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TO: Green Mountain Care Board

RE: Comments on OneCare Vermont's 2024 ACO Budget and a Transition

FROM: Julie Wasserman, MPH

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In L. Frank Baum's *The Wizard of Oz,* the Wizard appears to be formidable until the curtain he's hiding behind falls away. When we pull back the curtain on OneCare, here's what we see.

- OneCare's $1 Billion Budget for 2024 will serve an *all-time low* of ≈ 154,665 people, less than a quarter of Vermonters. The ACO's Operating costs per attributed life have grown from $61 in 2022 to $92 in 2024. This marks Year 8 of the All Payer ACO whose dwindling number of enrollees calls into question its very existence.

- OneCare cannot convince Vermont's dominant commercial insurer, BCBSVT, to rejoin, having left because it could find no value in participating.

- OneCare has shown a lack of transparency and accountability. Some examples:
  - OneCare wrote a misleading editorial about its successes, misrepresenting the NORC evaluation results. This piece was published in VTDigger, the St. Albans Messenger, Manchester Journal, Caledonian Record, Brattleboro Reformer, and the American Journal of Managed Care. Contrary to these media posts, the NORC evaluation demonstrated that Medicare Beneficiaries Statewide had better outcomes in savings, utilization, and quality than Medicare beneficiaries served by OneCare, as compared to their respective comparison groups.
  - OneCare claimed in a widely distributed press release that it had $11.3 Million in 2019 Medicare savings even though $6.3 Million of it was pass-through money from CMS to assist with OneCare's cash flow to fund Blueprint and SASH. OneCare's actual 2019 Medicare savings totaled only $4.9 million.
  - OneCare has refused to reveal whether its $10.5 Million in 2023 Population Health Management hospital payments (and prior PHM hospital payments) intended for primary care physicians actually benefitted them. OneCare is not only refusing to be transparent about these expenditures of public funds, it is using public dollars to fight *against* transparency and accountability. (See OneCare's Supreme Court Appeal.) Until we know whether the prior, current, and future hospital-based PCP payments support primary care physicians, the Green Mountain Care Board's (GMCB) 2024 OneCare Budget approval should stipulate that such payments be given solely to Independent practices and FQHCs.
  - OneCare has rebuffed the GMCB's 2023 Budget stipulations on ACO executive compensation. (See OneCare's Supreme Court Appeal.)

- OneCare has failed to address Vermont's most salient crises: the ever-increasing cost of care and growth rate, affordability, declining access to primary care, avoidable hospitalizations, unnecessary ER use, and the severe shortage of community mental health services.

- We do not know the number of lives OneCare actually served in any given year and whether the cost was worth the effort.

- OneCare bears virtually no risk. The GMCB's 2024 Certified ACO Budget Guidance requires OneCare to hold 100% of the Medicare Advanced Shared Savings dollars (Blueprint and SASH funding) at risk and not pass this risk along to the providers. However, OneCare has defied the GMCB by refusing to do so. The same applies to increasing risk corridors for all payer programs above 2023 levels.

- OneCare's 2022 Financial results (latest available) show losses with its BCBS-Primary and MVP-QHP programs, no savings in BCBS-QHP, meager savings with its Medicare program, and extraordinary savings in its Medicaid program (≈$12 Million). How can OneCare's Medicaid savings be explained given such tepid results with the other payers, especially since physicians are payer blind and treat all patients alike? Questions to ask:
  - What specifically did OneCare do to achieve these Medicaid savings?
  - OneCare needs to enumerate the interventions responsible for these Medicaid savings so they can be replicated in the ACO's other payer programs.
  - Is DVHA performing due diligence in negotiating its yearly contracts with OneCare? Is DVHA's methodology sound regarding calculation of the "Expected" Total Cost of Care at the beginning of each contract year?
  - Vermonters (i.e. taxpayers) have paid OneCare **$34.3 Million** in Medicaid "savings" over the last 3 years largely due to the difference between the "Expected" and "Actual" Total Cost of Care. (2020: $15.4M, 2021: $7.1M, 2022: $11.8M.)

  The $34.3 Million in "savings" is not savings at all. It is simply a transfer of public funds to the private sector. If these funds were truly "savings", they would be used to reduce the cost of health care and improve affordability. Instead, the opposite occurs. OneCare distributes these funds to the hospitals (the most overfunded sector in the system), with no abatement to the ever-growing cost of care.

