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TO: Green Mountain Care Board

RE: Comments on OneCare Vermont's 2022 ACO Budget

FROM: Julie Wasserman, MPH

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OneCare's 2022 Budget marks the *final* round of Vermont's 6-year experiment in health care reform. The All Payer ACO Model Agreement with CMS began January 2017 and concludes December 2022. Since Vermont is entering its final year of this initiative, these comments employ an overarching assessment of progress to date. Much has been learned thus far, but many questions remain. The following comments document:

- What we know
- What we don't know
- Recommendations for future efforts

The Green Mountain Care Board states: "*The All Payer ACO Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to risk-based ACO arrangements tied to quality and health outcomes.*" CMS states, "*This collaboration (with the State) supports Vermont's and CMS's goals towards health care reform by reducing expenditures and improving health outcomes under the Model.*"

Vermont's sole ACO, OneCare, is the vehicle to accomplish these stated goals. The question remains: How successful has OneCare been?

Participation in the ACO

The number of Vermonters participating in this initiative remains low; OneCare's reach is limited. After four years of effort, only 230,765 people, comprising a mere 36% (35.9%) of Vermonters, are included in the All Payer Model. (Latest available data - p.6.) Moreover, Green Mountain Care Board (GMCB) member Pelham recently acknowledged that OneCare is nearing a saturation point for eligible Medicare and Medicaid attributed lives.

OneCare's Medicare lives actually decreased in 2020. The ACO's prospectively aligned lives numbered 53,973 in 2019 and 53,842 in 2020. The counts used for financial reconciliation show an even greater decline. The number of Medicare lives fell from 48,303 in 2019 to 44,507 in 2020. (Slide 9) These 44,507 individuals comprise only 36% (36.1% - see p.6) of Vermont's Medicare population.

Further compounding Medicare's marginal participation, UVM Health Network has just created its own Medicare Advantage Plan. Enrollees in this Plan are ineligible for the ACO. Since UVM Health Network is the parent organization of the ACO, one would think they

would want the ACO to succeed. Nevertheless, the UVM Health Network has just created a new private Medicare Advantage insurance plan that further reduces the number of eligible lives for its ACO. In addition, five of Vermont's thirteen hospitals who have joined the ACO are *not* participating in OneCare's Medicare program.

Commercial participation in the ACO is essential to the success of the All Payer Model. Vermont's commercially insured lives add up to more than twice the number of Medicare and Medicaid lives *combined*. Vermont's Commercial market totaled 313,605 individuals in 2019; however, Commercial participation in the ACO is relatively minor at 62,588, or 20%. (2020 – see p.2) Total Vermont Commercial market counts are latest available – see p.50).

In order for Commercial lives to be officially counted in the All Payer Model, they need to meet the definition for "scale". One of the fundamental aspects of "scale" is that there be some kind of risk arrangement with the ACO. BCBSVT has not borne risk since the inception of the All Payer Model, and OneCare reports BCBSVT is bearing zero risk in 2021. How does BCBSVT's "Primary Risk" group meet the requirements for a risk arrangement and how does this group qualify for scale? A case in point: the State Employee Health Plan opted out of a risk arrangement with BCBSVT and OneCare in 2021. If these 12,675 State Employees are not counted as official "scale qualifying" lives for the All Payer Model (recently confirmed by GMCB staff), how then can other similar BCBSVT Self-insured Large Group lives qualify for scale?

Lastly, even though the year is almost over, neither the GMCB nor OneCare will provide the 2021 preliminary number of "scale qualifying" attributed lives by payer program, as has been routine in previous years. This is after multiple requests for this public information. Preliminary counts for 2020 were available in late 2019 (slide 53) and early 2020 (p.7). Why the lack of transparency for the 2021 counts?

Population Health

OneCare repeatedly reminds us that a foundational element of the ACO is "value-based care" which encompasses promoting wellness, keeping people healthy, and maximizing the population's health. One of the most effective methods to accomplish this is through annual wellness visits and prevention initiatives. This goal is best accomplished through community-based prevention efforts and a well-funded, stable, and rock-solid primary care physician workforce. However,

- OneCare has not employed any strategies to strengthen Vermont's primary care physician workforce.
- In fact, OneCare's reimbursement policies have actually weakened Vermont's primary care physician workforce through reduced upfront 2021 payments.
- The CMS commissioned NORC study of the All Payer Model for the period 2018 and 2019 (published in August 2021) observed "small declines in beneficiaries with AWV (annual wellness visits) for OneCare" in both years. (See p.71)
- OneCare's investments in Population Health have shown a steady decline over the course of the last several years (detailed below).

