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December 1, 2023

Owen Foster
Chair, Green Mountain Care Board
144 State Street, Montpelier, VT 05602

RE: Office of the Health Care Advocate Comments on FY2024 OneCare Budget Submission

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

The Office of the Health Care Advocate (HCA) would first like to thank the Green Mountain Care Board (Board) and its Accountable Care Organization (ACO) budget staff for their careful consideration of OneCare Vermont's (OCV or OneCare) FY24 budget submission.

We acknowledge OneCare's sincere belief that it is improving Vermont's health care system, that it is the current vehicle used to fund important state level population health programs with federal monies, and it transfers funds to support primary care providers. However, the HCA continues to question whether OneCare is providing sufficient value to Vermonters given its cost. During OneCare's time of operation, several concerning trends have emerged: a) commercial insurance rate increases in Vermont now far outpace the United States average[1] b) Vermont's rate of underinsurance among Vermont's privately insured residents has increased from 27.3% to 44.0%[2] and c) Vermont's hospital adjusted expenses per inpatient day are now growing faster than the national average.[3]

The HCA has long questioned whether OneCare's approach and place in the overall health care reform effort could achieve progress on the goals of the All-Payer Model (APM). After more than seven years of operations, the HCA remains concerned that OneCare can help achieve Vermont's health care reform goals. The uncertain future of the APM amidst the announcement of the new ACO-agnostic States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model, provides an important opportunity for the Board to dispassionately evaluate whether OneCare merits inclusion in a future APM-like agreement.

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[1] Green Mountain Care Board, Nov. 30, 2023, Presentation to the Health Reform Oversight Cmte., Slide 24, https://ljfo.vermont.gov/assets/Meetings/Health-Reform-Oversight-Committee/2023-11-30/14cefccead/GMCB-Slides-HROC-11.30.2023.pdf

[2] Vt. Dep't of Health, 2021 Vermont Household Information Survey at 45 (March 2022), https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR-VHHIS-2021-Report.pdf

[3] Green Mountain Care Board, Nov. 30, 2023, Presentation to the Health Reform Oversight Cmte., Slide 27, https://ljfo.vermont.gov/assets/Meetings/Health-Reform-Oversight-Committee/2023-11-30/14cefccead/GMCB-Slides-HROC-11.30.2023.pdf

Such an evaluation should examine OneCare's return on investment to Vermonters by comparing all the costs involved of funding it, including but not limited to its operating budget, hospital participation fees, payer contracts, the Board's costs of regulation and oversight with any potential impact it has had – if any - on affordability, access, and quality.

Below the HCA outlines several concerns related to OneCare's impact, population health management, payroll and consulting expenditures, and data analytics platform transition. We conclude by offering three concrete recommendations to the Board.

I. Impact Assessment

We reiterate the concern raised during the public hearing that OneCare misrepresented the results of the NORC evaluation to the Board, the HCA, and the public. The cover letter to OneCare's budget submission reads: "According to a recent independent analysis commissioned by the Centers for Medicare & Medicaid Services (CMS) Innovation Center, OneCare is making real progress on lowering costs and improving patient care. The analysis determined that OneCare successfully drove down costs and hospitalizations over a four-year period."[4] This statement is not an accurate characterization of the NORC evaluation's findings. The NORC evaluation reached no conclusion on whether OneCare was responsible for reducing costs or improving patient care, as those topics were not a focus of their analysis. While the report may be of interest to the federal government, as it is focused on the impact of the APM on Medicare spending, the HCA does not believe it is or should be of significant interest to Vermonters who are more concerned with well-documented erosions to affordability[5] and access[6] over time.

When the HCA raised concerns about OneCare's press pieces on the NORC evaluation, we were told in the public hearing that they were written in part to respond to "antipathy" and "negativity towards the ACO" while hoping to also "build a groundswell" that "some things are working."[7] Resorting to such tactics to push back on criticisms of OneCare—criticisms which have, in part, related to questions about the veracity of OneCare's claims of effectiveness—legitimizes rather than refutes such critiques. More importantly, however, we believe that the statement misleads the public about the return on their investment in OneCare.

II. Declining Population Health Management Expenditures and Increasing Payroll and Consulting Expenditures

There are troubling signs that OneCare is decreasing population health management (PHM) expenditures while increasing expenditures on consulting and payroll. We present an analysis

[4] OneCare Vermont. Cover Letter. October 2nd, 2023. https://gmcboard.vermont.gov/document/fy24-ocv-budget-cover-letter
[5] Vermont Department of Health. "Vermont Household Health Insurance Survey." March 2022. https://www.healthvermont.gov/stats/surveys/household-health-insurance-survey
[6] Vermont Department of Health. "Access to Health Services." Accessed November 30th, 2023.
[7] Nov. 8, 2023, Green Mountain Care Board Meeting, https://www.youtube.com/watch?v=Qr1gIvMIdtk&t=4556s.

of OneCare's historical budget data to substantiate this claim. To conduct this analysis, the HCA obtained all data used from public budget materials submitted by OneCare to the Board.[8] Our categorization of PHM spend is similar to that used in the third NORC evaluation with the exception that we removed PHM spend attributable to Blueprint programs (i.e., SASH, PCM, CHT).[9] We believe this exclusion is justified because the Blueprint is not a true OneCare PHM program. However, we note that including Blueprint funding would increase OneCare's PHM spend. To compare dollars over time, we converted the reported nominal dollar amounts reported to real 2023 dollars.[10] For 2023B, we decided to use OneCare's original budget submission that included Blue Cross and Blue Shield of Vermont (BCBSVT) participation in OneCare programs. Certain required data elements were redacted in the January 2023 resubmission, which limited our ability to present the results publicly, whereas all needed data elements in the original submission were public. Given this fact, we decided that it was more important that our analysis be public than using one year of slightly more accurate data (especially since most changes introduced by BCBSVT's non-participation would be shifted from appearing in 2023B to 2024B). Lastly, we do not present data from 2016 or 2017 as we deemed data from this period to be indicative of one-time start-up costs and growth associated with a new organization. In general, this decision resulted in the presented data being more favorable to OneCare (i.e., concerning negative trends were less negative and/or desirable positive trends were more positive).

