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M E M O R A N D U M

TO: Green Mountain Care Board

RE: Comments on OneCare Vermont's 2022 Budget

FROM: Kirsten Murphy, Executive Director and Susan Aranoff, J.D., Senior Planner and Policy Analyst

DATE: December 17, 2021

Thank you for providing this opportunity to comment on OneCare Vermont's 2022 Budget.

In recent years, the Vermont Developmental Disabilities Council (hereafter "the DD Council") has raised concerns many times about the All-Payer Model and its sole Accountable Care Organization (ACO) OneCare Vermont. These comments continue in the same vein, focusing on three key issues that the DD Council believes to be more relevant today than ever.

- The All-Payer Model has relied heavily on Medicaid to stand up the operations of the ACO, amounting to a considerable, but yet unquantified, public subsidy to OneCare Vermont. The return on this investment is unknown.

- Vermont has lost the opportunity to shore up its underfunded, community-based system, despite the critical role it plays in addressing the social determinants of health. Instead, Medicaid investment dollars have been directed solely toward OneCare Vermont.

- Vermont has failed to address the anti-trust implications of OneCare Vermont's unique status in the healthcare marketplace and to reconcile the dual role that the legislature has asked the Green Mountain Care Board to play as both regulator and promoter of the All-Payer Model.

The Council believes that continued approval of the OneCare Vermont budget must be contingent upon tangible progress in addressing each of these three issues

Background: The Vermont Developmental Disabilities Council

The Vermont Developmental Disabilities Council is a statewide board created by the federal Developmental Disabilities Assistance and Bill of Rights (hereafter "the DD Act"), first adopted by Congress in 1970. Our constituents are health care users who have an important stake in the cost, quality, and availability of both traditional healthcare and disability long term services and supports (DLTSS). An estimated 86,000 Vermonters experience a developmental disability as defined by the DD Act, with approximately 5,100 receiving some type of community-based support through Medicaid.

The DD Council is charged under federal law with engaging at the state level in "advocacy, capacity building and systems change activities that… contribute to the coordinated, consumer-and-family-centered, consumer-and-family directed, comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families."

Further, the DD Council's signed Assurances with the Vermont Agency of Human Services state: "The Council will participate in the planning, design or redesign, and monitoring of State quality assurance systems that affect individuals with developmental disabilities." Rationalizing the coordination of healthcare and the quality metrics by which OneCare Vermont is measured place Vermont's All-Payer Model squarely in the area of state quality assurance.

For all these reasons, the DD Council pays close attention to healthcare reform and Medicaid spending.

Delivery System Reform Funds and their Return on Investment

The State of Vermont has paid OneCare Vermont (OCV) millions in Medicaid dollars.

Vermont's 2016 Global Commitment Medicaid Waiver gave Vermont authority to spend Medicaid funds on Delivery System Reforms (DSR) in two categories: Category 1 was to be directed toward Accountable Care Organizations (ACOs), which effectively meant OneCare Vermont after other ACO's folded in 2016. Category 2 consisted of funding to

community-based providers, including designated and specialized services agencies, community substance use disorder programs, and other entities that deliver Medicaid-funded long-term services and supports.

The Agency of Human Services, a party to the All-Payer ACO Model Agreement, chose to direct all Medicaid DSR funds to OneCare Vermont. None of the Medicaid dollars available to assist community-based organizations in delivery system or payment reform ever went directly to an organization other than OneCare Vermont. For most of the period during which it received these DSR funds, OneCare Vermont was a for profit corporation. As such, it could have received money to stand up its operations from its parent organizations, Dartmouth Hitchcock Medical Center and the University of Vermont Health Network, which throughout the relevant time period were flush with excess capital, rather than the Vermont Medicaid Program.

At the time the All-Payer ACO Model Agreement was announced, the parties to the agreement -- AHS and the GMCB -- gave sound reasons for investing DSR funds in community-based organizations, as well as OneCare Vermont. In testimony to the legislature and elsewhere, then-Chair of the GMCB Al Gobeille, said that "bending the cost curve" in healthcare would require both restructuring the way that traditional care is paid for and strengthening the community resources that address the social determinants of health. If we pay hospitals and physician practices to keep people healthy, then those providers need better-resourced community partners with expertise in addressing the root causes of poor health. These upstream factors include poverty and social isolation, as well as substance use and chronic mental health conditions. This theory of change was valid in 2016 when the agreement was signed, and it is valid today.

