Report of the Vermont State Auditor

DOUGLAS R. HOFFER
Vermont State Auditor

Vermont's All-Payer Accountable Care Organization (ACO) Model

An Overview of the All-Payer ACO Model and the State's Oversight of Vermont's Only ACO, OneCare Vermont, LLC.

June 26, 2020 Rpt. No. 20-02

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Mission Statement

The mission of the Auditor's Office is to hold state government accountable.

This means ensuring that taxpayer funds are used effectively and efficiently, and that we foster the prevention of waste, fraud, and abuse.

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Dear Colleagues,

The State's most recent health care reform effort is a federal-state test, called the Vermont All-Payer Accountable Care Organization (ACO) Model. The single ACO operating in Vermont, called OneCare Vermont, LLC, which was created by the two largest providers of Vermont care – University of Vermont Medical Center and Dartmouth Hitchcock Health – participates in this model. OneCare's network includes all Vermont hospitals except for one as well as numerous independent practices and Federally Qualified Health Centers.

Bringing the lion's share of Vermont hospitals and many other providers under one organization's umbrella and building a health care finance and delivery system around this central structure has the potential to profoundly impact the quality and cost of care for Vermonters. I felt compelled to direct the limited resources of the State's government accountability office to understand this organization in light of the hundreds of millions of public dollars that flow through OneCare and its network of providers and the State's responsibilities to regulate this organization.

Before we began this work, I was concerned that neither policymakers nor members of the public fully understood how this complex project actually works. Therefore, we decided to begin a series of audits about this subject starting with a descriptive audit that details: (1) how the ACO Model is structured and implemented and (2) the Green Mountain Care Board and the Department of Vermont Health Access's roles in overseeing and monitoring OneCare. I'm hopeful this report will help lawmakers, administrators, health care professionals, and the general public better understand this complex and expensive undertaking that is under consideration for a subsequent five-year agreement.

Although descriptive in nature, this audit makes two key recommendations to the Green Mountain Care Board. The first recommendation is that the Board should design and deploy a transparent method to measure the financial outcomes of the Vermont All-Payer ACO Model and determine whether they outweigh OneCare's operating costs. This method and determination should be established prior to agreeing to a subsequent ACO model agreement and, to the extent possible, include consideration of available quality results.

OneCare has an operating budget of $19.3 million in 2020, but it does not provide direct health care to Vermonters. This cost appears to be in addition to administrative costs already built into the health care system. At a time when we see our state's largest hospital cutting compensation for providers, it's imperative that we ensure Vermont is getting the greatest benefit possible for the price tag of OneCare's administration and the State's work on this effort.

Our second recommendation to the Green Mountain Care Board is to devise an alternate method to assess quality improvement for certain measurements to encourage continued improvement. More than 25 percent of the quality

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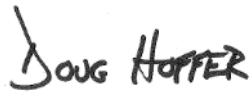
measures in the All-Payer Agreement have baselines that are the same or greater than their targets. Using this evaluation design, quality of care could worsen, and targets could still be achieved.

In the Chair's management response to our audit report, he did not directly address our two recommendations. These recommendations are straightforward, and I am concerned that the Board in its dual roles as health care reformer and regulator is not taking the latter role as seriously as the former. The ACO model is ultimately aimed at improving the value of health care delivery in Vermont by controlling cost growth and advancing quality of care. If Vermonters cannot determine whether this program accomplishes these goals for the added expense and risk, that poses problems for the viability of this effort. Our recommendations are intended to ensure that the GMCB achieves these objectives and conducts an arms-length evaluation of OneCare's performance.

Conceptually, the ACO model holds promise. But a consolidated system of any kind (utility, health care, etc.) requires rigorous regulation. While I'm hopeful this effort yields positive results for Vermonters, there has been limited evaluation to determine its benefit. The ACO model and OneCare are too important to the well-being of Vermonters for the State to allow them to operate without consistent appraisal and accountability, and we intend to continue our scrutiny of this effort.

I would like to thank the staff at the GMCB, AHS, DVHA, and OneCare for their professionalism during this audit. This report is available on the state auditor's website, https://auditor.vermont.gov/.

Sincerely,



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ADDRESSEES

The Honorable Mitzi Johnson
Speaker of the House of Representatives

The Honorable Tim Ashe
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The Honorable Phil Scott
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Mr. Adam Greshin
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Mr. Kevin Mullin
Chair, Green Mountain Care Board

Mr. Cory Gustafson
Commissioner, Department of Vermont Health Access

Ms. Susan Barrett
Executive Director, Green Mountain Care Board

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Highlights

Vermont has a long history of aiming to improve the quality and affordability of health care, with reform efforts stretching back to the first half of the twentieth century.[1] Major initiatives in the 1990s featured a push for universal health care that never went into effect and an expansion of Medicaid insurance coverage.[2] Since then, the State has explored and tested a range of tactics, as it attempts to reel in spending, expand access, and improve quality of care.

The State's most recent health care reform effort is a federal-state test, called the Vermont All-Payer Accountable Care Organization (ACO) Model. Under this model, public and private insurers – together called "all payers" [3] – pay providers within an ACO network by using similar payment structures that aim to improve the value of health care. Currently, there is one ACO operating in Vermont, called OneCare Vermont, LLC.

Due to the ACO Model's potentially profound effect on the delivery and cost of health care services to Vermonters, the State Auditor's Office (SAO) decided to begin a series of audits about Vermont's All-Payer ACO Model. It is helpful for Vermonters and their elected representatives to understand how the ACO Model works in the context of a complex, multi-billion-dollar industry that touches all our lives. This audit is the first in the series, and it describes:

1. Vermont's All-Payer ACO Model; and

2. The Green Mountain Care Board (GMCB) and the Department of Vermont Health Access's (DVHA's) roles in overseeing and monitoring OneCare.

Our work in Objective 1 describes how Vermont has implemented the All-Payer ACO Model Agreement, focusing on how health care payments have been coordinated through OneCare (See Figure 1).[4]

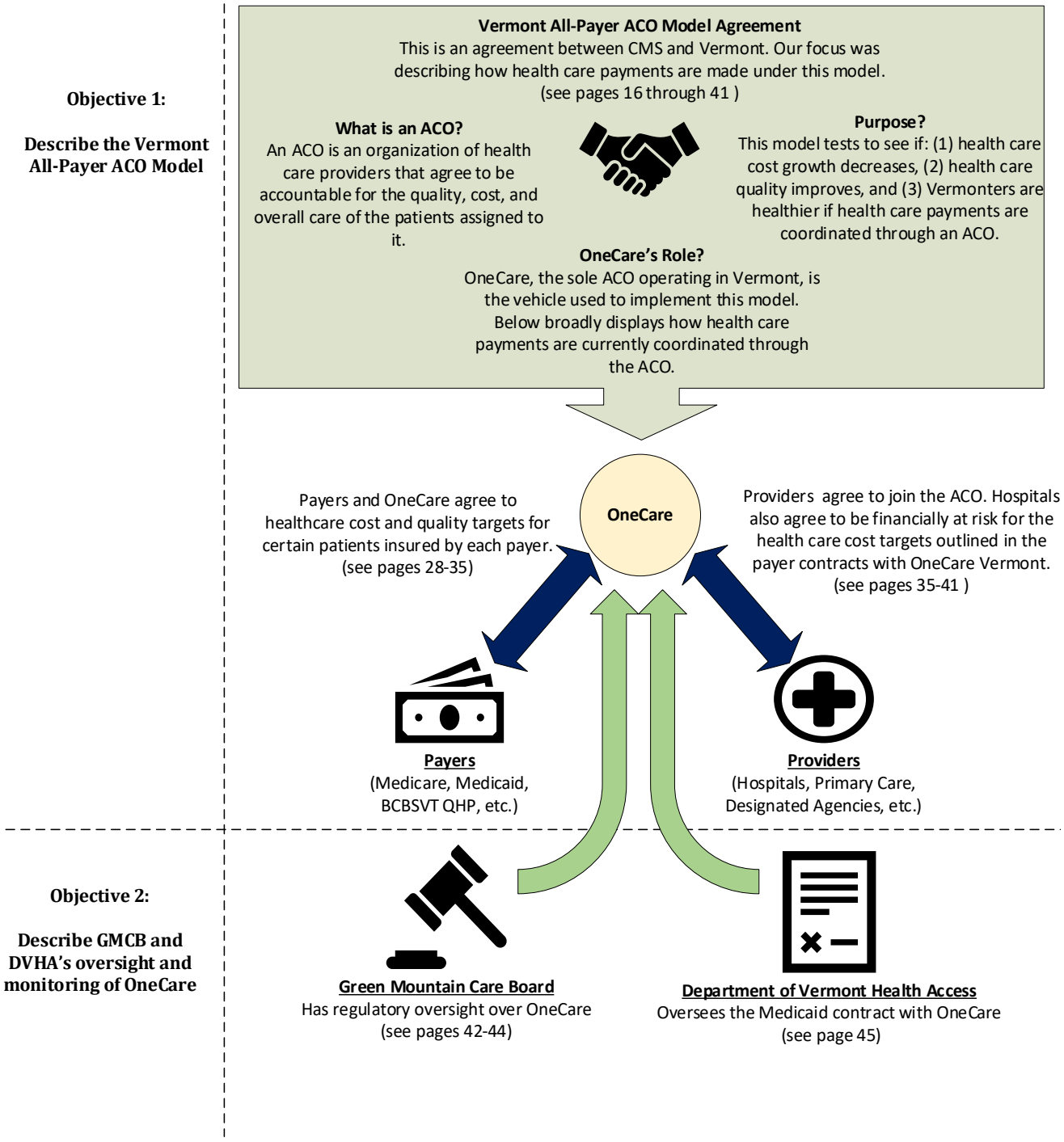
1 Vermont's Legislative Joint Fiscal Office and Legislative Council, Vermont: A Brief History of Health Care Reform.

2 Ibid.

3 In 2019, the public insurers were the federal Centers for Medicare and Medicaid Services (CMS) for Medicare and DVHA for Medicaid, and the private insurers were BlueCross BlueShield of Vermont for its qualified health plans (BCBSVT QHP) and University of Vermont Medical Center's (UVMMC's) self-insured plan. In 2020, OneCare also contracted with MVP Health Care.

4 Appendix I on page 48 details the scope and methodology of the audit. Appendix II on page 51 contains a list of abbreviations used in this report.