- OneCare has failed to implement initiatives to reduce hospital costs, a major driver of escalating health care expenditures.

- OneCare has failed to implement initiatives to reduce Specialty care costs, also a major driver of escalating health care expenditures. The ACO states in its Narrative (page 36), "*OneCare does not currently have any direct incentive programs for specialists of any type.*" OneCare has not incentivized Specialists to improve care coordination with Primary Care Physicians. This easy source of savings could occur through simple approaches like "pre-referral" telephone access, and "consultative" referrals which ensure that patients return to their primary care practice for on-going management instead of remaining with costly Specialists. While OneCare holds harmless expensive Specialists (they bear no risk), it weakens community providers with increased risk and less funding.

- OneCare's 2024 Budget *reduces* the Total amount of Population Health Management (PHM) Investments (slide 43). Although the number of 2024 ACO attributed lives has declined, community providers still face the same caseloads. As you can see from the table below, these community providers are receiving less in 2024 than in 2023.

	2023	2024
Independent PCP	$5,618,833	$4,502,696
CPR Program - PCP	$1,617,513	$1,323,900
FQHC	$6,143,166	$4,858,998
Designated Agencies	$1,297,403	$1,245,862
Home Health	$1,423,634	$1,333,200
Area Agency on Aging	$211,774	$180,000
Total	**$16,312,323**	**$13,444,656**

2023: Slide 32 2024: Appendix 6.8 CPR: Slide 43

OneCare also reduced the percentage of "base" funding for community providers. In 2022 and 2023, base funding was 85%, but has fallen to 75% in 2024. "Bonus opportunity" payments have risen from 15% to a whopping 25%. Why does OneCare increase risk for the most vulnerable entities? Independent Primary Care Practices, Designated Agencies, and Home Health Agencies are seriously challenged; squeezing them by reducing investments while adding risk and uncertainty to their funding further destabilizes them. Instead, OneCare should have *expanded* funding for community providers in an effort to reduce avoidable hospitalizations and unnecessary ER visits.

- Non-hospital Primary Care Physicians bear more risk (5%) than hospital-based Primary Care Physicians (4%) in OneCare's Accountability Pool - slide 6. And yet, the Non-hospital PCPs have no safety net while the hospital-based PCPs are secure.

- OneCare's Mental Health Screening Initiative - $3.3M ($1.6M in 2023, $1.7M in 2024)
  - The GMCB needs proof that these payments to hospital-based primary care physicians actually accrue to them, rather than to the hospitals.
  - This initiative will *exacerbate* Vermont's mental health crisis by increasing the number of people waiting for services. Due to a shortage of mental health providers, over 800 adults, children, and youth are waiting for community-based mental health and substance use services at the Designated Agencies. Wait times at Washington County Mental Health have increased from 84 days in June to 115 days. At Howard Mental Health, 55 Adults are waiting an average of 90 days for outpatient services and 62 children/youth are waiting up to 180 days.
  - It is disingenuous of OneCare to showcase this Screening Initiative while simultaneously reducing the Designated Agencies' budget. OneCare funded the DAs at $3.4 Million in 2020 (slide 20) but consigns only $1.18 Million in 2024, the majority of which is "bonus" funding at $612,950. "Base" funding totals $564,750. In other words, the DAs have to "earn" more than they are guaranteed. (See Appendix 6.8.) OneCare's approach with the DAs calls into question its supposed commitment to the crisis in community mental health, as well as its promise to address unnecessary ER utilization.

- OneCare's Quality Performance Scores have spiraled downward with Medicare, Medicaid, and MVP's latest scores (2022) at an all-time low of 66%, 65%, and 45% respectively. BCBSVT states its non-attributed lives have better quality outcomes than its ACO attributed lives. The 2023 Medicare Benchmarking Fall Report shows some positive movement although there are declines in Annual Wellness Visits, Primary Care Visits, and all Prevention Quality indices. Given OneCare's $110+ Million in cumulative Administrative/Operation Costs over the course of the All Payer Model, one would expect this costly statewide ACO to do far better on these outcomes, with consistent year over year improvement. This has not occurred.