However, Vermont did not follow this theory. Vermont did not use any of its DSR funds to support systemic reforms of Vermont's home and community-based services or service providers. With the added stress of the pandemic, these already under-funded partner organizations are now struggling for their very survival. Workforce shortages for home health, developmental services, and community mental health have reached unprecedented levels. Never truly competitive, the wages of frontline staff are too low to attract the dedicated staff required to perform these important and challenging jobs. In some cases, agencies have more vacancies than filled positions. The result is often a cascading series of events whereby a client experiences increase isolation and stress, leading to greater need, increasing pressure on staff, and ultimately culminating in a costly crisis that could have been prevented. Disappointingly, OneCare Vermont has dramatically cut funding for Community Mental Health Centers in its 2022 Budget.

In short, despite promises made at the time the All-Payer Model was unveiled, resources and care now lean even more heavily toward traditional medical interventions and away from creating communities that support health and wellbeing. In fact, OneCare's budget contains plans to redirect public health investments away from community resources that have promising approaches to addressing social determinants of health and instead focus on clinical approaches.

Just how skewed investment has been, however, remains a matter of speculation. The exact amount of DSR funds that the State has invested to date in OneCare Vermont is difficult to track and routinely sidesteps the regular state budget process. There was never a transparent public process for applying for DSR funding. Instead, funds moved to OneCare Vermont by state contracting through the Department of Vermont Health Access (DVHA).

At the Green Mountain Care Board hearing on OneCare's 2022 budget (November 10, 2021), the undersigned asked about the amount of Medicaid and health information technology funds OneCare has received from the State since the beginning of the All-Payer Model Agreement. Chair Kevin Mullin directed GMCB staff to work with DVHA and OneCare Vermont to identify the total state and federal funding received for start-up, DSR, and Health Information Technology since 2017.

Determining the amount of investment, however, is only a first step in evaluating OneCare Vermont's impact on Vermont. In 2014, the Vermont Legislature set in place Act 186, the "Outcomes Bill," which requires State government to evaluate its work through the lens of Results-Based Accountability (RBI)™. Pioneered by Mark Freedman and field-tested in Vermont, RBI seeks to understand quality improvement activities from the broad perspective of population accountability. RBI asks not only how much and how well an organization is doing in a particular initiative, but most importantly why it matters. "Is anyone better off?" the RBI evaluator asks, and "If so, how do we know?"

For the State of Vermont to justify continuing to contract with OneCare Vermont, it must first quantify the scale of its investment to date and evaluate the return on that investment in terms of its impact on the health and financial well-being of all Vermonters.

<u>The State Action Doctrine Requires Active Supervision</u>

The "state action doctrine" is the legal standard that essentially immunizes states and private participants from federal antitrust liability when a state chooses to regulate conduct that could be considered anti-competitive under federal standards. ACOs like

OneCare Vermont have a safe harbor to engage in anti-competitive practices like price setting for services across all providers. In fact, this safe harbor allows ACOs to engage in a raft of business practices that would otherwise be impermissible under federal and state anti-trust laws. However, this immunity must be accompanied by active state supervision, known as the State Action Doctrine.

State action immunity can be given to an ACO if the State has: First, clearly articulated a state policy condoning the conduct; and second, shown itself to be actively supervising the conduct of the ACO. The purpose of the first requirement is to confirm the state's intent to displace normal competition to achieve some tangible public benefit. In Act 113 of the 2016, the legislature expressed its intent to replace competition between payers with State-supervised cooperation in the hope of achieving certain public benefits, including the benefit of reduced healthcare costs. Thus, the State has satisfied the clear articulation requirement for immunity from anti-trust laws.

However, Vermont falls far short of meeting the second requirement to confer immunity from anti-trust laws on OneCare Vermont. The basic requirement of the state action doctrine is that the State act. At a bare minimum, the State needs to monitor the activity in question in order to ensure that the harms of anticompetitive behavior are offset by some tangible benefit to the people of Vermont. That benefit could fall in any of several domains. For example, cooperative price setting could be shown to lowers healthcare costs; or it could be found to improve the quality of care to such a degree that the health benefits to the population outweigh the negative impact of anti-competitive practices. In either case, the State has an affirmative obligation to monitor the impact of the ACO on healthcare costs to its citizens.