A. Declining Population Health Management Expenditures

[8] OneCare Vt., OCV FY24 Budget Guidance Workbook – Sheet 6.8, https://gmcboard.vermont.gov/document/ocv-fy24-budget-guidance-workbook; OneCare Vt., OCV FY24 Budget Adaptive Sheets – Sheet A1, https://gmcboard.vermont.gov/document/ocv-fy24-budget-adaptive-sheets; OneCare Vt., OCV FY23 ACO Budget Guidance Workbook – Sheet 6.8, https://gmcboard.vermont.gov/document/ocv-fy23-aco-budget-guidance-workbook; OneCare Vt., OCV FY23 Appendices 6.1-6.3 Adaptive Sheets A1-A2-A3 – Sheet A2, https://gmcboard.vermont.gov/document/ocv-fy23-appendices-61-63-adaptive-sheets-a1-a2-a3; OneCare Vt., OCV FY22 ACO Financial Workbook (10/24/2021, corrected) – Sheet 6.2, https://gmcboard.vermont.gov/document/ocv-fy22-aco-financial-workbook.

[9] Due to limited documentation, we were unable to exactly reproduce the values used in the NORC report. The numbers we calculated deviated from those calculated in the NORC report by less than 5% which gave us confidence in our categorization method. See NORC at the University of Chicago, Evaluation of the Vermont All-Payer Accountable Care Organization Model – Third Evaluation Report (July 2023), https://www.cms.gov/priorities/innovation/data-and-reports/2023/vtapm-3rd-eval-full-report.

[10] We used CPI-U (series CPIAUCSAL, seasonally adjusted) to convert nominal dollar values into real 2023 dollars. As a full years CIP-U data is not yet available for 2023, we averaged the 10 months of data available as of 11/28/2023 to estimate the average annual CPI-U for 2023. For 2024 CPI-U, we assumed the percentage CPI-U growth would occur from 2023 to 2024 as occurred between 2022 and 2023. This resulted in an assumed CPI-U growth of roughly 3.7%. We checked the general reasonableness of this assumption by comparing it to the estimate of consensus CPI-U forecast of the Vermont Joint Fiscal office and the Vermont executive branch. U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: All Items in U.S. City Average (CPIAUCSL), https://fred.stlouisfed.org/series/CPIAUCSL (last visited Nov. 28, 2023); Vt. Joint Fiscal Office, Relevant Inflation and Other Economic Measures: Consensus JFO and Administration Forecast – November 2022, https://ljfo.vermont.gov/assets/Subjects/Inflation-and-Economic-Measures/91fc9965d5/Inflation_and_Other_Economic_Measures-October_2022.pdf.

The HCA's analysis showed that PHM expenditures have decreased over time both in absolute terms and relative to gross accountability revenue and starting attributed lives. We do not believe this decrease aligns with OneCare's purpose or with the public's reasonably expected return on its direct and indirect investments in OneCare.[11] From 2018B to 2024B, absolute PHM spend decreased from roughly $23.5 million to $15.0 million (**Graph 1** in Appendix). Indeed, PHM spend decreased, compared to the previous year, 8% in 2020B, 25% in 2021B, 15% in 2022B, 2% in 2023B, and 26% in 2024B.

PHM spend also decreased over time as a percent of gross accountability revenue (**Graph 2** in Appendix). In 2018B, PHM spend was 3% of gross accountability revenue and in 2024B it is 1.5%. Put differently, real PHM spend as a percent of gross accountability revenue decreased 50% from 2018B to 2024B.

OneCare's PHM spend looked at as a percentage of hospital dues paints a slightly rosier picture. PHM spend was 80% or more of hospital dues in all years between 2018 and 2024 (**Graph 3** in Appendix). In fact, in certain years, PHM spend as a percent of hospital dues is over 100%. One possible explanation is that PHM funding comes from more than just hospital dues. We note, however, despite this fact, PHM-spend-as-a-percentage-of-hospital-dues trend decreases over time. Further, 2024B PHM spend as a percentage of hospital dues is less than 2018B which is troubling. It seems reasonable to expect an organization to perform at least as well as it did six years ago. It also should be noted that the data we present is at an aggregate state-level. We did not evaluate whether PHM spend is distributed across hospital service areas (HSA) consistent with the amount of hospital dues that a given hospital paid.

Lastly, we examined PHM spend per starting attributed life. PHM spend per starting attributed life is also trending downward over time (**Graph 4** in Appendix). In 2018B, PHM spend was $215.16 per starting attributed life. In 2024B, PHM spend is $74.45 per starting attributed life. That is a decline of roughly 88.6%.

Based on the above-described analysis of public data reported by OneCare, we conclude that PHM spend, when looked at in absolute terms or relative terms, has decreased substantially over time. We also find evidence that OneCare's assertion that PHM spend is highly correlated with hospital dues is correct. However, this observation causes the HCA to wonder why, after seven years of operations and known challenges facing Vermont hospitals, OneCare has been unable to diversify PHM funding sources.

[11] Hospital dues are, indirectly, a substantial public investment. This investment can be thought of as some portion of the value of state and local tax exemptions for a given hospital, the cost of the various regulatory processes of health insurers, hospitals, and ACO, the value of direct state expenditures, and/or the money donated by Vermonters to hospitals. The Auditor's 2020 report also speaks to many of the issues we raise related to reasonably expected return on investment. Vermont State Auditor, Vermont's All-Payer Accountable Care Organization (ACO) Model, https://auditor.vermont.gov/sites/auditor/files/documents/ACO%20Model%20Final%20Report_0.pdf.

In sum, our analysis leads us to ask a fundamental question: how are Vermonters meant to evaluate OneCare's performance towards helping Vermont achieve any goal of the APM if over the course of its tenure it has invested comparatively less in population health?

B. Increasing Payroll and Consulting Expenditures

When put in real dollars, we find trends in OneCare's expenditures on payroll and benefits, legal, consulting and purchased services (Payroll and Consulting) to be similarly troubling. From the period between 2018B and 2024B, Payroll and Consulting spend has increased from $8.4 million to $11.2 million, or roughly 33% (**Graph 5** in Appendix).

