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M E M O R A N D U M

TO: Green Mountain Care Board

RE: Comments on OneCare Vermont's 2023 Budget

FROM: Susan Aranoff, J.D., Senior Planner and Policy Analyst and Kirsten Murphy, Executive Director

DATE: December 21, 2022 (Revised)

Thank you for providing this opportunity to comment on OneCare Vermont's 2023 Budget.

In recent years, the Vermont Developmental Disabilities Council (hereafter "the DD Council") has raised concerns many times about the All-Payer Model and its sole Accountable Care Organization (ACO) OneCare Vermont. These comments continue in the same vein, focusing on three key issues that the DD Council believes to be more relevant today than ever.

- OneCare Vermont's materials for newly attributed Vermonters must be accurate and written in plain language. OneCare should send a letter annually. Not one and done as is the practice now.

- The All-Payer Model has relied heavily on Medicaid to stand up the operations of the ACO, amounting to a considerable, but yet unquantified, public subsidy to OneCare Vermont. The return on this investment is unknown.

- Vermont has failed to address the anti-trust implications of OneCare Vermont's unique status in the healthcare marketplace. The Green Mountain Care Board's role as a regulator is weakened by its promotion of the All-Payer Model.

The Council believes that continued approval of the OneCare Vermont budget must be contingent upon tangible progress in addressing each of these three issues.

Background: The Vermont Developmental Disabilities Council

The Vermont Developmental Disabilities Council is a statewide board created by the federal Developmental Disabilities Assistance and Bill of Rights (hereafter "the DD Act"), first adopted by Congress in 1970. Our constituents are health care users who have an important stake in the cost, quality, and availability of both traditional healthcare and disability long term services and supports (DLTSS). An estimated 86,000 Vermonters experience a developmental disability as defined by the DD Act, with approximately 5,100 receiving some type of community-based support through Medicaid.

The DD Council is charged under federal law with engaging at the state level in "advocacy, capacity building and systems change activities that… contribute to the coordinated, consumer-and-family-centered, consumer-and-family directed, comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families."

Further, the DD Council's signed Assurances with the Vermont Agency of Human Services state: "The Council will participate in the planning, design or redesign, and monitoring of State quality assurance systems that affect individuals with developmental disabilities." Rationalizing the coordination of healthcare and the quality metrics by which OneCare Vermont is measured place Vermont's All-Payer Model squarely in the area of state quality assurance.

For all these reasons, the DD Council pays close attention to healthcare reform and Medicaid spending.

OneCare Vermont's Communications to Vermonters are Inaccurate and Inaccessible

The Green Mountain Care Board should require OneCare Vermont to provide information describing itself to newly attributed Vermonters in plain language.

OneCare Vermont's new patient information statement is inadequate. All newly attributed Vermonters receive a letter at the time of attribution. The Council recommends that a letter be sent annually instead.

The Council also recommends that the letter be re-written so that it is understandable to the average Vermonter. In the letter, OneCare should explain what value based payments mean to insurance policy holder or Medicaid beneficiaries. OneCare should inform Vermonters that their health care providers are being paid on their behalf regardless of how much care they receive.

When a provider receives fixed or capitated payments, a clear incentive to withhold care is created. Patients have a right to know that their providers are receiving capitated payments as the providers behavior is likely to be influenced by such payments. Patients also have a right to know if their provider's pay is contingent on the patient's behavior- e.g. whether or not they lose weight or manage their diabetes.

Patients need to understand that the APM ACO Agreement may create an incentive for providers to treat healthier patients. The problems of cherry -picking and lemon dropping have been well-documented.

OneCare Vermont's new patient letter describes itself as an organization of volunteer doctors working together. In fact, there is nothing in OneCare Vermont's welcome letter that lets readers know that OneCare is even a company.

The materials are written in a question and answer format. In answer to the question, What is an Accountable Care Organization (ACO), the letter claims that "An ACO is a group of doctors, hospitals and other health care providers who voluntarily work together to give coordinated high quality care to their patients."