OneCare's support for Population Health has diminished significantly. The ACO's 2022 budget reveals a substantial decrease in funding. In 2020, OneCare allocated $43.1 Million to Population Health, yet 2022 funding has fallen to $28.9 Million. This amounts to a 33% *decline*. (For 2020 data – see slide 20. For 2022 data – see slide 42.)

OneCare's deep cuts to the Community Mental Health Centers (DAs) and Home Health Agencies speak volumes about OneCare's priorities as a *hospital based* ACO. OneCare budgeted $3.4 Million for the DAs in 2020; however, that funding has dropped to $1 Million in 2022. This represents *more than a three-fold cut* while Vermont is in the midst of a full-blown community mental health crisis. We need more resources for early intervention and treatment, *not less*.

OneCare's $2.2 Million funding for Home Health Agencies in 2021 will decline to $1.5 Million in 2022. We know that hospital expenditures drive the high cost of health care. We also know from a recent consultant's report presented to the GMCB that Vermont hospitals have longer lengths of stay relative to benchmarks, especially UVM Medical Center which had markedly high lengths of stay (1.73 days longer relative to benchmark). Home Health services not only prevent or delay hospitalizations, they also foster early discharge. Why then has OneCare reduced funding to Home Health Agencies? Furthermore, why has OneCare not deployed any explicit measures to reduce or prevent hospitalizations?

Community prevention activities also have been curtailed. OneCare's 2022 funding for DULCE is being reduced to $204,485, and OneCare's support of RiseVT is being phased out. In addition, OneCare's "prevention strategies" will shift away from community-based prevention activities at the expense of addressing social determinants of health. Instead, the ACO's prevention efforts will be performed by physicians in the clinical setting.

In sum, OneCare's 2022 budget cuts fly in the face of its purported commitment to value-based care and systemwide change.

Vermont providers dependent on the ACO for funding have privately expressed that while they have major concerns about these funding reductions and OneCare's priorities, they are unwilling to speak publicly for fear of retribution.

Misplaced Priorities

Paradoxically, OneCare's most current Organizational Chart has five (5) full-time staff devoted to public affairs, marketing, and strategic communications. Additionally, the ACO's 2022 Budget includes $110,00 for "Advertising". Yet, no clearly identified positions exist in OneCare's Organizational Chart to evaluate this $1.4 Billion initiative.

OneCare's total administrative costs for implementing the 6-year All Payer Model will exceed $80 Million, a large sum of money by any standard. Proponents might expect far reaching ACO penetration given these expenditures. Yet, OneCare was responsible for a mere 13% of Vermont's total health care spending in 2019 (p.9). We are awaiting 2020 results.

(Note: OneCare's administrative costs are *in addition to* current administrative costs borne by Medicare, Medicaid and the Commercial insurers.)

OneCare was recently subsumed by the large private multi-organizational UVM Health Network which will use its infrastructure to support and sustain the ACO by aligning processes and sharing resources to achieve efficiencies. This merger constitutes a significant conflict of interest and yet no one in a leadership position has seriously challenged this development or contested it. How will the public interest be served by giving the UVM Health Network expanded control over how the ACO determines and allocates payments to providers, of which the UVM Health Network is the largest? Where are the guardrails?

Fixed Prospective Payment (FPP)

The promise of the All Payer Model was to move away from fee-for-service reimbursements to risk-based ACO payments (capitation). Yet, OneCare has shifted *less than 2%* of Vermont's total health care spending from fee-for-service to fixed prospective capitated payments (latest available data - slide 10).

OneCare's 2022 Budget blurs the distinction between OneCare's true Fixed Prospective Payments (capitation) and OneCare's monthly advance provider payments reconciled to Fee-for-Service at the end of the year. In its recent Budget submission, OneCare documents $270 Million in Medicare "Fixed Prospective Payments" to hospitals. (See tab "6.6 All Hospitals") These payments are not true Fixed Prospective Payments (capitation), but instead are monthly advance payments that are reconciled to Fee-for-Service at year's end.

