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November 29, 2022

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

RE: HCA Comments on FY2023 OneCare Budget Submission

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

The Office of the Health Care Advocate (HCA) is charged with representing Vermonters in health care matters, including before the Green Mountain Care Board (GMCB or Board).[1] In that capacity, we submit the following comments on OneCare Vermont (OCV)'s 2023 Accountable Care Organization (ACO) budget submission. During this year's budget cycle, we met regularly with the GMCB ACO Budget staff to provide feedback on the budget guidance documents, review information, and discuss questions and concerns about OCV's budget submission. We submitted pre-hearing written questions to OCV and met with members of their leadership team. We also met with OCV's Patient and Family Advisory Committee. The HCA thanks GMCB ACO Budget staff, OCV leadership, and OCV's Patient and Family Advisory Committee for participating in these informative meetings. Below we provide comments on two areas of concern related to OCV's FY2023 budget submission: 1) OCV's deepening ties to the University of Vermont Health Network (UVMHN) and 2) OCV's continued lack of demonstrated benefit to Vermonters and the state. The HCA also provides concrete recommendations to the Board in accordance with established statutes and rules.

OCV's Deepening Ties with UVMHN

The HCA believes that the substantial and growing ties between OCV and UVMHN risks undermining the effectiveness of Vermont's All-Payer Model (APM). When it became known that OCV intended to outsource its data analytics functionality to UVMHN, we requested that OCV share the contract with the HCA and the GMCB. GMCB ACO Budget staff made similar requests. Although the contract was executed on October 28th, 2022, OCV did not provide a copy of it until November 15th, six days after the budget hearing. Regardless of the reason for the delay,[2] the effect was to deny the Board, the HCA, and the public the opportunity to ask OCV witnesses foundational questions about the contract and OCV's deepening ties to UVMHN.

[1] 18 V.S.A. § 9601

[2] At the November 9th budget hearing, OCV cited the need to redact confidential information as the reason for the delay. However, Board Rule 5.106 allows entities to share confidential with the Board and the HCA. Subsequently, in a November 15th cover letter to the Board, OCV clarified that the need to revise and re-execute a portion of the contract caused the delay.

Now that we have reviewed the contract and related exhibits, it is even more clear why it would have been valuable to have been able to ask OCV questions about it in a public hearing. Provisions of the contract will be discussed generally to protect confidential information, but what is clear is that the arrangements are complex, involve large sums of money, and the protected health information of nearly 300,000 people. The contract is financially lucrative to UVMHN and further concentrates technical resources within their network. It is unclear if or how Vermonters and other ACO members stand to benefit. The contract fails to demonstrate how planned data and analytics efforts would tell the state anything more than we already know about the pressing health care issues facing the state and Vermont families. It bears noting that Vermont already has substantial depth and breadth of data on these issues through, among others, the GMCB, Department of Health, Program for Quality in Health Care, and the Agency of Human Services, as well as databases such as the All-Payer Claims Database and Health Information Exchange.

Fundamental to the contract is OCV's assurance of a firewall between ACO data and UVMHN. However, we remain concerned that the contract could permit UVMHN to leverage state-wide ACO data to secure competitive advantages, particularly in the Medicare Advantage (MA) market. It is in UVMHN's financial interest to increase MA penetration in Vermont because it offers its own MA plan with MVP Health Care. [3] Furthermore, given that UVMHN is the parent organization and OCV is a subsidiary,[4] it remains unclear how ACO-wide data would be handled if OCV is dissolved for any reason in the future. The HCA raises these matters here given that we did not have an opportunity to ask questions in a hearing and the substantial overlap between OCV's increasingly narrow focus on data analytics and UVMHN's recent commitment to investing millions of dollars to create a new Population Health Services Organization.[5] It is with this focus on data that we focus next on the need for objective evaluation of OCV's programs and the importance of achieving benefits for Vermonters.