Figure 1: Overview of How the Vermont All-Payer ACO Model Currently Works and Its Relationship to the SAO's Audit Objectives



In 2016, the State of Vermont and CMS agreed to test this alternative health care payment and delivery arrangement starting in 2018.[5] Although there were previously three ACOs in Vermont, OneCare is the only ACO that remained to participate in this project.

OneCare promotes patient care coordination, acts as a pass-through agent between payers and providers, and monitors costs and quality related to its network of providers. This network includes all but one Vermont hospital and dozens of other providers. OneCare's 60-plus employees do not provide medical services but instead provide support to providers in its network.

The ACO Model relies on insurers paying providers using both fee-for-service and monthly lump-sum payment structures. OneCare is held financially responsible for meeting health care cost and quality targets, and it distributes the financial risk to participating hospitals. Ultimately, the model aims to decrease the growth in health care expenditures and improve the quality of and access to care for Vermonters.

The Vermont All-Payer ACO Model Agreement is currently scheduled to conclude in 2022. Before the end of 2021, the GMCB in collaboration with the Agency of Human Services (AHS) and the Governor's Office can submit a proposal for a subsequent agreement. This proposal does not require legislative approval. According to the AHS Director of Health Care Reform, the State has begun preliminary work on this decision-making process.

The GMCB has developed reports that allow it to evaluate various aspects of the ACO Model, such as cost growth and specific quality measures. However, as the State prepares to make the important decision of whether to enter into a subsequent agreement with CMS for an ACO Model, this audit found that:

- **The GMCB has not developed a methodology to determine whether OneCare's operating costs will be greater or less than the benefits of the ACO Model.** The ACO seemingly poses new administrative costs to the health care system, (OneCare has an operating budget of $19.3 million for 2020). The GMCB has recognized the importance of this cost-benefit analysis and requires estimated savings from the ACO exceed OneCare's operating costs over the duration of the agreement. However, the Board's staff have noted that it is difficult to quantify costs that were avoided as a result of the ACO, and a determination of the ACO's value should also consider quality improvements. While there is limited performance data as of today, the GMCB can quantify the value of indicators that are known, such as OneCare's financial data. Until the GMCB completes this cost-benefit analysis, the State cannot determine whether the ACO Model's claimed financial and quality outcomes outweigh OneCare's operating costs.

[5] Medicaid was an early adopter and started in 2017.

Recommendation

The GMCB should design and deploy a transparent method to measure the financial outcomes of the Vermont All-Payer ACO Model and determine whether they outweigh OneCare's operating costs. This method and determination should be established prior to agreeing to a subsequent agreement and contain a consideration of available quality results.

- **Six of the 22 quality measures in the All-Payer Agreement have baselines — the numbers used as starting points to measure progress — that are either the same or higher than their corresponding 2022 targets.**[6] That means quality of care could decline and yet the targets achieved. Therefore, should this occur, the public could be misled if the GMCB emphasizes that a target was met without also acknowledging that quality had declined.

Recommendation

The GMCB should devise an alternate method to assess quality improvement for those quality measures in the All-Payer Agreement that have a baseline that is higher than or equal to the target.

- **Critical gaps in the State's knowledge may exist.** It is likely the State will only have quality data for 2018 and 2019 when it is required to decide about a subsequent agreement. GMCB has also requested to change some of the baselines from 2016 to 2018, which means the State will only have one year of trend analysis for certain quality measures. Furthermore, while CMS has contracted for an independent evaluation of Vermont's All-Payer ACO Model, it is unclear if a final evaluation of the first two years of the model (2018 and 2019) will be completed before the end of 2021.

On April 27, 2020, the Governor, the Secretary of AHS, and Chair of the GMCB sent a letter to CMS requesting that 2020 be a "reporting-only" year for quality measure results in 2020 due to COVID-19. The letter also informed CMS that Vermont may propose other adjustments to the All-Payer Agreement due to the unanticipated consequences of the pandemic.

Throughout this report, we provide examples of information reported by OneCare and the GMCB to help readers understand the ACO and its role in a complex and often opaque health care system. We relied on this information for descriptive purposes only and therefore did not assess its reliability and do not make any assertions to its accuracy.[7]

[6] Some of the quality measures are statewide and not limited to the care given within the ACO network.

[7] In light of the complex nature of the Vermont All-Payer ACO Model, we have included multiple appendices in this report to add clarity and details about how the ACO operates. Examples include Appendix III on page 52, which contains additional information regarding OneCare, and Appendix IV on page 55, which discusses patient's rights.

Background

Health Care Reform

The U.S. Congress passed the Patient Protection and Affordable Care Act in 2010, which allowed for the creation of ACOs as part of its overall goal of improving the value of health care. An ACO forms a network of health care providers who collaborate in an effort to provide higher quality care at lower costs for a defined group of patients.

Following the Affordable Care Act, the Vermont General Assembly passed several acts aimed at reforming the state's health care payment system. One of these Vermont laws was Act 48, which created the GMCB. The purpose of the GMCB is to: (1) improve Vermonters' health, (2) reduce the growth in health care spending, (3) enhance experiences of care, (4) recruit and retain quality professionals, and (5) simplify health care financing and delivery.[8]

In 2016, the General Assembly authorized the GMCB and AHS to enter into the Vermont All-Payer ACO Model Agreement[9] (hereinafter referred to as the All-Payer Agreement) with CMS.[10]

Under this model, certain health care providers that participate in an ACO may opt to receive alternative health care payments called fixed payments instead of the more common fee-for-service payment method, which pays health care providers for each service performed. Fixed payments are monthly lump-sum payments to a health care provider (e.g., hospital) that cover qualified services. Most payments to providers participating in Vermont's sole ACO are still fee-for-service. Nevertheless, under the model both fee-for-service and fixed payment structures are considered value-based because in either case providers may receive financial rewards for meeting quality measures and cost targets. (We discuss these payment structures in greater detail on pages 28-33 and 36-39). The intent is to shift the delivery and payment of some services from a volume driven system toward one that is value-based.

The model allows CMS to provide additional Medicare benefits and waives certain federal requirements. This includes telehealth, home visits after discharge from a hospital, and allowing individuals to be admitted to skilled nursing facilities without first being admitted to a hospital.

8 18 V.S.A. §9372.

9 The State of Vermont and CMS entered into the Vermont All-Payer ACO Model Agreement on October 27, 2016.

10 Act 113 (2016).

OneCare Vermont

Between 2014 and 2016, there were three ACOs operating in Vermont, which included OneCare Vermont, LLC (hereinafter referred to as OneCare). In anticipation of the All-Payer Agreement, Vermont's three ACOs explored consolidating into a single ACO, but this effort was abandoned in 2017. Two of Vermont's ACOs no longer exist. Some of the providers from these ACOs have joined OneCare.

Currently, OneCare is the only ACO that still operates in Vermont. In 2012, the University of Vermont Medical Center and Dartmouth Hitchcock Health – the two hospitals providing the most amount of care to Vermonters – formed OneCare as a for-profit limited liability company (see sidebar at right). At the request of the Secretary of AHS, OneCare is currently considering whether to apply for non-profit status with the Internal Revenue Service.

WHY IS ONECARE A FOR-PROFIT COMPANY?

OneCare is a for-profit Limited Liability Company because it could not be structured as a non-profit and comply with both state and federal requirements. According to Vermont's 11B V.S.A. §8.13(a), no more than 49 percent of the board of a non-profit public benefit corporation can have a financial interest in the organization. However, CMS' Medicare contract with OneCare requires that at least 75 percent of the ACO's governing body be ACO participants. GMCB also incorporated a similar requirement when the Board drafted Rule 5.202(b).

Prior to the Vermont All-Payer Agreement, OneCare participated in shared savings programs with Medicare, Medicaid, and BlueCross BlueShield of Vermont's Qualified Health Plans[11] (BCBSVT QHP). These programs were active from 2014 to 2016[12] and featured cost and quality targets paired with financial incentives to improve affordability. OneCare achieved savings in 2014 for the Medicaid program, but it exceeded cost targets in 2015 and 2016. It also exceeded cost targets every year for its Medicare and BCBSVT QHP programs. With respect to the

[11] Qualified health plans are certified by DVHA that they meet requirements of the Affordable Care Act. Vermonters purchase these plans through the Vermont Health Connect which is the State's health insurance exchange for Medicaid and commercial plans.

[12] The Medicare and BCBSVT QHP shared savings programs were also active in 2017.

quality targets, OneCare improved its quality scores every year from 2014 to 2016.

OneCare's Provider Network

Health care providers – including independent primary care physicians, Federally Qualified Health Centers,[13] and hospitals[14] – contract with OneCare to become part of the ACO's network. Table 1 summarizes the types of providers that have agreed to participate in the OneCare network for 2020 as of June 2, 2020.

Table 1: Summary of OneCare's Provider Network for 2020

Provider Type	Number
Hospitals	14
Federally Qualified Health Centers	9
Independent Primary Care Providers	28
Home Health Providers	9
Skilled Nursing Facilities	27
Designated Agencies	11
Other[a]	39
Total	**137**

[a] Includes specialists, naturopaths, specialized service agencies, physical therapy, and others.

OneCare's provider network is divided into geographic areas, called health service areas (HSA). Each HSA has an assigned hospital (see Figure 8 in Appendix III on page 54 for a map of OneCare's HSAs).

OneCare's Budget

OneCare develops an annual budget that contains three primary components: (1) provider reimbursements for health care services given to patients assigned to OneCare in the upcoming year; (2) population health management programs; and (3) OneCare's operating costs.

For 2019, health care expenditures for Vermont residents were projected to be $6.3 billion (the actual amounts for 2019 are not yet available).[15]

[13] Federally Qualified Health Centers are private non-profit organizations that provide comprehensive primary care services to patients living in federally designated underserved areas.

[14] As of 2017, hospitals employed approximately two-thirds of physicians in Vermont.

[15] See slide 36 of GMCB's 2017 Vermont Health Care Expenditure Analysis found here.

OneCare's budget was $899 million, which is 14 percent of the projected health care expenditures.[16]

For 2020, OneCare's total budget is $1.4 billion. See Table 2 for a high-level summary of this budget.

Table 2: Summary of OneCare's Budget for 2020

Budget Component	Amount (In Millions)	Percent of Total Budget
Provider Reimbursements (see pages 28 through 30 for more detail)	$1,362.2	95.6%
Population Health Management Programs (see pages 40 through 41 for more detail)	$43.1	3.0%
OneCare Operating Costs (see the following paragraphs for more detail)	$19.3	1.4%
Total	**$1,424.6**	**100%**

Although OneCare's $19.3 million operating costs are a tiny fraction of the total budget, it is not the total spent for provider administration. The $1.362 billion paid to the providers covers costs associated with providing health care services, which would include the providers' overhead.