The Board should require OneCare to create written materials in plain language that clearly inform readers that doctors have a financial stake in the health outcomes of their patients under certain value based arrangements. Readers must understand for instance that their doctors might make more money if the reader manages their diabetes better. OneCare's welcome letter must put the reader on notice that their health care providers motivations to serve them may be impacted by new payment arrangements.

Delivery System Reform Funds and their Return on Investment

The State of Vermont has given OneCare Vermont (OCV) more than 50 million dollars of public money, including more than 30 million dollars of Medicaid investment funds[1].

Vermont's 2016 Global Commitment Medicaid Waiver gave Vermont authority to spend Medicaid funds on Delivery System Reforms (DSR) in two categories: Category 1 was to be directed toward Accountable Care Organizations (ACOs), which effectively meant OneCare Vermont after other ACO's folded in 2016. Category 2 consisted of funding to community-based providers, including designated and specialized services agencies, community substance use disorder programs, and other entities that deliver Medicaid funded long-term services and supports.

The Agency of Human Services, a party to the All-Payer ACO Model Agreement, chose to direct all Medicaid DSR funds to OneCare Vermont. None of the Medicaid dollars available to assist community-based organizations in delivery system or payment reform ever went directly to an organization other than OneCare Vermont.[2] For most of the period during which it received these DSR funds, OneCare Vermont was a for profit corporation. As such, it could have received money to stand up its operations from its parent organizations, Dartmouth Hitchcock Medical Center and the University of Vermont Health Network, which throughout the relevant time period were flush with excess capital, rather than the Vermont Medicaid Program.

At the time the All-Payer ACO Model Agreement was announced, the parties to the agreement -- AHS and the GMCB -- gave sound reasons for investing DSR funds in community-based organizations, as well as OneCare Vermont. In testimony to the legislature and elsewhere, then-Chair of the GMCB Al Gobeille, said that "bending the cost curve" in healthcare would require both restructuring the way that traditional care is paid for and strengthening the community resources that address the social determinants of health. If we pay hospitals and physician practices to keep people healthy, then those providers need better-resourced community partners with expertise in addressing the root causes of poor health. These upstream factors include poverty, housing and social isolation, as well as substance use and chronic mental health conditions. This theory of change was valid in 2016 when the agreement was signed, and it is valid today.

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[1] Global Commitment Investment Report https://legislature.vermont.gov/assets/Legislative-Reports/Global-CommitmentFund-Investment-Report-SFY22-10.12.22.pdf

[2] Some DSR funds flowed to community agencies but only as subcontractors of OneCare Vermont.

However, Vermont did not follow this theory. Vermont did not use any of its DSR funds to support systemic reforms of Vermont's home and community-based services or service providers. With the added stress of the pandemic, these already under-funded partner organizations are now struggling for their very survival. Workforce shortages for home health, developmental services, and community mental health have reached unprecedented levels. Never truly competitive, the wages of frontline staff are too low to attract the dedicated staff required to perform these important and challenging jobs. In some cases, agencies have more vacancies than filled positions. The result is often a cascading series of events whereby a client experiences increase isolation and stress, leading to greater need, increasing pressure on staff, and ultimately culminating in a costly crisis that could have been prevented. Disappointingly, OneCare Vermont has dramatically cut funding for Community Mental Health Centers in its 2023 Budget.

In short, despite promises made at the time the All-Payer Model was unveiled, resources and care now lean even more heavily toward traditional medical interventions and away from creating communities that support health and wellbeing. In fact, OneCare's budget contains plans to redirect public health investments away from community resources that have promising approaches to addressing social determinants of health and instead focus on clinical approaches.

Just how skewed investment has been, however, remains hard to quantify. The exact amount of DSR funds that the State has invested to date in OneCare Vermont is difficult to track and routinely sidesteps the regular state budget process. There was never a transparent public process for applying for DSR funding. Instead, funds moved to OneCare Vermont by state contracting through the Department of Vermont Health Access (DVHA).

