Comments to Green Mountain Care Board: May 4, 2022

Bill Schubart

Brief Intro: Former Fletcher-Allen Chair 2003-2007, retired businessman, author, Digger columnist, lived in Vermont 75 years. I want the best for UVM Medical Center. I am not an antagonist.

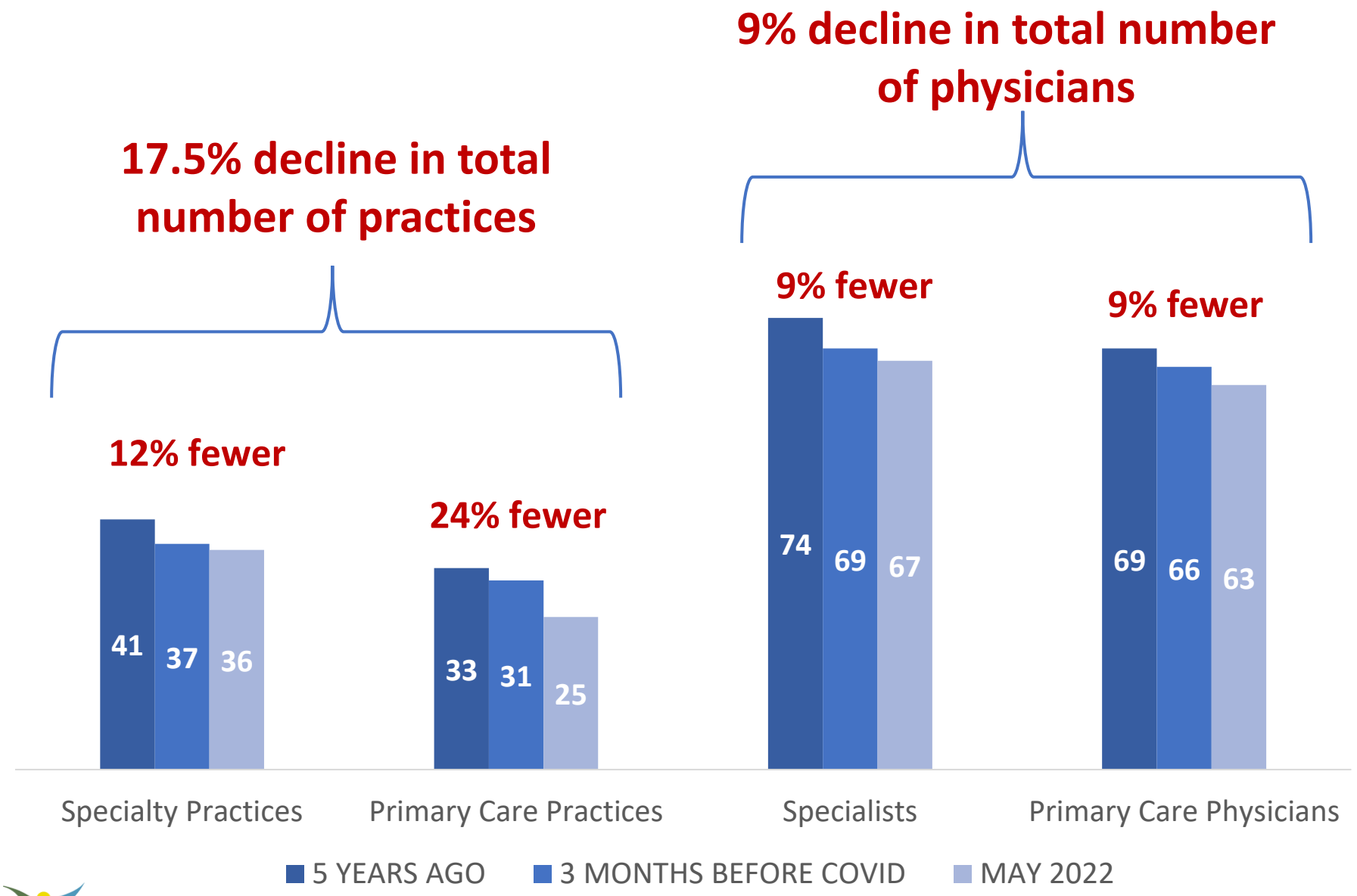
1. Overview: Current state of healthcare and population health in Vermont
a. Lack of access, delayed appts. Legal liability for late-stage diagnoses. I.E. Cancer and standard of care (early diagnosis/treatment)
b. Flight of caregivers and shrinking clinical departments.
    i. Cost of travelers, UVM Nursing students debt forgiveness, an effective recruiting tool in lieu of $40M spent on temp workers. Student loan debt, a reason many leave and become travelers (X3)
    ii. Lab techs, nurses, and doctors leaving
    iii. Upcoding scandals
    iv. Denial management costs
2. Current State of mental health care and access:
a. Youth and adolescence – a crisis affecting our very future.
b. Suicide and addiction statistics on a steep rise.
c. Inpatient services of which there are few and community outpatient services which are underfunded but offer better outcomes.
3. Health system must be reimagined and redesigned with stakeholder input:
a. Driving philosophy must be the mission of population health: access, cost, and outcome quality.
b. Driving ethos must be collaboration of diverse components from early education (prevention and early intervention), primary care, through tertiary care. Competition works in business but not in mission-driven services. (We have yet to agree that healthcare is an established right.)
c. A driving regulatory tool must be global budgeting and uniform cost of services.
d. In general, investments must be moved upstream to prevention, education, intervention and early treatment instead of remediation and emergency treatment. The simple measure of our systemic failure is the number of patients in emergency rooms, homeless shelters, and jails. I know that ERs are a major source of revenue but ERs are not how to treat low acuity people seeking help.
4. State's absence of leadership:
a. Complex systems: executive role, legislative role, judicial role