As shown in Table 3 on the next page, most of the $19.3 million in OneCare's operational expenses are for wages and benefits, software, contracted services, and risk protection expense. This risk protection expense is the cost to have a third-party cover some of the losses OneCare may owe CMS if it has high losses in the Medicare program.

OneCare's wages and benefits for 2020 grew 33 percent ($2.9 million) from its 2019 budget. OneCare had the equivalent of 58 full-time employees in 2019, and the number of full-time equivalent employees is expected to increase to 78 in 2020.[17] OneCare's employees do not provide health care or perform care coordination.[18] Instead, some of their employees act as facilitators and trainers to providers in the OneCare network who deliver and coordinate care. (see Table 17 in Appendix III on page 52 for an explanation of the various employee functions).

16 According to a GMCB health services researcher approximately $20 million of OneCare's budget was for Medicare health care costs for out-of-state residents.

17 The ACO had 61 employees as of April 2, 2020, according to OneCare's Chief Executive Officer.

18 Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Table 3: Breakdown of OneCare's Estimated Operating Budget Expenses for 2020

Expense Category	2020 Budget Request	OneCare's Notes About Expenses	Percent of Total Operating Budget
Wages & Benefits	$11,776,602	Staff positions and ordinary benefits	61%
Software	$3,726,889	WorkBenchOne; Care Navigator; VITL; eLearn	19%
Contracted/Consulting	$1,173,970	Actuarial; software development	6%
Risk Protection	$1,075,912	Medicare risk protection	6%
Occupancy	$456,859	Rent; common area maintenance charges; utilities	2%
Other Operating	$418,000	GMCB billback; letter of credit fees	2%
Supplies	$188,830	Office supplies; mailings; copiers	<1%
Insurance	$150,000	General business insurance	<1%
Travel	$103,250	Mileage reimbursement	<1%
Professional Development	$103,238	Staff training and development	<1%
Marketing	$67,500	Informational materials; RiseVT	<1%
Meetings	$35,700	Network meetings; learning collaboratives	<1%
Total	**$19,276,750**		

OneCare's operating costs, which seem to add new costs to Vermont's health care system, are funded primarily by Medicaid and participating hospitals. DVHA estimates that Medicaid will pay $3.8 million of OneCare's operating costs in 2020.[19] Hospitals are responsible for paying the remaining amount ($15.5 million).

Table 4 provides the estimated dues hospitals will pay to OneCare in 2020. In addition to paying for OneCare's operating costs, these dues also include $9 million for population health management programs , as discussed on pages 40 and 41 of this report. Non-hospital providers, such as Federally Qualified Health Centers and independent primary care providers do not pay dues to OneCare.

[19] This amount is based upon per member per month calculation and the exact amount will likely change because the number of members in the calculation will likely change.

Table 4: Summary of Estimated Hospital Dues for 2020

Hospital	Budgeted Dues
UVM Medical Center	$9,555,249
Central Vermont Medical Center	$3,247,717
Southwestern VT Medical Center	$1,900,307
Northwestern Medical Center	$1,571,870
Rutland Regional Medical Center	$1,430,792
Porter Medical Center	$1,259,946
Dartmouth Hitchcock Hospital	$1,153,414
Brattleboro Memorial Hospital	$1,152,539
North Country Hospital	$1,062,571
Mt. Ascutney Hospital	$772,046
Northeastern VT Regional Hospital	$749,946
Gifford Medical Center	$245,459
Copley Hospital	$204,388
Springfield Hospital	$160,982
Total	**$24,467,226**

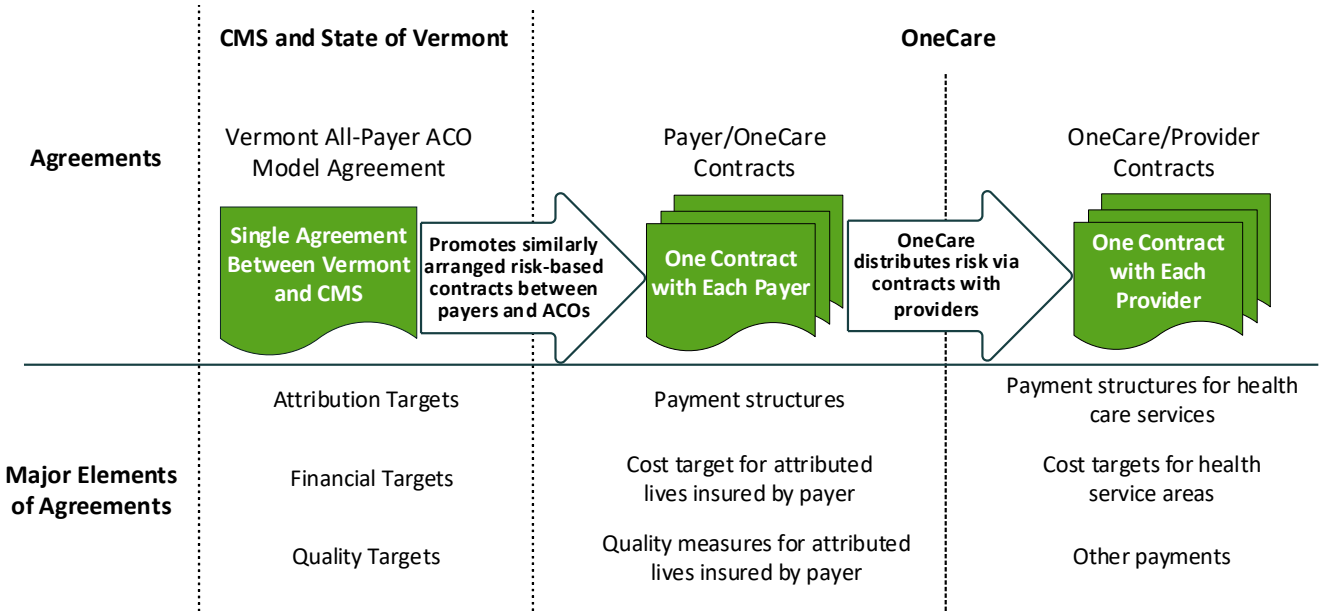
COVID-19

On April 6, 2020, the GMCB allowed OneCare to reduce the $24,467,226 hospital dues budget by $1,351,984 because of the financial pressure hospitals are facing during this pandemic.

Objective 1: Description of Vermont's All-Payer ACO Model

Figure 2 summarizes the three types of agreements that provide the legal framework for the Vermont's All-Payer ACO Model (hereafter referred to as the ACO Model). Throughout this section of the report, we provide sidebar visuals based on this figure to help readers navigate the agreement types and their major elements.

Figure 2: Summary of the Three Main Types of Agreements and How They Interrelate



Vermont's All-Payer ACO Model Agreement with CMS

The All-Payer Agreement promotes payers and ACOs in Vermont to enter into risk-based contracts that include cost and quality targets for providers participating in the ACO Model for those patients that meet criteria for being assigned to OneCare. The ACO Model is a federal-state test to determine whether these risk-based contracts and other provisions of the model decrease Vermont's health care cost growth while improving the quality of and access to care in the state.

The model began on January 1, 2017 and is scheduled to conclude on December 31, 2022. The test involves five performance years (2018 – 2022)

each spanning a full calendar year.[20] Before the end of 2021, the GMCB in collaboration with AHS and the Governor's Office can submit a proposal for a subsequent agreement (the General Assembly is not required to approve any subsequent agreement). According to the AHS Director of Health Care Reform, the State has begun preliminary work regarding a subsequent All-Payer Agreement with CMS. AHS and GMCB had expected to formally engage stakeholders in July 2020 to meet the December 31, 2021 deadline for a proposal for a subsequent five-year agreement, which would end in 2027. However, the timing of this planned stakeholder engagement has been postponed due to the COVID-19 pandemic and they are unsure when it will take place. The GMCB has developed reports that allow it to evaluate various aspects of the model.

CMS is responsible for evaluating this model and has contracted with a research organization called NORC at the University of Chicago to conduct annual evaluations, starting with the 2018 performance year. CMS expected a final evaluation of the first two years of the model (2018 and 2019) to be completed by the end of 2021. However, CMS is unsure if that timeline still stands as the data collection may have been paused.

Vermont All-Payer ACO Model Agreement

Single Agreement Between Vermont and CMS

Attribution Targets

Financial Targets

Quality Targets

Attribution Targets Outlined in the All-Payer Agreement

Under the ACO Model, OneCare is accountable for the cost and quality of care for certain patients. Attribution is the process used to identify the patients for which OneCare will be accountable.[21] The All-Payer Agreement includes attribution targets that increase each year from 2018 through 2022. These targets are referred to in the All-Payer Agreement as "scale targets."[22]

These attribution targets are tracked across all payers participating in the model and for Medicare only. The Medicare group is a subset of the All-Payer group. By 2022, the All-Payer Agreement requires that 70 percent of all eligible Vermonters and 90 percent of Medicare patients to be attributed to OneCare.

Table 5 shows which Vermonters are included and excluded from the All-Payer attribution target. Appendix V on page 56 contains a summary of Vermont's population by payer and outlines which segments were included or excluded from the All-Payer attribution target for 2018.

[20] 2017 was a start-up year and Medicaid was the only payer to participate that year. 2018 is referred to as performance year 1 and is the start of the model measurement.

[21] Patients attributed to OneCare are not limited to seeing only providers that are part of its network.

[22] Attribution targets are goals that pertain to the percentage of Vermonters that are attributed to an ACO. It is possible that patients could be attributed to OneCare under a payer program but not meet the minimum requirements to be included in the scale targets. To date this has not happened.

