospital is that higher or lower than
20 what we budgeted. So it's almost a separate
21 reconciliation. The way these fixed payment models
22 work under the program that gives us the money is the
23 tax identification number is either a hundred percent
24 in or a hundred percent out. We can't just ask for
25 the payments for the fee-for-service for services

1 delivered to the local population. It's everything
2 that they deliver in the base year for the attributed
3 population.
4 MS. USIFER: And then, Tom, we can talk
5 about this separately, but I calculate on your fixed
6 payment it seems like it's higher than 25 percent. I
7 think it's like 37 if I looked at you had 205 million
8 of -- you just had 205 million of Medicare and 110 of
9 Medicaid. You're at 330 out of 850. That's like 36
10 percent, and if you go to each area, so like Medicaid
11 is about 50 percent fixed and Medicare -- Medicare is
12 about 50 percent and Medicaid higher.
13 MR. MOORE: We'll take a look at it.
14 It's even helpful for me to see some of the ways that
15 we can slice the data that will be meaningful to you
16 and the percentage that's paid. Non fee-for-service
17 sounds like a good one and those sound like, from
18 you, Jess, some targets and plans.
19 MS. USIFER: My last area is on risk.
20 So couple things on the risk in total. So you have
21 34 million dollars of risk in total. I guess the
22 first thing is when we talk about the 2.8 million
23 that you're expecting to put into a risk reserve, but
24 I would just challenge why you don't put that in as
25 an expense whether rather than as net income and put

1 it in because I think if you want to commit to the
2 2.8 and you get a reimbursement from the hospitals
3 put it in as 2.8, go to a zero, and then if you
4 become favorable to that zero I guess it's your
5 choice whether -- with discretion whether that would
6 increase the reserve, but --
7 MR. BORYS: I have had conversations
8 with our auditors about this one and because it's
9 unobligated technically at the time. I mean it's a
10 reserve that really has no direct -- no determination
11 at that point in time. It's not actually
12 calculatable like we have 2.8 million dollar reserve,
13 but we might only need a million. We don't know
14 exactly how much so they say we can't accrue it as a
15 true expense because of some accounting
16 technicalities.
17 MS. USIFER: But now you're actually
18 putting it up --
19 MR. MOORE: We agree with you.
20 Effectively that's how it works, but from an
21 accounting treatment because it isn't funding a
22 business expense against a current year's business
23 activity it's to have a balance sheet to fund an
24 expense against a future year which is a shared loss
25 pay back. That's the reason why they asked us to --

1 MS. USIFER: And then I think when you
2 talk about the risk in total because you're expecting
3 to get reinsurance again, correct, on the Medicare?
4 MR. BORYS: Yes we are.
5 MS. USIFER: And that would give, you
6 know, the worst case, right? Everything on -- every
7 single one went way over that would provide 10.5
8 million dollars worth of benefit. That's 90 percent
9 of the 50 percent risk in that category. So the
10 total risk is like 22 million and the worst case
11 scenario we said it was 35 million. So I would just
12 -- maybe because you're getting that you may want to
13 quantify, and then you have 5 million against that
14 and then the hospitals may or may not have other
15 reserves.
16 MR. MOORE: And that's right. The whole
17 risk management thing is an interesting world and
18 there's no guarantee that we're going to be able to
19 replace that policy or get that swap placed that we
20 have in place this year. So we have to have a game
21 plan to cover 34 million dollars of risk. So in that
22 I don't have a guarantee or multi-year contract that
23 will be renewed I do need the hospitals to sign up
24 for this, but you're right. If we maxed out all
25 programs and all risks under the budgeted plan to

1 have that reinsurance risk, it would then dial it
2 back.
3 MR. BORYS: The one other reason that's
4 important to show it this way is we give each
5 hospital a maximum risk limit. Even if we did have a
6 protection kick in that minimized our total ACO risk,
7 every hospital needs to be eyes wide open up to that
8 maximum risk limit because that protection we get
9 back to cover everything above the maximum risk limit
10 for them. So it's important for each HSA to know
11 what's the top end number for them, but you're
12 absolutely right in terms of the ACO payment we -- it
13 could be offset in a material way through some other
14 protection.
15 MS. USIFER: And I know we're going to
16 have some followup meetings with you guys and the
17 hospital. How do we handle and look at potentially
18 that risk? One thing I would put out there is if the
19 best estimate is what we have in there, which is
20 right now the middle, right, and the risk corridor is
21 on either side, typically in the accounting world you
22 only book up to that best estimate. You could have
23 overages and underages on every single line on your
24 P&L. There's always risk. So I think it's important
25 that everybody knows what the risk limit is and what

1 the risk corridor is, but whether or not we actually
2 reserve for that all or look at other metrics like
3 cash on balance sheet, things likes that, that they
4 can provide for it because if you reserve for it, you
5 take it as an expense on your P&L and the cash
6 doesn't go out until a later date if at all. So --
7 and we're seeing some favorability issues as you said
8 on some of the programs which I think is great.
9 CHAIR MULLIN: I would just say that the
10 worst fears of any person running a meeting we're
11 about 30 minutes behind. So efficiency would be
12 greatly appreciated.
13 MS. LUNGE: Thank you as the person
14 doing clean up.
15 MR. PELHAM: I will be efficient -- as
16 efficient as I can. I want to echo Jess and Maureen
17 in saying thank you for what you're doing. It's a
18 very complex design build and not only are you
19 building as you're doing it, but you're having to
20 come and tell us all about it while you're doing it
21 and I'm very much appreciative for the effort. It's
22 a big thing and if we get to 20 in '22 and you're
23 successful, it will be well worth it.
24 I just have a couple quick questions.
25 One is just curious in terms of metrics having to do

