Submitted on Tue, 03/23/2021 - 11:15

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**Topic**
Accountable Care Organization

**Comment**
Vermont All Payer ACO Model
Thoughts and Comments from David Sichel
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March 22, 2021

Some History
When considering changes to the All Payer ACO model it is important to remember where we came from in managing health care system costs. During the 1980-90's health insurance rates in Vermont regularly saw double digit annual health insurance rate increases. When I worked at the Vermont League of Cities and Towns member municipalities breathed a sigh of relief if the Health Trust rate increases were under 10%. At that time, the Health Trust rate increases, while often in double digits were less that the insurance company health trends. Today we wring our hands if annual rate increases are in the mid-single digits.

Health insurance deductibles and co-pays have gone up dramatically. It is important to remember that so has medical inflation. Many high deductible plans do have subscribers paying a larger portion of health care costs, if they have medical high needs. Other plans, such as the Health Exchange Platinum and Gold plans have subscriber co-pays and deductibles that have remained relatively static, while health care costs have gone up dramatically. A ten-dollar primary care co-pay twenty-five years ago paid a much bigger percentage of the cost of the visit than it does today.

Many heath system users and providers do not like care management, cost control measures and system accountability, such as outcome-based payments. This was true during the height of HMO systems and it continues to be true today. While sometimes mis-directed and taken to extremes (Health insurance companies are often penny wise and pound foolish in their health plan designs and rules.), some form of coherent management strategy is necessary to improve outcomes and control costs.

While many might disagree, I think Vermont has a much better handle on managing the increase in health care costs than it did 10 years ago. This is in large part to the reform processes that are currently under way.

Expectations
An all Payer ACO model will not solve all of the challenges of Vermont's health care system. It is a framework that reimagines how heath care services are delivered and paid for. For this to be successful the manner of paying for health services must be aligned to the goals of a better managed health care system with better outcomes.

• This is a long-term process. It will not come without mistakes and missteps being made.
• A single payer system is also an all-payer system because there is only one payer.
• A single payer system will fail if the payer does not insist on better outcomes. It will fail if it does not move away from fee for service payments. Solely lowering provider fees and eliminating insurance companies will not lead to better quality or outcomes. This is sometimes forgotten by proponents of this system. This accountability will be demanded by the taxpayers that support the system. The single payer entity becomes the insurance company and over time will begin to act like an insurance company in many ways.

Measuring outcomes and service quality incurs administrative costs. Many do not understand this. While there are excessive administrative costs in the health care system, I do not think they are as large as many believe. Yes, I do agree that dealing with health insurance payment issues can be frustrating, time consuming and often should be unnecessary (again arising from poor policy design), that is not the only administrative cost. Much of the administrative costs are tied up in recording and measuring services and outcomes. Ensuring better outcomes will require rules and algorithms to assure quality care is provided. Some practitioners will not like this and will push back.

Needs Going Forward
We need to get more people in the system. This should be a priority of the ACO going forward. Without a large percentage of Vermonters in the system it will be difficult to achieve population health goals laid out in the ACO plan.

The all payer ACO is difficult for people to understand and appreciate. Health plan design must be aligned with the ACO system. This means moving cost sharing away from fee for service-based payments. This is complicated by ability to pay issues. How can health system users understand the ACO model if they still pay fee for service-based deductibles and co-pays? I believe this is a major stumbling block that has not been adequately addressed. Why can't health system users benefit from the efficiencies and improved outcomes that can be provided by the ACO model?

Many state legislators do not understand the ACO model. Legislative champions are needed! The State Auditor seems to be focusing on the wrong things in its review of the ACO model. There is too much politics being inserted into the process.

Preventative care and lifestyle issues must be addressed in the ACO going forward. More must be invested here. I think "boots on the ground" provision of screening and services will be necessary. It would be nice, though challenging, to determine the return-on-investment for these programs. The ROI must determine both soft and hard numbers.

Employers have been neglected in the ACO process. This seems odd to me because employers pay a sizable amount of health insurance costs in the state. They also make decisions about the types of health plans offered to employees. Employees spend a significant part of their waking hours engaged with their employer. They typically spend much of their time at the employer's place of business (at least before COVID) or work sites. There is a large opportunity to engage employers in the process. This can include help with changing health insurance plan design and incentives. It is also a point of access for health and wellness programs for employees and their families. I think it is about time this system gap be addressed.

Big data has a major role to play in improving health system outcomes. While not directly a function of

the ACO, the scale of the ACO should make improving use of big data capabilities throughout the health care system more feasible. This includes, among other things, determining which treatments result in the best outcomes, improved diagnosis and treatment of less common illnesses and diseases, cost effectiveness of various treatments and pharmaceutical usage, success of population health and wellness initiatives, return on investment.

Care coordination must be enhanced and expanded. This is one way to directly reduce unnecessary testing, care, prescription drug usage to assure the best and most effective treatment for each patient.

The role of health providers will need to be reimagined. More use of nurse practitioners and such. Use each medical provider to best and highest function. The ACO is in a unique position to develop and implement these changes. The same can be said for the hospital system in Vermont.

Perhaps more tele-health for some services can be utilized. Perhaps some specialist consultation services can be provided by tele-health. The ACO would be a good place to develop best use practices within the Vermont health care system. Can it improve efficiencies and outcomes in the system?

While these are not specific detailed suggestions for the ACO renewal they are my thoughts on bigger picture changes needed to move forward. It is important to keep an eye on the big picture and measure how specific proposed changes will move the broad agenda forward.

While it is important to set ambitious goals, it is also important not to over promise. It is also important to understand that going back to the way we used to do things is not an option. That is how we got to where we are today.