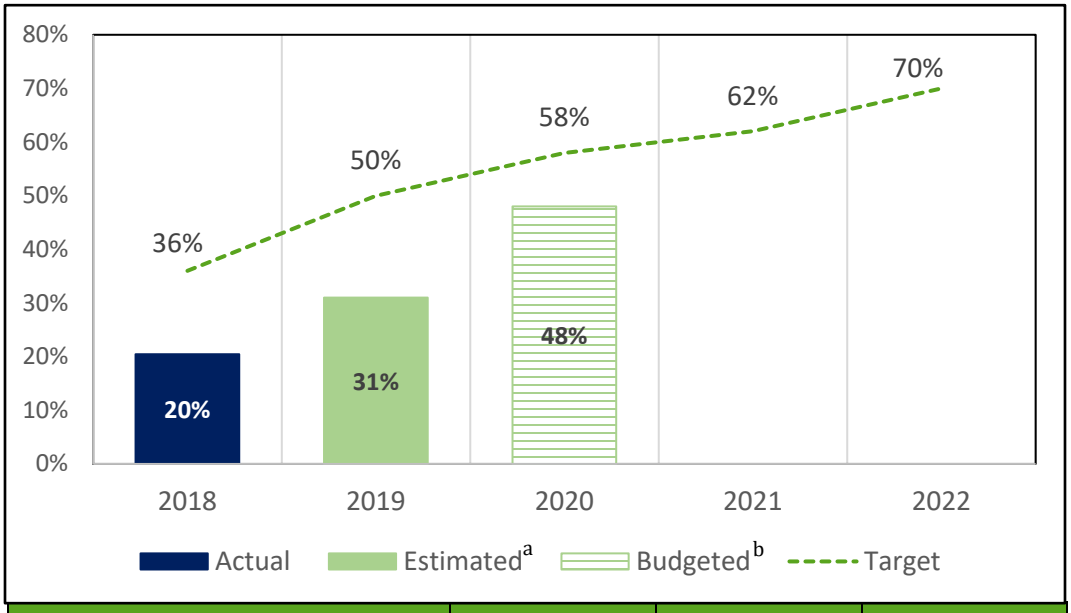
Table 5: Vermonters Included and Excluded from the All-Payer Attribution Target

Payer	Vermonters Included in All-Payer Attribution Target	Vermonters Excluded from All-Payer Attribution Target
Medicare	• All Medicare fee-for-service members who are enrolled in both Part A and Part B.[a]	• Medicare members who are enrolled in only Part A or Part B.
Medicaid	• Medicaid members not specifically excluded.	• Medicaid members with evidence of third-party coverage. • Medicaid members who receive a limited benefit package (e.g., prescription assistance only). • Medicaid members dually eligible for Medicare as they are included in the Medicare attribution numbers.
Commercial / Self-Funded	• Fully insured members not specifically excluded.[b] • Members of self-insured health plans.[c] • Members of Medicare Advantage plans (Medicare Part C).[d]	• Members of federal employee health plans. • Members of insurance plans without a Certificate of Authority from Vermont's Department of Financial Regulation. • Members of military health plans.
Other	• None.	• Uninsured individuals.

[a] Medicare Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Medicare Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
[b] Fully insured members do not include those who only have stand-alone dental or vision benefits; long-term care insurance; disease-specific or other limited coverage.
[c] Self-insured plans are provided to a Vermont resident by an employer operating in Vermont who takes on the responsibility of paying employees' and their dependents' medical costs.
[d] Medicare Part C (Medicare Advantage Plans) are a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits.

Vermont is significantly behind its attribution targets to date. Figure 3 shows the progress that has been made toward the All-Payer attribution targets, including estimates from GMCB for 2019 and 2020. (Appendix VI on page 57 shows progress toward the Medicare-only targets.)

Figure 3: Performance Against the All-Payer Attribution Target



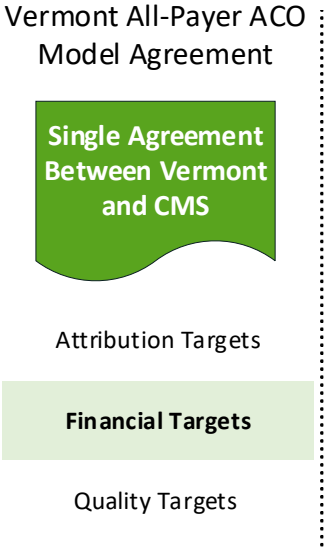
	2018 (Actual)	2019 (Estimated[a])	2020 (Budgeted[b])
Number of Vermonters eligible for attribution	550,809	521,818	521,759
Target for the year	198,291	260,909	302,620
Number of Vermonters attributed	112,756	160,106	249,464
Target Shortfall	**(85,535)**	**(100,803)**	**(53,156)**

[a] GMCB does not yet know the number of Vermonters that were eligible for attribution in 2019. Therefore, that number, the target for the year, and the target shortfall are estimates.
[b] GMCB has not received final attribution numbers for all the payers. Therefore, all numbers are estimates, with attribution based on OneCare's 2020 budget.

Changes have been made or are under consideration to address the performance gap between the target and actual number of attributed lives. For example, DVHA and OneCare have made changes to the attribution methodology for the Medicaid program in 2020 to attribute a greater portion of the Medicaid population. In addition, the GMCB intends to discuss with CMS the challenges of the Medicare attribution methodology. The GMCB reported that the way the current CMS methodology accounts for patients who obtain services outside of Vermont may make it impossible to reach the attribution target.[23]

[23] Vermont All-Payer ACO Model ACO Scale Targets and Alignment Report Year 1 (2018), section 5.3.2 on p. 12.

If the State fails to achieve either the All-Payer or the Medicare-only attribution targets for two consecutive years between 2018 and 2022, then CMS will send the State a warning notice to which the State must respond. After reviewing the State's response, CMS may require a corrective action plan to correct deficiencies. There are no financial penalties for not meeting these or the other targets outlined in the All-Payer Agreement.



Financial Targets Outlined in the Vermont All-Payer Agreement

The All-Payer Agreement also specifies two statewide financial targets for Vermont under the All-Payer and Medicare-only patient categories. These targets are the:

1. **All-Payer cost growth target,**[24] which limits the compounded annual cost growth for most Vermont payers, including Medicare, Medicaid, and commercial insurers. The All-Payer Agreement limits compounded annual cost growth to no more than 3.5 percent from 2017 to 2022.[25]

2. **Medicare-only cost growth target,**[26] which is only for Medicare costs and patients. The target is set to 0.2 percent less than the projected national Medicare growth rate.[27]

The All-Payer Agreement excludes certain costs from the All-Payer cost growth target such as:

- Costs due to increasing Medicaid reimbursement rates to levels comparable to or greater than Medicare rates (which was $9.9 million in 2018),

- Medicare Part D,[28]

[24] This target is known as the All-Payer total cost of care per beneficiary growth target in the All-Payer Agreement and is generally limited to the cost growth for members that could be attributed to OneCare as described in Table 5 on page 18. The target also includes costs for members who have only Medicare Part A or Medicare Part B. It excludes costs for members with self-insured plans in which GMCB does not have access to the claims data.

[25] According to the AHS Director of Health Care Reform, the 3.5 percent target was to bring health care spending more in line with the Gross State Product which was determined to be 3.3 percent from 1999 to 2013 and that economic growth and health care spending could likely grow more rapidly during the term of the All-Payer Agreement.

[26] This target is known as the Medicare total cost of care per beneficiary growth target in the All-Payer Agreement.

[27] For 2018 and 2019 the Medicare cost growth target is limited to only the costs of attributed Medicare patients. For 2020, if the Medicare attribution is less than 65 percent, the target is only for attributed patients. Otherwise, the target is for all Medicare patients regardless of attribution. For 2021 and 2022, the targets are for all Medicare members regardless of whether they are attributed.

[28] Medicare Part C (Medicare Advantage Plans) are a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits. Medicare Part D are plans offered by companies approved by Medicare that add prescription drug coverage to Medicare plans.

- Dental services under Medicaid, commercial, and self-insured payers,
- Medicaid behavioral health services,
- Medicaid home and community-based services, and
- Medicaid long-term institutional services.[29]

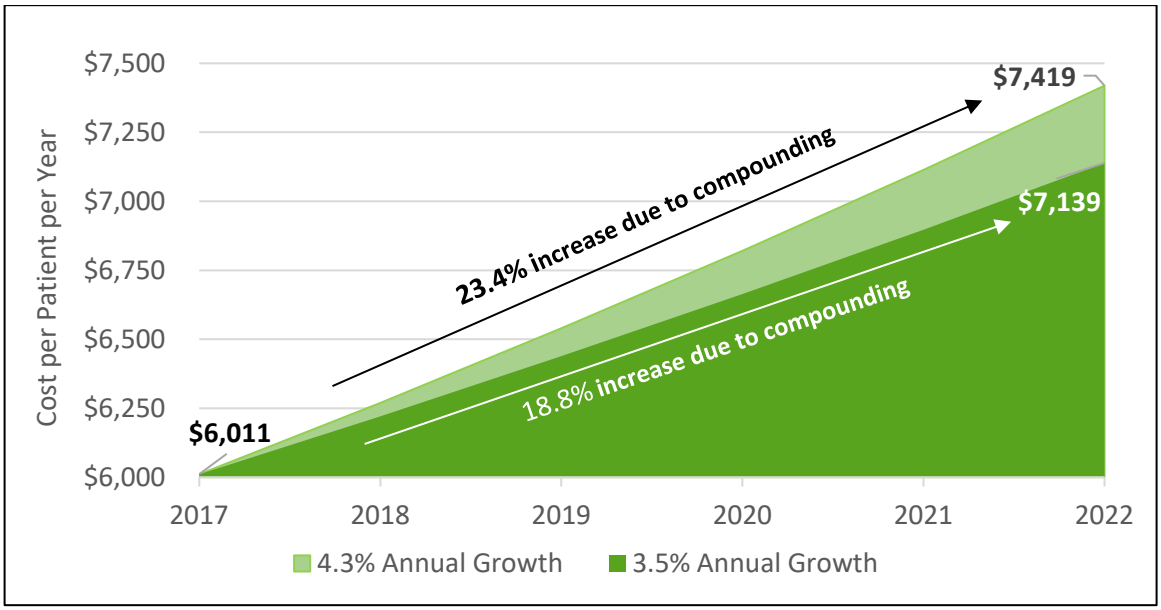
Because the 3.5 percent All-Payer target is calculated from the previous year, there is a compounding effect. Therefore, costs could increase up to 18.8 percent by 2022 but still be within the annual 3.5 percent growth target. If Vermont exceeds this cost growth target, CMS may require corrective actions. However, the All-Payer Agreement allows for some leeway before CMS may require corrective actions. Beginning in 2019, if the cumulative annually compounded All-Payer total cost of care growth rate is greater than 4.3 percent (4.3 percent is 23 percent higher than 3.5 percent) , CMS will consider the state off track to meet the target growth rate.

Figure 4 shows the compounding cost growth increase between 2017 and 2022 at both a 3.5 percent and a 4.3 percent rate, which are the target and the maximum allowable before corrective action may be required, respectively.[30]

[29] Medicaid long-term institutional services will be included in 2021 and 2022.

