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December 9, 2019

Kevin Mullin
Chair, Green Mountain Care Board
144 State Street
Montpelier, VT 05602

RE: 2020 OneCare Budget Submission

To: Chair Mullin and Members of the Green Mountain Care Board
Green Mountain Care Board ACO Budget Staff

Thank you for considering the Office of the Health Care Advocate (HCA)'s comments on OneCare Vermont (OneCare)'s 2020 Accountable Care Organization (ACO) Budget submission. In our capacity representing Vermonters, we have met monthly over the last few months with Green Mountain Care Board (Board)'s ACO Budget staff to review information and discuss the HCA's concerns and questions about the ACO budget process. The HCA has submitted two sets of written questions to OneCare, and met with OneCare in person on November 8, 2019. We additionally met with Board staff to share our thoughts on OneCare's budget in anticipation of the Board's staff recommendation. We thank Board staff and OneCare for taking the time for these meetings, which we have found to be helpful and productive. This document memorializes the comments we have previously shared with Board staff.

As our office has repeatedly stated, Vermont is in a health care affordability crisis. Vermont's all payer model is an ambitious attempt to curb this affordability crisis while maintaining quality care. Yet, the affordability barrier many Vermonters face represents a significant risk to the all payer model's success.

We appreciate that Vermont was courageous to try a novel health reform approach in an attempt to improve the state's health care system. Given that this important model is untested, Vermont must proceed cautiously and purposefully to give it the best chance of success. As Vermont approaches the third year of this five year model, it is critical for the Board to ensure that OneCare's strengths and weaknesses are transparent, that OneCare is adequately investing in population health, and that the regulatory process is running as effectively as possible.

Transparency - Information Disclosure

Throughout the budget review process the HCA was disappointed in the lack of necessary details in OneCare's budget submission and its responses to Board and HCA questions. OneCare's submission and answers failed to disclose requested historical data, explanations of past quality and

financial outcomes, and the rationale and assumptions that it incorporated into its budget projections.[1] The Board and the HCA cannot conduct a serious review of OneCare's budget and programs with significant pieces of information missing.

OneCare reports several very positive outcomes and promising population health initiatives. The HCA is supportive of these initiatives, however, it is impossible to tell if the Board is seeing all of the significant information or if OneCare is presenting only the information that is most flattering. For example, OneCare did not provide any information to allow the HCA or the Board to assess whether year to year changes in quality scores are due to changes in care or attribution. Without more detail, we cannot know whether year to year quality results are a cause for concern.

We have been heartened to see the Board and its staff ask important written questions to fill in the gaps in the budget and to elicit sufficient answers. Because there is no established blueprint for the all payer model's success, clear information from OneCare is the best way for Vermont to mitigate potential problems and enhance positive results to create the best possible outcomes for Vermonters. We ask the Board to extend the current ACO budget review process as long as is necessary for full disclosure of all requested information from OneCare.

To the extent that needed information cannot be established in final contracts before the Board's decision, we ask the Board to require OneCare to provide follow-up information as soon as it is available as it did in the 2019 ACO Budget Order. This information should include actuarial certifications of commercial benchmarks and confirmation that the new commercial contracts meet scale target requirements.

Transparency - Confidentiality

We have had concerns about the fact that OneCare has tried to avoid providing some requested information on the basis that it is confidential, proprietary, and/or the subject of ongoing negotiations. We appreciate that the Board has required OneCare to fully disclose requested information while the Board reviews OneCare's confidentiality requests, in line with the Board's requirements in its other regulatory processes.

If OneCare maintains that it cannot share some requested information with the Board due to confidentiality/proprietary restrictions in its contracts, the Board should require OneCare to include in its contracts an agreement that OneCare will disclose information, to the extent allowed by law, in response to requests for information made as part of the official ACO Budget regulatory process. OneCare could still request that the Board keep the information confidential from public disclosure, and the Board could designate the information confidential, as appropriate.

Population Health Management Investments

OneCare's 2020 population health management (PHM) investments are significantly underfunded in proportion to its population increase. It projects its population to grow 47% between 2019 and 2020, an increase of 90,000 lives.[2] Even with additional money from the state budgeted for 2020, OneCare projects its population health management investments (with SASH and Blueprint

[1] See e.g. OneCare October 25, 2019 Responses to GMCB Questions 9.a, 10, 12, 13 and OneCare October 25, 2019 Responses to HCA Questions 1, 2, 3, 4, 6.

