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TO: Green Mountain Care Board

RE: Comments on the OneCare Vermont All Payer Model 2019 ACO Budget

FROM: Julie Wasserman, MPH

DATE: December 4, 2018

Thank you for the opportunity to comment on the OneCare Vermont All Payer Model 2019 ACO Budget. The following comments focus on three specific areas: the All Payer Model Performance Measures, the ACO Scale Targets for All Payer Model Attributed Lives, and the Privatization of Public Assets.

A. All Payer Model Performance Measures

There is an increasing focus on measuring, reporting, and rewarding quality of care based on objective measures of ACO performance within a budget cycle. This is particularly critical given the shift from fee-for-service to capitated payment models; regulators want quality improvement as well as assurances that care has not been withheld. The Vermont Agency of Human Services (AHS) has touted OneCare's Performance score of 85% for their Vermont Medicaid ACO 2017 Quality Measures. Yet on closer examination, a different picture emerges.

Vermont's All Payer ACO Model Agreement with CMS specifies the following Quality Target: ***Initiation and engagement of alcohol and other drug dependence (AOD) treatment.*** *The State must achieve the 50th percentile, as compared to healthcare plans nationally, on initiation and the 75th percentile on engagement of alcohol and other drug dependence treatment for Vermont ACO-aligned residents.* This measure is one of Vermont's ten Medicaid ACO 2017 Quality "Payment" measures. Unfortunately, OneCare performed below the 25th percentile and received "zero" points for this Medicaid measure. Given Vermont's opioid crisis, this is likely one of the most important quality performance measures.

Vermont's ten Medicaid ACO 2017 quality "Payment" measures are associated with financial compensation. In 40% (4 of the 10) of these "Payment" measures, OneCare received the highest rating possible regardless of their performance. The explanation for this is there were no national benchmarks for these four measures. (See page 5 for the 2017 Quality Performance Measures from DVHA's report *Vermont Medicaid Next Generation ACO Pilot Program* presented to the Green Mountain Care Board on November 19, 2018.)

Thus, for fully half of the ten Medicaid ACO 2017 "Payment" measures, OneCare received no points due to poor performance, or they received the highest score possible *regardless* of performance. As a result, OneCare ended up with an impressive overall quality score of 85%. This does not pass the straight-face test.

The Vermont Medicaid ACO 201**8** Performance Measures are similarly concerning. For four of the ten "Payment" measures, OneCare will be awarded full credit (highest score) for merely *reporting*, regardless of their performance. These four measures should be classified as "Reporting" measures and do not merit quality "Payment" points. (See page 6 for the Vermont Medicaid ACO 2018 Performance Measures from the DVHA-OneCare Contract #32318, Amendment 2, p 81.) Note: Two of these measures actually have national benchmarks.

For the 201**7** Vermont Medicare Quality Measures, OneCare scored 87.91%, a -9.26% drop from the previous year's 2016 score of 96.88%. The 201**7** Blue Cross/Blue Shield QHP Quality Measure results show OneCare achieving 73.07%. Given the importance of ACO quality measures, the Green Mountain Care Board should require OneCare to submit a plan as part of the 2019 ACO Budget approval process detailing how OneCare will improve its quality performance outcomes for attributed Medicaid, Medicare and Blue Cross/Blue Shield Commercial lives (all payers).

The Green Mountain Care Board may want to ask/answer the following questions:

1. How can OneCare improve their Medicaid ACO performance on "**Initiation of Alcohol and Other Drug Dependence Treatment",** given Vermont's current Opioid crisis?
2. Can the Green Mountain Care Board delineate which of the 2019 ACO-CMS Quality Framework "Payment" Measures are absent adequate benchmarks, and which "Payment" measures will confer quality points for merely reporting the data?
3. Neither Medicare nor BlueCross/Blue Shield awards quality points for "Payment" measures lacking benchmarks. Why is Medicaid the only payer who awards "Payment" quality points when there are no benchmarks, or for merely *reporting* on a "Payment" measure?
4. Will performance measures guarantee accountability and incentivize high quality care if the ACO is awarded the highest possible score regardless of performance?

