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December 19, 2017

Kevin Mullin
Chair, Green Mountain Care Board
3rd Floor City Center
89 Main Street
Montpelier, VT 05620-3601

Re: HCA Comments on OneCare Vermont Accountable Care Organization 2018 Budget Review

Dear Chair and Members of the Green Mountain Care Board,

Thank you for the opportunity to comment on the Green Mountain Care Board (the Board)'s review of OneCare Vermont (OneCare)'s 2018 Accountable Care Organization (ACO) budget. The Office of the Health Care Advocate (HCA) has been engaged in the Board's payment and delivery system reform work since the Board's inception, and has advocated for transparency, accountability, and consumer protection for patients attributed to Vermont's ACOs since ACO programs began in the state. We advocated for the Board to have strong regulatory authority over ACOs during the development of Act 113 of 2016 and continued to advocate for strong transparency, accountability, and consumer protections during the development of the Board's Rule 5.000: Oversight of ACOs.

The 2018 budget review process has provided us with a substantial amount of insight into the operation of OneCare and the flow of money in Vermont's health care system, and we appreciate our role on behalf of consumers in this process. We have remaining concerns about information missing from OneCare's budget submission, including its payer and provider contracts and risk mitigation information, and about OneCare's policies surrounding transparency, accountability, and consumer protection.

In our 2015 policy paper, [*Consumer Principles for Vermont's All-Payer Model*](#), we outlined our preliminary concerns about risk-bearing ACOs and the steps we believed would be necessary to protect consumers under such a model. Throughout the development of the APM and ACO programs in Vermont, we have maintained that payment reform may benefit Vermonters if quality and access are prioritized, and if there is sufficient transparency, accountability, and consumer protection to ensure that patients are not harmed and that any quality or access issues are identified and addressed in a timely manner. As Vermont moves into the APM and substantially expands its risk-bearing ACO programs in 2018, we are concerned that the transparency, accountability, and consumer protection practices described by OneCare in its budget submission are insufficient to keep Vermonters informed and protected, to counterbalance some of the potentially harmful incentives inherent in acceptance of financial risk by providers, and to ensure success of the model. We ask the Board to require OneCare to complete its budget submission and to improve upon its proposed practices in the above-described areas prior to approval of OneCare's 2018 budget.

The Office of the Health Care Advocate, previously named the Office of Health Care Ombudsman, is a special project of Vermont Legal Aid.

Transparency and Risk Mitigation

We ask the Board to obtain, review, and evaluate each of OneCare's contracts with insurers, risk-bearing providers, and any other entities to which OneCare is delegating financial risk prior to approving OneCare's 2018 budget. As OneCare is primarily a contracting organization and the majority of its program details are dependent upon its contracts, we do not believe the Board has the necessary information to approve OneCare's 2018 budget until the contracts are executed and have been closely reviewed. Review of OneCare's contracts with insurers is necessary to ensure that OneCare's financial arrangements, accountability for quality and access, and patient protections are in the interest of attributed Vermonters. Review of OneCare's contracts with risk-bearing provider entities is necessary to ensure that the risk-sharing methodology described by OneCare is consistent with each of its provider contracts and that the contracts hold provider organizations sufficiently accountable for providing access to high quality health care in their communities. Based on the information provided to date by OneCare, it is not clear how much risk each risk-bearing provider entity will be assuming and how any remaining risk and/or credit risk will be covered by OneCare. OneCare has described numerous possible scenarios (e.g., reinsurance, reserves, credit from academic medical centers) for covering its risk. It is important for the Board to understand exactly how financial risk is shifting in our health care system in order to effectively regulate the model and make appropriate adjustments in its other regulatory processes.

Additionally, we ask the Board to request regular reports from OneCare and its risk-bearing participating provider entities on their budget performance throughout the year. The Board must closely monitor OneCare and risk-bearing providers to ensure that the ACO and/or providers do not avoid or address budget overruns by rationing care, denying access, or inappropriately referring patients. The ACO and/or participating provider organizations may engage in these behaviors if they are not able to operate within their budget. Close monitoring of these entities' finances, utilization patterns, and quality and access metrics are essential. We are concerned that the Board may not have the tools in place to adequately monitor utilization, quality, and access in a timely way during the 2018 budget year. This will make it difficult to identify any problems that may arise and to assess whether or not the model is successful.

We would like to note that lack of executed contracts is an ongoing problem in the Board's regulatory proceedings. This makes it difficult for all parties to adequately assess the regulated entities' activities and provides an opportunity for parties to avoid oversight. We ask the Board to work to ensure that in the future contracts relevant to its regulatory reviews are in place in time for appropriate evaluation by the Board, the HCA, other stakeholders, and the public. We understand that this is a challenging area for the Board. However, we hope the Board will make this a priority in its regulatory proceedings. We ask the Board to use its available regulatory levers to ensure that contracts are executed on a timeline that works with its review processes. Additionally, we ask the Board to look at risk across its regulated entities to ensure that shifts in risk are accounted for where necessary. For example, risk assumed by OneCare reserves or reinsurance should be offset by comparable reductions in insurer reserves during the commercial insurance rate review process.