[2] See OneCare October 30, 2019 2020 ACO Budget presentation, slides 4, 14; OneCare's operating costs are increasing by over 21% between 2019 and 2020 (Budget Appendix 4.2).

payments included) to decrease from 4.1% of its budget in 2019 to 3% in 2020. OneCare is also under budget for its projected 2019 PHM investments compared to 2019 budgeted.

We understand that not all of OneCare's population health management investments are tied to its attributed population, and we have no objection to OneCare administering population health programs that benefit non-attributed Vermonters. However, we disagree with OneCare's conclusion that its PHM budget should not increase as its budget and attribution increases. We ask the Board to consider the fact that OneCare's budget is a subset of the health care spend in Vermont, and that OneCare is investing only 3% of its budget towards population health programs. When OneCare's investments in population health management are such a small percentage of overall spending, it will not improve population health enough to bend Vermont's health care spending curve while maintaining quality. This is not the time to pull back on population health investments to save money.

OneCare's budget hearing presentation described several promising pilots that expand access to care, reduce costs, and reduce unnecessary utilization. OneCare also stated that all innovation fund projects are required to have the potential to be scaled to other sites and communities.[3] In order for this requirement to make sense, there needs to be a plan to fund expansion of projects that are showing positive outcomes. Additionally, OneCare's presentation showed that only 2% of its attributed Blue Cross Blue Shield of Vermont (BCBSVT) Qualified Health Plan (QHP) population that are considered high and very high risk are receiving care management. The high and very high risk populations make up 16% of the overall BCBSVT attributed population, meaning only 0.32% of the overall BCBSVT attributed population are receiving care management. As the Board is aware, this population has seen skyrocketing premium costs over the last few years, much of which is due to a small, high-cost, portion of the population. OneCare's Complex Care Coordination Program should be doing more with this population.

OneCare states that to increase its population health management investments, it would have to charge the hospitals higher participation fees and the hospitals cannot afford to contribute more money. Yet, as budgeted, the 2020 hospital participation fees will be less than 1% of the total 2020 Vermont hospital budgets,[4] and a fraction of these fees are used for PHM investments. All of Vermont's hospitals are nonprofit and required to give back to their communities. Additionally, under global payments, hospitals should benefit financially from investments that improve the health of the population. For example, projects that incorporate social workers into health care settings reduce burden on health care staff. Social workers can also help patients to address social determinants of health by connecting them to resources outside of the health care field that are not funded by health care dollars. Further, if population health management investments are successful, they should help hospitals avoid shared risk payments. This would be particularly beneficial to the hospitals to the extent that claims outside of the attributed provider network are reduced.

If some hospitals need relief from the past hospital provider fees, the Board should direct OneCare to consider hospital margins in its distribution of provider fees. Hospitals that are hurting financially could pay less while the more affluent hospitals could contribute more so that a sufficient level of

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[3] October 30, 2019 ACO Budget Hearing Transcript, p 54, line 13.

[4] See Vermont Hospital System total NPR and FPP from https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY20%20Summary%20of%20Budget%20Submissions%20and%20Approvals.pdf and hospital participation fee total from OCV 2020 budget appendix 4.3.

population health management investments can be maintained. If OneCare's population health management programs are evidence-based and show promising results, payers should also be willing to contribute more with the expectation that they will see a return on their investment over time.

Investing in population health is the right thing to do for Vermonters and furthers the mission of the nonprofit hospitals. We believe that in order to bring about the culture change that is necessary to improve quality and decrease costs, Vermont needs significantly more investments in population health. We ask the Board to require OneCare to maintain or increase the percentage of population health management investments in comparison to its overall budget that the Board ordered in 2019.

We further ask the Board to require OneCare to report quarterly on PHM Investments by Health Service Area (HSA) and by social service provider as part of a data dashboard (see below). We also ask the Board to require OneCare to develop a written plan for its PHM investments including how it measures the success of PHM programs and determines which programs to scale; how it will scale successful PHM programs; how it will sunset those PHM programs that are not successful; a work plan for the innovation and specialist funds to include distribution of dollars, scope of projects, timeframe, measureable outcomes, and risk/issues/challenges; and a work plan for the Designated Agency investments to include distribution of dollars, scope of projects, timeframe, measureable outcomes, and risk/issues/challenges.

Regulatory Process

Due to the newness of ACO budget regulation, it is natural that the process has some room for improvement. We ask the Board to consider a few changes.