B. ACO Scale Targets– All Payer Model Attributed Lives for 2018

OneCare Vermont presented their 2018 ACO Update to the Green Mountain Care Board on July 18, 2018. Slide #4 of this presentation included the table below which showed the number of All Payer Model attributed lives through June 2018. This table was recently updated with September counts provided by Green Mountain Care Board staff.

Attribution Update 2018

Program	GMCB Budget	Jan Actual	June Actual	Sept Actual	Change Rate Jan to Sept
Medicare	33,474	39,384	37,589	35,786 (Nov)	-9%
Medicaid	44,211	42,342	39,936	38,228	-10%
BCBSVT QHP	34,943	20,838	19,008	18,095	-13%
Self-Funded	9,962	9,962	9,627	8,970	-10%
Total	122,590	112,844	106,160	**101,079**	**-10%**

The total number of All Payer Model attributed lives as of September 2018 is 101,079. From January 2018 to September 2018, there was a decrease of -10% in the number of attributed lives

due to the inevitable attrition that occurs over the course of an ACO year. Vermont's All Payer Model Agreement with CMS stipulates that the Scale Targets for Performance Year 1 (2018) reach 60% for Medicare beneficiaries and 36% for the All Payer Total. These 3rd Quarter counts translate into a Scale Progress of 31% for Medicare and 18% for the All Payer Total, both roughly half of the mandated CMS Year 1 Targets.

Estimates for the number of 201**9** ACO attributed lives come from OneCare's forecasted predictions and although much higher than 2018, they may be overly optimistic. Even if OneCare's 2019 estimates prove to be accurate, the result would be a Scale Progress of 35% for the All Payer Total, far short of the CMS Target of 50% for Performance Year 2.

Can Vermont justify OneCare's 2019 budget, and the substantial *publicly-funded* costs and resources devoted to supporting the OneCare ACO Model given the small and decreasing number of Vermonters currently participating in the All Payer initiative? Participants make up only 16% percent of Vermont's total population. Vermont taxpayers are paying for this publicly-supported project but only a minority of Vermonters is being served. OneCare's 2019 operating costs are proposed at roughly $16 million; these ACO administrative costs are *in addition to* current administrative costs borne by Medicare, Medicaid and the Commercials. The Green Mountain Care Board needs to calculate the return on investment for Performance Year 1 before approving OneCare's 2019 Budget for Performance Year 2.

C. **Privatization of PublicAssets**

- State-authorized Public Funds
  State-authorized public funds have financed start-up and infrastructure costs of the private for-profit OneCare ACO. To date, almost $20* million (non-PMPM, non-administrative) have been given to OneCare through the SIM State Innovation Model, DVHA contracts, and Global Commitment Medicaid Waiver Delivery System Reform (DSR) Investments. (* Based on publicly available information.)

  OneCare's 2019 ACO Budget includes a request for an additional $10.8 million in Medicaid DSR public funding. Before approving more DSR funds for this hospital-based ACO, the Green Mountain Care Board should conduct a cost/benefit analysis to determine the effectiveness of this expenditure on improving health outcomes and containing costs. This analysis is especially important given the value of Vermont's primary care physicians and the state's non-profit community-based providers, both of whom do the vital work of keeping people healthy and preventing costly hospitalizations.

- Vermont Medicaid ACO 2017 Program
  The Vermont Medicaid ACO 2017 Program resulted in OneCare receiving $2.4 million in savings. These results are not surprising given the lower cost/lower risk population served. Almost half of OneCare's 29,000 Medicaid ACO attributed lives were children[1] whose costs tend to be relatively low (well-child care). Only 6% of the Medicaid ACO beneficiaries were "Complex/High-Cost", and another 10% were "Chronic Illness and Rising Risk". The remaining 84%, (a sizable portion) were either "Healthy" or "Stable" [1]. (See page 7 for the pie chart from *The Commonwealth Fund* article cited below.)