These explicit questions remain unanswered:

- OneCare shifted *less than 2%* of Vermont's total health care spending from Fee-for-Service to Fixed Prospective Payments (capitation) in 2019. When can we expect to see the same calculation for 2020?
- The GMCB has calculated that 14.5% of the 2021 Hospital Budgets are "Fixed Prospective Payments" (slide 52). Does the entire 14.5% comprise true Fixed Prospective Payment (capitation) or does some portion of the 14.5% include monthly advance payments that are actually reconciled to Fee-for-Service at year's end?
- What percent of the 2022 Hospital Budgets are true Fixed Prospective Payment (capitation)?
- Where are the GMCB's promised definitions to distinguish between true Fixed Prospective Payment (capitation) and monthly advance payments?
- Will the GMCB and OneCare be making the distinction between these two types of payments in forthcoming presentations?

ACO Savings

The Federal NORC study of the All Payer Model covering 2018 and 2019 chose to focus *only* on Medicare lives even though these lives comprised roughly a third of all ACO participants. Compounding the problem of studying only one third of all ACO participants, the Medicare ACO lives studied were a minority of Vermont's Medicare population, making up only 33%

of all Vermont Medicare lives in 2018 and 47% in 2019. Neither of these percentages were representative of Vermont's Medicare population. The study would have been more credible had it included Medicaid lives since Medicaid participation in the ACO is far greater. Hopefully, the Federal study's omission of Medicaid was not an attempt to avoid the ACO's 2019 Medicaid losses (an overspend of $13.5 Million).

The NORC report found that the ACO had no net Medicare savings in 2018 and 2019. Net savings are the true and most accurate indicator of savings because they remove items like CMS's pass-through payments for the Blueprint. Accordingly, NORC did find net Medicare savings with the state level group, *outperforming* the ACO in this domain.

The GMCB has just released OneCare's 2020 financial results which show OneCare had "savings" in both its Medicare and Medicaid programs. These purported savings are dubious given health care utilization fell precipitously in 2020 due to the COVID pandemic.

Nevertheless, OneCare's Medicare "underspend" means CMS will pay the ACO $7.9 Million. As a result of OneCare's Medicaid "underspend", the State (DVHA) owes OneCare $15.4 Million. These alleged savings totaling $23.3 Million occurred during a time when patients literally avoided care and providers postponed non-essential care.

How can we justify DVHA paying OneCare $15.4 Million for less (utilization plummeted in 2020) and poor performance? Taxpayers may not like the idea of the state giving precious public dollars to a private entity for providing less care, with lower quality. (See quality results below.)

Something has gone terribly wrong. Is the ACO model inherently flawed? Are there fundamental problems in the DVHA/OneCare Contract? The Green Mountain Care Board and the Agency of Human Services owe the public a thorough explanation.

ACO Quality Performance – 2020

OneCare's Medicare quality performance dropped in 2020; half of the measures had worse outcomes. In 6 out of 12 measures, OneCare's performance declined from the prior year.

OneCare's Medicaid quality measures worsened as well. Quality performance *declined in 9 of the 10 measures**, compared to the prior year. These performance declines were across the board, and yet DVHA's recent presentation before the GMCB failed to include a Summary overview slide depicting overall results (as has been done in the past).

BCBSVT saw no difference in quality outcomes between its ACO attributed and unattributed populations. MVP's ACO attributed lives scored 50 out of 100 points.

* OneCare's worsening Medicaid quality performance occurred in the following measures: control of hypertension and diabetes; screening and follow up for depression; engagement of alcohol and substance abuse treatment; developmental screening in the first 3 years of life; 30-day follow up after discharge from the ER for alcohol, substance abuse, and mental health; adolescent well care visits; and avoidable hospital readmissions.

Moving the Goalposts

1. An important and overarching measure of the ACO's success is a comparison of ACO savings with costs. Do savings outweigh the cost of administering this initiative? Simply put, does the ACO pay for itself, at a minimum?