1 with RiseVT and it just seems like it's a program
2 that can develop different personalities in different
3 hospital service areas, and I'm wondering how you
4 expect to be able to tease from the population health
5 data any kind of incremental benefits or effects or
6 changes that are engineered by RiseVT?
7 MS. BARRY: Thank you. I think you hit
8 it right on the head. What we're trying to do here
9 is balance a statewide approach with that local care
10 delivery, and so what we've done through RiseVT is
11 work with a steering committee to develop a set of
12 standard metrics that will be looking at across the
13 state and really looking for where there are
14 improvements, where is there variation that will help
15 inform future planning. At the same time there is
16 flexibility and opportunity through these amplified
17 grants to be able to invest in particular activities
18 that we think can really spark and highlight,
19 accelerate the pace of change at the local level, and
20 we'll need to pay attention to those and really
21 evaluate which ones are more effective and make sure
22 we are sharing that information as we move forward.
23 MR. PELHAM: Is there any connectivity
24 between your investments in population health and
25 those that we approved in the hospital budget

1 process, additional four-tenths of one percent spend,
2 or are these kind of in your experience two separate
3 worlds?
4 MR. MOORE: They are meant to be
5 complimentary, and you know in that we don't want to
6 have to fund all the needs of a local community, but
7 provide some structure and some resources that
8 otherwise would go wanting. We hope and expect that
9 the incentives that we drive to do this and do this
10 well will mean local communities will find out ways
11 to fund programs on their own as well, and so they
12 are meant to be complimentary and non-duplicative,
13 but I think there's a role for both.
14 MR. PELHAM: Finally for me I'm just
15 looking at the Medicaid total cost of care spend
16 rate. I think it's -- you don't have to turn there,
17 but it's on slide 16 and it's relatively flat. As
18 you move from to 2019 to 2018 it's one-half of one
19 percent per member per month, and in the year prior
20 2018 it was about the same, and I just want to
21 understand, and then if you look at that growth rate
22 relative to Medicare and commercial, for Medicare
23 it's a little bit higher, 1.08 percent, and for the
24 commercial it's 4.73 percent. So I just want to
25 understand if I'm looking at anything that pertains

1 to cost shift is it -- is it that the Medicare rate
2 is driven by the cost of the payer which DHVA
3 controls or is it driven by the actual medical cost
4 incurred by providers?
5 MR. MOORE: Well I mean it has both. So
6 any time you have got a medical expense trend made up
7 of utilization changes and reimbursement changes and
8 DHVA doesn't do reimbursement changes that often so
9 that does lead to some flatness. Our efforts to do
10 population health management have managed to stem any
11 utilization increases fairly effectively. You know
12 one thing that if you really want to tell the truth
13 3.5 percent doesn't immunize us from the cost shift,
14 right, and for every dollar that Medicaid can provide
15 an increase, even if it's just to cover inflation for
16 provider expenses that they absorb, would have a
17 direct impact on how much we need to do for
18 commercial, right, and that always was part of the
19 model.
20 As a matter of fact the All Payer Model,
21 if Medicaid were to increase reimbursement rates, we
22 are held harmless from that against the target growth
23 rate because they definitely didn't want to do
24 anything to keep us from doing that. I know that
25 from being in the room that CMMI innovation under CMS

1 was concerned the most fatal flaw in how we
2 constructed it would be that Medicaid would underpay
3 or even go backwards and that therefore looked like
4 it wasn't providing affordability for Medicare.
5 MR. PELHAM: I just did a quick
6 calculation looking at what if -- just a
7 hypothetical. If the Medicare per member per month
8 rate was growing at 2 and a half percent, which seems
9 within a reasonable amount, and that would, if it
10 grew at that amount, it would be an increase of 3.8
11 million in the Medicaid allotment, but that would
12 allow for a reduction of the commercial rate from 4.7
13 percent to 2.6. I'm not suggesting that. I was just
14 trying to get a sense of what the scale of it might
15 be, and finally just it's been an experience in my
16 life that's probably given me a few white hairs, but
17 how do you think your All Payer Model will respond in
18 the next recession when the state budget really
19 tightens up, case loads in Medicaid increase, and as
20 opposed to now we're experiencing a situation where
21 case loads are decreasing, the economy is good,
22 people are getting jobs in the private sector, but
23 that's not always going to be the case.
24 MR. MOORE: It's a hard one to answer.
25 I mean what cycles we still have to come in this

1 five-year period are going to be interesting and we
2 hope that none of them will be so profound as to
3 break the model and the dedication to it. I do
4 believe this resonates with the provider community.
5 This is the way we want to deliver care, the
6 population health management route. I think having
7 some economics that are in the top of the premium and
8 challenging us to live within those while improving
9 the system is exciting work and I think we have a lot
10 of support for it, but there are cycles to these
11 things and some of them are related to business and
12 general economic cycles. Even some of that, though,
13 can move in different directions because positive
14 economic conditions, you know, might mean fewer
15 social safety net spending on one end, but it also
16 means people want to spend against their deductible
17 when they have commercial insurance and it sort of
18 has a suppression rate on the commercial utilization.
19 So we'll have to see where we're going.
20 I think one of the more important things that seems
21 to be happening is through some combination of those
22 cycles long term investments in Vermont and the
23 things like the Blueprint for Health and the efforts
24 of OneCare really sharpen the incentives. You know
25 we seem to be in a good place on Medicare where we're