  Furthermore, Vermont's most expensive and high risk Medicaid beneficiaries, the Dually Eligible, were carved out of OneCare's Medicaid ACO attribution-eligible pool. (DVHA-OneCare Contract #32318, p 5.) "Risk-bearing" entities work to minimize their risk, as well as spread the risk. OneCare appears to have been successful on both counts.

OneCare's $2.4 million in 2017 Medicaid savings are *public dollars.* Are there any restrictions on how these public Medicaid funds can be used by the OneCare Corporation? In the past, these savings would have accrued to the State and been used to expand or enhance Medicaid services. This has historically occurred through Vermont's Global Commitment Medicaid Waiver which utilized the savings from lower cost Medicaid beneficiaries to cross-subsidize higher cost Medicaid beneficiaries, many of whom are Dually Eligible (Vermont's poorest and sickest). But beginning with the Vermont Medicaid ACO 2017 Program, OneCare now has many of the lower cost/lower risk Medicaid beneficiaries as well as the savings associated with serving them. This trend will likely continue with each subsequent ACO year.

Over time, with a decreasing ability to cross-subsidize and spread the risk, how will the State cover the expenses of the higher cost/higher need Medicaid beneficiaries who comprise over 70% of Vermont Medicaid claims expenditures[2]? (See page 8 for data from the report "*Medicaid Expenditure Analysis*" cited below.) The costs of individuals participating in programs such as Choices for Care, Community Rehabilitation Treatment (CRT) and Developmental Services are featured in these Medicaid claims expenditures which include both traditional medical care costs as well as specialized care. Over 90% of Choices for Care participants are Dually Eligible as are two-thirds of CRT and Developmental Services clients. Will there be adequate State funding for Vermont's high cost/high risk Dually Eligible Medicaid beneficiaries over the long term?
(Note: Medicaid expenditures for the Dually Eligible are not attributed to any ACO, nor are they included in the ACO's Total Cost of Care.)

Before approving OneCare's 2019 All Payer Model ACO Budget, the Green Mountain Care Board needs to evaluate the long-term effects on Vermont's Medicaid safety net resulting from the privatization of these public assets. A 10-year projection is needed to rule out the possibility of financial losses for the State which could trigger significant budget cuts to critical AHS programs.

[1] *The Commonwealth Fund*, "Vermont's Bold Experiment in Community-Driven Health Care Reform", May 10, 2018. Martha Hostetter, Sarah Klein, and Douglas McCarthy https://www.commonwealthfund.org/publications/case-study/2018/may/vermonts-bold-experiment-community-driven-health-care-reform

[2] *Medicaid Expenditure Analysis*. State of Vermont Disability & Long Term Services and Supports - Medicaid Expenditures, April 2015. Report prepared by Pacific Health Policy Group for the Vermont Health Care Innovation Project (VHCIP). Slide 11. https://healthcareinnovation.vermont.gov/content/medicaid-expenditure-analysis-final-april-2015

Overview of VMNG Quality Performance, 2017

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Measure Description	Numerator	Denominator	Rate	Quality Compass 2017 Benchmarks (CY 2016) National Medicaid Percentiles				Points awarded
				25th	50th	75th	90th	
Payment Measures								
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence^	49	162	30.25%	N/A	N/A	N/A	N/A	**2**
30 Day Follow-Up after Discharge from the ED for Mental Health^	157	194	80.93%	N/A	N/A	N/A	N/A	**2**
Adolescent Well Care Visits	3335	5800	57.50%	43.06	50.12	59.72	68.06	**1.5**
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	13	880	1.48%	N/A	N/A	N/A	N/A	**2**
Developmental Screening in the First 3 Years of Life‡	1205	2017	59.74%	15.70	36.00	50.50	N/A	**2**
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	116	368	31.52%	48.57	41.12	35.52	29.07	**2**
Hypertension: Controlling High Blood Pressure	230	356	64.61%	47.69	56.93	64.79	71.69	**1.5**
Initiation of Alcohol and Other Drug Dependence Treatment	287	811	35.39%	35.79	40.72	45.13	50.00	**0**
Engagement of Alcohol and Other Drug Dependence Treatment	143	811	17.63%	7.98	12.36	16.25	21.31	**2**
Screening for Clinical Depression and Follow-Up Plan	117	247	47.37%	N/A	N/A	N/A	N/A	**2**
							Total Points Earned	**17**

