



Supporting Vermonters to lead healthy and satisfying lives community by community

## Legislative Update for April 9, 2019

### House Health Care Committee Learns about OneCare Vermont

Vicki Loner, Chief Operating Officer of OneCare Vermont of which she explained that Vermont is only in year two of the All Payer Model Waiver and we are learning as we go. OneCare supports the delivery reform effort to achieve the goals of increased access, reduce deaths from suicide and drug overdose and reduce prevalence of morbidity of chronic disease.

#### Key Facts:

- OneCare has a contract with the Federal Government/State of Vermont from 2017-2022
- It's a voluntary program for providers in Vermont
- The ACO agrees to cost control targets for health spending growth for Vermonters
- OneCare emphasizes population health management
- Payment and service delivery flexibility is part of the waiver
- The plan is for 70% of all insured Vermonters and 90% of Vermonters with Medicare to be in the ACO by 2022

The Green Mountain Care Board (GMCB) provides oversight which includes certifying the ACO and reviewing and approving the budget. The OneCare governance board has one representative from Medicaid, one from Medicare and one commercial insurer representative and all types of providers are represented among the 20 members.

Currently there are 172,000 Vermonters attributed to the ACO which includes people on Medicaid, Medicare, commercial insurance or ERISA self-insured employer insurance. Each provider may choose which insurances they want to include in their contract with OneCare. Provider participation includes:

- 13 Hospitals
- 132 Primary Care Practices
- 242 Specialty Care Practices
- 6 FQHCs
- 23 Skilled Nursing Facilities
- 9 Home Health Agencies
- 9 Designated Agencies for Mental Health and Substance Use
- 5 Area Agencies on Aging

Hospitals bear financial risk in each community for all attributed lives of the providers in the twelve participating communities. Vicki noted that OneCare is a unique ACO in that it has multiple hospitals and health service areas involved. Copley Hospital in Morrisville and Grace Cottage Hospital are not participants, currently, but may become participants next year.

#### Delivery Support Annual Investments to Date:

- Primary Care Population Health Support (\$3.25pppm for PCPs) ~\$ 5.6 M
- Complex Care Coordination (Primary Care, HHA, DAs, AAA) ~\$ 9.1 M
- Value Based Incentive Funds (70% Primary Care and 30% participating providers) ~\$ 7.8 M
- Comprehensive Payment Reform (Independent Primary Care) ~\$ 2.25 M
- Specialty Provider Payment Reform (Select Specialties) ~\$ 2.0 M
- Primary Prevention (Rise VT) ~\$ 1.0 M
- DULCE, Howard Center/SASH, and St. Johnsbury Pilots ~\$ 600,000
- SASH ~\$ 3.8 M
- Community Health Teams ~\$ 2.3 M
- Primary Care Medical Home Payments (Blueprint) ~\$ 1.8 M
- Community Innovation Fund ~\$ 1 M
- Total ~\$37.25 M

Vicki said that the investments are likely to change over time. Funding for the initiatives come from the hospitals and payers. The hospitals are at risk if the savings don't materialize. If the targets are achieved the hospitals can recoup their investments. As attribution grows investments will grow. Vicki said that will require squeezing out inefficiencies in the State. The ACO will need to take on responsibilities currently still being conducted by DVHA and insurers such as prior authorization. Right now there is a foot in both canoes with repetitive administrative functions.

#### Provider Led Reform Integration and Investments in Communities:

##### Community Primary Prevention

- New partnerships with VDH, 3 Parent Child Centers, Legal Aid, and the Developmental Understanding and Legal Collaboration for Everyone (DULCE)
- St. Johnsbury Accountable Community for Health
- Rise VT and Amplify Grants

##### Team Based Care Coordination (PCP, DA, HH, AAA, SASH)

- Financial, technical, and educational support to primary care and continuum of care ~ \$9.1M
- Financial support to all existing SASH panels ~\$3.8M

##### Mental Health Integration

- SASH/ Howard embedded clinician
- Support to primary care to embed mental health clinicians in their practices

##### State Reform Efforts

- Complete Blueprint funding for Medicare ~ \$4.1M
- Innovation funding to support best practices ~ \$1M

Representative Anne Donahue expressed concern about our progress in achieving scale targets. Vicki replied that it's a big operational lift and OneCare wants to ensure that it works out the kinks before pushing too hard on enrollment. She added that the expectations may not have been realistic. For instance, self-funded businesses are not very interested in participating. Additionally, there is an expectation for greater investments by the federal government for start-up.