When normalized by gross accountability revenue, we observe a slight decreasing trend in Payroll and Consulting (**Graph 6** in Appendix). We also observe, however, that OneCare's spend on Payroll and Consulting is higher in 2024B (1.25%) than it was in 2018B (1.16%).[12]

Similarly to Payroll and Consulting spend normalized by gross accountability revenue, Payroll and Consulting spend per starting attributed life has decreased over the period examined (**Graph 7** in Appendix). However, Payroll and Consulting spend per starting attributed life has increased in recent years. Again, a possible explanation of the recent increases in Payroll and Consulting spend is a "right sizing" lag issue due to BCBSVT's non-participation in OneCare.

Payroll and Consulting spend as a percentage of hospital dues paints a somewhat different picture. Namely, a larger proportion of hospital dues over time are going towards Payroll and Consulting (**Graph 8** in Appendix).[13] During the period examined, the amount of hospital dues per year has indeed decreased and the compound average growth rate (CAGR) of hospital dues is -1.9%. The CAGR of Payroll and Consulting is, in contrast, positive and larger at 4.4%. In other words, hospital dues are decreasing at a much slower rate than Consulting and Payroll spend is increasing.

Lastly, PHM spend as a percent of Payroll and Consulting spend has decreased roughly 53% since 2018, 264% to 124% **(Graph 9** in Appendix). This negative trend shows that OCV is spending even less on PHM relative to Payroll and Consulting.

In sum, we conclude that Payroll and Consulting spend has increased substantially in both absolute terms and relative terms. This is concerning in and of itself – as it is at best unclear

[12] One possible explanation of this fact is BCBSVT's cessation of its participation in OCV programs and the expected lag in "rights sizing" staff. While this explanation is likely reasonable, it ignores a deeper question. Namely, why was OCV unable to demonstrate value to BCBSVT which would presumably lead to its continued participation in OCV? On a more practical level, it is unclear to us what, if any, consequences senior management has faced due to this failure or how OCV plans to remedy the issue that BCBSVT's departure made apparent. Considering steadily decreasing PHM spend, explicating the value proposition of participation seems particularly complicated.

[13] As we state about normalizing PHM spend by hospital dues, it appears that OneCare has sources of revenue other than hospital dues. Given this, PHM and Payroll and Consulting spend in a given year will not, when summed, be equal to 100%.

what benefits there are to Vermonters from rising and substantial investments in consultants – but it is particularly alarming in context of decreasing PHM spend over time.

III. Data Analytics

OneCare's transition from CareNavigator to the UVMHN-administered Arcadia platform raises three interrelated issues. First, moving from in-house data analytics to analytics-as-a-service from UVMHN raises the specter of self-dealing. Such concerns are only heightened when the subsidiary already contracts with the parent for employees, services, and various goods, and there is minimal anti-trust oversight of OCV.

Second, the further financial entanglement of UVMHN, the dominant market participant for medical services in the state, and OCV, the sole non-Medicare-only ACO in the state, argues in favor of more extensive anti-trust oversight to ensure that OCV and UVMHN are not unreasonably constraining market competition to the detriment of consumers.

Lastly, we remain concerned that the benefits and purpose of the Arcadia platform are vague and that there are inadequate systems in place to measure whether UVMHN and OCV are delivering actionable intelligence to ACO participating providers. While it is proper for OCV to transition out of CareNavigator due to demonstrated system inefficiencies, it concerns us that the need for this transition took nearly seven years to identify. OCV should implement systems that let it evaluate whether the Arcadia platform can be used to meet the analytic needs of participating providers in a timely manner. Similarly, OCV should create feedback loops to ensure that the data needs of all participants are met, and not just those of a large participant like UVMMC, whose needs for actionable intelligence may not be the same as for a CAH or small independent practice.

The statements of participants in the Act 167 listening sessions highlight the importance of such feedback loops to ensure the analytic needs of small providers are met. As some providers and community members said clearly during these sessions, Vermonters are tired of having the same needs and care barriers retabulated using new and expensive analytical tools that are detached from the purpose of care. Providers do not want to be data entry clerks for OCV. They want actionable intelligence that leads to better care. So do their patients.

With these concerns in mind, the HCA provides three recommendations to the GMCB.

Recommendations to the Board

1. Request that the Board reduce OneCare's purchased services line by 50% (currently $4,327,955) and evenly reallocate these funds to non-hospital owned, independent PCPs to improve primary care. The HCA believes such a change is warranted because a) OneCare has not provided evidence of why this amount is needed b) there Is substantial evidence that independent PCPs provide high quality care at comparatively lower cost[14] and c) Vermont has historically underinvested in primary care compared to the rest of the country.[15]
2. Request that the GMCB and its staff conduct a comparative analysis of return on investment of OCV's activities to non-Chittenden County based HSAs compared to the Chittenden County HSA.
3. Request that the GMCB and its staff conduct an analysis of OneCare's impact on affordability, health outcomes, and access to help inform whether OCV merits inclusion in any future APM agreement

