March 26, 2021

Susan Barrett, Executive Director, GMCB
Alena Berube, Director of Health Systems Policy, GMCB
Ena Backus, Director of Health Care Reform, State of Vermont

Dear Ms. Barrett, Ms. Berube and Ms. Backus:

As a member of the Green Mountain Care Board Advisory Committee, I am writing to provide feedback on the All Payer Model (APM), specifically with regard to the negotiation for a new agreement. We were asked to discuss what is currently working in the model, and whether and/or how the State of Vermont should proceed to enhance health care reform efforts. The current model falls short of its goals and should not be renewed without significant changes that strengthen and expand primary care and improve healthcare costs and access for Vermonters.

To assess how the model is working, I found it interesting to review the description of the All Payer Model on the GMCB website. As stated, if successful, the All Payer Model should reduce the cost of care, improve the quality of care, and improve the health of the population, all on a foundation of enhanced preventive (i.e. primary) care. To date, there have been minimal improvements in these areas despite the significant shift of financial resources to the ACO. The money would be better spent on primary care where there is ample evidence that investments result in a long-term decrease in medical costs[1].

The APM description also suggests that the majority of patients are operating in a capitated system, whereby the practice or provider is receiving an adequate per-member per-month (PMPM) payment that allows them to drastically change or improve their model of provider care. Only 6 of our 26 (23%) primary care practices are part of this capitated system. This is partly because the capitated rate would cause many of our practices to lose money, threatening their viability. In addition, many smaller practices lack the office staff or resources to invest in the ACO without a tangible return.

For practices that are participating, approximately 30% of patients are eligible, while the other 70% remains in a fee-for-service (FFS) system. Additionally, while there were initial incentives to enroll in the pilot version of the program, those financial incentives have gradually decreased so that the program may now be financially detrimental to many practices. The end result is that there are very few, if any, practices who are able to make any structural changes in the way they provide care. Real change is unlikely unless at least 65% of a practice's patient panel is included in a model. Our current model is unlikely to get there as there is little to entice self-insured employees to sign on.

Many primary care providers (PCP) were hopeful that the APM, with its stated goal of enhanced primary care, would increase funding to primary care at a level commensurate with its value. While there have been small increases in funding through the care management payment, primary care continues to be grossly underfunded. Independent primary care practices are particularly challenged as payor reimbursements are their only source of income.

Commercial rates have been stagnant for years and there is no ability to negotiate. Medicaid reimbursements are insufficient and, in fact have decreased for primary care. This is particularly challenging for practices with high Medicaid populations, which includes all our pediatric practices. The All Payer Model does not address any of these financial

[1] Jabbarpour Y et al. Investing in Primary Care: A State-level Analysis. Robert Graham Center. July 2019. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

concerns. In fact, the model actually compounded the problem when it put a portion of practices' upfront payments at risk and tied to factors largely out of their control. There must be a sufficient PMPM floor that practices can rely on to sustain their practices that is not at risk. Primary care practices currently do not receive PMPM levels that are high enough to permit risk without jeopardizing practice viability. Each of these challenges has resulted in a decline in the number of independent primary care practices (we've lost 15 since 2015, most in rural areas). Continued loss of the independent practices will further increase cost and decrease access for Vermonters. Any model that aims to control healthcare costs should be supporting and embracing these high value options.

With regard to cost and quality, our independent practices demonstrated through our previous ACO that they routinely provided high quality, lower cost care than hospital-owned practices.[2] Studies have demonstrated time and again that when a hospital acquires an independent practice, health care costs increase and health care quality decreases[3][4]. As such, it is imperative that independent practices continue to be a key player in meeting the stated goals of lower costs and higher quality.

In addition, we strongly championed the opening of the Green Mountain Surgery Center (GMSC), which offers a high quality, lower cost alternative to a costly hospital visit for many patients. Such centers align with the stated goal of ensuring that Vermonters are provided "the right care, at the right place, at the right time". It seems that a system with a stated goal of improving quality and reducing cost would strongly support this independent system. To date, that support has been largely absent. If the model did support such lower cost networks, it's likely that more self-insured employers would be interested in joining, as they would be able to pay less for healthcare.

