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TO: Green Mountain Care Board

RE: Comments on OneCare Vermont's 2023 ACO Budget

FROM: Julie Wasserman, MPH

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The All Payer ACO Model, Vermont's 6-year experiment in health care reform, began in January 2017 and concludes this month on December 31, 2022. The state's All Payer Model has utilized Vermont's sole ACO, OneCare Vermont, as the vehicle to lead health care reform efforts. However, OneCare has failed to reduce health care costs, slow the rate of growth, improve quality, shift to a better payment system, serve a majority of Vermonters, address the critical lack of access to care and shortage of primary care, or remain free from conflicts of interest.

Overview

Vermont's ACO model as currently designed is inherently flawed. It does not matter if the ACO has savings or losses. Either way, Vermonters foot the bill. Either way, there appears to be *no net financial gain*.

If the ACO has losses, Vermonters pay for them through higher premiums, co-pays, deductibles, and rising school budgets; hospitals recoup their losses in the annual Hospital Budget Hearings whose increased costs get passed on to rate payers.

If the ACO has savings, as OneCare did with both Medicare and Medicaid in 2020 and 2021, we pay for them through public funds and taxpayer dollars. OneCare's 2020 financial results showed "savings" in both Medicare and Medicaid, the result of deferred care due to Covid-19. This "underspend" cost Vermonters over $23M in public dollars because DVHA had to pay the ACO $15.4M and CMS had to pay the ACO $7.9M. In 2021, these public payers owe OneCare another $8.3M combined.

OneCare cannot demonstrate what interventions were instituted that resulted in these savings. Vermonters would be hard pressed to identify the benefits as well, even though they are paying for both its gains and its losses.

OneCare comprises 17.6% of Total Vermont Resident Health Care Expenditures. The latest available data (2020) for the former totals ≈ $6.4B; OneCare's 2020 Budget was $1,118,699,485. $1,118,699,485 ÷ $6,368,000,000 = 17.6%.

*OneCare is entering its **7th** year as the primary agent of Vermont's health care reform efforts. What do we have to show for it? Consider the following:*

Participation in the ACO

The number of ACO lives OneCare has budgeted to serve in 2023 has *declined*. We will be paying OneCare more in 2023, but it will be serving fewer people. (The 258,926 lives budgeted in 2022 has dropped to 256,592 in 2023.) Roughly 38% of Vermonters are being served by the ACO. We need initiatives that cover all Vermonters, not just a minority of the population.

This minority of Vermonters grows even smaller by the end of each year due to *attrition*. For example, Medicare ACO attributed lives began the 2021 year with 62,392 people but ended the year with only 47,575, a 24% drop. Members cannot be added during the course of the year. (Also, note that 2023 Commercial participation in the ACO has declined.)

Attrition is only one of the problems with this model; attribution is another. Attribution of members occurs at the start of the year so the ACO's budget can be determined and OneCare can identify and engage its beneficiaries. However, yearly contracts between the ACO and the Commercials are not finalized until April, nor are the final counts of attributed lives. How can OneCare manage the care of attributed lives when it doesn't know who they are until a third of the year is over? How can the Green Mountain Care Board approve OneCare's 2023 budget when final contracts between the ACO and the Commercials have yet to be signed?

Medicare participation in the ACO, essential to the success of the All Payer Model, will likely decline in 2022 and further decrease in 2023 due to the siphoning off of Medicare enrollees into private Medicare Advantage Plans. This problem is exacerbated by UVM Health Network's aggressive efforts to enroll participants into its Medicare Advantage Plan which undermine both its ACO and the All Payer Model. (CMS states that Medicare Advantage "does not qualify as a Scale Target ACO Initiative under section 6.b" of Vermont's All Payer Model Agreement.)

OneCare's Administrative Costs

OneCare's administrative costs to operate the ACO totaled $83M for the first 6 years. If the ACO's 2023 Budget is approved, another $15.2M will be added, for a total of nearly $100M – see table below. These substantial operating costs are difficult to justify for so few Vermonters. Such costs are an added administrative burden to an already administratively cumbersome system, and are *in addition to* administrative costs already borne by Medicare, Medicaid and the Commercials. Essentially, Vermont has added another layer of administrative overhead to the existing cost of health care.

All Payer Model	OneCare Operating Costs
2017	$9M
2018	$13.7M
2019	$15.3M
2020	$13.7M
2021	$15.9M
2022	$15.4M
Total for APM 1.0	*$83M*
2023	$15.2M
TOTAL	**$98.2M**

Community-Based Services

Vermont's All Payer ACO Model began in 2017 with promises of a high performing Primary Care network that would increase access to care, improve health outcomes, and reduce costs. Expansion of primary care was to be a fundamental and pivotal component of OneCare's efforts. "We are on our way to a statewide network that focuses on primary care and population health for all Vermonters" (OneCare Press Release 2017); and, the model "would help up to 12,000 Vermonters get primary care physicians who don't already have them". Yet OneCare has neglected to address Vermont's dwindling number of primary care physicians. (UVM Health Network was instrumental in the 2019 closure of Barre's only downtown clinic.)