b. Empowered Agency role: difference between mission, policy-generation, oversight, and regulation.
c. GMCB role – policy setter or financial regulator, if regulator, against what policy?
d. Who owns this? No answers.

ABOUT HEALTHFIRST

- Independent Practice Association since 2010
- Represent ~85-90% of Vermont's physician owned practices
- Practices located in 8 VT counties
- Our primary care practices care for ~76,000 patients
- Our practices also employ hundreds of Vermonters

DECLINE IN NUMBER OF PRACTICES AND PHYSICIANS



HEALTH FIRST

Why Maintaining Access to Independent Providers is Good for Vermonters

- Independent practices have demonstrated high quality and the ability to keep overall cost of patient care low*
- Patients want options for care -- health care services are personal, tailored services unique to different individuals
- Having independent practice as a viable option attracts physicians to Vermont, allowing Vermonters better access and choice of providers

* Source: New England Journal of Medicine 2016 , JAMA 2014

HEALTH FIRST

Why Maintaining Access to Independent Providers is Good for Vermonters

- The experience of care at small, community-based, practices is different
  - More personalized care
  - Efficient, nimble, less costly
  - More accessible, often have shorter wait times

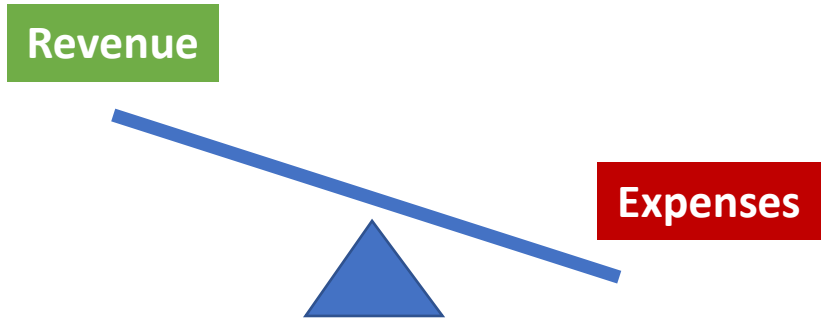
WAIT TIME COMPARISON: DERMATOLOGY
Mean wait times for non-emergent issue

State report	**140 days (range 11 to 410 days)**
HealthFirst Derm practices	**21 days (range 6 to 45 days)**

TOP BARRIER TO INDEPENDENT PRACTICE VIABILITY

- Reimbursements that don't keep pace with expenses

- Significant increases in:
  - Labor costs
  - Medical malpractice rates
  - Vendor/supply costs
  - Employer health insurance premiums
  - Other insurance like cyber, business owners