1 going to have decent Medicare economics that help us
2 fund the transformation, drive the incentives, and
3 really something of a reverse cost shift you should
4 root for Medicare to be above that 3.5 percent as it
5 injects itself into this math. So hopefully that
6 will continue for a few more years and we continue to
7 have success with that really flat Medicare growth
8 that we've seen since 2016 which is on the actual
9 pure claims spend is a pretty amazing story for a
10 Medicare population.
11 MR. PELHAM: Thank you.
12 CHAIR MULLIN: Robin.
13 MS. LUNGE: Thank you. Thank you, Tom.
14 Turning for a minute to attribution numbers, so I
15 wanted to get your thoughts on how you would react if
16 the attribution estimates were significantly
17 different than what you're currently anticipating.
18 For example, last year your Medicare numbers were
19 much higher than you expected which I think
20 influenced your decision about which risk sharing
21 model to sign up for. So I would be curious to know
22 what you're thinking in terms of potential changes
23 there.
24 MR. BORYS: Good question. Every year
25 we learn a little bit more about what to project for

1 attribution. I think the things that are the most
2 likely to change, and I'm getting feelers for this,
3 it is not all that substantiated, Medicaid we're
4 working on the methodology for attribution. I
5 wouldn't be surprised to see this go up a little bit
6 which would be a great thing.
7 The biggest single change I think we
8 would experience if we don't get a self-funded
9 program off the line, that would be the most material
10 downside risk of the attribution model. The OneCare
11 business model itself all scales with attribution.
12 Most things will flow with that; total cost of care,
13 the risk, the spending that we make. There are some
14 probably more in the operations side which is a
15 relatively small portion of the whole budget that are
16 more fixed costs and not so dependent on attribution,
17 but even contracts we have with our software vendors
18 for informatics flow with that attribution. So if we
19 lose attributed lives, there's some expense there
20 too. So it is designed to be a model that can absorb
21 that type of change not only when you start one year,
22 but throughout the year as we have attrition.
23 MS. LUNGE: Thank you. I have a couple
24 questions related to care management, and I think
25 both Jess and Maureen and Kevin all touched on this,

1 so maybe what I'll do is just make a comment and then
2 we can move on, but I think the care model and the
3 care management information is hard to absorb in a
4 written format, and I think that presentation
5 actually is very helpful in terms of really giving us
6 the flavor of it, but one of the things that I have
7 been thinking about that I was going to throw out
8 there for you to think about moving forward is
9 whether we should have our staff do a little bit more
10 of a deep dive to understand more of the nuances with
11 you around the balance between the kind of analytical
12 approach where you want to make sure that you have
13 consistency in terms of achieving metrics across the
14 state while also allowing some tailoring on the local
15 level. So no need to comment right now. I just
16 wanted to throw that out there for you to think about
17 so it's not a surprise and I'll talk about it later.
18 I did have a question around the shared
19 care plan uptake. I know when you came in earlier in
20 the year you talked a little bit about the -- how the
21 ramp up was taking a little more time in 2018 than
22 you had initially anticipated. I'm guessing that
23 that's why your primary care spend is coming in on
24 the lower side because of those 15 dollar payments
25 being tied to the shared care plans, and I know this

1 is the hardest work of all, but I wanted to know if
2 you could talk a little bit about lessons learned and
3 what you may adapt or change for 2019 to increase
4 that take uprate?
5 MS. BARRY: Sure. So I think core
6 infrastructure that we've been building and
7 supporting is really an effective mechanism for us to
8 continue to leverage. So we're talking about those
9 care coordination training. We had piloted what we
10 call care coordination core teams and really expanded
11 those this year. So we have a north team and south
12 team and those are really well attended. We rotate
13 the locations of those events, and there's tremendous
14 pride in accomplishment in what's happening at the
15 local level that's able to be shared around that. So
16 I think those are some of the things that we're going
17 to continue to capitalize on.
18 A couple other things that took us a bit
19 by surprise or that were not as well anticipated is
20 the staff turnover in some of the local organizations
21 has been larger than we expected. So when we look --
22 and I thought back to our discussions a year ago
23 together about where might we expect the need to
24 train more individuals in the use of care navigator
25 and I believe I said something to the effect of maybe

1 150 more individuals might need that because we're
2 moving into some smaller communities. In fact it's
3 been hundreds and hundreds. I can look through my
4 notes, but I believe it's over 300 individuals that
5 needed training. Some of that's refresher. Some of
6 that is people who have been in an organization
7 moving into new roles, but a tremendous amount has
8 been turnover or transitions in local organizations,
9 and I think it speaks to the larger question about
10 work force development, capacity, the aging work
11 force, all issues that I know we are all interested
12 in addressing.
13 MS. LUNGE: Thank you.
14 MR. MOORE: It's also helpful to think
15 about for the high risk patients ultimately we do
16 want a share care plan which means the patients
17 involved in the plan setting the goals and that's the
18 15 percent number. That doesn't mean that we don't
19 want to get resources to get medical homes in
20 combination with our local community partners to have
21 a plan of care for high risk patients even if the
22 patient's not ready to fully engage in a shared care
23 plan. So part of this is also to get resources out
24 there to help the medical homes develop plans and
25 care with their local community's members.