One area that the APM has succeeded is in the enhancement and standardization of care coordination. This was care that many PCP practices had already been providing but in a more informal manner. The incentive payments for practices to hire care coordinators have helped many PCP's to be able to provide this care coordination for Vermonters at highest risk. However, the required documentation tool provides little to no benefit while increasing the workload of the care coordinator, resulting in decreased efficiency.

As the State of Vermont looks to negotiate another waiver, it is paramount that it reviews its own stated goals of the higher quality, lower cost and improved population health, and determine what structural supports are needed. As stated above, we believe the following is needed in any model.

1. Increase payments to primary care. For health care reform to truly change the way care is delivered, there needs to be a substantial increase in primary care funding. In addition to supporting existing primary care practices, reform efforts need to directly address the worsening primary care provider shortage and use aggressive and creative strategies to entice more primary care providers to join their ranks.

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[2] Vermont's ACO Shared Savings Programs: Results and Lessons Learned 2014-2016. Green Mountain Care Board. December 2017. https://gmcboard.vermont.gov/sites/gmcb/files/FINAL%20Year%203%20Shared%20Savings%20Program%20Results%2012%2019%202017%20to%20GMCB%20FINAL_DVHA%20update.pdf

[3] Capps C, Dranove D, Ody C. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending. Institute for Policy Research Northwestern University. February 2015 https://www.ipr.northwestern.edu/documents/working-papers/2015/IPR-WP-15-02.pdf

[4] Short MN, Ho V. Weighing the effects of vertical integration versus market concentration on hospital quality. Published online February 2019. https://journals.sagepub.com/doi/full/10.1177/1077558719828938

2. Support lower cost sites of care such as independent practices. Any model that wants to reduce cost, improve quality, and ensure access needs to include and support independent health care providers.

3. Include a Return on Investment (ROI) analysis when evaluating the success of the APM. We've seen reports on performance on Total Cost of Care, scale targets, quality measures and shared savings but nothing seems to consider the savings/perceived benefits relative to the cost of the program. To not include such an analysis almost ensures that Vermonters won't get their money's worth out of the program.

4. Improve quality reporting to practices. Practices need to be aware of their own performance on quality measures. While measures can be uniform across the health service area or State, actionable quality data should be reported regularly to practices so that they can target quality improvement efforts.

5. Listen to consumers. Legislators and the GMCB should hear not only from practices and health care systems, but from employers and consumers who are shouldering the burden of insurance premiums and high deductibles.

In summary, the performance to date of the current healthcare reform falls short of its stated goals and we do not believe the State should move forward with the model without significant changes. Vermonters will not gauge the success of healthcare reform efforts by a cost growth trend of 0.1% less than the national trend. Rather, success will be evaluated on an increased ability to see their primary care provider when needed, a decrease in their insurance premiums, or a reduction in their out-of-pocket medical costs. If we are unable to achieve those goals with the current program, then it is time to look at alternative models of reform.

Respectfully,

Rick Dooley, PA-C
Clinical Network Director, HealthFirst

From: Allison Ebrahimi
Sent: Tuesday, February 23, 2021 6:29 PM
To: Barrett, Susan <Susan.Barrett@vermont.gov>; Berube, Alena <Alena.Berube@vermont.gov>
Subject: Feedback requested for All-Payer Model

Dear Susan and Alena,

Hope this email finds you both well. Please kindly find below my contributions to the conversation as requested:

Though I will admit I don't quite have much insight into the All-Payer Model as a healthcare provider, I would like to mention one omission I have not seen addressed: dental care and mental health, specifically inpatient psychiatric care. These are both critical for health and in short supply in Vermont, yet seem to be consistently siloed and excluded from the conversation.

Happy to discuss if you have any questions!

Warmest regards,
Allison Ebrahimi Gold

Sharon Gutwin
March 26, 2021

I am getting back to you with some feedback that was requested of the advisory board regarding Vermont health care reform efforts.

1. While intent to improve health outcomes and reduce expense continues to be the focus of reform, I see little change in either. The time frame in which the Vermont All Payer ACO program is given to collect evidence of success is drawing to a close, unless opportunity for an extension is granted.