OCV's Lack of Demonstrated Benefit to Vermonters

Missing from all the data and analytics from OCV is an attempt to measure what tangible benefits they provide to Vermonters. OCV still has not conducted an objective causal analysis of the impact of any of its programs to date. Yet OCV continues to speculate—without evidence—that its programs have had a positive causal impact. To cite several examples:

- Care coordination: "Several positive outcomes resulted from OneCare's new approach."[6]
- Quality improvement: "Many examples of quality improvement efforts resulting from OneCare's VBIF program were evident when evaluating PY2021."[7]

[3] University of Vermont Health Network. "Welcome to UVM Health Advantage."
[4] OneCare Vermont. "UVM Health Network Becomes Sole Parent Organization of OneCare Vermont." 24 Sept. 2021.
[5] University of Vermont Health Network. "Fiscal Year 2023 Hospital Budget Submissions to the Green Mountain Care Board." Page 8. 1 July 2022.
[6] "OneCare Vermont. FY 2023 Budget Submission Narrative." Page 63. 30 Sept. 2022.
[7] Narrative, 74.

- Cost containment: "Assigning programmatic risk/reward to hospitals provides a direct incentive to support ACO activities that result in overall health care cost containment that would otherwise harm hospital revenue generation."[8]
- Sunset of Care Navigator: "Result[ed] in more clearly focused population interventions and effective panel management which will, in turn, result in improved outcomes within the quadruple aim."[9]

When the HCA or the GMCB has requested that OCV provide evidence to support claims that their programs improve population health outcomes, care coordination for Vermonters, or reduce costs, OCV often deflects and responds that their goal is "not to tie direct causation of OneCare activity to the particular outcome of interest"[10] or that "determining causality resulting from specific OneCare program implementation is a highly complex goal as health care reform efforts are often additive over time and influenced by changes in state policy, resources, and participation."[11] Oral remarks in response to HCA questions at the public hearing confirmed that OCV does not perform causal analysis or seek to establish causality as a part of their work, citing the complexity of the work. Despite clear feedback from Board members and the HCA over the years to focus on monitoring and evaluation, OCV continues to not prioritize this work. Concerningly, OCV's planned analytical efforts (again through a contract with UVM) contain biased directives such as "Which metrics best demonstrate value or potential value of OneCare?"[12] These statements *assume* rather than *evaluate* OCV's value.

The HCA is skeptical about the return on investment for health care reform efforts that do not appear connected in a meaningful way to improving quality, access, and affordability across the state. Despite care coordination being mentioned extensively throughout their narrative, OCV provides care coordination to just over 1% of its attributed patients (3,678 out of 296,658).[13] Board member questioning of OCV in the hearing highlighted that only 5% of patients in the highest risk level and only 6% of high-cost members receive care coordination.[14] In theory, improved care coordination could be a clear deliverable for Vermonters; but OCV has not provided evidence of measurable improvements in this area over any duration. The sunset of CareNavigator—a platform that OCV spent millions of dollars on with little if any demonstrated benefit to providers or consumers—provides another example of what transpires when investments are not properly vetted by rigorous cost/benefit analysis or connected to measurable goals.

For all that Vermonters have invested over five years of the APM,[15] they deserve health care reform efforts that are objectively evaluated and provide tangible value. OCV states on its website that it is a "provider-informed Accountable Care Organization working to improve the

[8] Narrative, 31.
[9] Narrative, 66.
[10] OneCare Vermont. "FY 2023 Budget Responses to Round 1 Questions." Page 15. 8 Nov. 2022.
[11] OneCare Vermont. "FY 2023 Budget Responses to Round 1 Questions." Page 11. 8 Nov. 2022.
[12] Narrative, 53.
[13] Narrative, 65.
[14] OneCare Vermont. "ACO Budget Guidance Workbook." Appendix 7.4 30 Sept. 2022.
[15] Green Mountain Care Board. "Vermont's All-Payer Model."

health of Vermonters and lower health care costs."[16] This declaration, however, contrasts with more cautious and narrow public statements from OCV during the hearing about the nature of their work. Improving the health of Vermonters and lowering costs are laudable goals that Vermonters support. However, OCV must at least *attempt* to evaluate the causal impact of programs on population health outcomes to realize its mission and be accountable to the public. The fact that OCV has not committed to evaluating its causal impact is unacceptable.