1 MS. BARRY: So just to that point,
2 because we can cut the data in so many different
3 ways, one of the statistics that we provided for you
4 was that 46 percent of those high and very high risk
5 individuals actually have activity documented in the
6 system which indicates to us that trajectory has
7 started. Progress is being made. It just hasn't
8 gotten to the rigor of our definition of what a
9 completed share plan looks like.
10 MS. LUNGE: Thank you. At the hospital
11 budget hearings we had two hospitals talk about using
12 their own EHRs and integrated shared care plan. Are
13 you expecting that this approach, which would
14 obviously mean they weren't using care navigator, you
15 will be able to still implement with your care model?
16 MS. BARRY: So we're actively discussing
17 exactly that in two health service areas. We had
18 conversations about what the core criteria are that
19 need to be met and they shouldn't be any surprise.
20 It has to do with making sure that the entire
21 continuum of care partners have access and the
22 ability to effectively engage in that care plan
23 development and achievement of those goals. It also
24 requires that data be sent back to us that we can
25 then integrate into our care coordination software,

1 and so we're continuing those conversations. I do
2 think we'll move forward with at least one pilot in
3 2019.
4 MS. LUNGE: Great. Can you speak to
5 what you're using the state HIT investment for?
6 MS. BARRY: So we have a large set of
7 activities and deliverables that relate to that HIT
8 investment. We would be happy to share a more
9 exhaustive list, but it really has to do with the
10 ability for us to be able to take in this
11 information. We still have the slide showing the
12 complicated system here, but it's developing new
13 visualizations, it's new ways to develop standard
14 reporting packages as well as address what we call ad
15 hoc or kind of one time request from individuals that
16 might be highly nuanced and really need the talents
17 and advanced analytic skills of our team to be able
18 to get to the answer that can drive that change and
19 improvement. We would be happy to give you further
20 examples.
21 MS. LUNGE: That would be great. Not
22 now. I just have one more question. I wanted to
23 just talk a little bit more about the commercial
24 program, particularly the QHP program which I know
25 you're currently negotiating. I think it's -- and in

1 your slide around how you were looking at the QHP
2 filing compared to the trend rate I know you
3 indicated that you hadn't risk adjusted, but many of
4 the adjustments that are built in really are in my
5 mind designed to do the same thing as a risk
6 adjustment model which is to address the fact that
7 the population that you might have in your commercial
8 ACO program may not mirror the population that Blue
9 Cross has either in the entire QHP market or in all
10 of their book of business.
11 So I was just curious if you could speak
12 to that a little bit more, and also as part of that
13 as we move forward with more inherent volatility and
14 lack of stability in the QHP market due to federal
15 and state policy decisions around the Affordable Care
16 Act, I would anticipate that premium setting becomes
17 a much less precise -- not particularly precise now,
18 but even less precise as you add volatility into the
19 market. So that leads me to question whether the QHP
20 premium estimation process is even the right place to
21 start.
22 MS. LEE: So that is one of the things
23 that we are struggling with, both Blue Cross and
24 OneCare, in trying to figure out what is the right
25 methodology. We do have contractual terms that has

1 language that talks about mirroring the filing,
2 understanding though there are two components of the
3 filing. The filing is taking premium from 2017 to
4 2018 which is different than taking the claims
5 expense. The 2018 filing will be based on 2016
6 numbers. The cost of care from 2016. So needing to
7 take -- to find the pieces that affect the cost of
8 care and it's unit cost, it's utilization, it's
9 elimination of the individual mandate, it's the
10 ability to move. It becomes very, very complicated
11 before you even factor in what does the OneCare
12 cohort look like compared to the Blue Cross cohort.
13 So we have exchanged a lot of data.
14 We're working in good faith to try to come up with
15 something, and then also saying well okay here's what
16 our contract is in 2018. What do we want to do in
17 2019. So we're actually re-engaging, just actually
18 doing a start over, if you will, of let's just look
19 at both years and try to figure out what's a model
20 that makes sense. QHP is really difficult. It is
21 the most volatile of any of the commercial programs
22 -- any of the programs that we have for a lot of
23 reasons. So it's not an easy task to try to get a
24 lot of different actuaries agreeing on really what
25 should be adjusted. We just took our best shot at

1 saying okay we're starting with our 2016 actual cost
2 of claims, trending it forward. We used about
3 approximately 10 percent for unit cost, utilization
4 increases, and then used estimates for AHP,
5 elimination of the federal mandate, a population
6 morbidity, that excludes --
7 MR. MOORE: The 10 percent was across
8 two years.
9 MS. LEE: Two years, absolutely, because
10 it's 2016 to 2018 on the claims side which is our
11 target that excludes the risk transfers that happens
12 between the payers that we don't have. So Todd
13 alluded to this a little bit earlier. It's a lot
14 more complex. The Green Mountain Care Board made
15 some decisions with regard to Blue Cross's rate
16 filings with regard to the fact it has reserves, it's
17 getting a 16.6 million dollar tax refund. Those are
18 not things we have to offset costs so we have to look
19 at it what do we really think our costs are going to
20 be, and so that's -- it's a complicated discussion,
21 and so we've spent a lot of time and effort trying to
22 figure out what is the right answer, what is fair,
23 and what's fair to both parties. I think we'll get
24 there. It's just taking a lot longer than one had
25 hoped.