Thank you,

The HCA Policy Team

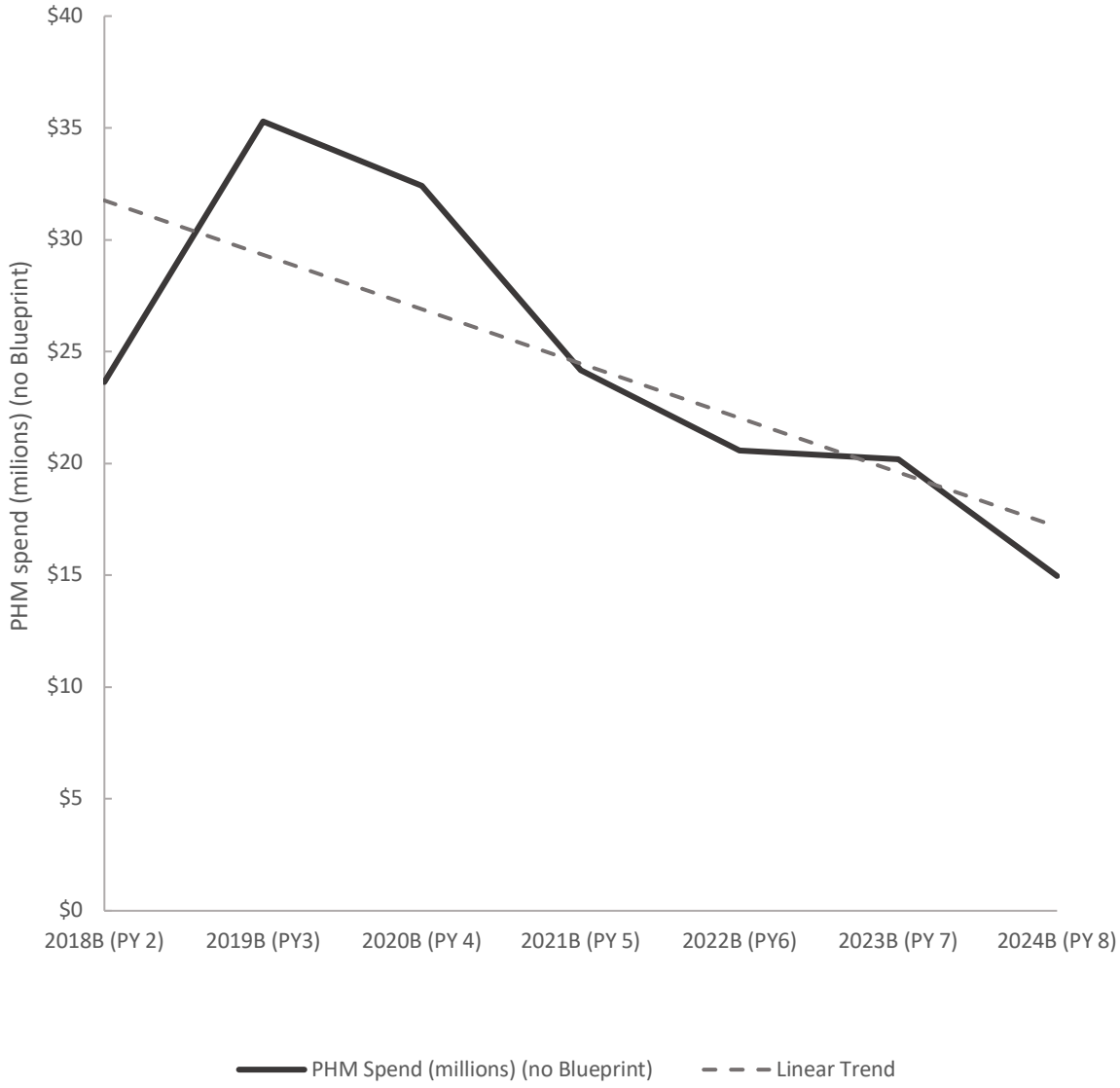
s\ Mike Fisher, Chief Health Care Advocate
s\ Sam Peisch, Health Policy Analyst
s\ Charles Becker, Staff Attorney
s\ Eric Schultheis, Staff Attorney

[14] E.g., James Robinson & Kelly Miller, Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California, 312 JAMA 1611, 1663–1669 (2014); Lawrence Casalino et al., Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions, 33 Health Affairs 1502, 1680–1688 (2014); Michael McWilliams et al., Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries, 173 JAMA Internal Med. 1389, 1447–1456 (2013).

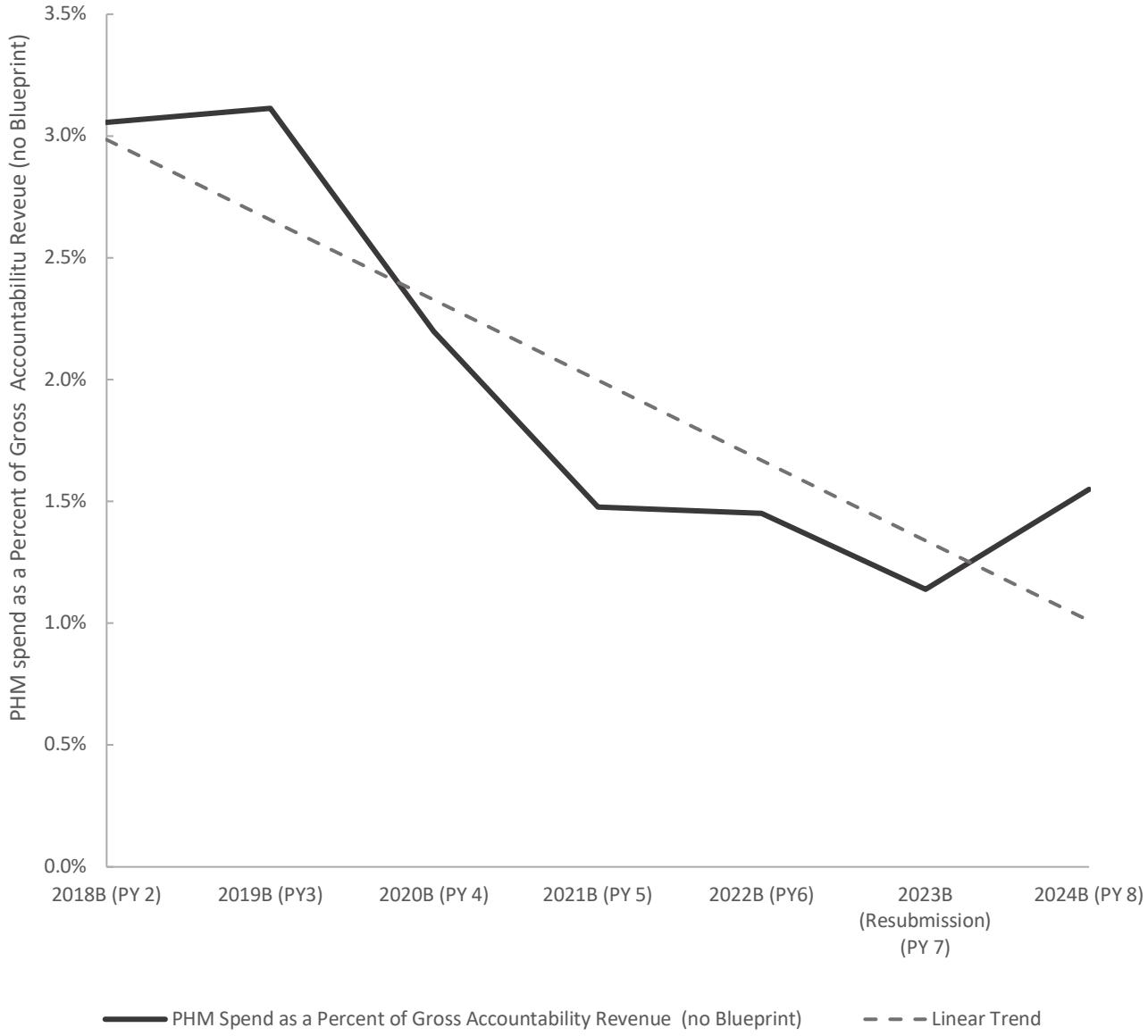
[15] Green Mountain Care Board, Nov. 30, 2023, Presentation to the Health Reform Oversight Cmte., Slide 16, https://ljfo.vermont.gov/assets/Meetings/Health-Reform-Oversight-Committee/2023-11-30/14cefccead/GMCB-Slides-HROC-11.30.2023.pdf.