Other states are providing active supervision to the ACOs within their borders. For example, in New York State, ACO regulations require both an affirmative showing that the ACO is achieving at least one of six enumerated possible public benefits. New York's regulations also require its ACO regulators to consider the impact that the ACO might have on the State's overall healthcare provider landscape and any potential disadvantages to the beneficiaries of ACO-affiliated providers. (See, 10 NYCCR Part 1003)

As early as 2017, the DD Council commented that the administrative rules by which OneCare Vermont is governed and the statutory oversight contemplated in Act 113, do not adequately ensure the active and close supervision that would allow anti-competitive practices.

Under Act 113 of 2016, the Green Mountain Care Board is identified as the entity tasked with overseeing the activities of OneCare Vermont. However, the terms of this arrangement were unusual in that Act 113 gave the GMCB the authority both to pursue the all-payer agreement and to promulgate the necessary regulations for the operation of any resulting accountable care organizations in Vermont. Unfortunately, the legislature burdened the GMCB with the impossible task of being both a regulator of ACOs and a promoter of the all-payer model agreement. In Act 113, the GMCB is directed to promulgate regulations "balancing oversight with support for innovation." Playing a dual role, as both promoter and regulator, is not only difficult but arguably untenable.

Even then the Legislature recognize the troubling anti-competitive nature of Vermont's healthcare marketplace. Although worded in very general terms, Act 113 charges the GMCB with:

> "To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods."

How has OneCare Vermont fared in demonstrating a tangible benefit to the population of Vermont? On the financial side, there have been several auditor's reports that question the financial impact of the All-Payer Model, suggesting instead that Vermont's ACO has driven costs higher. Most significantly the Auditor found that the GMCB has no way of knowing if the All-Payer Accountable Care Organization Model Agreement is benefitting Vermonters.

In its 2020 Report on the All-Payer Accountable Care Organization Model Agreement, the Office of the State Auditor found the following:

> **The GMCB has not developed a methodology to determine whether OneCare's operating costs will be greater or less than the benefits of the ACO Model. The ACO seemingly poses new administrative costs to the health care system,** (OneCare has an operating budget of $19.3 million for 2020). The GMCB has recognized the importance of this cost-benefit analysis and requires estimated

savings from the ACO exceed OneCare's operating costs over the duration of the agreement. However, the Board's staff have noted that it is difficult to quantify costs that were avoided as a result of the ACO, and a determination of the ACO's value should also consider quality improvements. While there is limited performance data as of today, the GMCB can quantify the value of indicators that are known, such as OneCare's financial data. **Until the GMCB completes this cost-benefit analysis, the State cannot determine whether the ACO Model's claimed financial and quality outcomes outweigh OneCare's operating costs.** (Emphasis added).[1]

Furthermore, the Green Mountain Care Board recently released the 2020 financial and quality care results for OneCare Vermont. The results show that OneCare Vermont "saved" almost $8 million in Medicare spending and over $15 million in Medicaid spending. However, those savings result from the effect of Covid 19. In 2020, because of Covid, people and providers postponed care. Nonetheless, because of the way the contract is written, Medicare and Medicaid spent less than was budgeted, therefore the state and federal government must pay the difference to OneCare. Essentially, taxpayers and ratepayers are paying a private entity more for doing less.

At the same time, OneCare Vermont's quality results are mixed at best and in many cases appear to be trending downward. In 2020, OneCare Vermont's scores on quality-of-care measures such as blood pressure and diabetes management declined. For OneCare Vermont's quality performance in Medicare, half of the measures had worse outcomes. In six out of 12 measures, OneCare Vermont's performance declined from the prior year. For Medicaid, OneCare's performance declined in nine of the 10 measures, when compared to the prior year.

As a result, the state and taxpayers are paying OneCare $23 million, not only for less care, but also for lower-quality care.

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In Summary, the Green Mountain Care Board should not approve OneCare Vermont's budget until it can quantify both the public's investment to date and the return on that investment. At present the GMCB is not tracking the public's investment, nor does it have means to measure the impact of that that investment in terms of Results Based

[1] Office of the State Auditor's Report on the All-Payer Accountable Care Organization Model Audit Report 20-02 (June 26, 2020) P. 5.

Accountability. In addition, Vermont is not currently providing the active supervision required to waive anti-trust laws.

The most basic tenant of healthcare is “do no harm,” often interpreted to mean that for any intervention good must clearly outweigh harm. Prior to approving another budget for OneCare Vermont, the Green Mountain Care Board should promulgate an amendment to Rule 5 that requires an affirmative showing that OneCare Vermont does the same: The good that OneCare does must outweigh the harm.