OneCare 2020 Budget Commentary

Public Comment by Ethan Parke, a citizen of Montpelier, Vermont

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Structural and functional problems with the OneCare/All Payer Model are beginning to become evident; the GMCB should take these problems into consideration in the OneCare 2020 budget review.

- Halfway into the OneCare pilot there is no indication that OneCare has the means to make a significant positive impact on the pressing health care needs of Vermonters. A recent article in the Journal of the American Medical Association put Vermont among the states with the greatest increase in death rate between 2010 and 2017 of people aged 25–64. Vermont's suicide rate is higher than average and is increasing faster than most other states, according to a recent study by SeniorLiving based on census data. Changing how providers are paid does not get at the root causes of these issues, which are mostly about affordable access and provider capacity. Given the emerging doubts about OneCare/APM, and given that the pilot will expire in 2022, the GMCB should begin planning now for the post-OneCare era.

- OneCare, and indeed the entire ACO movement, is founded on the false premise that doctors who are paid by fee-for-service over-prescribe, over-diagnose, over-treat, and generally want their patients to remain sick so that doctors can make more money. How many times have we been told that payment reform will result in doctors being paid to keep us well, as if doctors until now have been paid to do the opposite? Besides being insulting to the medical profession, this assumption ignores the fact that many countries around the world, including our neighbor Canada, pay providers on the fee-for-service model, have universal access, have good quality care, and spend far less per capita than the U.S.

- Under OneCare/APM we were promised there would be new emphasis on prevention, early diagnosis, and primary care access. But many indicators show we are losing ground with respect to these goals. For 2018, OneCare showed sharp declines in the following Medicare quality measures: health promotion, shared decision making, influenza immunization, and access to specialists. OneCare showed declines in several Medicaid measures as well, such as the rate of blood sugar control in diabetes patients. Recently, the Central Vermont Medical Center, a OneCare affiliate, sent a letter to patients warning them not to discuss their health concerns with their primary care doctor, pointing out that discussion of a patient's health is not included in a physical exam. CVMC thus encouraged its patients to ignore prevention and early diagnosis. At the same time, the message to doctors was to treat on the basis of billable diagnosis codes only. So much for care coordination and efficiency!

- The UVM Medical Center recently implemented a $151 million computer system, blessed by the GMCB, ostensibly to allow medical records to be more easily shared and to help "align" with OneCare. In fact, the EMR, especially the Epic software used by UVM, is not about patient care or coordination; it's all about billing. Samuel Shem, writing in Newsweek, asserts that Epic is an electronic cash register. Doctors, rather than looking patients in the eye, now spend precious hours on data entry; another employee checks to see if the doctor has maximized the number of codes entered, and whether any can be up-coded. The EMR is then transmitted to the insurer who tries to down-code the entries or to exclude items from reimbursement; finally all this confidential patient information goes to OneCare so it can decide how to extract "savings." What an absurd and complicated system!

- Vermont now has the ignominious distinction of leading the nation in the regressive privatization of two time-tested publicly funded health care programs—Medicare and Medicaid. Taxpayer dollars for Medicare and Medicaid that should go directly to health care are now funneled through OneCare, a private for-profit corporation that closes the doors of its board meetings whenever substantive issues are discussed. OneCare's 2020 budget submission adds $19.2 million for a year of administrative cost to the health care system we all pay for, and yet OneCare will not even reveal the salaries of its executives. Discourse between OneCare and the GMCB is so full of acronyms, jargon, euphemisms, double speak, and group-think that public understanding of what OneCare/APM does is impossible. Such complexity and opacity does nothing for accountability.

- OneCare misled the GMCB by claiming Medicare savings that did not exist. OneCare's financial report shows $13.3 million in supposed Medicare savings for 2018, and yet $7.7 million of that total was Medicare money that passed through OneCare and was spent on the Blueprint for Health and SASH. Because this money reverts to CMS if OneCare does not produce an equal amount of Medicare savings, it is essentially an expense, a cost of doing business that has nothing to do with savings over and above the base cost of care. OneCare used a sleight of hand to label the $7.7 million as savings, maybe in an effort to deflect criticism of its expensive administrative costs. In fact, if one deducts the $7.7 million, and also takes into account the losses in Medicaid and commercial, actual savings for 2018 were less than $3.5 million, at a cost of $11.7 million in operational expense.

- The GMCB should:
  (1) Push back on the OneCare 2020 budget request on the basis that the company has underperformed and has not been transparent.
  (2) Stop being the promoter of OneCare and concentrate on being its regulator.
  (3) Have an independent financial analyst scrutinize OneCare's budget submissions for accounting tricks that hide shortcomings.
  (4) Make a concerted effort to see if OneCare's data analytics are statistically valid.
  (5) Ask the Speaker of the House and the Chair of the House Health Care Committee to stop blocking legislation that will allow the state Auditor full access to the information he needs in order to complete a performance audit of OneCare.
  (6) Require public disclosure of OneCare executive salaries and examine minutes of OneCare board meetings to ensure the company is following the law with respect to open meetings and executive sessions.
  (7) Propose a rule change that would require OneCare to notify every patient when he or she is attributed to OneCare and give every patient the right to opt out.
  8) Begin to transform the APM away from dependence on an ACO and into a true rate-setting model that would impose one reimbursable rate (a percent of the Medicare rate) on all providers.
  (9) Develop strategies to revitalize rural hospitals, recruit a robust primary care workforce, and reinstate independent primary care practices.
  (10) Focus on non-ACO-based policy initiatives that would increase affordable access, particularly to primary care.