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TO: Green Mountain Care Board

RE: Comments on the OneCare Vermont All Payer Model 2020 ACO Budget

FROM: Julie Wasserman, MPH

DATE: December 2, 2019

Thank you for the opportunity to comment on the OneCare Vermont All Payer Model 2020 ACO Budget. The following comments focus on four critical areas: ACO Financial Performance, ACO Administrative Costs, ACO Quality Performance, and Primary Care. In summary, ACO cost overruns total $70 million, offset by $5.8 million in savings for the period 2014-2018. Cumulative ACO administrative costs are projected to top $90 million over the course of the All Payer Model. Medicaid and Medicare ACO quality performance are declining, and access to primary care has decreased.

ACO Financial Performance

An important and overarching measure of an Accountable Care Organization (ACO) is financial performance; cost reductions and savings are paramount. OneCare Vermont LLC is Vermont's sole ACO participating in the All Payer ACO Model and began operating as an ACO in 2013. This veteran ACO organization has been serving Medicare, Medicaid and commercially-insured Vermonters since 2014, allowing a 5-year review of its financial performance. Over this period, OneCare has had fifteen opportunities (5 years with 3 payers each year) to demonstrate its financial proficiency.

During the 5-year period, OneCare realized savings only twice: Medicaid in 2014 and 2017 ($5.8M). For the other twelve opportunities, OneCare was either "over budget" or had losses for a combined total of $70M. (2018 Medicare Expected vs Actual TCOC - unavailable.) See table below.

OneCare ACO Financial Performance						
	Shared Savings Programs				All Payer Model	
	2014	2015	2016	2017	2017	2018
Medicaid	Under Budget by $6.8M $3.4M Savings Earned	Over Budget by $1.3M No Savings Earned	Over Budget by $1.5M No Savings Earned		Under Budget by $2.4M $2.4M Savings Earned	Over Budget Loss of $1.5M
Medicare	Over Budget by $4.2M No Savings Earned	Over Budget by $26.9M No Savings Earned	Over Budget by $18.6M No Savings Earned	Over Budget by $4.5M No Savings Earned		
Blue Cross/ Blue Shield	Over Budget by $5.5M No Savings Earned	Over Budget by $3.8M No Savings Earned	Over Budget by $1.9M No Savings Earned	?		Over Budget Loss of $646K

DVHA data for Medicaid 2014-2018. CMS data for Medicare 2014-2017. DVHA data for Blue Cross/Blue Shield 2014-2016. GMCB data for Medicare and Blue Cross/Blue Shield 2018.

Moreover, OneCare is projecting Medicaid losses of $8 million in 2019. In its 2020 ACO Budget deliberations, the Green Mountain Care Board needs to scrutinize and address the cost increases related to this $8 million overage.

With regard to payment reform, the Green Mountain Care Board, DVHA and OneCare frequently remind us that the ACO is changing the way we pay for care. Yet OneCare data show only 6 independent primary care physician practices participating in "fixed payments" for 2020. (*OneCare 2020 Budget, Appendix 2.1*) OneCare's total "fixed payments" comprise only 8% of Vermonters' health care costs. (*OneCare 2020 Budget Presentation, October 30, 2019, slide 12.*)

Given OneCare's financial performance to date, the question Vermonters, Legislators and the Green Mountain Care Board must ask is, "Do we want to entrust our health care system to a corporation whose financial performance is poor and whose payment reforms are minimal?"

ACO Administrative Costs

A second important and overarching measure of success is a comparison of ACO savings with costs. Do savings outweigh the cost of administering this program? Does the ACO pay for itself?

The Green Mountain Care Board (GMCB) wanted to ensure the answer to this question was "yes" so they stipulated in their 2018 Budget Order, "*ACOs should provide a net benefit to the system and we will monitor OneCare's administrative expenses to ensure they are less than the total health care savings generated through the All-Payer ACO Model.*" (GMCB FY18 Accountable Care Organization Budget Order, January 3, 2018.) This assessment of "net benefit" was to be performed yearly, affording oversight and routine corrections, if needed.

However, one year later the GMCB revised this provision; the assessment would occur over the life of the All Payer Agreement and the definition of savings was expanded. "*Over the duration of the agreement, OneCare's administrative expenses should be less than the health care savings, including cost avoidance and the value of improved health, projected to be generated through the Model."* (GMCB FY19 Accountable Care Organization Budget Order, February 5, 2019.) This revision rendered the provision ineffective, and points to a relinquishment of regulatory responsibility. If administrative costs have outpaced savings at the end of the 6-year All Payer Agreement, it will be too late to do anything about it. Given OneCare's poor track record with savings so far, is it realistic or even possible for the ACO to have over $90 million in savings by the end of 2022? (See table below; 2017-2020 data are from OneCare's 2020 Budget.)

All Payer Model	OneCare Administrative Costs
2017	$9M
2018	$11.7M
2019	$15.9M
2020	$19.3M
2021	$19.3M (est) ^
2022	$19.3M (est) ^
TOTAL	**$94.5M (est)^**

^ Estimates use the 2020 cost as a base but the actual amount may be higher.