Appendix

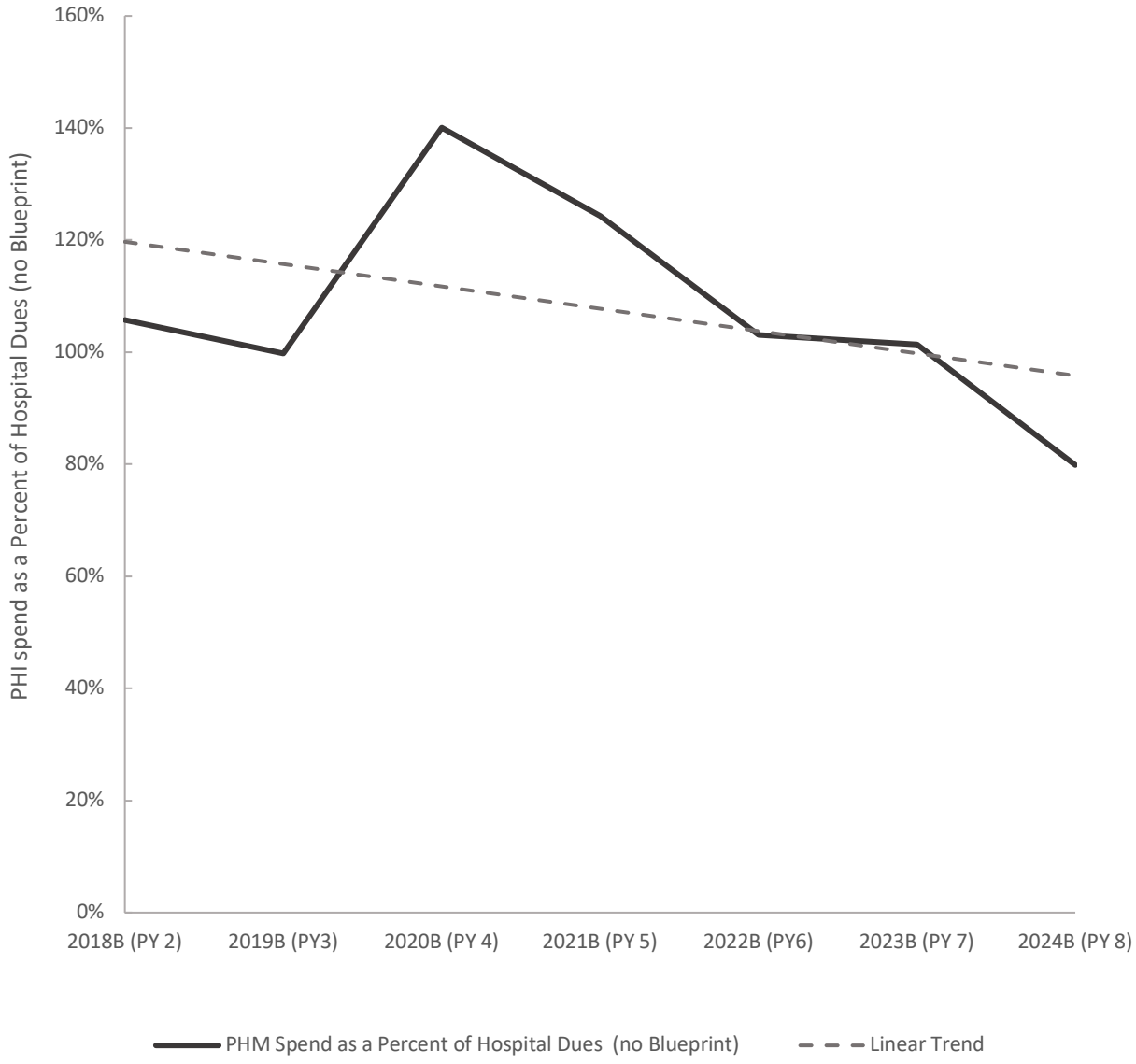
Graph 1. PHM spend (in millions of real 2023 dollars) (no Blueprint).