^ denotes first-year HEDIS measures for which benchmarks are not yet available
** denotes measures for which a lower rate indicates higher performance*
‡ denotes measure with multi-state benchmarks: 26 states reporting (FFY 2016)

Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (1 point)
Above 50th percentile (1.5 points)
Above 75th percentile (2 points)
Above 90th percentile (2 points)

year basis as program priorities shift and as necessary to support continuous quality improvement. The performance measures and targets applicable during subsequent years of the Contract shall be established annually by DVHA and reflected in an amendment to the Contract. Payment measures are measures for which ACO performance will impact the way the quality incentive pool funds may be distributed. Reporting measures are those that the ACO is required to report; however, ACO performance on Reporting measures will not impact the distribution of quality incentive pool funds.

Contractor performance shall be calculated based on care delivered during Calendar Year 2018. Contractor shall submit information to DVHA, in the format and detail specified by DVHA, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment.

Measure	Measure Use	Data Source	National Medicaid Benchmarks Available for 2018 Contract Year
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	Payment*†	Claims	Yes
30 Day Follow-Up after Discharge from the ED for Mental Health	Payment*†	Claims	Yes
Adolescent Well Care Visits	Payment	Claims	Yes
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Payment*‡	Claims	No
Developmental Screening in the First 3 Years of Life	Payment	Claims	No^
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	Payment	Clinical	Yes
Hypertension: Controlling High Blood Pressure	Payment	Clinical	Yes
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	Payment	Claims	Yes
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Payment	Claims	Yes
Screening for Clinical Depression and Follow-Up Plan	Payment*‡	Claims and Clinical	No
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	Reporting	Claims	Yes
Tobacco Use Assessment and Tobacco Cessation Intervention	Reporting	Claims	No
Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey Composite Measures collected by DVHA§	Reporting	Survey	No

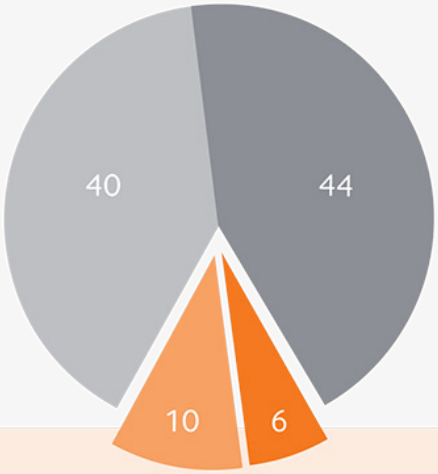
* Award full credit for reporting performance for 2017 and 2018 contract years.
† 2019 contract year performance will be compared to national HEDIS benchmarks released in September of 2018.
‡ 2019 contract year performance will be compared to ACO-specific performance in the 2018 contract year if national benchmarks.
^ Multi-state benchmark; not national
§ DVHA's certified CAHPS vendor will calculate ACO-specific performance on behalf of OneCare.

a. Each Payment Measure will carry equal weight in the scoring methodology; Reporting measures

Exhibit 1

Four Risk Categories and Services for Each

While OneCare had planned to focus care-coordination efforts on the highest-risk patients, care coordinators urged the organization to include those with "rising risk," as they believed they had the greatest leverage with such patients. Patients in lower-risk tiers benefit from the ACO's focus on preventive health measures and health assessments.