- OneCare's 2020 Budget requests $19 million in administrative costs, up from almost $16 million in 2019 and approximately $12 million in 2018 (a **65% increase**).
- Salaries and benefits comprise roughly $12 million in OneCare's 2020 Budget request, up from a projected $7.4 million in 2019 (a **58% increase**).
- OneCare's 2020 Budget allocates almost half a million dollars for office space ("Occupancy"), **up 28%** from 2019.
- Clinical Programs comprise only about 20% of OneCare's administrative costs, and the amount allocated in 2020 (roughly $3.9 million) appears to be unchanged from last year (i.e. **no increase**).
- The GMCB asked OneCare in its October 14, 2019 Round 1 List of Questions, "*Why are your Population Health Investments not growing proportionally to your population (**decrease of 4.0% to 3.0%** from 2019 to 2020 after excluding SASH, Blueprint, Community Health Teams)?*" (Bold added.)

OneCare's administrative costs are *in addition to* current administrative costs borne by Medicare, Medicaid and the Commercials. Does the GMCB sanction OneCare's dramatic increases in 2020 administrative costs in the face of flat spending on Clinical Programs and decreases in Population Health Investments?

ACO Quality Performance - 2018

Quality performance is judged by objective measures that are used to evaluate the ACO's quality of care. This evaluation occurs yearly with the expectation that performance will steadily improve. Furthermore, quality performance scores are used to determine incentive payments for participating ACO providers.

Medicaid

DVHA's opening paragraph in its Vermont Medicaid ACO 2018 Performance Report (September 20, 2019) states, "*OneCare and its network of providers agree to focus on increasing the quality of care and moderating the cost of care for these Vermonters.*" Neither happened in 2018. OneCare scored worse on 70% of the Medicaid quality measures, and its costs were $1.5 million over budget.

A primary goal of the All Payer Model is to improve "population health". Two critical measures for improving population health are controlling diabetes and hypertension. However, both of these measures saw declines in 2018. OneCare's 2018 Medicaid Quality Performance scores show a decline from the prior year in 7 of the 10 measures. Declines occurred in the following:

1. Diabetes Mellitus
2. Hypertension: Controlling High Blood Pressure
3. Adolescent Well Care visits
4. Developmental Screening in the First 3 Years of Life
5. Screening for Clinical Depression and Follow-Up Plan
6. Follow Up After an Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days
7. Engagement of Alcohol and Other Drug Dependence Treatment

In defense of these 2018 declines, OneCare stated that given the growth in attributed lives, year over year comparisons cannot be made. If this is the case, what is the point of having performance measures in a program whose yearly growth is projected to reach 70% of all Vermonters by 2022? If performance cannot be compared from one year to the next, what is the point of having "aligned measures" across payers and years, an often stated GMCB goal.

Although OneCare's performance showed improvement in "*Initiation* of Alcohol and Other Drug Dependence Treatment", there were declines in "Follow Up After an Emergency Department Visit for Alcohol and Other Drug Dependence" (#6 above) and "*Engagement* of Alcohol and Other Drug Dependence Treatment" (#7 above). These findings are particularly concerning given the All Payer Model's primary goal of reducing suicides and drug overdose deaths, not to mention Vermont's opioid crisis.

OneCare is a seasoned ACO (established in 2013) and DVHA has required OneCare to meet similar if not identical Medicaid ACO quality performance measures since 2014. The GMCB should require OneCare to submit a plan as part of the 2020 ACO Budget approval process detailing how OneCare will improve its quality performance.

Medicare

The Medicare Quality Performance Score of 100% does not reflect OneCare's 2018 performance. OneCare was awarded full points on all measures (100%) for merely "reporting" the information. OneCare has been evaluated on their performance of similar if not identical Medicare measures since 2013. Because OneCare transitioned from a Medicare Shared Savings ACO Program (2013-2017) to a Medicare Next Generation ACO Program in 2018, OneCare is considered a "new participant in its first year" and is required to simply report the data. Nevertheless, OneCare showed sharp declines from the prior year in: "Access to Specialists", "Health Promotion", "Shared Decision Making", and "Influenza Immunization". OneCare's *actual* 2018 score of 82.4% is a decline from 2017 (87.9%) and a dramatic drop from 2016 (96.88%).

Commercial

The 2018 Blue Cross/Blue Shield QHP Quality Measures show OneCare achieving a performance score of 86.12%, a significant improvement over the prior year's 73.07%. However, OneCare had declines from the prior year in two critical "population health" measures: diabetes and hypertension; plus a high hospital readmission rate (All-Cause Hospital Readmissions).

Primary Care

Vermont's All Payer ACO Model began in 2017 with promises of a high performing Primary Care network that would increase access to care, improve health outcomes, and reduce costs. Expansion of primary care was to be a fundamental and pivotal component of OneCare's ACO efforts, yet evidence is lacking. The number of primary care physicians in Vermont is decreasing (*2018 Physician Census*, Vermont Department of Health, October 2019); primary care practices are full and not taking new patients; OneCare's Dashboard Data on Medicaid ACO enrollees for the 3-year period 2016 through 2018 show a *decline* in Primary Care Physician Office Visits for both adults and children (*OneCare Board Meeting Materials, February 2019*); and OneCare's 2020 Budget makes no mention of addressing the dearth of primary care practitioners.

Impending retirements will exacerbate Vermont's current shortage of primary care physicians. (*2018 Physician Census*) The GMCB needs to condition its approval of OneCare's 2020 Budget on the submission of a detailed implementation plan to improve and increase access to primary care.

Conclusion

The Green Mountain Care Board needs to account for and directly address in its 2020 ACO Budget decision the ACO's historically poor financial performance, the ACO's inability to provide a net benefit to the system (savings need to outweigh administrative costs), the ACO's declining performance on Medicaid and Medicare quality measures, and the decreasing access to primary care.