OneCare Vermont

April 21, 2021

Dear Senate Committee on Health and Welfare,

On behalf of OneCare Vermont (OneCare), I would like to thank you for the opportunity to offer testimony on S.120 and S.132; specifically, the sections of the bills that relate to the Accountable Care Organization and the All Payer ACO Model, in which we are participants. I have reviewed both bills with the OneCare Board of Managers, a representative body of health care providers and consumers from across Vermont. The consensus is that S.132 as written does not further payment and delivery system reform efforts.

Managing through change is difficult, especially when we are discussing something as fundamental as people's health. At OneCare, our job is to support the innovation needed to implement the agreement the State of Vermont has with the federal government through the All-Payer ACO Model (APM). We understand the urgency to make the shift from the broken fee for service model to the value-based payment system is about improved results at a better value. Our continued focus, and this is hard work to do, is on building the infrastructure necessary for the health care providers we are here to serve so they can transform the way care is delivered while we restructure how it is reimbursed. We have stakeholders who are concerned the rate of change is too fast, while we have others who think it is all moving too slowly.

Recently, the Agency of Human Services (AHS) released a detailed *All Payer Model (APM) Implementation Improvement Plan* for all Model participants, including OneCare. The APM signers and CMS have accepted the Plan as the path forward to spur alignment around the Model. OneCare's Board is also poised to release a strategic plan to establish a focused direction and priorities for the next several years. The strategic plan is informed by and in alignment with the State's Improvement Plan. We believe that collective energy needs to be focused on successfully achieving the activities detailed in the Improvement Plan, and are committed to doing our part in support of that body of work.

There is no silver-bullet for the type of large-scale health care reform effort before us. Anyone expecting dramatic short-term gains will be disappointed. We should be looking to solutions that support the providers who have clearly dedicated themselves to these efforts. The proof of providers' commitment can be measured through ongoing participation in reform efforts even during a pandemic. To that point, we are very excited to have Rutland joining the Medicare ACO program this year, despite the added uncertainty of current times. We also appreciate that

Vermont's bond rating agency, Fitch Ratings, noted the APM as positive factor in their Stable Outlook rating[1]

Below we provide specific input into the two bills currently under consideration.

As it relates to S.120, I understand the proposed commission is generally focused on health care insurance and out of pocket cost affordability. The main purpose of OneCare is to shift providers from fee for service to value based payments. While, in time, the goal is to increase health care insurance affordability, the focus of the effort is on fundamental changes to provider reimbursement and delivery reform. Mixing an assessment of a provider focused payment reform strategy with consumer level insurance affordability is an awkward fit.

In regard to the inclusion of the consideration of the efficacy of the APM, the state and federal government already have in place a good amount of transparent oversight. In particular, an independent evaluation of the APM is required and included under the agreement between the State and CMS. CMS has contracted with NORC at the University of Chicago, a non-profit, non-partisan research institution, to lead the independent evaluation. As part of this effort, NORC has been conducting in-person and remote surveys of Vermont providers, the ACO, AHS, and GMCB to understand all stakeholders' experiences with this initiative and other local efforts, and about practicing in Vermont more generally. The Model will be evaluated on cost metrics, quality metrics, and engagement with the Model (or, what we call "scale"). This evaluation is already underway through a contract with the federal government and is paid for with federal funds. CMS intends to share a report on their findings thus far in the late summer or fall. As such, we believe the evaluation described in S.120 is redundant and adds unnecessary costs and burden to an already stressed system.

OneCare Vermont is generally opposed to S.132. We recognize legislators may want more involvement with the oversight and efficacy evaluation work underway in support of the Improvement Plan and being performed by NORC. Options for increased engagement include mandated briefings for the Health Reform Oversight Committee or joint meetings of the Committees of Jurisdiction.

With your help and support, the future is bright for Vermonters, including our vital health care workforce. An opportunity for the State to spur this work would be to make investments through the Delivery System Reform (DSR) funding mechanism, which would enhance population health programs and allow providers to make the delivery system changes that are necessary to achieve better health for Vermonters. I understand this committee has recommended support of the AHS DSR request for $3.9 million and I thank you on behalf of our providers who will receive and benefit from those funds.

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[1] https://www.fitchratings.com/research/us-public-finance/fitch-rates-vermont-151mm-gos-aa-outlook-stable-16-04-2021?ct=t(ENEWS_4_16_2021)

"Vermont has been particularly aggressive in addressing the long-term national trend of steadily rising healthcare costs (including Medicaid), including a recent shift towards outcome-based care under an 'all-payer' system, rather than the traditional fee-for-service model."

Accountable Care Organizations, like OneCare, were created through the Affordable Care Act and are the federal vehicle for national implementation of health care reform. I would direct the Committee's attention to an article recently published in the *Journal of American Medicine (JAMA)* called "Reinventing the Center for Medicare and Medicaid Innovation," by Donald M. Berwick, MD and Rick Gilfillan. Both authors are former CMS officials and recommended that:

> CMMI use its authority to scale the ACO model nationally by making it mandatory for all Medicare participating clinicians and hospitals. Clinicians, hospitals, and payers find it difficult to operate in an ambiguous world straddling payment for volume and value. Although voluntary participation has made evaluation of ACOs difficult, the Medicare Payment Advisory Commission and others have concluded that different CMS ACO models during the last 15 years have consistently produced modest savings for CMS. CMS should gradually but steadily expand ACO adoption during the next 5 years until virtually all Medicare participating organizations and clinicians are operating within accountable organizations. Advanced primary care practice models will be a natural core feature. Part of the expansion should include, as much as feasible, progressing to capitation of ACOs for total cost of care.

The work of ACOs like OneCare, is not in conflict with policy agendas like Medicare for All, Universal Primary Care, or a Single-Payer healthcare system. Regardless of payer structure, the system benefits from a value-based models that provides fixed payments to care for a population rather than charging for every pill, test, or service.

We appreciate the opportunity to provide feedback to ensure that health care reform efforts are well coordinated, transparent, and accountable.

Respectfully,

Vicki Loner, RN.C, MCHDS
Chief Executive Officer