- From 2001 to 2021:
  - Practice costs increased 39%*
  - CMS increased physician pay by only 11% (a 20% reduction after adjusting for inflation)*

*Source: https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf

PROFESSIONAL FEES ARE THE ONLY REVENUE SOURCE FOR INDEPENDENT PROVIDERS

PAYMENT SOURCE	INDEPENDENTS	HOSPITALS	ACADEMIC HOSPITALS
Professional Fees			
Commercial Payers	Y	Y	Y
Medicare	Y	Y	Y
Medicaid	Y	Y	Y
Facility Fees			
Commercial Payers		Y	Y
Medicare		Y	Y
Medicaid		Y	Y
Medical Education Payments			
Medicare DIRECT Grad Med Education payments			Y
Medicare INDIRECT GME augmentation			Y
Medicaid Fixed Annual Payment to UVMMC			Y
Medical School Tuition from Students			Y
Medical School Endowment + Donations			Y

Independents have little to no negotiating ability with payors, especially in a market with a dominant health system.

As a result, rates essentially remain flat or increase at a rate well below the pace of rising costs.

HEALTH FIRST

WHAT VERMONT NEEDS TO DO

- Encourage a health care system that supports a diverse array of community-based health care providers and services
  - Increase provider/facility choice by ensuring fair reimbursement across providers regardless of site of care delivery
  - Hold hospitals accountable by requiring that pricing be tied to a benchmark such as a percentage of Medicare
  - Shift resources to high-value services like **Primary Care** and **Mental Health**, which will result in decreased need for hospital services
  - Support non-hospital alternatives for services such as ambulatory surgeries, procedures and imaging.

- Understand that increases in hospital & payor rates have a double negative effect on independent practices
  - Increases expenses for employee health insurance
  - Ensures continued flat/decreased revenue because fewer dollars available in system
  - Expenses > Revenue is unsustainable business model & will ultimately result in more practice closures, forcing more patients into a higher cost, lower value hospital-based system

Julie Tessler
Executive Director
Vermont Care Partners: VT Council

Outline of Presentation to Green Mountain Care Board
May 4, 2022

1. **Brief History and Overview of Community-based services: Mental Health, Developmental Disabilities, Substance Use Disorders**
2. **Prevalence and Health Impacts of Mental Health, Developmental Disabilities and Substance Use Disorders**
3. **Critical Investments for Improved Health Outcomes**
4. **Questions for Consideration**
    - **What is the right balance of inpatient and community-based mental health services and how and who should best determine it?**
    - **What is the right balance of medical and home and community-based services, and how and who should best determine it? What is the cost of not fully funding community-based care?**
    - **What level of investment is required to improve access to care, experience of care, and population outcomes, while controlling costs?**
    - **What would true mental health parity look like?**
    - **What factors (workforce, payment models, resource distribution, care delivery models) are most critical to improve access to a high-quality continuum of health care services for all Vermonters?**
    - **How can we ensure sustainability of health and home and community-based services as demands increase?**
    - **What actions are necessary and who should lead the efforts to reform Vermont's health care system?**

Vermont – ACO Model Failures

May 4, 2022

Julie Wasserman, MPH

1. The State of Vermont and the federal government have spent tens of millions of dollars to implement the ACO model, yet Vermonters are not better off and our health care system is not more affordable, more equitable, or more accessible. This model does not address the real causes of health care problems, including cost, equity, and access, is costing too much, and accomplishing too little.

2. After multiple years of implementation, the ACO model has failed to meet its stated goals, has failed to reduce health care expenditures, and has failed to address the real drivers of high health care costs: unnecessary bureaucracy and administrative costs, high hospital costs, specialist costs, and pharmacy costs.

3. OneCare's total ACO administrative costs for implementing the All Payer Model over a six-year period will exceed $80M, yet the latest available data (slide 9) show that the ACO was responsible for a mere 13% of Vermont's total health care spending. The ACO's administrative costs are *in addition to* current administrative costs borne by Medicare, Medicaid, and Commercial insurers.