- OneCare lacks the ability to self-correct. A clear example is OneCare's Medicaid performance on the all-important quality metric of "Initiation of Alcohol and Other Drug Dependence Treatment". OneCare's score from 2017 through 2022 was *at or below* the 25th percentile. (2022 was significantly below the 25th percentile.) This 6-year trend reflects the ACO's fundamental inability to address weaknesses in performance, especially with one of the most critical mandates of the All Payer Model (reduce drug overdose deaths and suicides).

- Commercial insurers and Vermonters with Commercial insurance appear to be subsidizing the ACO even though Commercial participation in OneCare is minimal (given BCBSVT's absence). This is because the ACO's Hospital Participation Fees "are the primary source of how OneCare keeps its doors open". Yet, these Participation fees appear to be predominantly sourced from hospitals' Commercial income because hospitals "are barely able to break even with Medicare and Medicaid".

- OneCare was supposed to have a significant and positive impact on the pressing health care needs of Vermonters. But as an engaged 86 year-old commented after OneCare presented its 2024 Budget to the GMCB, "I've been listening to you since 10:00 am this morning and nothing you've discussed improves the situation for patients." She went on to describe access problems, the lack of care coordination, how impossible it is to navigate the system, and how patients are supposed to be the focus of health care reform ("patient-centered") but instead are completely excluded.

- Lastly, OneCare has been subsumed by UVM Health Network, raising the specter of *conflicts of interest* as well as monopolistic concerns. UVM Health Network's ACO determines and allocates payments to Vermont providers of which UVM Health Network is the largest.

Given the above, one could reasonably conclude that OneCare has not achieved Vermont's health care reform goals.

The time is ripe to consider approaches that allow Vermont to transition away from the ACO model. Which elements of the All Payer Model do we retain and how best to replicate them in the absence of an ACO? Suggestions focus on four domains:

- Comprehensive Payment Reform program (CPR)
- Medicaid Payments
- Blueprint/SASH
- Monthly Advance Medicare Hospital Payments

Comprehensive Payment Reform program (CPR)

OneCare's signature CPR program for Independent primary care practices has lost much of its value due to the lack of Commercial participation. This absence of Commercial insurance payments undermines the intent of the CPR program (blended fixed payments) and renders the term "Comprehensive" inapplicable since Commercial insurance payments comprise a significant portion of many primary care practices. Medicaid and Medicare are the only CPR payers identified in OneCare's 2024 Budget submission p.2. Participating Pediatric practices are left with a mere Medicaid payment since Medicare coverage of their patient population is either minimal or non-existent.

CPR funding in OneCare's 2024 Budget has declined (slide 43), and comprises only 0.13% of OneCare's 2024 budget ($1.3M ÷ $1B). The number of attributed lives has also fallen - slide 15. With regard to quality and the all-important performance measure of Annual Wellness Visits, patients are better off in Non-CPR practices since they perform significantly more Annual Wellness Visits than CPR practices (slide 32).

What remains of the Program? Some CPR practices might answer: "PMPM payments" (Per Member Per Month payments). However, these PMPM payments are not exclusive to the CPR program, nor do they qualify as capitated payments. In 2023, BCBSVT's PMPMs (formerly delivered through the ACO) went directly to providers. BCBSVT will continue in the same vein with its own value-based programs in 2024. MVP could follow suit, since funneling PMPM payments through an ACO middleman incurs additional (and unnecessary) administrative costs.

Vermont needs a newly reformulated comprehensive payment program for *all* Independent primary care practices that provides enhanced blended payments from the full array of payers.

Medicaid Payments

OneCare's $34.3M in Medicaid "savings" (over the last 3 years) is public money that should instead accrue to the State for needed services, not to a private ACO. What prevents DVHA from replacing OneCare's Fee-for-Service payments with its own payments? Vermont Medicaid has been making payments to providers since at least the mid-1970s. Several hospitals have recently indicated they might "do better" under DVHA's Medicaid Fee-for-Service program - p.15. Also, DVHA has continuously paid providers for the care of young children (throughout the duration of the All Payer Model) because the yearly DVHA/OneCare Medicaid Contracts exclude this cohort. (See the DVHA/OneCare 2018 Contract p.4 excluding newborns and children up to 1½ years old.)