[30] The 2017 All-Payer costs are used as the baseline and those costs per beneficiary were $500.88 per month ($6,011 per year). See Figure 4a on page 8 of the Green Mountain Care Board's annual report on the cost of care for 2018.

Figure 4: Overall Effect of Annual Costs Per Beneficiary Compounding at 3.5 and 4.3 Percent



The GMCB reported that the All-Payer growth rate for 2018 was 4.1 percent[31] which exceeded the 3.5 percent target but not by enough to cause CMS to take action.

ACO operating costs are not included in the calculation for the All-Payer cost target.[32] For example, GMCB reported the 2018 All-Payer expenditures were $2.9 billion. OneCare's operating costs for that year were $11.7 million, which if included, would have raised that total cost of care amount by nearly half a percent.

The GMCB has recognized that over the duration of the All-Payer Agreement, OneCare's operating costs must be less than the health care savings from the ACO Model.[33] However, the GMCB has not devised a method to make such a determination, with its staff citing complexities for: (1) measuring health care costs that would have been incurred if it had not been for the ACO and (2) incorporating quality aspects into such a measurement.[34] While there is

[31] See Figure 4a on page 8 of the Green Mountain Care Board's annual report on the cost of care for 2018.

[32] According to the Vermont All-Payer ACO Model Lead at CMS, ACO operating expenses for any entity that participates in a model/program are not a factor when determining potential savings for the Medicare Trust Fund.

[33] The GMCB's 2020 Budget Order for OneCare (paragraph 20 on page 26) states that over the duration of the All-Payer Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

[34] GMCB's December 11, 2019 public meeting regarding GMCB staff recommendations on OneCare's 2020 budget submission and certification.

limited performance data as of 2020, the GMCB can quantify and identify the value of indicators that are known, such as OneCare's financial data.

By the end of 2021, the State must decide whether to propose a subsequent five-year agreement. To make an informed decision, the GMCB would need to determine whether quality benefits and savings of the ACO Model outweigh OneCare's operating costs. In the absence of this determination, the State cannot identify whether the All-Payer Agreement increases costs for Vermonters without achieving at least an equivalent benefit.

Vermont All-Payer ACO Model Agreement

Single Agreement Between Vermont and CMS

Attribution Targets

Financial Targets

Quality Targets

Quality Targets and 2018 Results

The All-Payer Agreement establishes targets pertaining to statewide health outcomes, health care delivery system quality, and process milestones in four prioritized areas: (1) substance use disorder, (2) suicides, (3) chronic conditions, and (4) access to care. In early 2020, CMS and the State reached a preliminary agreement to make technical changes to the quality measures in the All-Payer Agreement.[35] According to a memo from the GMCB staff and the annual report for 2018, the preliminary agreement includes:

- Changing the baseline years[36] for most targets from 2016 to either 2017 or 2018;
- Removing plans to use national benchmarks for some quality measures, instead setting specific 2022 targets;[37] and
- Updating how some of the results for some quality measures will be calculated in part due to errors in calculation methodologies in the original agreement.

COVID-19

On April 27, 2020, the Governor, the Secretary of AHS, and Chair of the GMCB sent a letter to CMS requesting that 2020 be a "reporting-only" year for quality measure results in 2020 due to COVID-19. The letter also informed CMS that Vermont may propose other adjustments to the All-Payer Agreement due to the unanticipated consequences of the pandemic.

The State's preliminary agreement with CMS to change the All-Payer Agreement also moves the deadline for the GMCB reporting quality results to CMS from September 30th to December 31st of the following year. Moreover, the State will only have two years of quality data for 2018 and 2019 by

[35] In light of the COVID-19 pandemic requiring both a state and national response, amending the All-Payer Agreement to reflect the preliminary agreement has been paused as priorities have shifted to address more pressing needs.

[36] Baselines are the numbers used as starting points to measure progress.

[37] According to GMCB staff, the national benchmark proposed to be used for some of the quality measures in the All-Payer Agreement is proprietary and cost prohibitive to use.

the deadline for submitting a subsequent five-year agreement. Furthermore, since some of the baselines are changed to 2018, the State will have only one year of trend analysis for some of the measures.

In early April of this year, the GMCB released the 2018 quality results using the preliminary agreed upon changes.[38] Six measures have baselines that are either the same or higher than the 2022 target in either the All-Payer Agreement or the preliminarily agreed to changes.[39] That means quality could decline and yet the targets could still be achieved. Therefore, the public could be misled if the quality had declined but the GMCB reported that the target was met or exceeded. Tables 6 through 8 contain a brief description of each quality measures by major target area and the reported results. The blue highlighted cells indicate that the updated baseline is either the same are higher than the target for that measure.

Table 6: Statewide Health Outcomes Targets and 2018 Results

Measure Name	Brief Description of Target	Updated Baseline	2018 Results (unless otherwise noted)	2022 Target
Substance use disorder target	Reduce Vermont deaths related to drug overdose by 10 percent by 2022. (This excludes out-of-state residents' deaths and Vermonters who die in other states.)	123 (2017)	117 (Preliminary 2018 data for January – October)	111
Suicide target	Reduce the number of deaths due to suicide to 16 per 100,000 residents or reduce the State's suicide rate ranking from 7th to 20th highest state in the United States.	17.2/100,000 (2016)	18.3/100,000 19th in the U.S. (2017)	16/100,000 or 20th highest rate in the U.S.
Chronic conditions target	Prevent an increase of more than 1 percent for chronic obstructive pulmonary disease.	6% (2017)	6%	Increase ≤1% from 2017
	Prevent an increase of more than 1 percent for diabetes.	8% (2017)	9%	Increase ≤1% from 2017
	Prevent an increase of more than 1 percent for hypertension.	26% (2017)	25%	Increase ≤1% from 2017
Access to care target	89 percent of adult residents reporting that they have a doctor or care provider.	87% (2017)	86%	89%

[38] Vermont All-Payer ACO Model Annual Health Outcomes and Quality of Care Report Performance Year 1 - 2018 (submitted April 7, 2020).

[39] Performance for these measures were either unknown or the known performance was below the target when they were originally established except for one measure. The target for that measure was the same as the known performance level.

Table 7: Health Care Delivery System Quality Targets and 2018 Results

Measure Name	Brief Description of Target	Updated Baseline	2018 Results	2022 Target
Suicide and Substance Use Disorder Targets (Goal: Reduce Deaths Related to Suicide and Drug Overdose)				
Initiation of alcohol and other drug dependence treatment	Achieve 40.8 percent for initiation of treatment within 14 days of diagnosis for adolescents and adults attributed to an ACO with a new episode of alcohol or other drug abuse or dependence.	38.9% (2018)	38.9%	40.8%
Engagement of alcohol and other drug dependence treatment	Achieve 14.6 percent on engagement within 34 days of initiation visit for on-going treatment of adolescents and adults attributed to an ACO with a new episode of alcohol or other drug abuse or dependence.	13.3% (2018)	13.3%	14.6%
Follow-up after discharge from the emergency department for alcohol or other drug dependence	At least 40 percent of Vermonters over 12-years-old attributed to an ACO receiving follow-up care within 30 days after discharge from an emergency department for alcohol or drug dependence.	28.2% (2018)	28.2%	40%
Follow-up after discharge from the emergency department for mental health	At least 60 percent of Vermonters over 5-years-old attributed to an ACO receiving follow-up care within 30 days after discharge from an emergency department for mental health.	**84.4% (2018)**	84.4%	**60%**
Mental health and substance abuse-related emergency department visits	Reduce the growth rate of emergency department visits with a primary diagnosis of mental health or substance abuse conditions.	5.3% (Change from 2016 to 2017)	6.9% (Change from 2017 to 2018)	3% (The target for 2018 was 5%)
Chronic Conditions Targets (Goal: Prevent an Increase in Chronic Disease)				
Diabetes: hemoglobin A1c poor control	Achieve at least the 70th – 80th performance rate percentile using the national Medicare benchmark for the percentage of ACO Medicare patients (ages 18 – 75) with diabetes who had hemoglobin A1c > 9.0%	**58.02% (2018)** (This falls within the Medicare 80th percentile)	58.02% (This percent falls within the Medicare 80th percentile)	**70th – 80th percentile (national Medicare benchmark)**

Measure Name	Brief Description of Target	Updated Baseline	2018 Results	2022 Target
Controlling high blood pressure	Achieve at least the 70th – 80th performance rate percentile using the national Medicare benchmark for the percentage of ACO Medicare patients (ages 18 – 85) who was diagnosed with hypertension and it was adequately controlled.	68.12% (2018) (This falls within the Medicare 60th percentile)	68.12% (This falls within the Medicare 60th percentile)	70th – 80th percentile (national Medicare benchmark)
All-cause unplanned admissions for patients with multiple chronic conditions	Achieve at least the 70th – 80th performance rate percentile using the national Medicare benchmark for the rate of risk-standardized, acute, unplanned hospital admissions for ACO Medicare patients over 64.	63.84% (2018) (This falls within the Medicare 30th percentile)	63.84% (This falls within the Medicare 30th percentile)	70th – 80th percentile (national Medicare benchmark)
Access to Care Targets (Goal: Increase Access to Primary Care)				
Getting timely care, appointments, and information	Achieve at least the 70th – 80th performance rate percentile, as compared to national Medicare performance for Vermont Medicare patients attributed to an ACO who state that they are getting timely care, appointments, and information.	**84.62% (2018)** (This falls within the Medicare 80th percentile)	84.62% (This falls within the Medicare 80th percentile)	**70th – 80th percentile (national Medicare benchmark)**

Table 8: Process Milestone Targets and 2018 Results

Measure Name	Brief Description	Updated Baseline	2018 Results	2022 Target
Substance Use Disorder Milestones				
Prescription drug monitoring initiative utilization	Increase the utilization of Vermont's prescription drug monitoring program for opioid prescriptions to at least 1.8 provider queries per opioid patient.	**2.19 (2017)**	3.10	**1.80**
Medication-assisted treatment utilization	Increase the number of Vermont residents receiving medication-assisted treatment for substance use disorder to at least 150 per 10,000 Vermonters ages 18-64 (or up to the rate of demand).	**257 per 10,000 Vermonters (2018)**	257 per 10,000 Vermonters	**150 per 10,000 Vermonters (or up to the rate of demand)**