1 MS. LUNGE: Thank you.
2 CHAIR MULLIN: So at this point I'll ask
3 Jackie Lee if she has any questions.
4 MS. J. LEE: Yes. Thank you. I do. I
5 have a quick question about the -- I was really
6 liking slide 21 where you did the total cost of care
7 change, and I guess I ran into a confusion as you
8 then moved towards slide 26. It appears this is
9 based on the same data, but there's a different
10 number there down at the bottom, the 479 versus --
11 the 490 number on the other side. Can you talk to me
12 about is it -- what the difference is between those?
13 MR. BORYS: Yes. So slide 21 is a
14 trending of our benchmarks and we're using that
15 because ultimately at the end of the year that is the
16 number to which we reconcile. If we're high, we owe
17 pay back to the payer and it gets us down to that
18 benchmark, and below we receive a shared savings
19 check and that gets us to a benchmark. So slide 21
20 is a benchmark-to-benchmark projection comparison
21 which I think is the right treatment for this. We're
22 happy to roll up our sleeves to figure out how we
23 want to measure overall trend.
24 The other slide you reference is really
25 our spend estimates and particularly because of the

1 shared savings carrying forward for Medicare they are
2 not the same. We're expecting a different spend
3 number for Medicare just on a claims basis and that's
4 what slide 26 portrays as compared to the benchmark
5 which is the trade on slide 21.
6 MR. MOORE: So because the shared
7 savings in Medicare go against our target or our All
8 Payer Model that's the reason why we put in the
9 benchmark in there at the higher number, but this is
10 the first time the actuarial model against one of our
11 targets makes us think we're going to spend less on
12 claims than what the target is now. I guess last
13 year or this year it has been true with the Blueprint
14 conservatism, but it's even augmented further with
15 the earned shared savings that we're rolling forward
16 on top of that.
17 CHAIR MULLIN: Anything else, Jackie
18 Lee?
19 MS. J. LEE: No, thank you.
20 CHAIR MULLIN: Mike or Barbara,
21 anything?
22 MS. BARRETT: No.
23 CHAIR MULLIN: So we're going to turn at
24 this point to the Health Care Advocate Mike Fisher.
25 MR. FISHER: Thank you, Kevin. Thank

1 you, Todd. Good to be here and good to be part of
2 this conversation. I think rather than asking this
3 as a question I'll make a statement, ask you if you
4 have a similar concern.
5 When I think about OneCare having a
6 reserve, and understanding that the payers have to
7 have a reserve and understanding that the hospitals
8 have to have cash on hand, and then also looking at
9 the risk that hospitals are taking on and having
10 heard some of the conversation in the hospital budget
11 process about hospitals maybe need to have some
12 reserve, from a consumer's perspective it gets pretty
13 concerning that everyone wants to hold my money for
14 good reasons on each level, but I don't know how to
15 reconcile that, and I just would welcome your
16 thoughts about that.
17 MR. MOORE: Well let's be clear that
18 OneCare doesn't have a balance sheet other than what
19 we can have available to us or have pledged to us,
20 right, and so we have a legal obligations to write
21 checks back up to 34 million dollars. Yeah Maureen
22 is right if it came to that we wouldn't have to write
23 that back so we have some mitigation, but what we
24 have done is delegated that to hospitals to cover
25 that risk; and like I said earlier some of that risk

1 is new type of risk that the hospitals are taking on
2 that previously was held by the Medicare trust fund,
3 the state budget of Vermont, and the reserves of a
4 commercial payer. We don't have the ability to force
5 getting some of that extra money on top of the
6 spending target from any of those three parties. In
7 a perfect world probably there would be what would be
8 considered separate from even administrative payments
9 against the infrastructure to manage the risk, but
10 there's a risk component, a risk premium. Part of
11 the premium that goes toward risk would be built on
12 top of the claims spend. That's just not the way it
13 works.
14 Medicare sort of set the precedent for
15 you want to take risk it's based on the claims spend
16 and you got to absorb the risk management expenses
17 yourself. So I know it's easy for me to say I've got
18 -- as the OneCare CEO in isolation saying I have to
19 have a business model that works. I have fully
20 delegated through contract a hundred percent of my
21 risk to hospitals, but if they default on that,
22 OneCare still legally owes the money, and so having
23 some reserves at OneCare at the very least prevents
24 against that what is actually called credit risk that
25 the people who have pledged against our obligations

1 would default. So that's the reason why our reserves
2 at OneCare have been pretty modest to date.
3 I do -- like I said in my closing
4 comment after the formal presentation, I do wonder as
5 we gain scale and these levels of risk get higher
6 figure out how we want to do that, but I think we do
7 need to talk about should OneCare have a risk
8 premium. Might we transfer through that method some
9 reserves that are held from the payers, you know,
10 over OneCare, and we could figure out with our
11 hospitals do you want us to flow it to you and give
12 you higher levels of pledged risk versus keep your
13 levels of pledged risk low knowing that we've this
14 bucket of money at OneCare to supplement -- to
15 supplement that. I'm not really sure I've answered
16 the concern, but, you know, all I can do is tell you
17 what OneCare needs to do.
18 MR. FISHER: And your answer makes total
19 sense from the OneCare perspective and that's why I
20 phrased it systemwide. I don't know that the mike is
21 working so I hope people can hear me.
22 CHAIR MULLIN: Speak loudly. We can
23 hear you, but I'm not sure if the people in the back
24 of the room can.
25 MR. FISHER: Talk about AHPs for a

