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December 2, 2020

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

RE: HCA Comments on 2021 OneCare Budget Submission

Chair Mullin and Members of the Green Mountain Care Board:

Thank you for considering the Office of the Health Care Advocate (HCA)'s comments on OneCare Vermont (OneCare)'s 2021 Accountable Care Organization (ACO) Budget submission. In our capacity representing Vermonters, we have met regularly with the 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 written questions to OneCare and met with OneCare on October 21, 2020. We thank Board staff and OneCare for taking the time for these meetings, which were helpful and productive.

There is a health care affordability crisis in Vermont. Vermont's All Payer Model (APM) is an ambitious attempt to curb health care cost growth while maintaining quality care by focusing on primary care and prevention. The APM's potential for success will be hampered if health care continues to become less affordable to large numbers of Vermonters. In our current system, many Vermonters insured commercially or by Medicare cannot and do not access needed care because of cost barriers that play out in the form of unaffordable premiums, deductibles, and out-of-pocket costs. When patients can't afford the care they need to prevent and manage chronic conditions, the APM will not benefit Vermonters or affect the health care system as intended.

For OneCare and the APM to be successful, and to improve affordability, Vermont must pair OneCare's programs with consumer affordability initiatives such as provider rate setting for Vermont's qualified health plans (QHPs), additional cost-sharing support for lower income QHP and Medicare beneficiaries, protections against prescription drug price gouging, and improvements to hospital patient financial assistance and billing practices. Without these changes, OneCare's programs and the APM will not improve affordability and are unlikely to succeed in their broader goals due to cost barriers to Vermonters accessing care.

Below the HCA provides comments on four areas of OneCare's 2021 budget submission: the 2020 change to OneCare's risk model from HSA-level to statewide, OneCare's care management goals

and methodology, the lack of a conceptual model of how population health investments will impact Vermonters and Vermont communities, and OneCare's responses to follow-up questions.

Change in Risk Model

The HCA has significant concerns about OneCare's shift, beginning in 2020, from an HSA-level risk model to a statewide risk model. While we understand OneCare's desire to decrease HSA performance volatility related to random variation, we believe this change represents a substantial shift in the ACO model's incentives for agreements paid through or reconciled with fee-for-service claims. With this move away from HSA-level accountability, providers have little incentive to reduce health care costs. This is particularly true given that the University of Vermont Medical Center's performance will drive the ACO's performance statewide. As this change could incentivize providers to focus more on volume and less on providing high-value care, we believe it must coincide with other incentives including broad implementation of fixed prospective payments. We are concerned that OneCare is moving to a statewide risk model before these other incentives have been widely implemented.

Further, as others have argued, substantial changes to the ACO model during the five-year demonstration do not provide predictability or give the ACO model sufficient time to be implemented and evaluated. This shift to a statewide risk model is one reason among many that it will be difficult for the state to evaluate the effectiveness of the APM at the end of the five-year period.

Care Management

We applaud OneCare's and the state's plans to create self-management programs for diabetes and hypertension and to make these programs available to all Vermonters, not just Medicaid or OneCare attributed populations. We also appreciate that OneCare has given providers discretion to suggest patients who need care management who are not otherwise identified for the service. However, the HCA continues to have concerns that OneCare's investments in care management programs are not significant enough to impact the cost curve or to provide enough support for the highest risk populations. Based on the HCA's experience hearing from Vermonters who call our hotline, we have learned that there is a significant need for more care management services in Vermont. Not including the DULCE program, it appears that around 2% of OneCare's population is in care management in 2020 - a little under 3% for Medicare and Medicaid populations and under 0.5% for commercial plans.[1]

OneCare has an overall goal of providing care management for 15% of its high- and very high-risk populations, which means that even when OneCare achieves its goal 85% of high- and very high-risk individuals will not receive care management.[2] In 2021, OneCare is planning to increase its attributed population by 28,000 lives while at the same time reducing its care coordination budget by 25%.[3] OneCare should instead be increasing its care management budget and systematically working

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[1] OneCare FY2021 ACO Budget Narrative 10-01-20, p. 44.
[2] FY21 Budget – Round 1 Questions Combined 11-09-20, p. 12, 19.
[3] OneCare FY2021 ACO Budget Narrative 10-01-20, p. 5, 33.

to increase the percentage of high- and very high- risk individuals in care management, with the goal of reaching more high-risk, and a significant majority of very high-risk, patients.