Measure Name	Brief Description	Updated Baseline	2018 Results	2022 Target
Suicide Milestone				
Screening for clinical depression	Achieve at least the 70th – 80th performance rate percentile, as compared to national Medicare performance for the percent of Vermonters attributed to an ACO who received a screening for clinical depression and a follow-up plan if the screening detected depression.	50.23% (2018) (This falls within the Medicare 50th percentile)	50.23% (This falls within the Medicare 50th percentile)	70th – 80th percentile (national Medicare benchmark)
Chronic Conditions Milestones				
Tobacco use assessment and cessation intervention	Achieve at least the 70th – 80th performance rate percentile, as compared to national Medicare performance for attributed Vermonters over 17-years-old who, through screening, were identified as a tobacco user and who received cessation counseling intervention as a result.	70.56% (2018) (No national Medicare benchmark provided for 2018)	70.56% (No national Medicare benchmark provided for 2018)	70th – 80th percentile (national Medicare benchmark)
Medication management for people with asthma	Achieve at least 65 percent of Vermonters ages 5 to 64 attributed to an ACO receiving appropriate asthma medication management for at least 50 percent of the treatment period.	**75.3% (2017)**	75.5%	**65%**
Access to Care Milestones				
Medicaid adolescents with well-care visits	Achieve 53 percent of adolescents enrolled in Medicaid who have a well-care visit.	47.8% (2017)	49.9%	53%
Medicaid beneficiaries aligned to a scale target ACO initiative	The percentage of Medicaid members attributed to an ACO must not be less than the percentage of Medicare members attributed by more than 15 percent.	35% Medicare attribution rate in 2018	31% Medicaid attribution rate in 2018 (4% less than Medicare)	≤15 percentage points below Medicare attribution

Payers Contract with OneCare

Payer/OneCare Contracts

Payment structures

Cost target for attributed lives insured by payer

Quality measures for attributed lives insured by payer

Payment Structures

The contracts outline how the payers intend to pay providers. The contracts may be based solely on fee-for service or a mix of fee-for-service and monthly lump-sum payments referred to as fixed payments.[40] The differences are:

- **Fee-For-Service** is a payment method in which health care providers are paid for each service performed, such as office visits and tests. Currently, this is the most common payment mechanism for health care in the United States.

- **Fixed Payments** are monthly payments paid by the payer to OneCare for attributed patient care for qualifying services, regardless of services provided. OneCare then distributes these monthly fixed payments to the hospitals and primary care providers who have agreed to receive fixed payments in lieu of fee-for-service payments based on the number of persons attributed to each organization. The GMCB has explained this strategy is to have providers accept responsibility for the health of a group of patients in exchange for a fixed amount of money rather than rewarding them for volume.[41]

Providers who participate in the fixed payment mechanism would still receive fee-for-service payments for patients who are not attributed to OneCare and for procedures that are not included in the payer contract, such as dental services. Providers may also participate in the ACO Model even if they choose not to receive fixed payments and only receive fee-for-service payments.

Generally, it is only hospitals that receive fixed payments. However, a small number of independent provider practices have agreed to participate in some form of a fixed-payment program.

In 2018, 65 percent ($389.5 million) of payments to OneCare's network of providers were fee-for-service[42] and 35 percent ($212.2 million) were fixed payments. Figure 5 shows how payments flowed from payers to providers, with fixed payments first going to OneCare. The ACO then distributed applicable lump sums to providers. The figure also shows a comparison of

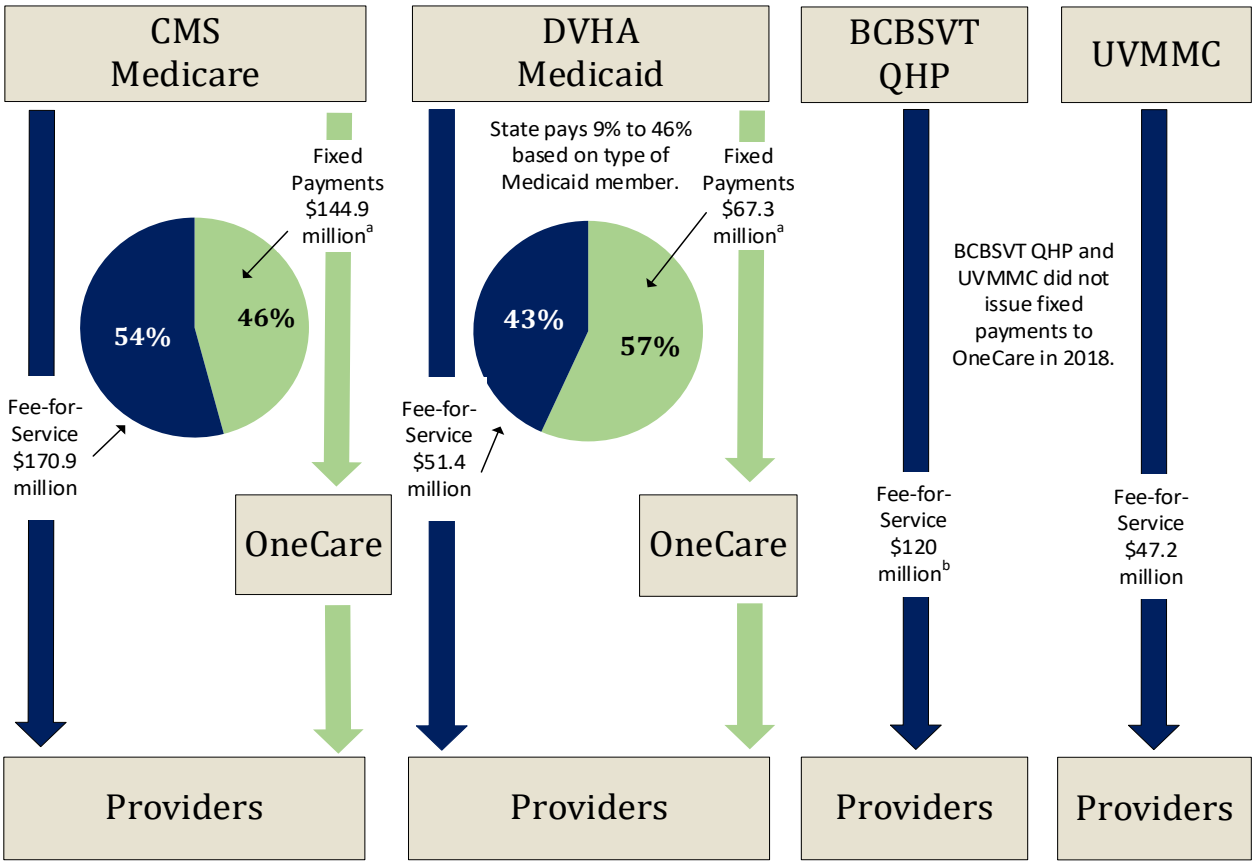
40 Both fee-for-service and fixed payment structures are considered value-based payment structures in the All-Payer Model.

41 GMCB 2020 preliminary recommendations presentation, page 5.

42 This includes approximately $1.5 million in capitated payments from BCBSVT to the providers made based on pre-existing agreements between the insurer and the providers.

the amount of fixed payments versus fee-for-service payments by payer. In the case of Medicaid, the State was responsible for paying 9 to 46 percent based on the type of Medicaid member, while the federal government paid the remainder.[43]

Figure 5: Fee-for-Service and Fixed Payment Flow from Payers to Providers for 2018



[a] Not all these funds are paid to providers by OneCare. Hospitals in the network owe OneCare hospital dues, which the ACO takes from the fixed payments as a mechanism to collect those dues. Additionally, the Medicare fixed payments are not true fixed payments as they are later settled to what the fee-for-service payments would have been.

[b] This includes approximately $1.5 million in capitated payments from BCBSVT to the providers made based on pre-existing agreements between the insurer and the providers.

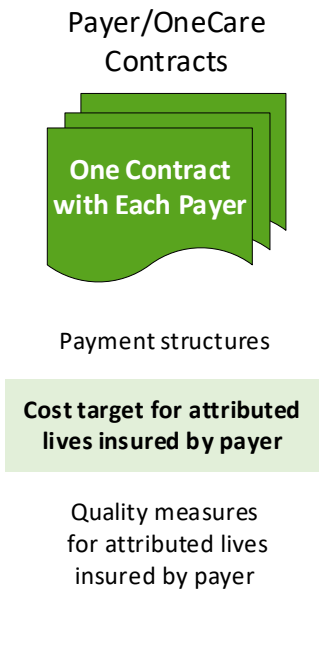
[43] Medicaid is jointly funded between the federal and State governments. The federal share is based on the Federal Medicaid Assistance Percentage, which can vary by Medicaid enrollment type. Medicaid enrollment types include, for example, adults categorized as aged, blind, disabled, or medically needy and children enrolled under the Children's Health Insurance Program.

Currently, Medicaid is the only payer that uses a true fixed payment mechanism. Medicare uses a variation that provides monthly fixed payments but reconciles these payments after the end of the year to the fee-for-service equivalent for the services performed. If the fixed payments were less than the fee-for-service equivalent, then CMS pays OneCare the difference. Likewise, if the fixed payments were greater than the fee-for-service equivalent then OneCare pays CMS the difference (see Table 9 below).

Table 9: Hypothetical Example of Medicare Fixed Payment Reconciliation

Fixed Payment (A)	Fee-For-Service Equivalent (B)	Reconciliation (A-B)
$100,000,000	$110,000,000	$10 million paid by CMS to OneCare.
$100,000,000	$90,000,000	$10 million paid by OneCare to CMS.

BCBSVT QHP has not used fixed payments in previous years but is testing a pilot program that uses this mechanism in 2020.



Cost Target for Attributed Lives Insured by that Payer

Each payer's contract with OneCare details how the cost targets will be determined. These cost targets represent the amount that OneCare is accountable for based on the number of Vermonters attributed to the network under that payer's program, and the services that are included (e.g., Medicaid's dental and pharmacy services are not counted). Being attributed means that OneCare is accountable for that patient's cost and quality of health care. See Appendix VII on page 59 for more detailed information on this process, by payer.

Each payer determines which patients are to be attributed at the start of the year. Attribution is used to determine the estimated total cost of care target for that year. The number of attributed patients is multiplied by the expected per member cost target to produce the total cost of care target for the year.[44] These per-member cost targets are based in part on the payer's historical health care costs.[45]

[44] The GMCB is responsible for submitting Medicare cost target information to CMS for the Medicare contract with OneCare.