Accountability

As the APM was developed, the HCA was repeatedly assured that there would be quality, access, and patient experience measures at the state, payer, and provider levels (described as three tiers) that would be comprehensive, tied to payment, and provide the Board, the HCA, patients, and the public

with accountability and accurate information about the care being delivered by ACO providers. While the state-level quality measures cover a number of areas important to the health of Vermont's population, it does not appear that OneCare will be held accountable for the results of these measures. Additionally, without access to the payer contracts, we have no concrete information about payer-level quality measures or the methodology by which OneCare will be held accountable for its quality results, if any. The 2017 Medicaid quality measure set includes only ten payment measures and is very limited in its breadth. We have no information about the quality measures that will be included in the Blue Cross Blue Shield of Vermont contract. We also have no information about the quality measures that OneCare will implement at the provider level or how risk-bearing provider entities will be held accountable for providing access to high quality patient care.

The HCA maintains its position that any model involving provider financial risk must include a robust set of quality measures tied to payment to assess the care provided across the patient population and hold providers accountable. Any such measure set should include a balance of screening/prevention, care delivery, outcome, and experience measures. We continue to advocate for inclusion of a timely point-of-care measure of patient experience to encourage and assess OneCare providers' engagement in shared decision-making. We have commented extensively on ACO quality measures and refer you to our most recent comments dated June 19, 2017 and June 29, 2017 for additional information on this topic.

We ask the Board to make approval of OneCare's 2018 budget contingent upon demonstration of a robust system of measurement and accountability for quality, access, and patient experience. We do not support the Board allowing 2018 to be a reporting-only year for quality measures. OneCare and its participating provider organizations have multiple years of experience reporting measures with all three payers and there is no justification for a reporting-only year at this stage. Without quality measures tied to payment there is no accountability in this model.

Consumer Protection

We maintain our position that patients must have, and be aware of, an avenue to report and appeal under-treatment, provider denials of service, and any other ACO issues they encounter. Under a model in which provider organizations bear financial risk, providers have a financial incentive to provide fewer services. In some circumstances, providers may deny medically necessary services to patients in order to meet the financial goals of the model. We continue to believe that patients must have clear processes for filing appeals and grievances related to provider denials of service. Patients must also be informed about any appeal and grievance avenues to which they have access. We do not believe that the policy submitted by OneCare, which applies to Medicaid only, is sufficient. We continue to advocate for uniform processes across payers and for grievances and appeals to be filed with, or reported in detail to, an independent entity. It is essential that reported issues be tracked and analyzed in a timely manner so that any patterns of under treatment or barriers to access that may emerge or worsen can be identified and addressed as quickly as possible.

Currently, patients are not informed that they can file grievances and appeals with the ACO. Grievances that are filed elsewhere (e.g., hospital patient complaint departments) by ACO-attributed patients are not reported as ACO complaints. Notably, one ACO grievance has been reported in 2017. This is indicative of poor knowledge about ACO grievance policies and lack of reporting of grievances filed by ACO-attributed patients via other avenues. As long as patients remain uninformed and grievances remain untracked we are confident that the ACO's reported grievances

will continue to be negligible. This does not give the Board, the HCA, the ACO, or the public an accurate picture about the care being delivered by ACO providers.

Attributed Population

Focus on patients who make frequent contact with the health care system and can benefit greatly from intervention is essential to improving system-wide health and cost outcomes. OneCare's attribution methodology excludes newborns who are born during the performance year and attributes individuals eligible for both Medicare and Medicaid (duals) to the Medicare program only. Because of these attribution methods, OneCare may not be motivated to address the needs of these often vulnerable patients and families in a complete and effective way. Investment in and focus on these and other high-need populations requires collaboration with and investment in community-based services and interventions to address social determinants of health. Such investments have the potential to greatly affect long term health outcomes, quality of life, and cost.

We ask the Board to ensure that OneCare is sufficiently investing in community-based services and interventions and to strongly encourage OneCare to invest in programs aimed at improving care, reducing costs, and addressing social determinants of health for vulnerable and potentially high-cost populations including duals and newborns.

Guidance

Finally, we ask the Board to form a stakeholder group to develop standard forms and metrics for its regulatory processes that would allow for comparison of documentation across review processes. For example, it would be helpful to be able to easily compare care coordination programs, utilization trends, provider payment increases, and cost factors currently outside the control of state-level actors (e.g, pharmaceuticals) across the Board's reviews. Standard forms and metrics would allow the Board, the HCA, other stakeholders, and the public to compare the information reported by each entity and more easily identify duplication, inconsistencies, points of consensus, and areas of concern.

Thank you for considering our comments. Please feel free to contact Julia Shaw with any questions.

Sincerely,

s\ Mike Fisher
Chief Health Care Advocate

s\ Julia Shaw
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