What prevents DVHA from replicating OneCare's prospective payments? Only about half of OneCare's Medicaid payments to providers are Fixed Prospective Payments, and NORC found these payments in 2022 accounted for only 14% of Vermont hospital net patient revenues - see page e-37. Note: If DVHA insists on utilizing a pass-through entity to disperse Medicaid payments in a future health care reform model, the State would need to go out to bid to find the most suitable vendor and price for this service.

Most noteworthy, DVHA is well-versed in prospective payments and has become an "*accountable entity that implements value-based prospective payment reforms*" in the same vein as the ACO. Examples of DVHA's prospective payment initiatives include: Hospital Outpatient Services, Adult Mental Health Services, Integrating Family Services, Children's Integrated Services, Residential SUD programs, Northeastern Family Institute Bundled Case Rate, Developmental Disabilities Services, Brattleboro Retreat, and FQHCs, among others.

Vermont has no structural need for an expensive, hospital-owned entity like OneCare to distribute public monies on behalf of Medicaid. DVHA, instead of the ACO, could disperse Population Health Management funds directly to providers since DVHA has done this with its "Value-Based Incentive Fund". Accordingly, publicly funded taxpayer investments in OneCare need to end. DVHA's "Provider Reform Support Payments" paid to OneCare at $4.75 per member per month (roughly $8M in 2023) should instead be sent by DVHA directly to providers. Such state-based payments to strengthen primary care would guarantee transparency and accountability, realms resisted by OneCare.

Blueprint/SASH

Vermont accomplished many critical reform initiatives long before the ACO existed. The Legislature created the Blueprint for Health in 2006, and AHS/DVHA implemented the program. Vermont's Blueprint website states, "*The state-level Blueprint team is a unit within the Department of Vermont Health Access (DVHA) and collaborates with the Department's payment reform, quality, and clinical units. As part of the Agency of Human Service's leadership group, the Blueprint is positioned to contribute to both health and human services reforms.*"

Of late, DVHA has significantly expanded the Blueprint by implementing a program that supports primary care practices in providing the following services across "*all ages and insurance payers*" to improve access to mental health and SUD services through increased integration with primary care via:

- Universal screening for mental health, substance use disorder, and social determinants of health;
- Brief intervention within the practices when there are positive screening results;
- Navigation to additional community-based services when warranted.

The DULCE model will serve as the framework for screening and brief intervention for families with infants birth to 6 months old. DVHA clearly understands the critical importance of primary prevention and early intervention.

Vermont needs to determine a way to return Blueprint and SASH funding to AHS/DVHA where it belongs, instead of funneling the money through OneCare. Redirecting these funds back to the State makes eminent sense given these programs serve people who have no connection to OneCare. Also, OneCare refuses to bear risk with these funds, rendering the funds a non-essential component of OneCare's budget. Regardless, a plan for the return of these funds needs to be developed because OneCare's future is not assured.

UVM Health Network's Population Health Services Organization (PHSO) is duplicative of the Blueprint program. Important questions to ask are:

- Does Vermont need an expensive *look-alike* Blueprint program run by a private entity?
- Will UVM Health Network's PHSO undermine the Blueprint?
- Will OneCare's "Population Health Management Program" morph into UVM Health Network's "Population Health Services Organization"?
- What funds, public or otherwise, are being used to spearhead the PHSO's $23 Million budget employing 154 FTEs? (Page 45.)
- Is UVM Health Network utilizing Blueprint funds to stand up its PHSO?

Monthly Advance Medicare Hospital Payments

OneCare's promise of systemwide Fixed Prospective Payments has not materialized. The ACO's Fixed Prospective Payments for its Medicare program are non-existent. Instead, OneCare sends hospitals monthly advance payments that are reconciled to Fee-for-Service at year's end. Hospitals welcome these advance Medicare payments because they provide predictable revenue.

How can Vermont continue monthly advance Medicare hospital payments in the absence of an ACO? One answer is hospital global budgets where predictable payments become the norm.

In conclusion, Vermont needs a fresh start. The ACO has not addressed the crucial needs of Vermonters. It has failed to address affordability, serve a majority of Vermonters, address the critical lack of access to care, tackle the shortage of primary care and community mental health services, remain free from conflicts of interest, or consistently demonstrate transparency and accountability.