Committee Chair Bill Lippert sees this as transformational change.

#### **House Health Care Takes Testimony on S.7 Social Service Integration with the Health Care System**

Senator Lyons introduced S.7 to the House Health Care Committee as being important to building integration between medical care and social services. She wants to identify improvements in the health care system to develop wrap-around, smooth and efficient services. The Bill sorts out what we have and

don't have, and works through the vision for health care and the (designated and specialized service agency) DA/SSA system. Senator Lyons acknowledged tensions about who makes resource decisions. The Bill asks the GMCB to assess linkages to social service agencies. She wants to understand the family and community services linkages to the ACO to achieve comprehensive care and care management.

Julie Tessler of Vermont Care Partners gave an overview of how the DA/SSAs participate in the ACO and raised questions for the Committee to address as they fine tune S.7. She noted that the APM Provider-led reform is clearly making progress in bringing providers together to achieve improved outcomes and that many of the initiatives will continue to advance and improve over time. The committee learned that DA/SSAs have non-risk bearing affiliation agreements with OneCare and receive shared savings based on the number of their attributed lives, with participating agencies also receiving a payment for documenting care in Care Navigator. Vermont Care Partners has one seat on the OneCare governance board and participates in advisory and other workgroups.

National data shows that over 40% of health care costs are related to co-occurring mental health and substance use disorder conditions and DA/SSAs reduce health care costs by addressing the social determinants of health and addressing trauma with a whole person-directed approach.

#### Future Focus for Further Progress

- Streamline coordination initiatives led by AHS and OneCare to reduce overlap between VT Chronic Care Initiative, Blueprint, SBIRT, SBINS, SASH, etc
- Make investments into areas that have proven gaps in care based on state and regional needs
- Build more meaningful opportunities for consumers, families and advocates to have active participation in resource and policy decisions
- Address workforce challenges by addressing funding levels and investing in education
- Determine necessary and cost-effective infrastructure investments
- Streamline and improve consistency of provider outcome measures across payers

#### The Big Picture Questions

- What would be the best process to ensure that OneCare Vermont and state government coordinate state policy and resource allocation wisely?
- What are the most appropriate roles of the Green Mountain Care Board, AHS, OneCare, Hospitals, community providers, advocates and people who use services in analyzing demographic trends, resource allocation, needs and investments to best achieve the triple aim?
- What would be the benefits and challenges of including mental health and other community-based services into the All Payer Model, including total cost of care, and who should be at the table to support state government in conducting this analysis?

Susan Aronoff of the Developmental Disability Council said S.7 could be strengthened with two additions. First, conduct a study to determine a general accounting of the public investment and the return on this investment. To guide the next phase of Vermont's healthcare reform the Legislature may want to ask for a review of important outcomes such as:

- Any cost shift related to increased reimbursement rates for Medicaid and Medicare part A/B under the All Payer – ACO Model
- The degree to which the All Payer – ACO Model fosters greater utilization of primary care
- How the All Payer—ACO Model addresses the needs of dually eligible Vermonters, who are high utilizers of medical services

Second, this study should be undertaken by an independent body, possibly the Joint Fiscal Office. She said GMCB has the very challenging duty under Act 113 of both regulating the ACO and ensuring that

the goals of the All Payer – ACO Model are achieved. In this regard, the GMCB is doing what the Legislature asked of it; but these two functions may not be well-paired. Susan said as a party to the APM and with the double role of promoting and overseeing the ACO the GMCB has conflicting roles. She also questioned putting the DA/SSAs under the cap when they are under-resourced.