[45] Regarding historical health care costs, the U.S. Bureau of Economic Analysis's personal consumption expenditure data shows that the per capita health care spending in Vermont rose by 51.4 percent between 2008 and 2018, an average of 4.2 percent per year. Per capita expenditures on all other goods and services in Vermont increased by only 32.6 percent during the same time period, averaging 2.9 percent annually.

For example, a payer could contractually agree to a $100 per member per month cost target for a group of people the payer insures that are attributed to OneCare. If the payer calculates that there are 500 of its insured patients attributed to OneCare, then the estimated total cost of care target would be $600,000 (500 patients x $100 per member per month x 12 months).

New patients are not added to the OneCare network during the year, but patients initially attributed may be removed from the network if they no longer meet eligibility requirements. Therefore, the estimated total cost of care targets may fall throughout the year. For example, patients may move out of state, die, or otherwise become ineligible to receive Medicaid coverage and would no longer be eligible to be attributed to the OneCare Medicaid program, thus reducing the Medicaid total cost of care target for that year. In 2018, there were 42,342 Medicaid patients initially attributed to OneCare. By December 2018, that number had fallen to 36,453. Because of this fluctuation, payers do not determine final cost of care targets until after the end of the year.

Only patient costs incurred for qualifying medical services used to develop the total cost-of-care target are factored into the payers' calculation for actual cost of care. Costs for these services are a factor in calculating actual cost of care regardless of where patients received them. For example, a Vermont patient may receive services outside of the State, but those medical expenses would still be included in the total cost of care calculation. Payers do not include OneCare's operating costs when determining whether the financial targets were met. Therefore, the payers will not be including OneCare's estimated $19.3 million in operating costs in any of their cost targets.

The payers' contracts with OneCare outline shared losses and/or shared savings to which the ACO may be subject. The following bullets explain each of these risk arrangements.

- **Shared Loss Arrangements**. If actual costs exceed the cost target, then OneCare is required to repay the payer starting with the first dollar that exceeded the target up to an agreed upon limit. In 2019, OneCare had shared loss arrangements with Medicare, Medicaid, and BCBSVT QHP payers.

- **Shared Savings Arrangements.** If actual costs are below the target, then OneCare receives a savings payment from the payer starting with the first dollar saved up to an agreed upon limit. In 2019, OneCare had shared savings arrangements with Medicare, Medicaid, BCBSVT QHP plans, and UVMMC's self-funded plan payers.

The contracts also contain a cap on the amount of shared losses OneCare is at risk for and the maximum amount of shared savings the ACO may achieve. For example, in DVHA's 2018 Medicaid contract, OneCare agreed to be liable for all costs that exceeded the actual Medicaid total cost of care target, up to 103 percent of the target (i.e., the cap on the loss was set at three percent above the target and any amount over that threshold OneCare was not liable for). Similarly, the cap on the maximum savings OneCare could achieve under that contract were all savings up to three percent under the target. Any savings greater than three percent stay with DVHA. Figure 6 shows OneCare's cap for Medicaid shared losses and savings for 2018. Appendix VIII on page 62 contains more information regarding how the risk sharing arrangements are outlined in payer contracts.

Figure 6: OneCare's Cap for Medicaid Shared Losses and Savings for 2018.

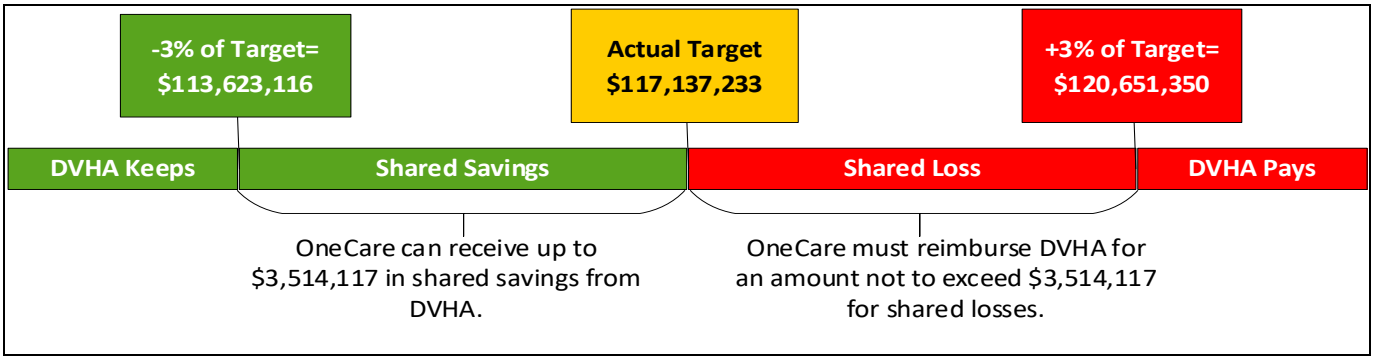


Table 10 contains the final settlement for 2018 that OneCare reported for each payer.

Table 10: OneCare's Shared Savings/Losses by Payer for 2018 (in Millions)

Payer	Target	Over or Under Payer Cost Target?	By How Much?	OneCare's Shared Savings or Loss (Based on Terms of Payer Contracts)
Medicare	$339.1	Under	$17.0	• $7.8 million prepaid to OneCare under what is called advanced shared savings.[a] • $5.6 million in shared savings to OneCare.
Medicaid	$117.1	Over	$1.5	$1.5 million in losses owed by OneCare to DVHA.
BCBSVT QHP	$120.6	Over	$1.5	$645,574 in losses owed by OneCare to BCBSVT QHP.
UVMMC Self-Funded	$45.1	Over	$2.9	None, because the UVMMC self-funded program was a shared savings arrangement. It did not have a shared losses arrangement. Therefore, it was not responsible for actual costs that exceeded the target.
Total	**$621.9**	**Under**	**$11.1**	**• $7.8 million prepaid to Blueprint and SASH programs.** **• $3.5 million in remaining net shared savings.**

[a] GMCB directed OneCare to use these advanced shared savings for Vermont Blueprint for Health and Supports and Services at Home (SASH) programs. See Appendix IX on page 64 for an explanation of Blueprint for Health and SASH.

Payer/OneCare Contracts

Payment structures

Cost target for attributed lives insured by payer

Quality measures for attributed lives insured by payer

Quality Measures for Attributed Lives Insured by that Payer

Each of the payer contracts with OneCare contain quality goals that the payers expect the network of providers to achieve for attributed patients. If quality goals are not met, OneCare may be required to pay a financial penalty to the payer.[46] For example, DVHA's contract with OneCare for calendar year 2018 required that OneCare pay DVHA a certain amount of money if the Medicaid quality goals were not fully met. OneCare scored 85 percent on the Medicaid quality measures for that year and owed DVHA $131,906 for not achieving 100 percent (see pages 40 and 41 for more discussion about the fund OneCare uses to pay for these quality goals).

The specific quality measures for which OneCare is held accountable vary by payer and sometimes by year. For example, CMS changed the quality measures for OneCare in their 2019 contract so that the Medicare quality measures better align with those in the other payers' contracts with OneCare. The quality measures in the payers' contract generally focus on provider engagement with patients. Table 11 shows the 2019 quality measures used by each payer and how they align.

Table 11: 2019 Quality Measures by Payer

Measures	Medicare	Medicaid	BCBSVT QHP	UVMMC Self-Funded
30 Day Follow-Up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence	X[a]	X	X	X
30 Day Follow-Up after Discharge from the Emergency Department for Mental Health		X	X	X
Risk Standardized, All Condition Readmission	X			
Adolescent Well-Care Visits		X	X	X
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	X	X		
Developmental Screening in the First Three Years of Life		X	X	X
Initiation of Alcohol and Other Drug Dependence Treatment	X[b]	X	X[b]	X[b]
Engagement of Alcohol and Other Drug Dependence Treatment		X		
ACO All-Cause Readmissions			X	X
Follow-Up After Hospitalization for Mental Illness		X	X	X
Influenza Immunization	X			
Colorectal Cancer Screening	X			

[46] Some measures are designated as reporting only measures and are not included in the overall quality score.

Measures	Medicare	Medicaid	BCBSVT QHP	UVMMC Self-Funded
Tobacco Use Assessment and Cessation Intervention	X	X		
Screening for Clinical Depression and Follow-Up Plan	X	X	X	X
Diabetes HbA1c Poor Control (> 9.0%)	X	X	X	
Hypertension: Controlling High Blood Pressure	X	X	X	X
Consumer Assessment of Health Care Providers and Systems' patient experience surveys	X	X	X	

[a] Medicare treats these measures as a single composite measure; Medicaid, BCBSVT QHP, and UVMMC Self-Funded treat them as two separate measures.

[b] Medicare, BCBSVT QHP, and UVMMC Self-Funded treat these measures as a single composite. Medicaid treats them as separate measures.

Under the terms of CMS's 2018 Medicare contract with OneCare, the ACO received a score of 100 percent for that year for reporting on the measures regardless of the outcomes. Similarly, Medicaid had 2 of 10 measures for which it provided OneCare with full payment credit for just reporting results.

Appendix X on page 65 explains how to read the quality scorecards OneCare posts on their website along with links to the actual scorecards.

OneCare Contracts with Providers

OneCare contracts with providers that: (1) meet the terms of participation in OneCare programs; (2) bill for items and services furnished to patients attributed to OneCare; and (3) are included in the list of providers submitted by OneCare to the payers if required by the payers.[47]

When providers join OneCare, they agree to participate in OneCare programs (including which payer programs they will participate in) and to be accountable for the quality, cost, and overall care of the attributed patients.

[47] OneCare has a separate contract for what it calls collaborators. These are entities such as various housing authorities throughout the State who agree to support OneCare's activities and goals.

OneCare/Provider Contracts

Payment structures for health care services

Cost targets for health service areas

Other payments

Payment Structures

When providers contract with OneCare, they agree on whether to receive traditional fee-for-service or fixed payments for agreed-upon services for their attributed patients. Except for a few independent primary care practices, it is primarily hospitals that receive fixed payments from OneCare. If a hospital agrees to receive fixed payments for attributed patients under a given payer, then OneCare determines the amount of monthly fixed payments it intends to pay the hospital based on expected utilization of services.

OneCare's contracts with providers also outline additional care payments that OneCare will make to the providers. For example, a primary care practice that attributes patients to OneCare will receive a monthly payment of $3.25 for each of those patients in 2020 if they meet certain criteria. Examples of this criteria include conducting patient outreach to ensure patients have had a preventive care visit and/or a disease specific visit with a specialist in the past 12 months and implementing quality improvement initiatives to strengthen person-centered care and outcomes.