Determining the amount of investment, however, is only a first step in evaluating OneCare Vermont's impact on Vermont. In 2014, the Vermont Legislature set in place Act 186, the "Outcomes Bill," which requires State government to evaluate its work through the lens of Results-Based Accountability (RBI)™. Pioneered by Mark Freedman and field-tested in Vermont, RBI seeks to understand quality improvement activities from the broad perspective of population accountability. RBI asks not only how much and how well an organization is doing in a particular initiative, but most importantly why it matters. "Is anyone better off?" the RBI evaluator asks, and "If so, how do we know?"

For the State of Vermont to justify continuing to contract with OneCare Vermont, it must first quantify the scale of its investment to date and evaluate the return on that investment in terms of its impact on the health and well-being of all Vermonters.

The State Action Doctrine Requires Active Supervision

The State Action Doctrine is the legal standard that essentially immunizes states and private participants from federal antitrust liability when a state chooses to regulate conduct that could be considered anti-competitive under federal standards. ACOs like OneCare Vermont have a safe harbor to engage in anti-competitive practices like price setting for services across all providers. In fact, this safe harbor allows ACOs to engage in a raft of business practices that would otherwise be impermissible under federal and state anti-trust laws. However, this immunity must be accompanied by active state supervision, known as the State Action Doctrine.

State Action immunity can be given to an ACO if the State has: First, clearly articulated a state policy condoning the conduct; and second, shown itself to be actively supervising the conduct of the ACO. The purpose of the first requirement is to confirm the State's intent to displace normal competition to achieve some tangible public benefit. In Act 113 of the 2016, the legislature expressed its intent to replace competition between payers with State-supervised cooperation in the hope of achieving certain public benefits, including the benefit of reduced healthcare costs. Thus, the State has satisfied the clear articulation requirement for immunity from anti-trust laws.

However, Vermont falls far short of meeting the second requirement to confer immunity from anti-trust laws on OneCare Vermont. The basic requirement of the State Action Doctrine is that the State **act**. At a bare minimum, the State needs to monitor the activity in question in order to ensure that the harms of anticompetitive behavior are offset by some tangible benefit to the people of Vermont. That benefit could fall in any of several domains. For example, cooperative price setting could be shown to lower healthcare costs; or it could be found to improve the quality of care to such a degree that the health benefits to the population outweigh the negative impact of anti-competitive practices. In either case, the State has an affirmative obligation to monitor the impact of the ACO on healthcare costs to its citizens.

Other states are providing active supervision to the ACOs within their borders. For example, in New York State, ACO regulations require both an affirmative showing that the ACO is achieving at least one of six enumerated possible public benefits. New York's regulations also require its ACO regulators to consider the impact that the ACO might have on the State's overall healthcare provider landscape and any potential disadvantages to the beneficiaries of ACO-affiliated providers. (See, 10 NYCCR Part 1003)

As early as 2017, the DD Council commented that the administrative rules by which OneCare Vermont is governed and the statutory oversight contemplated in Act 113, do not adequately ensure the active and close supervision that would allow anti-competitive practices.

Under Act 113 of 2016, the Green Mountain Care Board is identified as the entity tasked with overseeing the activities of OneCare Vermont. However, the terms of this arrangement were unusual in that Act 113 gave the GMCB the authority both to pursue the all-payer agreement and to promulgate the necessary regulations for the operation of any resulting accountable care organizations in Vermont. Unfortunately, the legislature burdened the GMCB with the impossible task of being both a regulator of ACOs and a promoter of the all-payer model agreement. In Act 113, the GMCB is directed to promulgate regulations "balancing oversight with support for innovation." Playing a dual role, as both promoter and regulator, is not only difficult but arguably untenable.

The Green Mountain Care Board's Conflicts of Interests

The Green Mountain Care Board (hereafter "GMCB") is a party to the All-payer Accountable Care Organization Model Agreement (hereafter "APM ACO Agreement") Vermont entered into with the federal government in October 2016. As a party to the APM ACO Agreement, the GMCB has certain obligations. Some of these obligations create significant conflicts of interest for the GMCB.

