VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05401
(800) 917-7787 (TOLL FREE HOTLINE)
(802) 863-7152 (FAX)

OFFICES:
BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

November 9, 2018

Kevin Mullin
Chair, Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Dear Chair Mullin and Members of the Green Mountain Care Board:

Thank you for the opportunity to comment on OneCare Vermont (OneCare)'s proposed 2019 Accountable Care Organization (ACO) budget. The Office of the Health Care Advocate (HCA) has reviewed OneCare's budget submission, submitted two sets of written questions, and participated in OneCare's budget hearing before the Green Mountain Care Board (the Board). We ask the Board and its staff to consider these comments when preparing the staff budget recommendation and voting on OneCare's 2019 budget.

The Board is tasked with assessing a wide range of information in its review of ACO Budgets (18 V.S.A. §9382(b)(1)).[1] The Legislature's directive to the Board is clear: the Board must use its oversight role to ensure that an ACO's work is in the best in interest of Vermonters, including many factors beyond the ACO's per member per month cost increases.

The University of Vermont (UVM) Medical Center and UVM Health Network control an increasing proportion of the state's providers as well as OneCare, the state's only ACO. The Board must ensure it is regulating the health care system effectively to prevent this monopoly from further exacerbating Vermonters' affordability challenges and undercutting the success of the all-payer model (18 V.S.A. §9382(e)). Our health care system must not privilege provider profits over cost containment and consumer affordability.

We frame our comments within the broad statutory criteria that the Board must use when reviewing an ACO budget. Our comments fall into five substantive areas: Oversight & System Alignment, Affordability, Transparency, Accountability, and Care Management.

[1]The Board must, among other things, examine the following: 1) Utilization of services delivered by attributed providers; 2) The expenditure analysis for the previous year and year under review by payer; 3) The ACO's character, competence, and fiscal responsibility; 4) ACO incentives to strengthen primary care; 5) ACO support of community-based providers; 6) The ACO's investments in the prevention of social determinants of health and adverse childhood experiences; 7) Public comment on all aspects of the ACO's costs and use and its proposed budget; 8) The ACO's administrative costs; 9) The effect of Medicaid reimbursement rates on the rates for other payers; and 10) Transparency of ACO costs for consumers. 18 V.S.A. §9382(b)(1)

Oversight & System Alignment

The Board's ACO budget decisions should be based on reasonably reliable information and align with the Board's other regulatory processes.

To adequately exercise its regulatory authority the Board requires information from OneCare regarding each payer contract it plans to execute covering any portion of the next budget year. This includes information on attribution, the scope of contracted services, payment rates and mechanisms, quality measures, and risk arrangements (Rule 5.403(a)(10)).

OneCare has not provided the Board with adequate information to exercise meaningful oversight. The Board should not approve OneCare's 2019 budget until target and trend agreements have been reached with all participating payers for 2019. Per its budget submission, OneCare still does not have a final target agreed upon with Blue Cross Blue Shield of Vermont for its 2018 ACO program, with less than 2 months remaining in the year. The 2018 target along with actual performance to date are essential for determining whether OneCare's proposed 2019 budget and targets are appropriate. We request that the Board require OneCare to return with final negotiated targets and trends for 2018 and 2019 which the Board would then approve, deny, or modify.

In its budget submission, OneCare asks the Board not to align its rate review and ACO budget review processes and to allow OneCare to implement a higher commercial trend than the Board approved for BCBSVT's 2019 Qualified Health Plans (QHPs). Lack of alignment between the Board's regulatory processes will undermine the Board's work to improve health insurance affordability and the state's overall health care reform efforts including the all-payer model. We ask the Board not to allow OneCare's budgeted commercial payer trend to exceed the trend approved in the Board's 2019 QHP rate orders.

Affordability

OneCare's budget fails to promote affordability for commercially insured Vermonters.

Vermonters continue to struggle to afford health care, affecting individuals and the overall Vermont economy. One of the primary goals of the all-payer model is to address this affordability crisis by slowing the growth of health care costs in Vermont. Realizing this goal requires regulation and reform efforts focused on the costs experienced by Vermonters. The Legislature tasked the Board with ensuring that the all-payer model aligns with Vermont's principles for health care reform (18 V.S.A. §9551(1); 19 V.S.A. §9371). The first of these principles states that "all Vermonters must receive affordable health care" (19 V.S.A. §9371(1)). OneCare's activities and 2019 budget proposal do not meaningfully address Vermont's health care affordability crisis.

First, OneCare's proposed commercial trend is not affordable for Vermonters or sustainable for Vermont's economy. At a minimum, the Board should set the growth rate for each ACO program at or below 3.5%. By asserting that its cost-containment activities are acceptable so long as average cost growth is less than 3.5%, OneCare effectively proposes that the relative cost growth between payers is irrelevant. This proposal is at odds with the legislative charge that the cost growth of one payer type relative to others (i.e. the "cost shift") must be considered by the Board (18 V.S.A. §9382(b)(1)(N)). OneCare's 2019 budget submission exacerbates the cost-shift by proposing a substantially higher commercial trend than that of public payers. An average growth rate across

payers will always appear low due to extremely low public payer growth, but is not meaningful for the many Vermonters who purchase commercial insurance. Further, allowing a high trend for the BCBSVT OneCare program ensures that BCBSVT will propose an untenable rate increase on QHP premiums next year. Vermonters and the Vermont economy cannot afford to continue on this health insurance rate trajectory. OneCare should provide analysis of the cost of care and reimbursement rates for its attributed population including the state of the cost shift and the measurable impacts of OneCare's cost reduction activities.