4. The cost of the model has far outpaced its savings. The Vermont Auditor of Accounts determined that the model has cost Vermonters $30 million more than it has saved (p.10).

5. The ACO employs a top-down, hospital-centric business model, rather than a person-centered or community-based approach to health care reform.

6. The ACO model serves a *minority* of Vermonters. Only 230,765 people (p.6), comprising a mere 36% of Vermonters, are included in the model after four years of effort. (Data for 2021 is not yet available.)

7. In addition to the currently low number of participating enrollees, ACO enrollment prospects are facing additional challenges:
   a) The latest (April 2022) CMS counts show 27% of Vermont Medicare-eligible beneficiaries are enrolled in a Medicare Advantage Plan (≈ 42,000).
   b) UVM Health Network's new Medicare Advantage Plan renders more than 2,500 (and growing) Vermont Medicare enrollees ineligible to participate in the ACO.
   c) UVM Health Network has insured all its employees (UVMMC, CVH, Porter, others) with a commercial insurer in South Carolina (BCBS of S.C.) This commercial insurer is NOT a participating payer in the All Payer Model.
   d) The last two items lead one to question UVM Health Network's commitment to the All Payer Model.

8. The model is not achieving its stated goal of payment reform. The GMCB's most recent available data show less than 2% of Vermont's health care costs are under true risk-bearing capitated arrangements (slide 10). NOTE: GMCB Board member, Jessica Holmes, recently described Fixed Prospective Payments reconciled to Fee-for-Service as "Cloaked Fee-for-Service" and stated such payments are not likely considered true "payment reform". (GMCB Hearing, April 28, 2022).

9. Risk is not being borne by providers.

10. Health care costs have not been lowered or stabilized. Hospitals are expected to submit double-digit rate increase requests at the upcoming GMCB Hospital Budget Hearings.

11. There is no compelling evidence that the ACO has improved the quality of care.

12. Access to care has not improved as detailed in this *Seven Days* exposé.

13. The State of Vermont and the federal government paid the ACO over $23 million because of reduced Medicare and Medicaid spending in 2020. The underspending, however, was due to patients and providers postponing care due to COVID. OneCare's quality measures declined as well. What sense does it make to pay a private entity MORE for doing LESS and doing it poorly?

14. Instead of employing a private ACO with a weak track record and inordinate administrative costs, DVHA should perform the core functions of a Medicaid Managed Care Organization when it becomes a public risk-bearing Medicaid MCO on July 1, 2022. Health care savings would instead accrue to the State in the public's best interest.

15. The ACO has weakened Vermont's primary care physician workforce through reduced upfront payments in 2021, and it has ignored the primary care physician shortage by not employing strategies to address it. Sustaining and strengthening Vermont's primary care physician workforce should be central to reform efforts.

16. OneCare's investments in and support of Population Health have diminished *significantly* over the last several years and fly in the face of its purported commitment to value-based care and systemic change:
    a) A 33% decline in Population Health funding. ($43.1M in 2020 fell to $28.9M in 2022).
    b) More than a 3-fold cut to the DAs. ($3.4M for the DAs in 2020 dropped to $1M in 2022.) All the while Vermont is in the midst of a full-blown community mental health crisis.)
    c) OneCare's $2.2M funding for Home Health Agencies in 2021 fell to $1.5M in 2022. Hospital expenditures drive the high cost of health care. Home Health services not only prevent or delay hospitalizations, they foster early discharge.

d) The ACO has not deployed any explicit measures to reduce or prevent hospitalizations.
e) The ACO has redirected public health investments away from community resources addressing social determinants of health and instead focused on clinical approaches.
f) Community prevention activities (DULCE, RiseVT) have also been curtailed.

17. The ACO model is rife with *conflicts of interest*:
    a) OneCare has become a subsidiary of the UVM Health Network. How will the public interest be served by giving UVM Health Network expanded control over how the ACO determines and allocates payments to providers, of which the UVM Health Network is the largest?
    b) There is a "revolving door" between State government and the UVM Health Network, leaving Vermonters with little confidence that the endeavor is operating in their best interests.
        i. Al Gobeille, former Chair of the Green Mountain Care Board and former Secretary of the Agency of Human Services, is now the Director of Operations for UVMHN.
        ii. Anya Rader Wallack, former Chair of the Green Mountain Care Board, is now Chair of the OneCare Board and lead spokesperson for UVMHN.
        iii. Cory Gustafson, former Commissioner of DVHA is now UVMHN's Director of Strategic and Business Planning.

