HEALTH FIRST

December 2, 2022

Owen Foster, Chair
Green Mountain Care Board
144 State Street
Montpelier, VT 05602

Re: HealthFirst Comments on 2023 OneCare Budget

Dear Chair Foster and Members of the Green Mountain Care Board:

Thank you for the invitation to suggest how the ACO budget could better support independent primary care practices. Fifteen of HealthFirst's 26 primary care practices participate in OneCare programs; seven of those are in the capitated CPR program.[1] The fifteen participating practices include all our larger and medium sized practices and collectively care for 94 percent of the over 85,000 total patients receiving care at our primary care practices.

The payments our independent primary care practices receive through OneCare have been beneficial for practices, including those that participate only in the standard (not capitated) program. The care management funds given directly to practices have allowed many to expand these services and hire or retain staff for these essential services that have been the unpaid cornerstone of primary care for many years. However, it is paramount to understand that the funds currently available still do not cover the cost of the services being provided. **It is vitally important that these payments be continued and enhanced** – with or without an ACO - if the state wants to ensure the sustainability of these high value primary care practices. It is also important that any payment reform model be flexible in design so that it adequately supports different practice types because not all practices benefit from the CPR (capitated) model.

While the care management funds have helped support vital services, we are concerned that the ACO model as currently constituted has not fundamentally changed the way care is delivered or resulted in true practice reform. Real change isn't likely until 65 percent or more of a practice's panel is attributed. Currently, about 30 percent of a

[1] The bulk of the primary care patients cared for by our network are patients at a OneCare participating practice. The 11 practices that do not participate are primarily direct pay or concierge practices (n=8) who have relatively small patient panels.

practice's panel is attributed and given the percentage of self-insured patients in our system, it is not clear that we will ever reach the critical mass that results in practice reform. We also are not clear what that practice reform will look like or what sort of outcomes it will provide.

Additionally, we've not seen evidence that there is any improvement in patient outcomes in participating CPR practices relative to non-CPR practices, nor have we seen any measurable improvement to access. Meanwhile, we have a concurrent persistent crisis of the primary care workforce. Primary care is the bedrock to any reform, and much more support is needed to attract and retain clinicians, to reduce administrative burden, and to tackle burnout. If health care dollars are to be used to support the ACO as a middle entity, there should be demonstrable benefits above what could be achieved by merely funneling those dollars directly to primary care practices.

If the ACO model is to continue, we would like to see Vermont's ACO engage in more activities that are key characteristics of high performing ACOs[2]. Such activities could include moving care to lower cost sites and reducing discretionary testing and imaging. In addition, a commitment to transparent and systematic sharing of practice level data to help drive improvements also is needed. Practices should be able to see where they stand relative to peers, targets, and benchmarks and given the opportunity to improve at various points throughout the year. A model that has worked well with prior ACOs and the Blueprint for Health is to have practice facilitators regularly meet with practice staff to review actionable data, identify strengths and areas for improvement.

We also continue to have serious concerns about the increasing consolidation and monopolization of our healthcare market. UVMHN's status as the parent organization of OneCare and UVMHN's subsummation of OneCare's data and analytical functions further cement UVMHN's dominant position in the market. Ample research has shown that such consolidation is not good for patients or providers. Steps should be taken to curtail such domination such as those outlined by the Health Care Advocate.

Also, with the data and analytical functions in the hands of UVMHN, UVMHN is in the position to access the data of its competitors. No such access will be afforded to ACO participants who are not part of UVMHN. OneCare asserts that there will be ample data protections to prevent unauthorized use by UVMHN. However, this gives us little

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2 https://gmcboard.vermont.gov/sites/gmcb/files/documents/CoreCompentenciesofHighPerformingACOs_Bailit_BoardPres_20210512.pdf

comfort as the data protections will be monitored internally. At the very least, an outside auditing entity should regularly monitor whether data is used appropriately, and the audit reports should be shared with all network participants and the GMCB.

Speaking publicly about these issues certainly gives us pause because of the potential harm to our practices, yet we feel compelled to provide honest feedback to the Board. Over the last two years in particular, OneCare leaders have done a lot to engage and consider the needs of independent practices and the financial support to our primary care practices through OneCare has been beneficial. While we acknowledge that OneCare provides certain benefits for independent practices, we believe that there are more efficient and cost-effective ways to deliver this support and to reform our system so that Vermonters have better access to high quality, more affordable health care services.

Regards,

Susan Ridzon and Rick Dooley
Vermont HealthFirst