OneCare has highlighted its Comprehensive Payment Reform (CPR) initiative which provides capitated fixed payments to independent primary care practices. Of Vermont's roughly 50 independent primary care practices, nineteen participate in this effort. Although it appears to be successful, this program comprises a meager 0.1% of OneCare's 2023 budget. ($1.5M ÷ ≈ $1.5B)

Primary care is the foundation of a highly functional, cost-effective system. When linked with community mental health and home health services, this triad not only delays and prevents costly hospitalizations but also fosters health promotion and disease prevention.

Yet, OneCare's budgets give testament to its tepid support of Community Mental Health. The ACO budgeted $3.4M for the DAs in 2020; funding dropped to $1M in 2022 and sits at $1.3M for 2023. This represents *almost a three-fold reduction* while Vermont is experiencing a full-blown community mental health crisis. We need more resources for prevention, early intervention, and treatment, *not less*.

Similarly, OneCare's $2.2M funding for Home Health Agencies in 2021 declined to $1.5M in 2022 and dropped further to $1.4M in 2023. We know that hospital expenditures drive the high cost of health care. We also know from a 2021 consultant's report that Vermont hospitals have longer lengths of stay relative to benchmarks, especially UVM Medical Center which had markedly high lengths of stay. Why then does OneCare continue to reduce funding to Home Health Agencies when they could promote early hospital discharge as well as prevent hospitalizations in the first instance?

Risk and Fixed Prospective Payment

The most fundamental tenet of the All Payer Model is the bearing of risk. "*The All-Payer ACO Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based arrangements for ACOs*". Regrettably, health care cost growth has not been reduced, and payers and providers have borne little risk throughout the 6-year All Payer Model initiative.

Moreover, the bearing of risk is distinct from "value-based payments" whose definition is so broad as to include bonus payments to Area Agencies on Aging as well as financial rewards for poor quality outcomes.

Fixed Prospective Payment (capitation) has been featured prominently as the hallmark of the All Payer Model with risk-based arrangements tied to hospital expenditures as the primary

financial construct of the ACO. However, OneCare has implemented little in the way of fixed prospective payments.

Payer Risk

- Medicare: OneCare's "Hospital Fixed Payments" are not fixed prospective payments (FPP) as alleged, but instead are monthly advance payments reconciled to Fee-for-Service at year's end (otherwise known as "Cloaked Fee-for-Service"). These cloaked fee-for-service payments comprise less than half of OneCare's Medicare payments; a mere 47.4% in 2023. Simply stated, more than half of OneCare's payments are still traditional Fee-for-Service. OneCare's 2023 budget serves only 50,430 Medicare lives, *less than a third* of Vermont's total Medicare population. OneCare has become a pass-through fee-for-service payer for a small subset of Vermont's Medicare beneficiaries.

  Note: The on-going Covid-19 Federal Public Health Emergency declarations mean OneCare's 2023 Medicare risk corridor of 3% will likely be pro-rated down to 0% (as has happened in prior years).

- Commercials: OneCare has had no Hospital Fixed Payments with the Commercial insurers in prior years and there appears to be little to none in 2023.

- OneCare: The ACO bears little to no risk.

- Medicaid: Contrary to popular belief, OneCare's Medicaid payments are not solely unreconciled Fixed Prospective Payments. Just over half of the payments are fixed (flat trend) while a substantial percent of the ACO's Medicaid payments remain Fee-for-Service. (DVHA's yearly ACO reports, Year-end Rec. Calcs for Traditional + Expanded.)

	2017	2018	2019	2020	2021*	2023 Proj'd
% Fee-for-Service Payments	**36%**	**44%**	**46%**	**44%**		**44%**
% Fixed Prospective Payments	**64%**	**56%**	**54%**	**56%**		**56%**

* Awaiting DVHA's 2021 Report. 2022 data not yet available)

Provider Risk

Even though hospitals constitute half of all health care spending, they bear little to no risk. The same cannot be said of primary care physicians who make up less than 10% of health care expenditures and community mental health and home health which comprise even less. OneCare has shifted risk to the providers who can least afford it.