18. UVM Health Network is becoming a monopoly due to the growing consolidation of health care in Vermont. Market consolidation inevitably leads to decreased competition and higher prices.

Testimony to the Green Mountain Care Board on Global Budgeting & Reference-based Pricing
Mark Hage, Director of Benefit Programs, Vermont-NEA
Wednesday, May 4, 2022

Good morning.

My name is Mark Hage and I'm the Director of Benefit Programs at the Vermont-National Education Association. I'm a former Vermont school teacher and, currently, I'm also a Trust Administrator with the Vermont Education Health Initiative (VEHI). VEHI is the self-insured risk pool that provides health insurance benefit plans to approximately 35,600 school employees, active and retired, and their dependents.

To be clear, I am testifying as a union advocate today; I am not testifying on behalf of or speaking for VEHI.

I want to state emphatically that it is time to design a model of global budgeting for Vermont's hospitals that will ensure they have sufficient funding on an annual basis. This is a social, economic, medical, and moral imperative. Equally imperative, all Vermonters must be assured access to affordable, high-quality, equitable health care. On that point, too, there can be no equivocation or evasion.

These two imperatives are not separate and distinct. Yet for too long the public regulatory conversation about hospital budgets and the cost of medical care generally – including in reference to OneCare Vermont – has not confronted directly and urgently the staggering inequities and unaffordability of health care for many thousands of Vermonters and their grave social and medical consequences.

This false binary must end – and this Board should be in the forefront of ending it, using its regulatory power to bring to fruition a global budgeting process that is fair and predictable for hospitals, that centers in hospital budgetary decision-making and population health planning, consistent with Act 48, the principles of universal access, affordability and equity, and that references hospital reimbursements to Medicare rates. I'll return to the matter of referenced-based pricing shortly.

First, I want us to keep in mind that according to the **2021 Vermont Household Health Insurance Survey**, **44 percent** of Vermont's privately insured residents are deemed **underinsured**, using a model developed by the Commonwealth Fund.[1] This means their private insurance plans do not sufficiently cover current or potential future out-of-pocket medical expenses – deductibles, co-insurance charges, and copays. To be clear, the Commonwealth Fund's designation of underinsured **excludes** premium bills, which also present a significant hardship.

In 2014, the percentage of Vermonters under the age of 65 with private insurance who were **underinsured** was **27 percent**; in 2018, it was **40 percent**; in 2021, as I said, it was **44 percent**.[2] That 44 percent represents **more than 131,000** privately insured Vermonters.

[1] Commonwealth Wealth Fund "Underinsured" Methodology: Current medical expenses, **excluding** the cost of insurance premiums, are equal to or greater than: • 10% of household income if 200% or higher of FPL • 5% of household income if below 200% of FPL **OR** • Have a deductible equal to or greater than 5% of household income.

[2] https://www.healthvermont.gov/sites/default/files/documents/pdf/VHHIS_Report_2018.pdf and https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR-VHHIS-2021-Report.pdf

In 2021, **two in five** privately insured Vermonters (41%) had a deductible over $4,000. And nearly **two-fifths of Vermonters** with private insurance (or 38%) had a deductible equal to at least 5% of their household income.

Not surprisingly, most of the underinsured have **the lowest incomes**.

The 2021 household survey also notes explicitly that Vermonters under the age of 65 who are **Black**, who are members of a **gender identity minority**, and who live with **a disability** were more likely to be **underinsured** compared to other groups of Vermonters. The same dynamic is present for these groups when it comes to delaying medical care due to cost.

The fear of medical debt among the underinsured also plays a larger role in their decisions to not get necessary medical care than it does for those who are not underinsured.