As a party to the APM ACO Agreement, the Green Mountain Care Board is required to work **with** OneCare to achieve the targets set out in the APM ACO Agreement. Regulators do not work "with" the entities they regulate. Regulators are expected to be as impartial and objective as judges. To comply with the APM ACO Agreement, the Chair of the Green Mountain Care Board is required to submit a letter to CMMI jointly with OneCare attesting to the fact that the GMCB and OneCare are working **together** to achieve the scale targets of the APM ACO Agreement. The APM ACO Agreement also obligates the GMCB to encourage providers to join OneCare. These obligations and others establish the GMCB as both a promoter and regulator of OneCare Vermont, which is a serious conflict of interest.

The Legislative Committee on Administrative Rules (LCAR) Recognized the GMCB's Conflicts of Interest

On January 22, 2018, the Legislative Committee on Administrative Rules (hereafter "LCAR") sent a letter to the Chairs of the House Health Care and Senate Health and Welfare Committees informing them that on October 12, 2017, LCAR voted to request the standing committees of jurisdiction review the dual nature of the Green Mountain Care Board's role

in both providing regulatory oversight of the ACOs and supporting their pursuit of innovation. (See, Attachment 1). The letter states that "LCAR's request for review is based on the concern that this duality of roles may cause the Green Mountain Care Board to have competing and potentially **conflicting** obligations in regard to ACOs. LCAR's concern is heightened because the State's EB-5 program similarly required the Agency of Commerce and Community Development to have the competing obligations of both promoting and regulating the program, ultimately with negative results." (Emphasis added).

The letter from LCAR states that the Chair of the Green Mountain Care Board indicated on the record that he would welcome a discussion of the conflict of interest and EB-5 issues with the appropriate legislative committees. To our knowledge, neither the Green Mountain Care Board nor the legislature has ever addressed these important issues at a public meeting. Nor has the Green Mountain Care Board ever raised the issue with its own Advisory Board.

The Green Mountain Care Board needs to determine what it costs Vermonters to operate OneCare Vermont

To fulfill its Act 113 supervision mandates, the Green Mountain Care Board must determine if Vermont's ACO is achieving the goals set out in both Act 113 and the APM ACO Agreement of improving care and reducing costs. It is VTDDC's position that to date, the Green Mountain Care Board has not exercised sufficient state supervision of OneCare to satisfy the state supervision requirement of the state action doctrine. The
Green Mountain Care Board has not tracked or evaluated the total cost of operating the ACO. Nor has the Green Mountain Care Board determined what it costs Vermont taxpayers to regulate and supervise OneCare. Finally, the Board has failed to properly evaluate the quality and financial performance of the ACO for which it has pilot authority.

ACO Administrative Expenses

The VTDDC commended the Green Mountain Care Board for the concern it expressed about OneCare's administrative expenses in its 2018 OneCare Budget Order when it wrote the following:

"While we believe the All-Payer ACO Model holds great promise for controlling health care cost growth and improving quality of care in Vermont, we understand the concern expressed by some that ACOs add another layer of complexity and expense to an already complicated and expensive health care payment system.

ACOs should provide a net benefit to the system and we will monitor OneCare's administrative expenses to ensure they are less than the total health care savings generated through the All-Payer ACO Model."

The Board also included the following mandate in its final budget Order: [O]neCare's administrative expenses should be less than the health care savings generated through the All-Payer Accountable Care Organization Model.

While the Board's 2018 concern about administrative expense was commendable – it was short-lived. In 2019, the Board issued the order that stands today and kicked the issue of measuring OneCare's value to Vermonters down the road.

It is incumbent upon the Green Mountain Care Board to objectively evaluate the financial and quality performance of OneCare Vermont. The Green Mountain Care Board has an affirmative obligation to determine that the benefits of the ACO outweigh its harms, including the possible negative impacts of health care price coordination and the impact of a monopoly on the bargaining power of Medicaid and Vermont's commercial insurers.