Second, OneCare argues that if the commercial trend is not favorable to providers, providers will not participate. Providers will choose to participate if there is value in participation. Undoubtedly, offering a high trend is one way to incent participation. At the same time, it makes little sense for OneCare to exist if trend growth is not curbed. OneCare must create value for providers without guaranteeing an unsustainable trend. Otherwise, OneCare will not succeed at bending the cost curve downward. Rather, OneCare will simply be a new bureaucracy funded by already struggling Vermonters. OneCare should gather and report to the Board information about why providers are choosing not to participate in its programs.

Third, OneCare's commercial trend cap should be set taking into account the low proportion of commercially insured Vermonters who are attributed to the ACO, and the potentially high-cost populations that the ACO systematically excludes. The ACO currently excludes newborns, people who get the majority of their primary care at a non-attributing urgent care center, people without a primary care provider, and people who have not used care in the past 2 years. Excluding these potentially volatile and high cost populations should bring OneCare's commercial trend down.

Finally, as OneCare builds reserves to offset its risk, there should be a corresponding decrease in reserves elsewhere in the health care system. Duplicating or triplicating reserves is in direct conflict with the goals of the all-payer model and precludes the possibility of meaningful system-wide savings. Vermonters should not have to bear the cost of funding additional reserves.

Transparency

OneCare's budget obscures its impact on the health care system.

The HCA continues to have concerns about the transparency of OneCare. The incompleteness and lack of clarity in the information provided by OneCare throughout the 2019 budget review process has heightened these concerns. In addition to the incomplete financial information, OneCare failed to adequately answer questions posed by the Board and the HCA and included information we believe to be inaccurate in its budget narrative. OneCare lists over five pages of community programs with which it is supposedly involved. The HCA has heard from providers whose initiatives are included in the narrative that OneCare has had no involvement in some of these programs. When given the opportunity to clarify, OneCare declined to answer our question.

In its review of an ACO's budget, the Board is mandated to review and consider the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care; for systemic integration of community-based providers in its care models or investments to expand capacity in existing community-based providers; for systemic health care investments in social determinants of health; and for preventing and addressing the impacts of adverse child experiences and other traumas (18 V.S.A. §9382(b)(1)(G-J)). The Board cannot assess these factors if OneCare

does not provide clear and complete information about its involvement in community programs throughout the state. OneCare should be required to support its claims with verifiable and reliable evidence.

Accountability

OneCare's quality measures are insufficient to show its impact on the quality of Vermonters' care.

The Board is required to ensure that each ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers (18 V.S.A. §9382(a)(7)). The HCA maintains its longstanding position that OneCare's quality measures are not sufficient to hold the ACO accountable to the Board, Vermonters, and insurers. Additionally, OneCare's reporting of its quality results is incomplete and lacks the detail needed to adequately assess the ACO's performance.

These failures conflict with a reasonable interpretation of the Board's rules. Specifically, the Board's rules require an ACO to submit financial and quality performance results under payer contracts and information on the progress made by the ACO through its quality programs (GMCB Rule 5.403(a)(4); GMCB Rule 5.403(a)(12)). Further, an ACO is required to report its performance on quality measures specified by the Board on a publicly accessible website (GMCB Rule 5.502(a)(3)). OneCare's website includes incomplete (Medicare only) and out of date (2012-2016) quality information. OneCare's failure to provide adequate quality reporting limits its accountability to the Board and to the public and is in contravention of the Board's own regulations.

The Board must require OneCare to provide its quality results in detail, including the ACO's actual results for each quality measure as well as benchmark comparisons. Detailed quality reports are essential for the Board and the public to understand the quality of ACO providers' care. There is no justification for the delays in presenting OneCare's quality information. We ask the Board to implement a formal evaluation process to examine OneCare's quality performance.

Finally, OneCare should track how providers use their quality incentive payments. This information is important for the Board and the public to be able to evaluate the ACO's quality programs and determine how these programs should be designed going forward.

Care Management

It is not clear that OneCare can meet the high standards for care management provided to unattributed Vermonters.

ACOs are required to collaborate with community-based providers (18 V.S.A. §9382(a)(11)). An ACO must not diminish access to any community-based service (18 V.S.A. §9382(a)(14)). Further, in its review of an ACO's budget, the Board is required to consider whether the ACO is preventing duplication of services that are provided by existing, efficient, effective, and high-quality community-based providers (18 V.S.A. §9382(b)(1)(F)); and the extent to which the ACO provides incentives for systemic integration of community-based providers in order to promote seamless coordination of care across the care continuum (18 V.S.A. §9382(b)(1)(H)).

Due to OneCare's Medicaid contract, fewer Vermonters have access to the Vermont Chronic Care Initiative (VCCI) care management program. We have concerns that these patients are not receiving

comparable services from OneCare. We are also concerned about OneCare's ability to take over care management from commercial payers. OneCare should provide substantial and convincing evidence that attributed patients are receiving care management services equal to or better than services provided to non-attributed patients, regardless of the status of the patient's primary care relationship. OneCare and participating insurers must ensure that there are not care management lapses as ACO programs expand.

Thank you for considering our comments. Please feel free to contact Julia Shaw with any questions.

Sincerely,

s\ Mike Fisher, MSW
Chief Health Care Advocate

s\ Kaili Kuiper, Esq.
Staff Attorney

s\ Eric Schultheis, Ph.D., Esq.
Staff Attorney

s\ Julia Shaw, MPH
Health Care Policy Analyst
jshaw@vtlegalaid.org
(802) 383-2211