The ACO Budget process would benefit greatly by incorporating standardized data formats, such as tables, that will be used every year, allowing us to look at the same data across multiple years. We ask the Board to require OneCare to create a performance dashboard that tracks important data by payer and provider such as utilization, quality, cost, attribution and fixed payments versus fee for service. We also ask the Board to develop, or to require OneCare to develop, a plan for how to normalize quality measures for year to year comparison for the ACO population and by HSA.

We further recommend that the Board develop standardized templates for information that will be significant to more than one regulatory process. The Board's three main regulatory processes: health insurance rate review, hospital budgets, and ACO budgets, could all be improved with more planning for integration between the three. We understand that full integration is complicated. One fairly straight-forward area that we think could be improved is standardized formats in which certain data are gathered. This preparation should improve the ease at which the Board can determine whether both parties to a contract agree with the data provided to the Board, it will reduce confusion on establishing apples to apples comparisons from two different regulatory processes, and it should reduce the administrative burden on many of the regulated entities. The HCA would be happy to help the Board pinpoint which data points will work for this purpose.

For example, when the HCA asked OneCare to explain its assumptions related to the QHP populations, it simply responded that the HCA should look at the rate filings. When we followed up with OneCare, OneCare said that it relied on data provided by the insurers to develop its QHP projections. To help clarify this information in the future, the Board could ask regulated insurers with OneCare contracts to provide certain data points and projections on their OneCare populations

that would be useful in reviewing the rate filing. Then, when it is time for ACO budgets, the Board could ask OneCare to review the insurers' submissions about their OneCare attributed populations. (A template made for this purpose would not ask for any information that must be kept confidential from OneCare.) OneCare could confirm any and all of the data that it agrees with, specify any information that it cannot confirm, and modify any information that it believes should be changed along with an explanation of why. (For example, updated information may become available in the time between rate review and ACO budget review.) OneCare, in turn, could provide information in a template on its upcoming contracts as part of the ACO budget process that would be confirmed and updated by the insurers in the next rate review process.

We also note that as OneCare becomes more established, it should be able to finalize contracts in time for the Board's review. We ask the Board to consider setting deadlines for contract renegotiations and recommended deadlines for new contracts in its future ACO budget guidance, requiring more timely contracts each year.

Further, we agree with Board Member Usifer's suggestion that full financial information should be included in hearing presentation. In line with the Board's hospital budget process, a move towards a more formal presentation where the Board provides several areas that must be covered would help ensure the best use of hearing time and reduce confusion. For example, several members of the public have expressed confusion over the way OneCare presented its 2018 Medicare savings due to the inclusion of Blueprint and SASH funds in both the benchmark and the actuals. This confusion can be avoided in the future by having OneCare present its Medicare benchmark and savings both with the Blueprint and SASH money included and with it removed, explain why the Blueprint and SASH funding is included in the benchmark, and explain any savings achieved that is in addition to those funds.

In addition, during this review process, the Board asked OneCare to provide more detail on a grant that was mentioned in the budget submission. As part of OneCare's October 25 response to the Board, it included a copy of its October 10 press release announcing the grant. In order to ensure that the Board receives timely notification, both during and outside of ACO budget review, on information OneCare deems significant enough to merit a press release, we ask the Board to order OneCare to submit to the Board copies of any press releases on the day they are released to the public.

Finally, OneCare must improve its ability to understand its quality and cost outcomes. OneCare cannot predict the future, but for the model to succeed, it should be able to make educated estimates informed by good data. OneCare's lack of ability to assess quality scores on the HSA level,[5] the reasons behind their Medicare performance,[6] the five highest cost conditions by HSA,[7] and whether the BCBSVT contract will ever save more money than it costs the payer[8] are serious concerns to Vermont's ability to improve its health care system. If OneCare does not have and cannot develop the in-house expertise to conduct these analyses then another entity should. We ask the Board to organize a work group consisting of DVHA, Vermont Department of Health, the Board, Blueprint,

[5] See OneCare October 25, 2019 Response to HCA Question 5.
[6] See OneCare October 25, 2019 Response to HCA Question 4.
[7] See OneCare October 25, 2019 Response to HCA Question 10.
[8] See OneCare October 25, 2019 Response to HCA Question 1.

the payers, the hospitals, and the HCA to pinpoint the types of information needed to understand the all payer model and optimize its success, pinpoint how accurate information can most efficiently be obtained, and establish a regular schedule for this information to be released.

We look forward to continuing to work with the Board and OneCare to improve health care access and affordability for Vermonters.

Thank you,

The HCA Policy Team

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s\ Kaili Kuiper, Staff Attorney

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