These facts and figures have a particular resonance for me because I'm the staffer at Vermont-NEA who received the lion's share of the phone calls in recent years from union members or their spouses who could not afford their out-of-pocket costs from high-deductible health plans or who were targeted by collection agencies. That experience still weighs heavily on my conscience; and, to leave no doubt, I am done – and we are done as a union – with "skin-in-the-game" rhetoric when it comes to justifying the excessive prices, medical deprivation, and the administrative waste our health care and health insurance systems inflict on us. And that we passively tolerate or endure, even when we know we don't have a so-called excessive "utilization" problem. **We have a price problem.**

When VEHI set its premium rates for FY23, 75 percent of that increase was generated by **price inflation** – not utilization. We are not alone in this regard. This board's presentation to the House Health Care Committee on April 14 stated that **"unit cost"** (e.g. price), *not utilization,* was the primary driver of a **20-percent increase** in health insurance costs from 2020- 2022 for Vermont's **individual and small-group markets.**[3]

If we hold two current social crises in our minds at the same time – *the worsening unaffordability of private insurance and the ever-escalating costs of medical care* – it brings us inexorably to the matter of global budgeting.

When I speak about global budgets for hospitals, I mean an empirically sound, rigorously regulated system of budgeting that allocates fixed annual payments to our hospitals to cover their verifiable operating costs and ensures funding for the delivery of vital health care services. By researching and distilling metrics on hospital costs, prices, surplus accumulation, volume and acuity of care, and breakeven points, we should arrive annually at a fixed allocation of payments for each hospital that is fair, sustainable over time, and can be explained in lay terms to workers, employers, and the public, all of whom desperately need health care and private insurance prices to come down soon and substantially. OneCare Vermont has certainly not delivered in lowering costs, certainly not that anyone with a private insurance plan or who runs an insurance risk pool can discern.

Further, any savings we accrue from hospital global budgets should be invested in expanding access to community-based medical services like primary care, nursing, mental health, home health care and hospice, and to addressing critical and longstanding workforce shortages in these fields. Respectfully, I

[3] PowerPoint Presentation (vermont.gov), see slide 7.

have seen no evidence that our ACO has undertaken efforts that would rectify staffing shortages, including in primary care, which OneCare has asserted is fundamental to its mission.

I'd like to speak now to the matter of reference-based pricing. I recommend to this Board that it not only vigorously commit to global budgets for hospitals, but that it do so in tandem with developing options for the design and implementation of reference-based pricing based on a multiple of Medicare rates for inpatient and outpatient hospital services. Reference-based pricing must be an integral part of hospital global payments and will be invaluable in eliminating the price variations we see now for the same services.

For well over a year, I've been investigating the potential of reference-based pricing for hospitals after learning of the State of Montana's success in implementing referenced-based hospital pricing pegged to Medicare rates for its state employees and their families. *I was driven to this research, in part, by the fact that better than 50% of every VEHI premium dollar is devoted to inpatient and outpatient hospital services, and, as I mentioned already, by the profound impact of medical inflation each year on VEHI's premium rates.*

Montana's achievement in respect to reference-based pricing is remarkable. It fused political will and fair negotiations with extensive data and analysis on actual hospital costs and prices at acute care centers. What I learned from extensive reading and speaking directly with the key individual who spearheaded the Montana project, Marilyn Bartlett, is that reference-based pricing can dramatically lower costs without endangering the fiscal solvency of hospitals or reducing essential services.

Referencing hospital rates to Medicare made eminent good sense to Montana because Medicare is the largest health care payer in the country; its rate-setting calculation process is publicly available, and its rates are adjusted for case mix, risk, quality and geography. As a common reference point, again, they can be used to overcome variation in charge masters and differences in billing rates.

What did the State of Montana achieve for its 31,000 state employees and their family members? In brief:

- It set inpatient hospital prices at acute care centers at between **220% to 225%** of Medicare rates and between **230% to 250%** of Medicare rates for outpatient services.
- There have been **no premium rate increases** for state employees for 6 consecutive years (2017 - 2022).
- Montana saw an **actual reduction** in its health insurance costs by nearly **$48 million** from 2017 – 19 alone.
- The state restored **the financial reserves** of its state health insurance pool, which had been in steep decline, and it substantially lowered its OPEB liabilities for its state pension system.

