

Bi-State Primary Care Association

S. 290 Comments – 2/26/20

These comments are in response to both the original bill language for S.290 and the proposed amendments submitted by the Green Mountain Care Board on 12/19/20, for the purpose of providing detailed feedback on specific language.

Section 1 – 18 VSA § 9382. Oversight of Accountable Care Organizations

- Agree with GMCB recommendation to move to budget section.
- (a)(2)(B) – Recommend striking. We have no indication that the ACO does not coordinate with AHS and coordination is part of existing standards. Agree with GMCB assessment that DVHA has the option to include more specific language in their contracts, disagree with a requirement to do so, we see this as being at the strategic discretion of AHS.
- (a)(4) & (5) – Recommend striking. Agree with GMCB analysis that this implies changing the contracting structure to multi-year, which would not be a viable option for FQHCs at this time. Long-term collaborations across the system are already embedded in other requirements and benchmarks for evaluating the ACO.
- (b)(3)(A) – Recommend striking. We have concerns about the current language affecting *all* employees and concerns on the lag time in analysis. We trust the ACO Board oversight as regards setting management-level salaries, but would support transparency in materials provided to the GMCB as outlined in the GMCB proposed change.
- (b)(3)(B) – Recommend striking.

Section 2 – 18 VSA § 9574. Annual Reporting

- Agree with GMCB, VAHHS, and OneCare Vermont analysis that this section is redundant to existing requirements and recommend striking.
- Disagree with GMCB suggestion of retaining (4) formal reporting of ACO's outreach efforts to educate the public about the ACO. We believe that public communications efforts by the ACO should be focused on achieving goals around population health. This includes supporting providers in the difficult tasks of engaging community members in preventive care and reaching those individuals who do not yet have an established primary care provider relationship. By singling out public outreach efforts by the ACO to improve public perception of the ACO itself as part of GMCB oversight, we believe this language incentivizes the ACO to focus resources on something that is a lower priority for many providers (and in fact will likely lead to negative perceptions by some providers).

Section 3 – Accountable Care Organizations; Two-Year Budget and Reporting Cycle; Report

- Neutral – we trust the expertise of the GMCB and ACO to determine the cycle that works best for alignment with federal requirements.

Section 4 – 18 VSA § 9454. Hospitals; Duties

- Neutral (leaning towards oppose) – we see the GMCB proposed language as raising two issues, 1. availability of confidential information to allow GMCB to accurately assess financial issues while safeguarding truly confidential details from being made public (we are neutral on whether this language reaches the correct balance) and 2. how much of public resources we put towards systems that rely on fee-for-service payment when we want to move away from FFS (we believe that much of the GMCB proposed language trends towards that problem).

Section 5 – 18 VSA § 8915. Designated and Specialized Service Agency and Preferred Provider Organization Budget Review

- Recommend striking all references to “Preferred Provider Organizations” as this refers to participation in a specific federally-funded program via VDH which has its own requirements and review process.
- Neutral on format of GMCB review of Designated and Specialized Service Agencies.
- We have concerns about a funding source for the 1 FTE required for oversight because of the door this opens to adding duties to the GMCB and questions about who pays for those additions under the current funding structure. We would like to see an analysis of how this work would be supported and its implications for how the GMCB handles future requests of a similar nature, plus recommendations for changes that may be needed in billback statute.

Section 6 – 18 VSA § 9374. Board Membership; Authority

- Neutral – We support the idea of having a provider on the GMCB. We believe that the process for getting one there is at the discretion of the nominating committee, Legislature, and Governor and support the approach that those familiar with the process would recommend.

Sections 7 through 10 – 18 VSA § 9375. Duties; 18 VSA § 9376. Payment Amounts; Methods; 18 VSA § 9384. Health Care Contract Review; 18 VSA § 4062. Filing and Approval of Policy Forms and Premiums;

- Agree with GMCB about shifting to a study. We want to emphasize that the focus of this study should be on regulatory systems entering a value-based and global budget environment for health care. Particular questions we would like to see addressed include how primary care investments and flows within the system will be tracked; investments in prevention with best practices for matching those investments with an Next Generation ACO structure and aligning them with systems for analyzing impact and savings; and the process to translate managing total cost of care into lower costs for consumers. It’s likely that this latter question might require inquiry into pharmaceutical prices, and individual states’ power to influence those, which we understand is the topic of other proposed legislation including S. 246.
- We agree with GMCB that this work will require funding support for contracted consultants.
- We have concerns about tying administrative expenses to the CPI. In executing work for health care reform efforts, there may be years in which the demands on administrative duties fundamentally shift and require more investment, even if for a short time. We support the GMCB proposed review of trends in this regard.

Section 11 – 18 VSA § 9418c. Fair Contract Standards

- Recommend striking the changes – we do not believe this system is reasonable to implement and believe it will create a barrier to doing business in health care. It also does not match with the recommended changes to Sections 7-10 outlined above.

Section 12 – Public Employee Attribution to Accountable Care Organizations; All-Payer ACO Model; Report

- Agree with GMCB that this report should be delivered sooner.