   It appears that the GMCB wanted to ensure the answer to this question was "yes" so they stipulated in their 2018 Budget Order: *"ACOs should provide a net benefit to the system and we will monitor OneCare's administrative expenses to ensure they are less than the total health care savings generated through the All-Payer ACO Model.*" (GMCB FY18 Accountable Care Organization Budget Order, January 3, 2018.) This assessment of "net benefit" was to be performed yearly, affording oversight and routine corrections, if needed.

   However, one year later, the GMCB revised this provision; the assessment would occur over the life of the All Payer Agreement and the criteria for savings was expanded and became more permissive: "*Over the duration of the agreement, OneCare's administrative expenses should be less than the health care savings, including cost avoidance and the value of improved health, projected to be generated through the Model.*" (GMCB FY19 Accountable Care Organization Budget Order, February 5, 2019.) Subsequently, the word "should" was changed to "must". Regardless, these revisions rendered the provision ineffective, and points to a relinquishment of regulatory responsibility.

   OneCare's $80+ Million in administrative costs will likely surpass its savings at the end of the 6-year All Payer Model Agreement. Unfortunately, by then, it will be too late to make any corrections.

2. To ensure robust participation in the All Payer Model, CMS stipulated targets for the number of people served by the ACO. As noted above, OneCare has been unable to enroll an adequate number of covered lives. To address this shortcoming, the Agency of Human Services and the GMCB convinced CMS that the ACO targets were unobtainable and should be altered. As a result, CMS waived the requirement. Vermont will no longer be subject to CMS corrective action plans or termination of the All Payer Model due to Vermonters' low participation in the ACO. *Even though Vermont will avoid CMS disciplinary action, the fact remains that participation in the ACO is lacking.* NOTE: the requirement for scale qualifying lives as the "official" count of people participating in the ACO remains intact and continues to be one of the key metrics for measuring the ACO's success.

3. Provider "risk" constitutes the central pillar of the All Payer ACO Model. Risk-based arrangements tied to healthcare expenditures comprise the financial construct of the ACO. However, OneCare has all but abandoned risk. Neither BCBSVT nor MVP has borne risk. Medicare and Medicaid's prorated risk has continued to drop and is essentially non-existent for both 2020 and 2021. *OneCare has evolved into a non risk-based model.*

Recommendations for Future Efforts

- *Vermont's health care reform efforts should not be concentrated on a minority of Vermonters (36% participation in the ACO).* Instead, Vermont needs to address the accessibility, affordability, and quality of health care for *all* Vermonters.

- There should be no renewal nor extension of the All Payer ACO Model. Replace it with state regulated hospital rate-setting, global budgets, and a more fully funded community-based service system. Vermont could implement some of the successful elements of the Maryland model.

- GMCB Board members concerned with the "cost shift" may find Vermont's hospital rate-setting language contained in Act 48 (p.31) an attractive option to replace the ACO model. Such an approach not only addresses price differentials among payers but can also be utilized to strengthen underserved areas of the state.

- DVHA becomes a public "state-run" risk-bearing Medicaid Managed Care Organization on January 1, 2022. DVHA should perform the core functions of its Medicaid Managed Care Organization rather than employing a private ACO with a weak track record and inordinate administrative costs. Health care savings would instead accrue to the State in the public's best interest.

- The state owes OneCare $15.4 Million for providing less care during the pandemic, accompanied by declining patient outcomes. DVHA and OneCare are presently negotiating a continuation of the Medicaid contract for the final year of the All Payer Model (2022). A moratorium on this final contract should be imposed until this issue has been adequately addressed.

- OneCare's recent 2022 Budget presentation to the GMCB included this statement: "The main challenge in the 2022 budget was accommodating the loss of Delivery System Reform (DSR) and Health Information Technology (HIT) funding - $3.9M revenue loss." (See slide 36) This loss of public dollars compelled OneCare to cut funding for the all-important Population Health initiatives (as described earlier). OneCare claimed that the only way to fully support their Population Health programs was through increased state and federal funding. (See p.60) Yet, all the while, OneCare anticipated receiving $23.3 Million in public funds resulting from the reconciliation of its 2020 budget. Did the GMCB, Agency of Human Services or Legislators notice this incongruity? If so, where is the accountability?

- The GMCB should carefully consider OneCare's $23.3 Million windfall when deliberating on the ACO's 2022 Budget.