Vermont suffers from a serious shortage of primary care physicians, insufficient community mental health services, and underfunded home health agencies. Yet, in 2021, OneCare reduced upfront payments to primary care physicians insisting they could earn the difference back at the end of the year if performance goals were met. This same approach has grown into the "Primary Care Accountability Pool" first dollar risk where primary care physicians carry an unbelievable 10% of OneCare's total risk, with independents bearing a greater share than hospital-based physicians. **Is OneCare unaware of research showing increased primary care spending is associated with fewer ER visits, fewer hospitalizations, better outcomes, and lower costs?**

In the same vein, OneCare has put funding for Community Mental Health and Home Health Agencies at risk, stipulating that base funding would drop over time as bonus funding increased. For 2022 and 2023, 85% of OneCare's funding is paid as a base payment while 15% will be a "bonus opportunity". In essence, this translates to a reduction in base pay for Community Mental Health and Home Health Agencies.

These approaches qualify as upside down policymaking and misplaced priorities by a hospital centric ACO. Primary care, community mental health, and home health are facing a critical crisis; squeezing them by adding risk and uncertainty to their funding only exacerbates the problem. Instead, these *underfunded* entities require stable and robust financial support to secure their ongoing survival.

In contrast, hospitals are *overfunded*. With hospital costs rising exponentially, why hasn't OneCare reduced hospital base funding to 85% and conditioned the remaining 15% on performance indices that address:

- Low acuity hospitalizations (documented avoidable care)
- Unwarranted long hospital lengths of stay
- ER mis-utilization (Quarterly reports detailing patient case-mix scores with associated revenue could guide the process.)
- Explicit efforts to reduce or prevent hospitalizations
- Utilization of lower cost providers

ACO Quality Performance

Quality metrics are meant to measure progress and incentivize the ACO to improve quality. However, meaningful incentives appear to be absent:

- In 2020, Medicaid ACO measures were "Pay-for-Reporting" which means the ACO was paid merely for reporting the measures regardless of its performance. 100% of the Quality Incentive Payments were awarded (for reporting) even though quality performance declined in 9 of the 10 measures.
- In 2021, the Medicaid ACO's "Pay-for-Performance" Quality Score of 68.75% (lowest ever) will be rewarded with $1.6M in Quality Incentive Payments.
- In 2021, Medicare ACO measures were "Pay-for-Reporting". The ACO earned a score of 100% (for reporting) which conferred financial rewards even though its quality score declined significantly.
- For Medicare quality measures that have no measurable benchmarks, the ACO is awarded full points. (When in doubt, assume the best.)
- When quality metric scores are low or have declined, corrective action plans are not required.
- There are no accountability mechanisms nor serious consequences for poor quality performance.

Medicaid

OneCare's 2021 Medicaid Quality Performance Score was a dismal 68.75%. This follows the ACO's poor performance in 2020 where quality performance *declined in 9 of the 10 measures* compared to the prior year.

Of particular concern is OneCare's performance on the all-important metric of "*Initiation of Alcohol and Other Drug Dependence Treatment*". OneCare's 2017 score was *below* the 25th percentile and its score has remained in the 25th percentile for 2018, 2019 and 2020. Its score again registered *below* the 25th percentile in 2021. This 5-year trend reflects woefully weak performance with no sign of improvement. Is OneCare aware of this? Will OneCare address this failing and, if so, when? Will DVHA take any action? These findings are especially disappointing given one of the All Payer Model's primary goals is the reduction of drug overdose deaths and suicides, not to mention Vermont's growing opioid crisis.

DVHA subsidizes OneCare by using public funds to support the ACO's administrative and IT costs. Why doesn't DVHA leverage these funds to demand better performance? If that is not possible, the State should discontinue using tax-payer money to subsidize the ACO.

Medicare

OneCare's 2021 Medicare Quality Performance Score of 82.5% shows a significant decline from both its 2020 score of 96.25% during Covid, and its 2019 score of 91.88%. "Initiation" and "Engagement" of Alcohol and Other Drug Dependence Treatment also declined in 2021.

Blue Cross/Blue Shield of Vermont

BCBSVT saw no difference in quality outcomes between its ACO attributed and non-attributed lives in both 2020 and 2021. Quality scores declined in "Alcohol/Other Drug Initiation/Treatment" and "Follow-up on Hospital Inpatient/Outpatient Mental Illness". Additionally, BCBSVT reports that OneCare has resisted adopting a mental health/ substance-use disorder measure.

MVP

MVP has increased its quality score to 85 points over the prior year's 50 points. However, the number of people served is small.

Conclusion

Do we continue to fund a failing ACO that has not addressed the issues below, or instead redirect our efforts to meet the needs of Vermonters?

The Green Mountain Care Board needs to consider alternative models of health care reform that address the most salient issues facing Vermonters:

- Affordability
- Access to care
- Unmet need for primary care
- Lack of access to prevention initiatives
- Insufficient community mental health and home health services
- Unsustainable increases in the cost of hospital care
- Wildly varying hospital prices for the same service (Standardize pricing tied to global budgets.)
- Untenable increases in commercial insurance rates
- Avoidable hospitalizations and unnecessary ER use
- Long wait times (unrelated to the pandemic)