Here in Vermont, **State Auditor Doug Hoffer** and his team released a well-documented report last November that examined the benefits of reference-based pricing benchmarked to Medicare to health care costs for state employees. It estimated that if reference-based pricing was implemented for Vermont state employees alone for all services, total savings could reach **$16.3 million annually**.

I implore you to investigate and to design models of reference-based pricing benchmarked to Medicare rates that would be fair to and sustainable for hospitals, that is fair to Vermonters and their employers, and that can eliminate or greatly reduce price variations statewide for the same services and save costs.

I recommend, too, that you speak with Auditor Hoffer and his team about their findings and invite Marilyn Bartlett back to hear her thinking on planning for global budgeting and referenced-based pricing. She is a special analyst for **National Academy for State Health Policy** now, and she offered testimony in recent years to this board about NASHP's hospital analytical tool and related hospital matters. NASHP has resources – including a newly engineered hospital tool – and experts like Ms. Bartlett to assist this board and pertinent state agencies in developing global budgets and reference-based pricing. This expertise, if requested formally by the state, would come at no charge.

If global budgeting is going to work and be sustainable, we must be confident from the outset that the hospital services we are budgeting for are essential and that their costs are verifiable based on the very best hospital data. With referenced-based pricing, I believe we can get the prices right at the starting line of this initiative, and not "bake in" costs from past budgets that cannot be justified on financial or clinical grounds.

I'll close by saying that I look forward, as do my colleagues, to a robust and public engagement on global budgeting, referenced-based pricing, and community-based care in the months to come.

Thank you.

CHRONIC CASE STUDY

CLIENT- D.G. –Client is 76 year old married male with diagnoses including COPD, DM, CAD, unstable angina, and anxiety.

May 2012-December 2012---- MINIMAL HOME HEALTH SERVICES

Patient had 10 ER visits (via ambulance) with 4 resulting in hospital admission from 5/2012-12/2012. Client was admitted to Home Health and seen for Skilled Nursing 6/22/12-07/31/12. Client and wife were resistant to services, allowing only 6 visits and refusing further care.

DATE	TYPE	REASON
05/12/12-05/15/2012	ER transfer to DHMC	Chest pain
06/06/12	ER	Shortness of breath
06/16/12-06/21/12	ER , admit to NVRH	COPD, pneumonia
06/25/12-06/28/12	ER, admit to NVRH	pneumonia
07/03/12	ER	Shortness of breath
08/02/12	ER	Chest pain
08/30/12	ER	?
10/01/12	ER	Shortness of breath
11/19/12	ER	Shortness of breath
12/06/12-12/07/12	ER, admit to NVRH SCU	Unstable angina

Health Care cost (estimated)

10 ER visits	**x $541**	**$5410**
12 hospital days	**x$1618**	**$19416**
Home Health episode	**x$2260**	**$2260**
Total		**$27086**

December 2012—August 2013---- CONSISTENT ONGOING HOME HEALTH SERVICES

Client was admitted to Home Health on 12/08/12. Since that admission, he has had 4 ER visits with only 2 hospital admissions. He was seen by SN 2-3xweek and then decreased to 1xweek. SN intervention included considerable teaching about disease process and management (COPD, cardiac, and anxiety), medication management, and use of on-call RN for symptom management prior to calling ambulance. Client was put on tele-monitoring for daily monitoring of vitals in an attempt to better manage symptoms as they began. Client was also seen by PT 2xweek for 6 weeks for strengthening, safety, endurance, energy conservation, and instruction in breathing techniques. Client had both an MSW and OT evaluation as well. Emphasis was to provide consistency with staffing and scheduling visits so that client was seen by disciplines on opposite days.

12/17/12	ER	Chest pain
02/10/13	ER	Chest pain
04/08/13-04/09/13	ER, overnight in observation	Chest pain
08/16/13-08/20/13	ER, admit to NVRH	Pneumonia, COPD

Health Care costs(estimated)

4 ER visits	**x $541**	**$2164**
5 hospital days	**x $1618**	**$8090**
4 Home Health episodes	**$6850**	**$6850**
Total		**$17104**

Community Health Systems and Health Care Reform

Let me introduce myself

Health Reform has been too hospital centric. Yes, hospitals represent almost half of all spending, but a lot of that is avoidable. The Hospital Sustainability:

> "In many VT hospitals, 10-34% of inpatient care is potentially avoidable."
>
> "In many VT hospitals, 25=40% of ED revenue is potentially avoidable."
>
> Savings could be realized by addressing both.

