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Date: March 7, 2018

Re: Public comment received for GCR 17-087: Vermont Medicaid Next Generation Accountable Organization Program, effective January 1, 2018.

Comment:

Please see letter below.

Response:

The Department of Vermont Health Access (DVHA) appreciates the Health Care Advocate's (HCA) comments on GCR 17-087. DVHA agrees with the Advocate's statement that quality and access must be prioritized in Vermont's ACO programs and other health reform efforts, and also agrees that transparency, accountability, and consumer protection mechanisms need to be sufficient to ensure the success of these programs. DVHA will continue to work with the Health Care Advocate to address these concerns as the program evolves.

VERMONT LEGAL AID, INC.

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January 29, 2018

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Re: GCR Proposed Policy 17-087 Vermont Medicaid Next Generation ACO Program

To Whom It May Concern:

Thank you for soliciting comments on Global Commitment Register Proposed Policy 17-087: Vermont Medicaid Next Generation Accountable Care Organization (ACO) Program. The Office of the Health Care Advocate (HCA) submits the comments below for your consideration. Our comments echo many of the concerns stated in our May 2017 comments on the Department of Vermont Health Access' 2017 Medicaid Next Generation ACO Program contract with OneCare Vermont, as well as our December 2017 comments on OneCare Vermont's proposed 2018 budget (submitted to the Green Mountain Care Board (GMCB)).

Throughout the development of Vermont's ACO programs, the HCA has 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 substantially expands its Medicaid ACO program in 2018, we are concerned that the transparency, accountability, and consumer protection practices in place remain 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 once again ask DVHA to require additional consumer protections in the Medicaid ACO model and to ensure that OneCare Vermont is held to a high level of accountability to Vermont Medicaid beneficiaries and to the state.

Our comments focus on the following areas: attribution, measurement and accountability, grievance and appeals, and shared decision making. We strongly encourage DVHA to allocate sufficient resources to enforce all provisions of its contract with OneCare Vermont.

Attribution

We continue to have concerns about the exclusion of vulnerable and potentially high-cost populations, including individuals dually eligible for Medicaid and Medicare ("duals") and babies born during the performance year, from Vermont's Medicaid ACO program. 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. Investment in and focus on high-cost and 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 DVHA to consider including these populations in future program years 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.

We reiterate our request that DVHA provide written plain-language notice of attribution to all ACO-attributed Medicaid beneficiaries on an annual basis, and include robust grievance and appeals information as well as contact information for the HCA in all such notices.

We restate our position that Medicaid beneficiaries should have the ability to fully opt out of the ACO model at their request.

Measurement and Accountability

The HCA continues to advocate for a robust set of quality measures. If, as DVHA states, “the overall goal of the program is to improve quality of care and contain the growth of healthcare costs,” the only way to measure the success of the program is to comprehensively measure quality. A comprehensive measure set would cover diverse populations including adult, maternity, and pediatric; healthy and chronically ill; and physically and developmentally disabled. A comprehensive measure set would also cover a wide range of process, outcome, and experience measures to ensure that patients’ health status and experience of care are not adversely affected by changes in provider payment methodologies. It is vitally important that we measure quality in the context of new payment methodologies with potential incentives to provide less care to Vermonters. We again strongly encourage DVHA to require additional quality measurement in 2018 to ensure that the quality measures cover the attributed population in a logical and systematic way.

We strongly support the addition of the Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey Composite Measures of patient experience in the 2018 program. In addition to the CAHPS Composite Measures we ask DVHA to, at a minimum, implement a pilot of a point-of-care measure such as CollaboRATE™ to further assess patients’ experiences of care under this model. As OneCare assumes financial risk for a larger population of Medicaid beneficiaries, it is increasingly essential for DVHA and policy makers to learn about the ways in which patients are experiencing the model. A point-of-care measure would give DVHA, OneCare, and health care providers insight into how patients are experiencing their interactions with providers participating in the model. We encourage DVHA to solicit feedback from attributed beneficiaries in other ways as well, such as via focus groups, member meetings, and/or other consumer engagement activities.

Grievance and Appeals

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 may 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. We continue to advocate for robust grievance and appeals processes for beneficiaries attributed to the Medicaid ACO program. Such processes must consider the risk-bearing model and resulting changes to the kinds of grievances and appeals that are likely to occur. Whereas in a fee-for-service system the provider generally advocates on behalf of the beneficiary in the case of an appeal, in a risk model the provider and patient may no longer be on the same side.

Patients must also be informed about any appeal and grievance avenues to which they have access. Currently, to our knowledge 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, only one ACO grievance was 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.

We do not believe that the policy submitted by OneCare in its 2018 budget submission to the Green Mountain Care Board is sufficient. We continue to advocate 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. DVHA and OneCare must have a systematic way of handling grievances from both patients and providers, resolving disagreements between patients and providers, resolving disagreements between providers and OneCare, and documenting all of the above. Since it will be impossible in many instances to determine which issues are caused directly or indirectly by the ACO, any complaint by an attributed member must be handled and documented as an ACO grievance.

Shared Decision-Making

We strongly believe that shared decision-making is one of the core ways to protect patients in a model based on provider financial risk. We ask DVHA to require OneCare to implement shared decision-making processes, to use shared decision-making tools, and to document such practices for its attributed population. There are numerous shared decision-making tools available, including Choosing Wisely, which provides informational materials for both patients and providers. Shared decision-making is a patient-centered approach and encourages respectful communication between providers and patients. We do not believe this payment model should continue to move forward without systematic implementation of shared decision-making.

Compliance

We ask DVHA to ensure that DVHA has adequate capacity to enforce compliance by OneCare with all provisions of the Medicaid ACO program, including transparency requirements and consumer engagement.

Thank you for considering our comments. If you have any questions please contact Julia Shaw at jshaw@vtlegalaid.org.

Sincerely,

s\ Mike Fisher, Chief Health Care Advocate

s\ Julia Shaw, Health Care Policy Analyst