Understanding the Impact of Population Health Investments

Vermont needs a clear conceptual model for how OneCare's population health investments (PHI) will result in measurable benefits for the Vermont health care system and for Vermonters. Vermonters and Vermont's hospitals have invested substantially in OneCare and should be given a clear explanation of OneCare's specific goals and the ways in which its PHIs will effectuate the desired goals. The lack of such a model makes oversight and evaluation of OneCare's PHI and its overall goals difficult. Regular concerns expressed by members of the public, the policy advocacy community, and the Legislature about OneCare's goals and progress toward those goals speak to this fundamental lack of a basic conceptual model of how OneCare's PHIs produce change.

We do not expect OneCare to immediately develop a conceptual model of the impacts of PHI that will respond to the evolving health care landscape. Rather, development of a conceptual model should be iterative and subject to rational revision as new data and learnings become available. We also do not expect a conceptual model to predict future outcomes. The model is not a prediction tool but a representation of our current and best understanding of how PHI operates. Such a conceptual model would inform evaluation and allow for selection of metrics based on the hypothesized causal relationships that underly each intervention.

Our understanding is that OneCare's current concept of how PHI effectuates change is that shifting provider financial incentives and investing in population health will, over the long-term, slow health care cost growth and improve the health of Vermonters. While this is a fine start for a model, it lacks specificity and is not subject to empirical evaluation. There are several reasons why this is not a reasonably specific conceptual model. First, the model does not specify a time frame when these benefits are expected to accrue to Vermonters. Will they begin to be observable in 5-10 years; 10-15 years; 15-20 years? Will the benefits shift over time? Absent this information, it is impossible to implement reasonable outcome measures that will allow for public understanding as well as effective oversight and evaluation.

Second, the model should specify whether and how PHI will have group and/or individual effects. It is impossible to determine appropriate outcome metrics without first knowing the type of change expected as a result of the intervention. For example, utilization and patient outcomes might be reasonable metrics for individual-level change but would not capture group effects as group effects are more complex than the aggregation of individual effects.

Third, the model does not specify the scale of PHI needed to achieve the desired outcomes. We do not have the information needed to assess whether OneCare's PHI fall within a reasonable range where there is enough investment to expect change, and not so much investment that there are diminishing returns. A model that hypothesized an appropriate investment range would better allow the public, the HCA, and regulators to evaluate specific PHIs in the context of OneCare's goals.

Lastly, on a related but separate topic, it is critical that OneCare's PHIs are transparent to the general public. Sufficient public buy-in and scale targets can only be achieved if OneCare is viewed as a trustworthy and effective health care partner. There are two ongoing projects aimed at increasing

PHI transparency, a public facing dashboard and an analysis of the return-on-investment (ROI) of OneCare's PHIs. The development of a public-facing dashboard is a critical component of transparency. We support OneCare's efforts to this end and respectfully ask OneCare to follow recent Board practices and create data dashboards that are interactive, user-friendly, and include the option for users to download the underlying data in commonly used spreadsheet or delimited text file formats. We also support the Board's efforts to evaluate the ROI of OneCare's PHIs. PHIs are funded by Vermonters and Vermont hospitals. As such, we should do our best to make sure these monies are spent wisely. This is particularly important given the increasing affordability challenges and related access issues faced by Vermonters, and the increasing burden on hospitals providing financial assistance to un- and under- insured Vermonters.

Impact of Covid-19 on Evaluation

The disruptions caused by Covid-19 will impair our ability to assess general APM and OneCare-specific financial and quality outcomes for 2020 and 2021. As the APM is only a five-year model, such disruption will challenge our ability to determine, based on evidence, whether the APM is on its way to success and therefore whether it should be continued. The loss of two years of OneCare financial and quality outcomes will substantially limit our ability to evaluate change during a critical moment in the ACO's development.

The state, the Board, and OneCare need to address the disruption caused by Covid-19 thoughtfully. Evaluation methods need to be adjusted to account for the disruption caused by Covid-19. At this point in the APM's lifespan and OneCare's development, the solution cannot be simply "throwing out" 2020 and 2021. We need to make our best effort to identify alternative evaluation methods so that these years are not lost.

OneCare Responses to Follow-up Questions

Technological disruptions have impeded OneCare's ability to respond to follow-up questions from the Board and the HCA this year. We ask the Board to extend the current ACO budget review process as necessary for full disclosure of all requested information from OneCare. To the extent that needed information cannot be provided before the Board's decision, we ask the Board to require OneCare to provide follow-up information as soon as it is available.

We look forward to continuing to work with the Board and OneCare to improve health care access and affordability for Vermonters. Please feel free to reach out to us at hcapolicystaff@vtlegalaid.org with any questions or concerns.

Thank you,

The HCA Policy Team

s\ Mike Fisher, Chief Health Care Advocate

s\ Kaili Kuiper, Staff Attorney

s\ Eric Schultheis, Staff Attorney

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