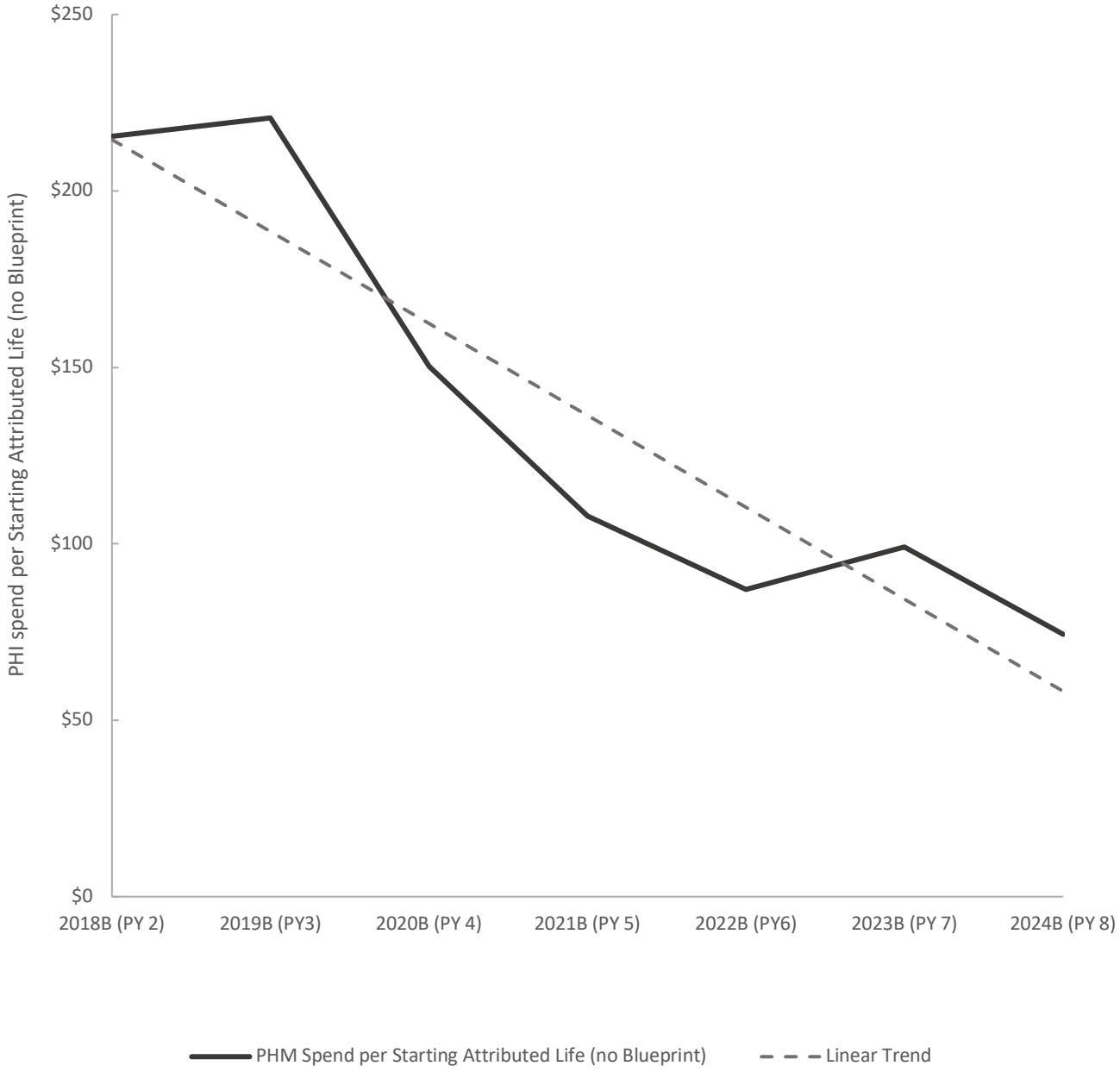
Graph 2. PHM as a percent of gross accountability revenue (in real 2023 dollars) (no Blueprint).



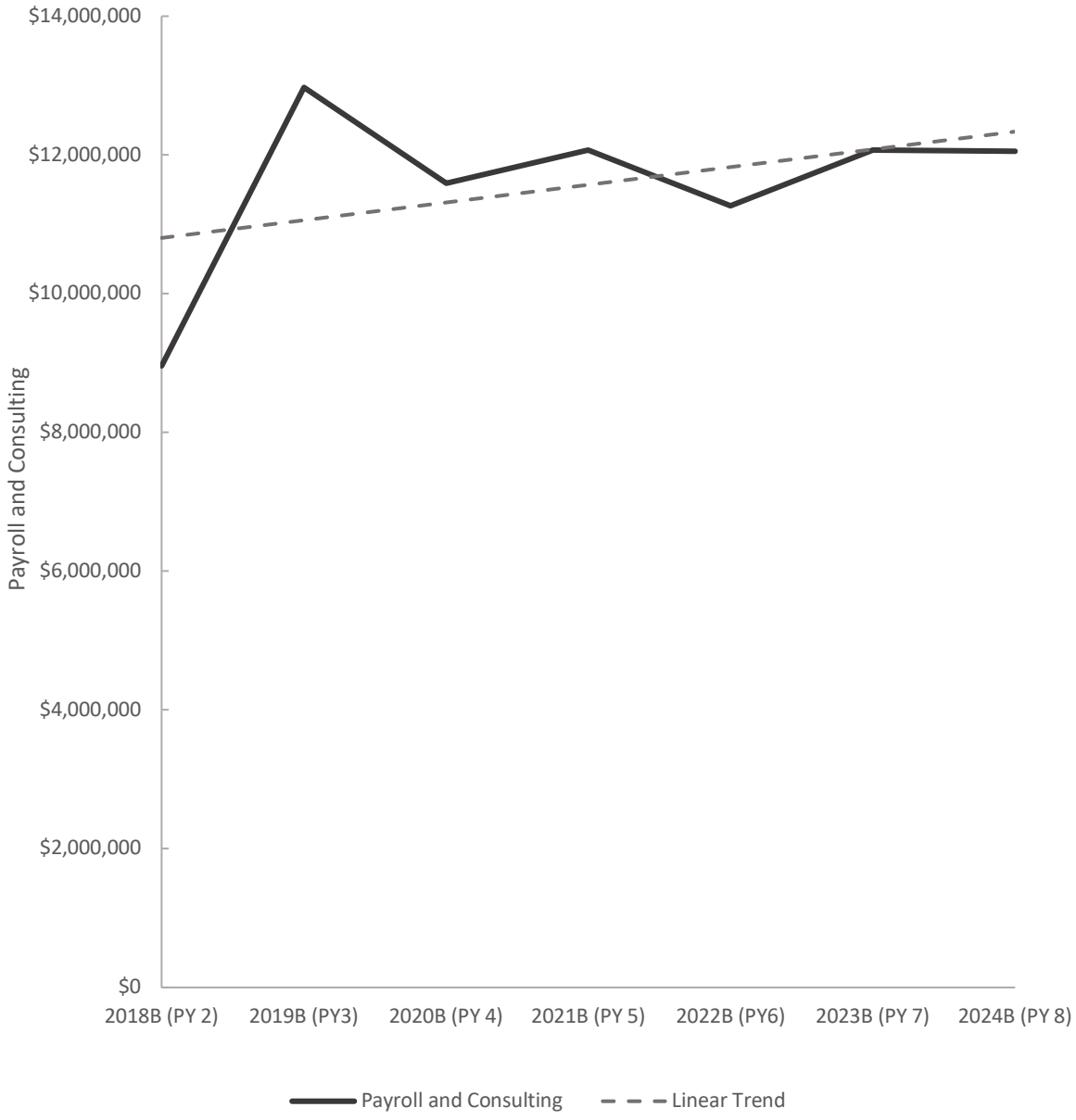
Graph 3. PHM spend as a percent of hospital dues (in real 2023 dollars) (no Blueprint).