Community services are what keeps people healthy and avoids more expensive care.

European health care systems cost far less, have better outcomes and rely more on social services and primary care.

Our goal needs to be to provide more prevention and early intervention, save money on expensive services and move that money into more prevention and early intervention.

Let me give one example from my days running a home health agency. (Chronic care case study)

LTC - Choices for Care, Moderate Needs Group

MH – Mental and emotional health issues cause or exacerbate a huge percentage of physical and medical problems

ACES - trauma data wheel; social determinants

FQHC's as a solution- primary care, mental health, substance abuse, dental care; federal grant, funding

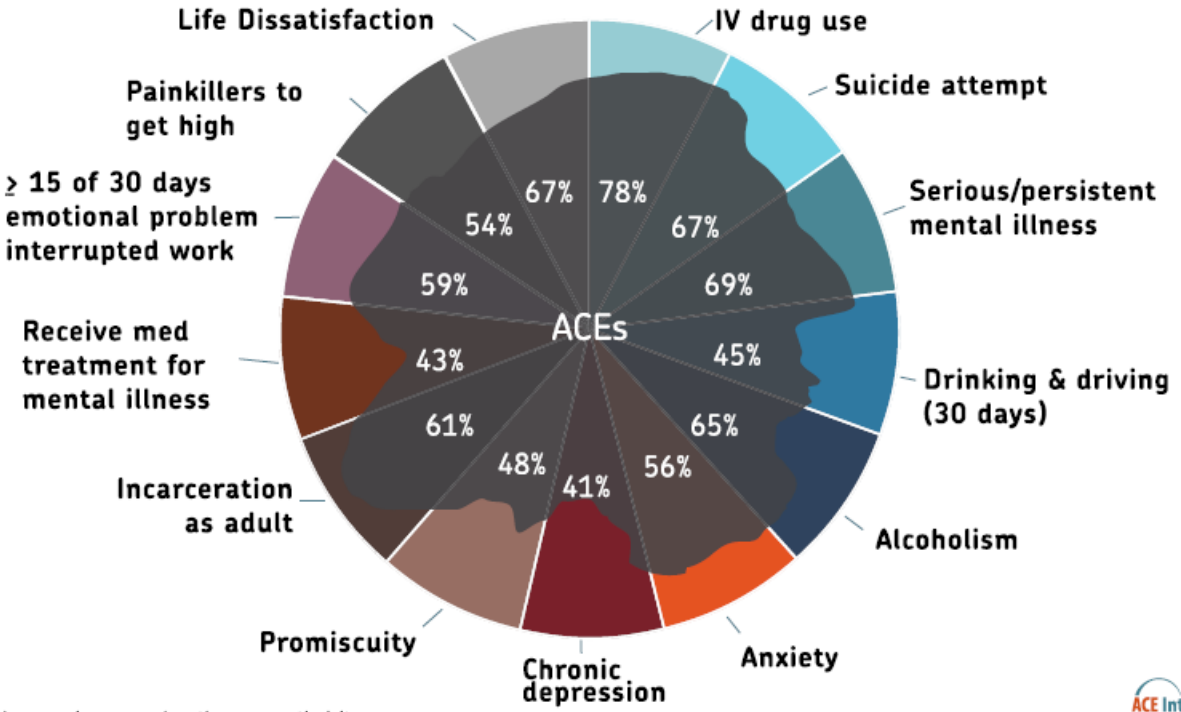
Hospice is grossly underutilized. Low cost investment with significant return.

School insurance funding

So what needs to be done?

> Expand and strengthen primary care
>
> Expand FQHC's
>
> Significantly expand and strengthen the Designated Agencies
>
> Expand Home Health
>
> Expand Hospice
>
> Expand Choices for Care

Population Attributable Risk



Controls: gender, age, income, education, race-ethnicity