To date, DVHA has given at least \$15 million of Medicaid Delivery System Reform funds to OneCare Vermont and none to Community Based Organizations like the DA/SSAs. Susan urged that these funds be invested into DA/SSAs. The evaluation proposed would be for the Joint Fiscal Office to look at these investments, as well as return on investment. The lack of investments of the Service Delivery Reform funds was one reason that Susan doesn't think it would make sense to include DA/SSAs into the total cost of care.

#### Recommendations for an Evaluation

- How much does the All Payer – Accountable Care Model cost Vermont?
- Are the Administrative Costs greater than the “savings”?
- What are Vermonters getting in return for this investment? Better health? More predictable costs?
- Were there unintended consequences – for example, were hospitals financially burdened by ACO dues?
- If Vermont signs another agreement, who should sign the document?
- How will it impact Medicaid Long Term Services?

Finally, Susan emphasized the need for improved consumer engagement.

Ena Backus, Director of Health Reform for the Agency of Human Services spoke to Section 1 on the bill that calls for a report of social services. She said that she plans to have stakeholders at the table in developing the Vermont proposal to the federal government. However, the State is the party who negotiates with the federal government.

#### **Senate Institutions Health Proposal for Psychiatric Inpatient Expansion**

University of Vermont Medical Center's (UVMHC) Eve Hoar, Network Director of Strategic and Business Planning, presented on the Central Vermont Medical Center Inpatient Bed Expansion Project in front of Senate Institutions. She explained how UVMHC had analyzed statewide and UVMHC-specific data to arrive at the proposed 29-35 bed number and embedded in that analysis is the assumption that community-based service levels will remain at the status quo. She reported that new inpatient bed capacity would not eliminate Emergency Department wait times but could potentially reduce them by 55%. She emphasized the importance of the work happening at designated agencies, saying they “need to be there so we don't have lengths of stay that grow over time.” She and DMH Deputy Commissioner Mourning Fox reported that they are feeling optimistic about the state's application for a new IMD waiver, because the waiver focuses on statewide average lengths of stay, where Vermont performs well compared to other states.

#### **House Human Services Hears about Limiting Prior Authorization of MAT**

House Human Services heard testimony on S. 43, which puts a limitation on prior authorizations for Medication Assisted Treatment [MAT], except for self-funded plans which lie outside of the scope of insurance statutes. Witnesses from the Department of Vermont Health Access (DHVA), the Department of Financial Regulation, and several insurers spoke in support of the bill. Sara Teachout from Blue Cross Blue Shield of Vermont noted that 200-300 of their members access MAT.

## **Decriminalization of Buprenorphine Considered by House Human Services**

House Human Services heard further testimony on H. 162, which would decriminalize possession of buprenorphine without a prescription. Dr. Deb Richter spoke in favor of the legislation as part of a harm reduction approach: because ‘street bupe’ is often an alternative to heroin, she saw use of street bupe as a ‘choice between life and death – it enables [her patients] to get into treatment, maintain jobs, and develop good habits.’ She noted that only 2-3 patients out of hundreds had become addicted to opiates by starting with street bupe as a teenager. When asked about whether this was needed in Vermont because of Vermont’s low wait times, she countered that many of her patients are not ready to access formal treatment right away and take a few years of success on street bupe to become ready to access formal supports. Representative Redmond wondered if Vermont would be at risk for what has happened in Scandinavian countries, with people shooting up buprenorphine. Dr. Richter acknowledged the point and talked about the risk of street abscesses, but noted “which do we want them on, that or heroin?” The committee also received written testimony from Dr. John Brooklyn, advocating against H. 162.

### ***To take action or for more information, including the weekly committee schedules:***

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- Sergeant-at-Arms Office: (802) 828-2228 or (800) 322-5616
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The purpose of the legislative update is to inform individuals who are interested in developmental, mental health and substance abuse services about legislative advocacy, policy development and activities that occur in the State Legislature. The Vermont Council is a non-profit trade association which works in partnership with Vermont Care Network to form Vermont Care Partners. Together our mission is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. Our membership consists of 16 designated developmental and mental health agencies.