The Legislature recognized the troubling anti-competitive nature of Vermont's healthcare marketplace. Although worded in very general terms, Act 113 charges the GMCB with:

"To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods."

How has OneCare Vermont fared in demonstrating a tangible benefit to the population of Vermont? On the financial side, there have been several State Auditor's reports that question the financial impact of the All-Payer Model, suggesting instead that Vermont's ACO has driven costs higher. Most significantly the Auditor found that the GMCB has no way of knowing if the All-Payer Accountable Care Organization Model Agreement is benefitting Vermonters.

In its 2020 Report on the All-Payer Accountable Care Organization Model Agreement, the Office of the State Auditor found the following:

The GMCB has not developed a methodology to determine whether OneCare's operating costs will be greater or less than the benefits of the ACO Model. The ACO seemingly poses new administrative costs to the health care system, (OneCare has an operating budget of $19.3 million for 2020). The GMCB has recognized the importance of this cost-benefit analysis and requires estimated savings from the ACO exceed OneCare's operating costs over the duration of the agreement. However, the Board's staff have noted that it is difficult to quantify costs that were avoided as a result of the ACO, and a determination of the ACO's value should also consider quality improvements. While there is limited performance data as of today, the GMCB can quantify the value of indicators that are known, such as OneCare's financial data. **Until the GMCB completes this costbenefit analysis, the State cannot determine whether the ACO Model's claimed financial and quality outcomes outweigh OneCare's operating costs.** (Emphasis added).[3]

Conclusion

In summary, the Green Mountain Care Board should not approve OneCare Vermont's budget until it can quantify both the public's investment to date and the return on that investment. At present the GMCB is not tracking the public's investment, nor does it have means to measure the impact of that that investment in terms of Results Based Accountability. In addition, Vermont is not currently providing the active supervision required to waive anti-trust laws.

The most basic tenant of healthcare is "do no harm," often interpreted to mean that for any intervention good must clearly outweigh harm. Prior to approving another budget for OneCare Vermont, the Green Mountain Care Board should promulgate an amendment to Rule 5 that requires an affirmative showing OneCare Vermont does the same: The good that OneCare does must outweigh the harm.

[3] Office of the State Auditor's Report on the All-Payer Accountable Care Organization Model Audit Report 20-02 (June 26, 2020) P. 5.

Attachment 1 Letter from the Legislative Committee on Administrative Rules

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SEN. JOSEPH BENNING
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SEN. MARK MACDONALD
SEN. MICHAEL SIROTKIN
REP. MICHAEL YANTACHKA
REP. ROBIN CHESNUT-TANGERMAN
REP. LINDA MYERS
REP. AMY SHELDON

Legislative Committee on Administrative Rules (LCAR)

To: Sen. Claire Ayer, Chair, Senate Committee on Health and Welfare
Rep. William J. Lippert, Jr., Chair, House Committee on Health Care
CC: Jennifer Carbee, Legislative Counsel
From: Sen. Mark MacDonald, Chair, LCAR
Date: January 22, 2018
Subject: Request for review of Green Mountain Care Board roles regarding ACOs

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On October 12, 2017, LCAR approved with modifications Rule 17-P15, regarding the Green Mountain Care Board's oversight of accountable care organizations (ACOs).
Although LCAR approved this rule, LCAR also voted pursuant to 3 V.S.A. § 817(e) to request that the standing committees of jurisdiction review the dual nature of the Green Mountain Care Board's role in both providing regulatory oversight of ACOs and supporting their pursuit of innovation.
LCAR's request for this review is based on the concern that this duality of roles may cause the Green Mountain Care Board to have competing and potentially conflicting obligations in regard to ACOs. LCAR's concern is heightened because the State's EB-5 program similarly required the Agency of Commerce and Community Development to have the competing obligations of both promoting and regulating that program, ultimately with negative results.
The Chair of the Green Mountain Care Board indicated on the record at LCAR's October 12 meeting that he would welcome a discussion with your committees about the Board's role and its duties.
Thank you for your consideration of LCAR's request for this review. Please feel free to contact our committee if you would like to discuss this issue further.