LEVEL 1

HEALTHY/WELL: facilitate access to activities and services that improve physical and mental health

LEVEL 2

EARLY ONSET OR STABLE CHRONIC ILLNESS: comprehensive health assessment, with outreach at least two times per year; disease management support

LEVEL 3

FULL ONSET CHRONIC ILLNESS AND RISING RISK: comprehensive health assessment, with outreach at least four times per year; access to a community-based care coordinator and completion of a shared care plan

LEVEL 4

COMPLEX/HIGH-COST WITH ACUTE CATASTROPHIC CONDITIONS: comprehensive health assessment with outreach at least 12 times per year; completion of a shared care plan with assignment of a lead care coordinator; care conferences as needed

Prevalence of Selected Conditions Among 4,780 Level 3 and Level 4 Medicaid Beneficiaries

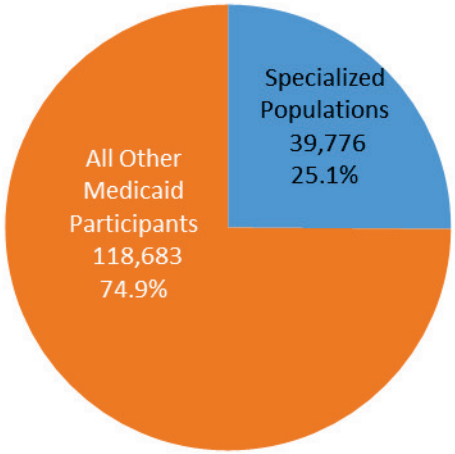
Depression	1,549	Coronary Artery Disease	599
Anxiety, Neuroses	1,541	COPD	489
Hypertension	1,379	High-Risk Pregnancy	286
Tobacco Use	1,248	Bipolar Disorder	225
Diabetes	924	Congestive Heart Failure	112
Asthma	894	Schizophrenia	102

Data: OneCare Vermont based on claims data for September through December 2017.
Note: Patients may have multiple conditions.

Source: Martha Hostteter, Sarah Klein, and Douglas McCarthy, *Vermont's Bold Experiment in Community-Driven Health Care Reform* (Commonwealth Fund, May 2018) http://www.commonwealthfund.org/publications/case-studies/2018/may/onecare-vermont.

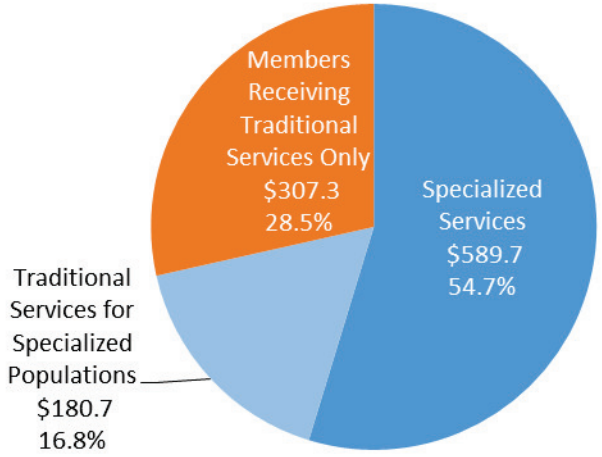
Expenditure and Enrollment Summary: Individuals Receiving Specialized Services v. All Other Medicaid Program Participants

Medicaid Participants



158,459 Service Recipients

Medicaid Claims Expenditures (Millions)



$1.08 Billion

Individuals receiving specialized services represent approximately 25 percent of total Medicaid participants receiving services, but coverage of services to meet their DLTSS and traditional medical needs comprises 72 percent of Medicaid claims

- Expenditures for these individuals' specialized services accounts for approximately 55% of Vermont Medicaid claims.
- Expenditures for these individuals' traditional medical services accounts for approximately 17% of Vermont Medicaid claims.
- In sum, services to meet these individuals' specialized services and traditional medical needs comprise 72% of Vermont Medicaid claims expenditures.
- The remaining 28% of Vermont Medicaid claims expenditures are for traditional medical services for the enrollees (75%) who are not served by specialized services and programs.