2. To date, what I observe is reform in payment structure for basically the same care as patients have seen in pre-ACO times. I do not observe significant change in the systems of preventative care.

3. Effective preventative care is the key to both health care outcomes and cost savings.

4. Relying on the same or similar systems of care, but paying with a different methodology, has not shown to be significantly productive in health care reform. It was imagined that if MDs were to be paid a lump sum vs. fee for service, that they would change the system(s) of care, but that has not happened to any significant degree.

5. There is an abundant research showing how effective nutrition and exercise is in treating all chronic disease. In fact, a person can reverse chronic disease and in many cases cure disease if they are effectively treated with food and exercise as medicine. The earlier chronic disease is treated, the greater the success.

6. The challenge is having primary care providers respect and implement nutrition and exercise in treating chronic disease and insurers reimburse it. Both the physician and the patient have to "buy into the truth of the matter". Patients are resistant to taking ownership of their health and physicians too often simply rely on drugs to treat symptoms. There is an unhealthy codependency between doctors and patients. Both want to do and be better, but lack connection to effective programs. It is easier for MDs to prescribe and patients to take pills...and insurance pays for it. There is little incentive to make change.

7. An effective programing to treat chronic disease and that insurance will reimburse in lacking. I thought I was close to starting up a pilot with BCBS, but they pulled out at the last minute citing other interests. Insurers must get behind innovative solutions in chronic disease.

8. Research shows and I have found that it takes 6-12 months to effect lasting change in a person. The program I created involved three parts that every patient participated in...exercise, nutrition and mental/behavioral care. Visits with medical professionals are for the initial evaluation, program set up and monthly re-evals to guide the progression of the program. The brunt of the work being between the patient and health coach - onsite - in the gym. Visits to the gym are on the patient's own schedule, but a minimum of 3 days a week. A coach would be onsite to motivate, answer questions and assist as needed. The coach's main role is simply to hold the patient accountable. Visits by telemedicine incorporated when a person can not make it into the gym.
The intent of the pilot was to demonstrate the system of care effective and outcomes successful, to then implement statewide.

9. In an ACO model, an effective integrative health program to treat chronic disease by empowering the patient in healthy behaviors is key to cutting down the need for primary care office time and resources in management of the large volume of chronic care patients.

10. Emphasis in health care reform must be both on systems of care and payments for there to be success.

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Submitted on Tue, 03/23/2021 - 11:15

Name
David M Sichel

Town/City
Barre

Topic
Accountable Care Organization

Comment
Vermont All Payer ACO Model
Thoughts and Comments from David Sichel
David Sichel is a member of the GMCB Advisory Committee
March 22, 2021

Some History
When considering changes to the All Payer ACO model it is important to remember where we came from in managing health care system costs. During the 1980-90's health insurance rates in Vermont regularly saw double digit annual health insurance rate increases. When I worked at the Vermont League of Cities and Towns member municipalities breathed a sigh of relief if the Health Trust rate increases were under 10%. At that time, the Health Trust rate increases, while often in double digits were less that the insurance company health trends. Today we wring our hands if annual rate increases are in the mid-single digits.

Health insurance deductibles and co-pays have gone up dramatically. It is important to remember that so has medical inflation. Many high deductible plans do have subscribers paying a larger portion of health care costs, if they have medical high needs. Other plans, such as the Health Exchange Platinum and Gold plans have subscriber co-pays and deductibles that have remained relatively static, while health care costs have gone up dramatically. A ten-dollar primary care co-pay twenty-five years ago paid a much bigger percentage of the cost of the visit than it does today.

Many heath system users and providers do not like care management, cost control measures and system accountability, such as outcome-based payments. This was true during the height of HMO systems and it continues to be true today. While sometimes mis-directed and taken to extremes (Health insurance companies are often penny wise and pound foolish in their health plan designs and rules.), some form of coherent management strategy is necessary to improve outcomes and control costs.

While many might disagree, I think Vermont has a much better handle on managing the increase in health care costs than it did 10 years ago. This is in large part to the reform processes that are currently under way.