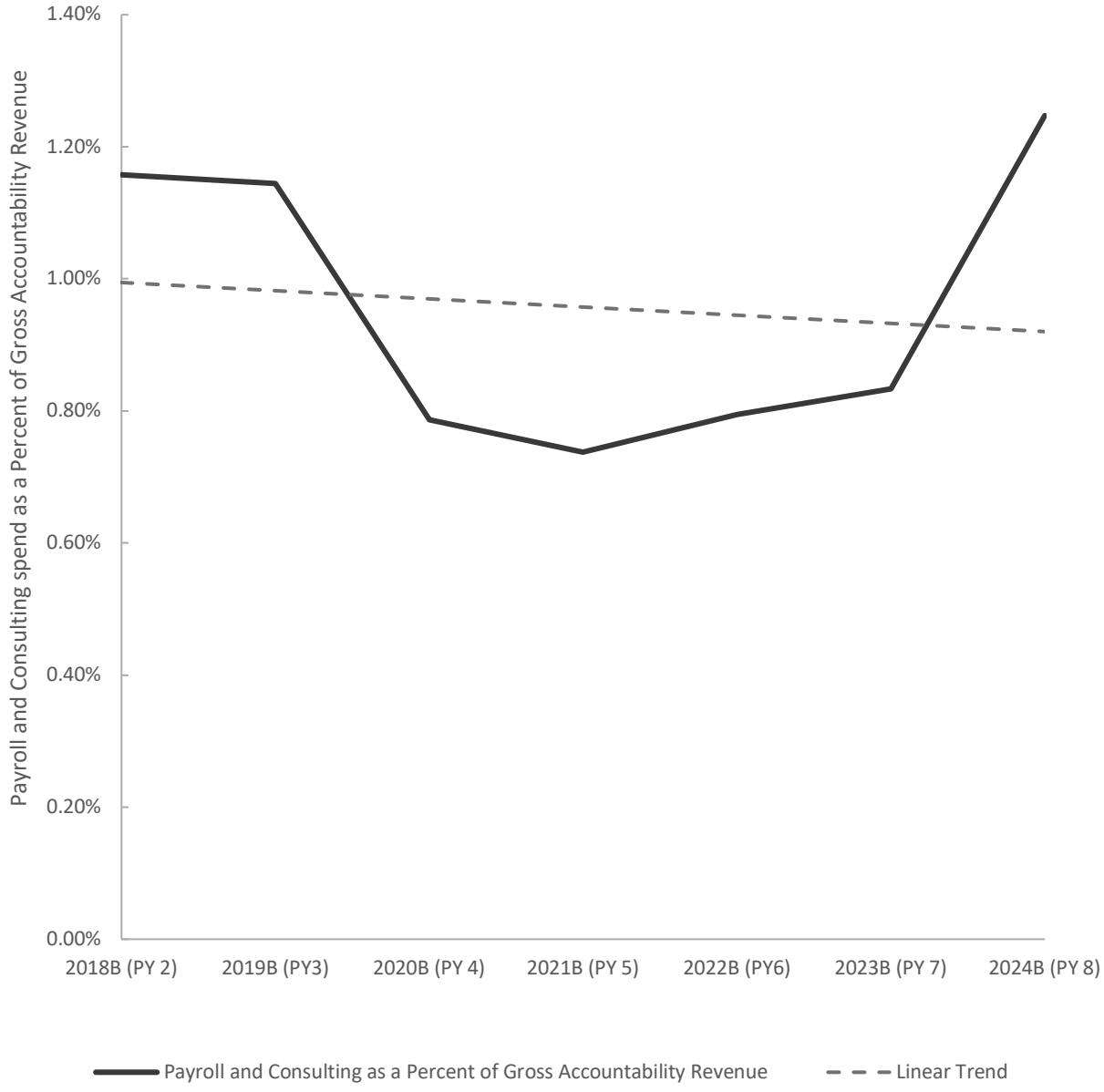
Graph 4. PHM spend per starting attributed life (in real 2023 dollars) (no Blueprint).



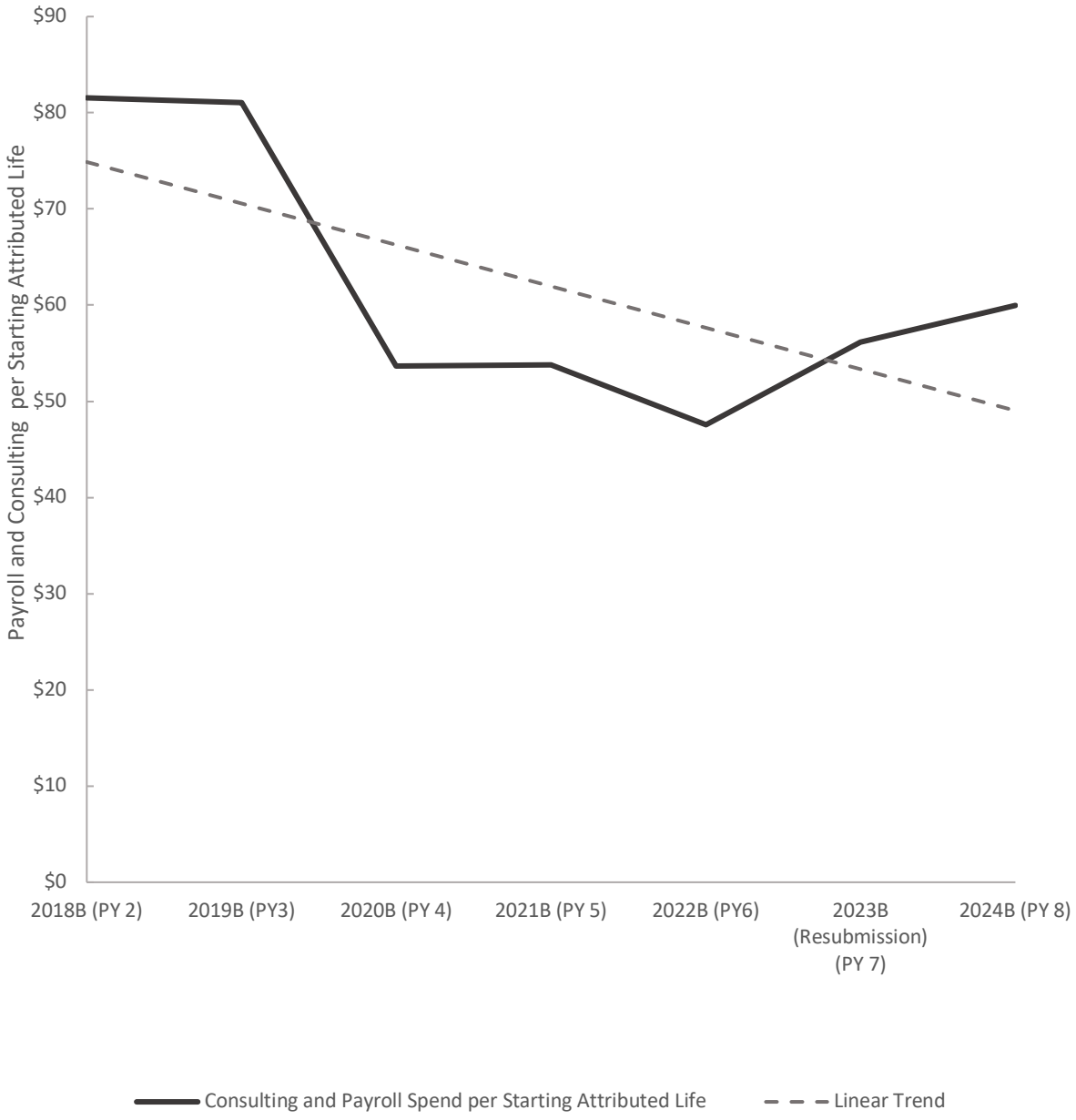
Graph 5. Payroll and Consulting spend (in real 2023 dollars).