1 minute and whether there was an offer to have AHPs
2 participate in OneCare, whether there was discussions
3 with Blue Cross about that.
4 MS. LEE: We did talk to Blue Cross
5 about that and they were going to lump that into
6 their large group market and that's a market that has
7 again a lot of volatility, and we offered to do an
8 one year -- do a multi-year contract but have no
9 downside risk the first year so we could get into the
10 model, see how that population differs from what we
11 have now, know how we might model the target. That
12 was unacceptable for 2019, and I think also given
13 that we really needed to focus efforts on the QHP,
14 that's a plan that we already participate in and
15 making sure we can come to terms we just decided to
16 focus there. We are -- we are open to doing that in
17 the future though. Absolutely.
18 MR. FISHER: Okay, and then I think
19 lastly for me this also goes to a high level
20 question. If OneCare works with self-employed --
21 self-insured groups and takes on or manages some of
22 the risk for them, I just become -- I have a very
23 basic question of at what point does an ACO start to
24 look like an insurer.
25 MR. MOORE: You know that's a great

1 question. Almost by definition self-funded accounts
2 are -- employer bears a hundred percent of the risk
3 for the claims spend and it's a fee-for-service
4 model, right, and that's part of the reason why it's
5 really, really challenging to make inroads in that
6 market because they have to agree to do something
7 different. We have one potential contract with a
8 carrier that ten years ago started to include some
9 sort of sharing of outcomes and affordability and
10 quality in their contracts that if they are willing
11 to share with us that could qualify for scale targets
12 and share it with us, but you're exactly right.
13 Now the one thing that you know the
14 self-funded employers want to do is still be fully
15 compliant with the ERISA law and be subject to the
16 advantages and protections of that including tax
17 deductibility, but there are -- there's a long well
18 trodden path on how to bring value based models into
19 that still consistent with the ERISA law. The
20 hardest point is convincing the employers and the
21 brokers and the HR departments that it's worth doing
22 something more complex than just saying
23 fee-for-service, and the reason why they are doubly
24 tempted to do that is all the stuff we're doing for
25 these 170,000 lives that we've invested in Vermont

1 seem to be working right, and so we -- really easy
2 for them to be free riders and say yeah we'll just
3 write our fee-for-service because the growth rate
4 seems to be pretty reasonable compared to what it was
5 five years ago and certainly better than it was ten
6 years ago. So they don't -- they aren't feeling as
7 much as the burning platform on affordability as they
8 were, and so that's going to be the tough nut to
9 crack is convince them that they really need to
10 inoculate themselves going forward from returning to
11 that, you know, but really how do we get them to pay
12 their share against this and contribute their lives
13 into what we all agree is the real promises is using
14 an informatics driven health care system, a
15 population management approach where we have a great
16 game plan for everybody that keeps them healthy,
17 happy, productive, and, yeah, it's going to yield a
18 sustainable growth rate for health care services.
19 MS. LEE: I would also add if you look
20 at slide 42 the risk shared corridor is much lower in
21 the self-funded program and that's because we need to
22 have at least 30 percent to qualify for scaled
23 target. So we're keeping the risk corridors low,
24 keeping the risk sharing at that maximum 30 because
25 we want to qualify for scaled targets, and so that's

1 really the conversation we have had, try to minimize
2 our risk. We're not trying to take over the world
3 and still have them qualify. So that's a balance we
4 have to consider, but that's why you will notice it
5 has a net 1.8 percent risk.
6 MR. FISHER: Thank you. Julia has a
7 question or two.
8 MS. SHAW: So we talked a little bit
9 already about how the commercial growth rate is
10 higher than the aggregate target of 3.5 percent cap
11 of 3.5 percent, and I'm wondering if you can just
12 speak a little bit to whether you believe that growth
13 target for the commercial and self-funded payers is
14 sustainable in terms of providers' ability to pay.
15 MR. MOORE: Yeah, my personal opinion
16 something probably has to give. That we can't afford
17 5 to 6 percent increases forever and have them be
18 affordable. However, we also need to make sure
19 there's a health care delivery system that's
20 available when people need it, and really having been
21 in the room for some of the conversations with CMS
22 around the 3.5 percent growth rate, you know, the
23 concern three years ago was wow is that too low. The
24 All Payer Model agreement allows us to go up to 4.3,
25 it was targeted 3.5 overall, and really their concern

1 was to try to grow a statewide health care delivery
2 system at general inflation has probably never
3 happened since the Medicare Act in 1964 on a
4 statewide basis. Health care inflation natural
5 growth rate has been high. Some of it has been the
6 incentives of a volume based reward system, but some
7 of it is just there's been a high degree of growth in
8 technology, pharmaceutical technology,
9 bio-technology, electronic health records, quality
10 improvement efforts. You know much higher skilled
11 labor in health care than an average industry that is
12 very mobile and has very transferable skills, and so
13 a lot of reasons that you convince yourself the
14 natural rate of health care as an industry compared
15 to other industries you would expect to be higher
16 than general inflation, and so the idea was we don't
17 want to cut muscle from the system as we try to
18 deliver this growth rate. That's the reason why we
19 set course for this 3.5 percent. Felt like the right
20 balance of it. You know underneath the covers does
21 it somewhat codify the cost shift? Yeah because
22 Medicare made their deal on what they are going to
23 contribute. It's the national rate of growth minus
24 .2 percent. You know Medicaid, like I said, there's
25 a lot of discussions in terms of this could be bad if