Whether the money is filtered through insurers, the state, or hospitals—OCV is spending Vermonters' money. However, unlike insurers, hospitals, and the state, Vermonters do not receive any shared savings if cost benchmarks are achieved. The cost of OCV to the state should always be compared with legitimate potential alternatives. For example, the state could consider leveraging existing partnerships between the state and community organizations, insurers, and providers to build on the Blueprint to implement evidence-based population health investments[17] that are efficient, transparent, and publicly accountable. Absent a genuine shift to evaluating its effectiveness and impact and delivering benefits to Vermonters, OCV risks being perceived as merely a pass-thru entity run by well-paid executives that simply moves money around between payers and providers. If OneCare does not believe it is responsible for or capable of improving population health outcomes, bending the cost curve, or delivering tangible benefits for Vermonters—despite its documented commitments to do so[18,19,20]—then the State should seriously consider whether the benefits of funding OCV exceed the costs.

With these comments in mind, the HCA offers the following concrete recommendations to the GMCB pursuant to their authority established in Vermont's rules and statutes.

Recommendations to the GMCB

1. Require that OCV appear at a narrowly defined hearing with a potential executive session to provide evidence of compliance with Board guidance pertaining to improper sharing of competitively sensitive information.[21] We believe that the OCV and UVMHN data analytics contract presents challenges not generally contemplated by ACO antitrust discussion/regulations. Specifically, existent discussions of prohibited activities center on participating providers using an ACO to enable price fixing.[22] However, the OCV/UVMHN partnership presents the possibility that a participating provider organization and the ACO could exploit sensitive data provided by other participating providers to engage in prohibited behaviors. Given the novelty of the issues that the

[16] OneCare Vermont.
[17] Jones Craig, Finison Karl, McGraves-Lloyd Katharine, Tremblay Timothy, Mohlman Mary Kate, Tanzman Beth, Hazard Miki, Maier Steven, and Samuelson Jenney. "Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care." *Population Health Management* 2016;19:196–205
[18] OneCare Vermont. "Strategic Plan Summary 2021-2023." May 2021.
[19] OneCare Vermont. "Payment Reform." 2022.
[20] OneCare Vermont. "Quality Improvement." 2022.
[21] GMCB Guidance re: Referral of Potential Violations of State or Federal Antitrust Laws to the VT AG, 1, GMCB Guidance re AGO Referrals_05.01.18.pdf (vermont.gov).
[22] See Federal Trade Commission and Department of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organization Participating in the Medicare Shares Saving Program, 76 Fed. Reg. 209,

OCV/UVMHN contract presents, and that the relationship creates antitrust concerns not previously present, we believe the Board should consider whether OCV is compliant with ACO antitrust law. We recommend the Board focus on the question of whether the OCV/UVMHN relationship presents the possibility of anti-competitive behavior, generally, and whether, specifically, there is evidence that the relationship provides "countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs."[23]

2. Make a formal request for UVMHN to respond to Board and HCA questions related to its goals and motivation for pursuing a data and analytics contract with OCV.

3. Create a Request for Proposal (RFP) for an independent entity to conduct an objective causal evaluation of the impact of OCV's programs on population health outcomes and cost containment.

4. Require OCV to develop and present a causal analysis plan to the Board in May 2023 and report on progress in October 2023.

5. If OCV's FY23 Budget is approved, we recommend the following conditions:
    a. Require OCV to refine its contracts to explicitly forbid UVMHN from using ACO-data from participating providers to target Vermonters eligible for their Medicare Advantage plan.
    b. Require OCV to perform an objective cost/benefit analysis to Vermonters of all current and future data analytics contracts.
    c. Require OCV to identify a major population health issue, such as affordability, access, or quality, and develop a clear proposal as to how they intend to provide a tangible benefit to Vermonters under both short-term and long-term timelines established by the Board.

We look forward to working with the Board to improve health care access and affordability for Vermonters. Please contact us at hcapolicystaff@vtlegalaid.org with any questions or concerns.

Thank you,

The HCA Policy Team

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

[23] 18 V.S.A. § 9382.