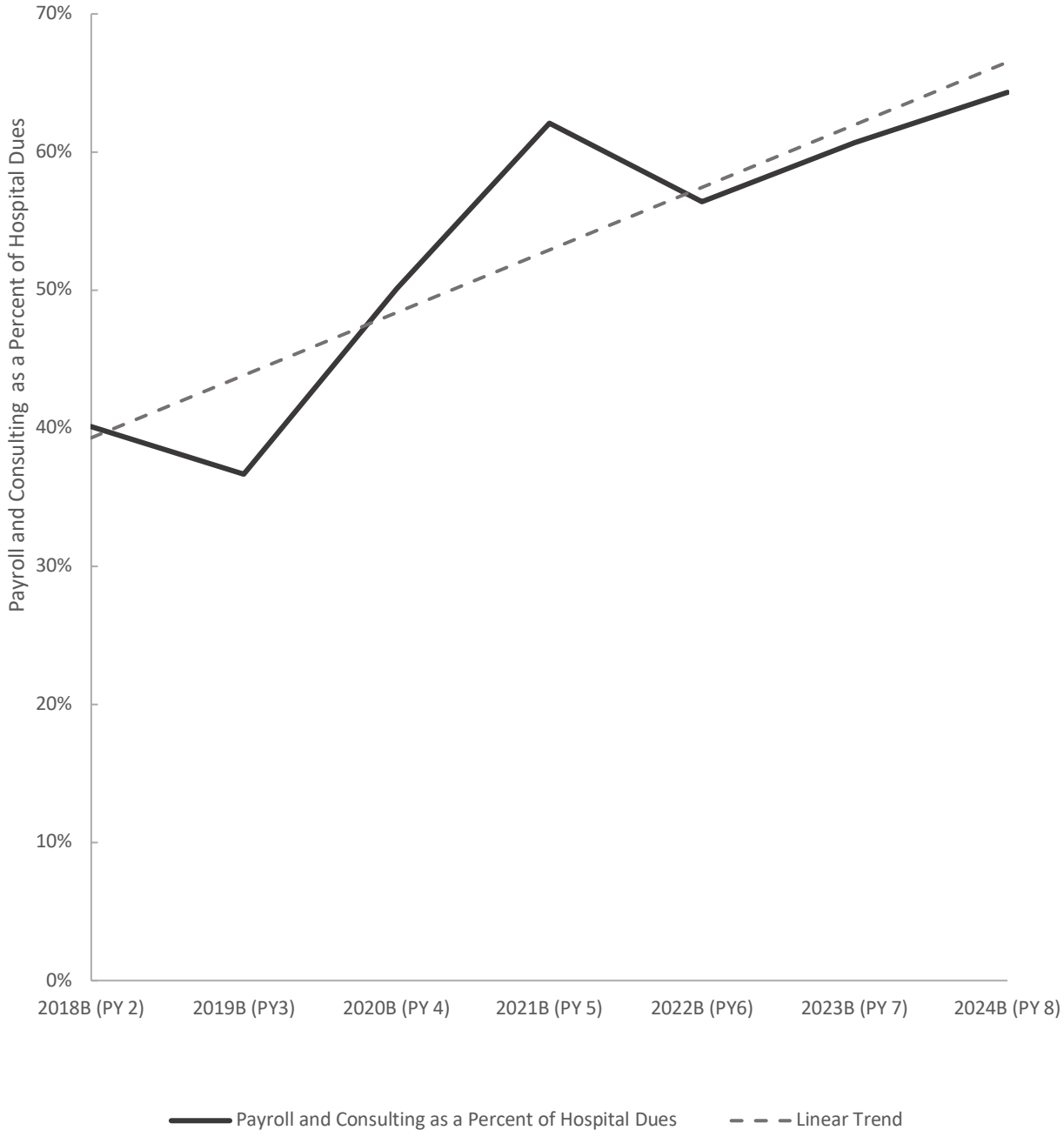
Graph 6. Payroll and Consulting spend as a percent of gross accountability revenue (in real 2023 dollars).



Graph 7. Payroll and Consulting spend per starting attributed life (in real 2023 dollars).



Graph 8. Payroll and Consulting spend as a percent of hospital dues (in real 2023 dollars).



Graph 9. PHM spend as a percent of Payroll and Consulting spend (no Blueprint) (in real 2023 dollars).