1 Medicaid doesn't try to get as close to the 3.5
2 percent as it could, but we all know the challenges
3 of the Vermont state budget make that extremely,
4 extremely hard to anticipate, and so we back into a
5 bit of a commercial increase that keeps us in the
6 ball park. Like I said, at least the way we do the
7 math you know we think we didn't even -- we didn't
8 ask for on our PMPM for our commercial all the way up
9 to what we think would be consistent with a statewide
10 3.5 percent. So we're trying to do our best ability
11 to offer as much value as possible and live within a
12 growth rate that would keep providers at the table
13 and tell us these are fair business models.
14 MS. SHAW: So in followup to that do you
15 see your model as making the cost shift worse or
16 better or staying the same as it would have been
17 without implementing this?
18 MR. MOORE: Well I think having lower
19 utilization, keeping people healthy, delivering care
20 in lower cost settings than our model and structure
21 both incents and designing processes to do can only
22 help. I do believe the state now has made a great
23 deal on Medicare; that if we didn't have OneCare
24 willing to say yes to the Vermont Medicare ACO
25 initiative and its building in the Blueprint for

1 Health sustainability, and our ability to have a rate
2 of growth that seems to be at least right now in
3 excess of what the rate of growth we can deliver as a
4 system for the attributed lives is, you know then I
5 think we're in a much better place than if we would
6 have had to decide how do we want to sustain
7 Blueprint investments that we believe in them. That
8 would have fallen probably to commercial payers would
9 be the only place to get it.
10 MS. SHAW: So you mentioned that in the
11 model you're held harmless if Medicaid rates do rise.
12 So if that were to happen would you anticipate like a
13 relief of pressure on the commercial side or would
14 you anticipate just the higher overall growth?
15 MR. MOORE: It's the state that's held
16 harmless and it's 3.5 percent in terms of how that
17 translates to OneCare. Really all we want is a fair
18 target from Medicaid, and if they increase
19 reimbursement rates and we did everything else right
20 and the only reason we see our target -- we do
21 believe we should adjust our target to accommodate
22 that to make sure the incentives aren't again
23 underwater from day one because it's really funny the
24 underwater incentives are what cause people to not
25 even try if they feel they can't even do everything

1 right and, you know, have a -- reward their efforts.
2 That's why they don't try.
3 MS. SHAW: Can you speak to what the
4 implications are of the way that the all payer All
5 Payer Model calculates the 3.5 percent trend as
6 compared to the methodology that you presented on
7 slide 21? So we're concerned that the growing
8 Medicaid population low growth rate can result in an
9 increased cost shift on to consumers who buy
10 commercial insurance based on how the All Payer Model
11 calculates the 3.5 percent.
12 MR. BORYS: I think the adjustments that
13 we made and the way that we developed slide 21 is
14 intended to adjust for where the growth by payer
15 program happens. We're seeing more lives increase in
16 Medicaid. It actually looks like our PMPM is going
17 down because we've set more of the lower cost people
18 in there. So the intent of slide 21 was to level the
19 playing field and say if we had the same payer mix
20 here's what a true growth rate would be. In terms of
21 how that translates into the Vermont All Payer Model
22 we did that subject to exercise, but we applied our
23 trends to the payer mix of the State of Vermont to
24 say if everyone had the same trend rates in the
25 state, here's what this would look like on a macro

1 level. It came out to 3.0 percent. That was an
2 encouraging sign to say that if this model scaled
3 statewide this would look like. I think doing those
4 two separate things are important. We could see some
5 shift in payer mix statewide. We need more Medicaid
6 patients driven by economic factors that will affect
7 economic growth. What's in the ACO is just one more
8 dynamic. If we get a community that comes in
9 Medicaid only, we're going to see a much steeper
10 growth rate in that program than the state would see.
11 So reconciling those two to do a very clean analysis
12 I think is an important step.
13 MS. SHAW: Thank you, and then so in
14 followup to that it's been our understanding that the
15 3.5 target statewide isn't meant to cover an entire
16 population. So if OneCare is managing to that target
17 while excluding some of the expensive populations
18 like newborns to mitigate risk, wouldn't that cause
19 the overall rate to be higher on a statewide level?
20 MR. MOORE: Yeah and we looked at --
21 when we did our analysis for the statewide we looked
22 at the scaled target report that the Green Mountain
23 Care Board developed and said there's 550 Vermonters
24 eligible for scaled target measurement and actually
25 broke it down into insured, self insured, Medicare,

1 Medicaid populations, also Medicare advantage, small
2 segment as well, but really that's part of the
3 challenge of trying to regulate our population. Give
4 us a fair target. You have to sort of understand is
5 the population we have relatively higher or lower
6 risk. So in Medicaid it could be lower risk because
7 we don't absorb some of those expenses for the
8 newborns in our model, and really the reason we
9 exclude that is volatility than it is the spending is
10 not there, right. It's just if they spend more on
11 newborns that we have to cover, who bears that risk,
12 and certainly if it happens and it's sustained, that
13 would mean a higher growth rate outside of the ACO,
14 but your point is well taken and that is part of the
15 challenge of trying to regulate us as a subset
16 consistent with the whole system needs to grow at the
17 3.5 percent. That's exactly the challenge we've been
18 talking about.
19 MS. SHAW: Thank you. We have a few
20 additional follow-up questions that are more
21 technical in nature. So if it's okay with you, I'll
22 submit those in writing and not take more of the
23 hearing time today.
24 MR. MOORE: Yes. We look forward to it.
25 We've got really good at quick responses to questions