Expectations
An all Payer ACO model will not solve all of the challenges of Vermont's health care system. It is a framework that reimagines how heath care services are delivered and paid for. For this to be successful the manner of paying for health services must be aligned to the goals of a better managed health care system with better outcomes.

• This is a long-term process. It will not come without mistakes and missteps being made.
• A single payer system is also an all-payer system because there is only one payer.
• A single payer system will fail if the payer does not insist on better outcomes. It will fail if it does not move away from fee for service payments. Solely lowering provider fees and eliminating insurance companies will not lead to better quality or outcomes. This is sometimes forgotten by proponents of this system. This accountability will be demanded by the taxpayers that support the system. The single payer entity becomes the insurance company and over time will begin to act like an insurance company in many ways.

Measuring outcomes and service quality incurs administrative costs. Many do not understand this. While there are excessive administrative costs in the health care system, I do not think they are as large as many believe. Yes, I do agree that dealing with health insurance payment issues can be frustrating, time consuming and often should be unnecessary (again arising from poor policy design), that is not the only administrative cost. Much of the administrative costs are tied up in recording and measuring services and outcomes. Ensuring better outcomes will require rules and algorithms to assure quality care is provided. Some practitioners will not like this and will push back.

Needs Going Forward
We need to get more people in the system. This should be a priority of the ACO going forward. Without a large percentage of Vermonters in the system it will be difficult to achieve population health goals laid out in the ACO plan.

The all payer ACO is difficult for people to understand and appreciate. Health plan design must be aligned with the ACO system. This means moving cost sharing away from fee for service-based payments. This is complicated by ability to pay issues. How can health system users understand the ACO model if they still pay fee for service-based deductibles and co-pays? I believe this is a major stumbling block that has not been adequately addressed. Why can't health system users benefit from the efficiencies and improved outcomes that can be provided by the ACO model?

Many state legislators do not understand the ACO model. Legislative champions are needed! The State Auditor seems to be focusing on the wrong things in its review of the ACO model. There is too much politics being inserted into the process.

Preventative care and lifestyle issues must be addressed in the ACO going forward. More must be invested here. I think "boots on the ground" provision of screening and services will be necessary. It would be nice, though challenging, to determine the return-on-investment for these programs. The ROI must determine both soft and hard numbers.

Employers have been neglected in the ACO process. This seems odd to me because employers pay a sizable amount of health insurance costs in the state. They also make decisions about the types of health plans offered to employees. Employees spend a significant part of their waking hours engaged with their employer. They typically spend much of their time at the employer's place of business (at least before COVID) or work sites. There is a large opportunity to engage employers in the process. This can include help with changing health insurance plan design and incentives. It is also a point of access for health and wellness programs for employees and their families. I think it is about time this system gap be addressed.

Big data has a major role to play in improving health system outcomes. While not directly a function of

the ACO, the scale of the ACO should make improving use of big data capabilities throughout the health care system more feasible. This includes, among other things, determining which treatments result in the best outcomes, improved diagnosis and treatment of less common illnesses and diseases, cost effectiveness of various treatments and pharmaceutical usage, success of population health and wellness initiatives, return on investment.

Care coordination must be enhanced and expanded. This is one way to directly reduce unnecessary testing, care, prescription drug usage to assure the best and most effective treatment for each patient.

The role of health providers will need to be reimagined. More use of nurse practitioners and such. Use each medical provider to best and highest function. The ACO is in a unique position to develop and implement these changes. The same can be said for the hospital system in Vermont.

Perhaps more tele-health for some services can be utilized. Perhaps some specialist consultation services can be provided by tele-health. The ACO would be a good place to develop best use practices within the Vermont health care system. Can it improve efficiencies and outcomes in the system?

While these are not specific detailed suggestions for the ACO renewal they are my thoughts on bigger picture changes needed to move forward. It is important to keep an eye on the big picture and measure how specific proposed changes will move the broad agenda forward.

While it is important to set ambitious goals, it is also important not to over promise. It is also important to understand that going back to the way we used to do things is not an option. That is how we got to where we are today.