1 from the Board and Health Care Advocate.
2 MR. FISHER: Thank you.
3 CHAIR MULLIN: Thank you, Julia and
4 Mike. Appreciate the efficiency. At this point
5 we're going to open it up to the public for comments.
6 Susan.
7 MS. ARANOFF: Susan Aranoff from the
8 Vermont Development Disabilities Council and this is
9 really a comment/question for the Board. OneCare in
10 its presentation referred to their quality
11 performance for 2017 and they referred to a score
12 that I think we're all going to be hearing a lot
13 about. It's my third time hearing it. They received
14 85 percent. It's really important to know that they
15 received for that 85 percent 40 percent of the
16 reporting measures. 4 out of 10 of their reporting
17 measures had no national benchmarks. So they could
18 have gotten zero points for that. They could have
19 been reporting measures. They could have gotten one
20 point, but someone, whoever contracted with them,
21 said if there's not a national benchmark you will get
22 full credit. So 40 percent of that 85 percent
23 because I'm getting full credit on nothing. There
24 are no benchmarks.
25 So one measure that they got zero

1 percent on -- that they actually earned zero percent
2 on the only measure they earned a zero on and earned
3 it because they scored less than the national 25
4 percentile that measure was initiating substance
5 abuse disorder treatment. Probably the most
6 important population health goal Vermont has set for
7 itself. So they are saying 85 percent on quality,
8 but they got zero for a quality measure that really
9 matters. 40 percent of a free pass and you guys are
10 at a disadvantage because you're considering this
11 material about the quality performance and their
12 Medicare performance, you're considering that in the
13 context of your budget deliberations, but you haven't
14 yet received a report either from DHVA or from
15 OneCare or from Blue Cross on their 2017 performance,
16 their 2017 performance which is the first time ever
17 in nextgen -- Medicaid nextgen is really important to
18 see how that played out and what the quality is.
19 2017 they were still in sort of shared
20 savings with Medicare. They have some data up there.
21 When you go to the Medicare web site there's no data
22 out yet publicly for 2017. So my request please
23 something for the Board is to schedule soon, but
24 before you vote on their budget, a full airing of
25 their performance for 2017. The report on the 2017

1 shared savings was really late on DHVA's end; was
2 going to be in June, then August, then September.
3 It's out now and it's being shown around some places.
4 Part of it was presented NEED (phonetic), but
5 interestingly enough when Alicia Cooper from DHVA and
6 Tyler got there from OneCare and presented on that
7 quality slide, that was in August, those materials
8 were not posted until today and they were only posted
9 -- Conor, you will appreciate this -- they were only
10 posted because I've sent, I don't know, six emails
11 and was at NEED (phonetic) on Monday saying can you
12 please post these materials. I'm using that slide in
13 a presentation tomorrow and wanted to have a publicly
14 available, publicly citeable source for it.
15 So between DHVA contracting on very
16 favorable terms with OneCare and the Green Mountain
17 Care Board not hearing the results I feel like a few
18 entities that are supposed to be regulating OneCare
19 are still -- very much seem to be either promoting
20 it, supporting it, anyway not holding them
21 accountable, not reviewing quality. So if that
22 information is going to be in the budget
23 presentation, which I sort of question why it is but
24 it's in there, I think it really deserves a full
25 hearing here.

1 CHAIR MULLIN: So I appreciate your
2 comments very much, Susan, because the thing that
3 keeps me up the most at night is worrying about how
4 we're going to meet the goals when it relates to
5 suicide and overdoses. So I think you really nailed
6 that one pretty good. I think the Board hears your
7 comments and will take that to heart.
8 Are there other members of the public
9 who wish to comment? Seeing none, I want to thank
10 the team from OneCare for a very informative
11 presentation and we keep moving forward in this grand
12 experiment to try to transform health care and I
13 thank you for what you're doing each and every day to
14 try to make this happen.
15 MR. MOORE: Thank you, Mr. Chairman.
16 (Whereupon, the proceeding was
17 adjourned at 4:15 p.m.)
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1 C E R T I F I C A T E

2

3 I, JoAnn Q. Carson, do hereby certify that
4 I recorded by stenographic means the Green Mountain Care
5 Board hearing re: ACO Budget Hearing, at the Pavilion
6 Auditorium, 109 State Street, Montpelier, Vermont, on
7 October 24, 2018, beginning at 1 p.m.
8 I further certify that the foregoing
9 testimony was taken by me stenographically and thereafter
10 reduced to typewriting, and the foregoing 144 pages are a
11 transcript of the stenograph notes taken by me of the
12 evidence and the proceedings, to the best of my ability.
13 I further certify that I am not related to
14 any of the parties thereto or their Counsel, and I am in
15 no way interested in the outcome of said cause.
16 Dated at Burlington, Vermont, this 29th day
17 of October, 2018.
18
19 JoAnn Q. Carson
20 Registered Merit Reporter
21 Certified Real Time Reporter
22
23
24
25