OneCare/Provider Contracts

Payment structures for health care services

Cost targets for health service areas

Other payments

Cost Targets for Health Service Areas

As previously described in the section about OneCare contracts with payers, OneCare has a total cost of care target, a maximum amount of shared losses the ACO may be required to pay (OneCare purchases risk protection that pays for Medicare losses when they reach a certain level) and a maximum amount of shared savings that they may receive for each payer. OneCare distributes these targets and risks among the ACO's participating hospitals.

As such, hospitals contractually agree with OneCare to be the risk bearing entities in the network. This means that the hospitals agree to be responsible for a cost target for the patients attributed to providers in the hospital's HSA for the payer programs in which they have agreed to participate.[48] These contracts between OneCare and the hospitals include the maximum loss that the hospital may owe if the costs for their HSA exceed their target and likewise the maximum amount that they could receive if these costs stay under their target.[49] As a simple example, if a hospital agrees to accept $1 million in risk in the Medicaid payer program, the maximum amount the hospital will have to pay if costs exceed targets is $1 million and the maximum amount of savings the hospital can receive is likewise $1 million.[50]

OneCare has a policy[51] regarding how shared savings or shared losses will be distributed among the risk-bearing hospitals in the network. Under this policy, regardless of the performance of OneCare and its network of providers as a whole, hospitals are responsible for meeting individual targets. If a hospital exceeds its specific target, it would still be accountable for a loss within its maximum loss threshold, even if the ACO collectively meets its payer-specific target. Likewise, a hospital that stays under its specific targets will receive savings, even if the ACO collectively exceeds the payer's target.

Figure 7 shows three simplified hypothetical scenarios that assume savings and losses were within OneCare and its participating hospitals' maximum risk levels.

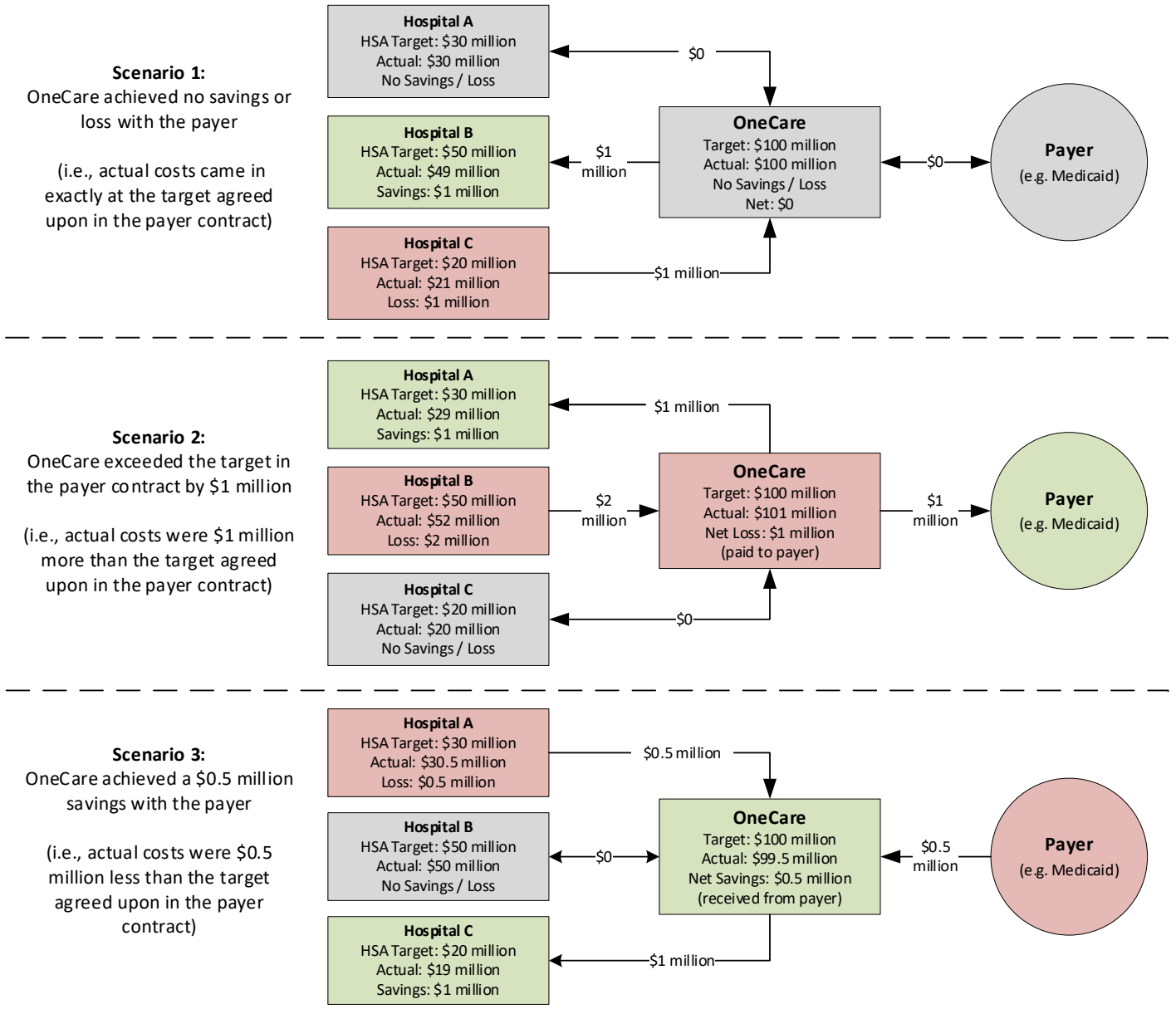
[48] Patients are attributed to individual providers. A patient does not actually need to live in an HSA in order to be included in it; they only need to be attributed to a provider within that HSA.

[49] OneCare aligns the hospital targets and maximum risk levels to the risk sharing agreements outlined in the payer contracts with OneCare.

[50] This example does not account for other risk-sharing arrangements, such as the Medicare risk protection which OneCare pays for to help cover the costs of Medicare losses if they reach a certain level.

[51] OneCare Policy # 04-03, OneCare 2018 Savings / Losses Sharing Model

Figure 7: Three Hypothetical Scenarios for OneCare and Shared Savings and Shared Losses



If a hospital exceeds its maximum risk limit in either savings or losses, the other hospitals in the ACO will share the excess up to their own maximum risk limits.[52]

[52] Before the excess risk is distributed to the other hospitals in the ACO, any proceeds from reinsurance or third-party risk protections will be applied to excess amount owed by the hospital.

OneCare estimates that the maximum amount that the 14 participating hospitals could collectively owe to the payers for failing to meet their targets is $44 million in 2020 (this amount may change due to COVID-19).[53] This amount could be reduced by the risk protection that OneCare purchases to guard against some of the Medicare losses. If OneCare exceeds 50 percent of agreed-upon shared loss arrangement with Medicare, the insurance will absorb 90 percent of the remaining loss, thus OneCare will never have to pay more the 55 percent of the total Medicare losses.[54]

OneCare has completed its shared savings and losses settlement with the ten hospitals that participated in Medicare, Medicaid, and/or BCBSVT QHP payer programs in 2018. Table 12 shows OneCare's reported settlement results, by payer for each hospital. This table does not include UVMMC because its arrangement with OneCare only included shared-savings and it did not achieve any savings in 2018.

Table 12: OneCare's 2018 Shared Savings and Losses Settlement with the Hospitals for 2018

Hospital	Medicare[a]	Medicaid	BCBSVT QHP[c]
Southwestern VT Medical Center	$ -	$ 247,913	$ -
Central Vermont Medical Center	$ 908,045	$ (490,634)	$ (139,706)
Brattleboro Memorial Hospital[b]	$ 170,875	$ (242,105)	$ (90,408)
UVM Medical Center	$ 2,525,225	$ (723,133)	$ (477,528)
Dartmouth Hitchcock Hospital	$ -	$ 96,717	$ 218,101
Porter Medical Center	$ 613,899	$ (75,052)	$ 4,764
North Country Hospital	$ -	$ 300,358	$ -
Springfield Hospital[b]	$ 509,324	$ (11,811)	$ 41,813
Northwestern Medical Center	$ 391,377	$ (380,885)	$ (160,359)
Mt. Ascutney Hospital	$ -	$ (24,233)	$ -
Founders/OneCare	$ 449,833	$ (237,669)	$ (42,254)
Total	**$ 5,568,578**	**$ (1,540,534)**	**$ (645,576)**

[a] Excluding Blueprint/SASH funds.
[b] Springfield Hospital and Brattleboro Memorial Hospital agreed to risk-sharing arrangements that limited possible savings or losses to 50 percent of what they would otherwise be.
[c] Total differs from the amount reported in Table 10 due to rounding.

53 OneCare's 2020 fiscal year budget submission to the GMCB dated October 1, 2019, page 5.
54 After accounting for this insurance, OneCare would be responsible for an estimated $31.8 million in maximum potential losses.

OneCare/Provider Contracts

Payment structures for health care services

Cost targets for health service areas

Other payments

Other Payments to Providers

OneCare distributes money to providers for health investments that they broadly refer to as population health management programs (originally budgeted at $43.1 million in 2020 but may change due to COVID-19).[55] These programs are funded by payers and hospital dues. The programs focus on care coordination, quality, and other health care issues.

For example, OneCare's 2020 budget includes $10.2 million for the complex care coordination program, which is a provider program aimed at better managing the care of the highest risk patients through enhanced communication between providers.

An example of a program focused on quality is the Value Based Incentive Fund (VBIF), which OneCare uses to incentivize its network of providers to achieve the previously discussed quality targets outlined in the payer contracts with OneCare. It also uses this fund to pay for any financial compensation owed to payers for not meeting the quality targets also previously discussed. OneCare uses the dues they collect from hospitals to fund this account. OneCare's 2020 budget includes $8.4 million for the VBIF.[56]

In 2018, 70 percent of available VBIF dollars went to attributing primary care providers and 30 percent went to the rest of the network. Table 13 shows the reported distribution of $3.67 million in VBIF funds for 2018 based on the quality scores achieved under each payer's contract with OneCare. Consistent with its contract with CMS, OneCare's Medicare quality score of 100 percent is based solely on reporting results and not on achieving specific goals.

[55] OneCare also refers to these programs using other names such as population health initiatives or population health investments.

[56] Due to COVID-19, the GMCB has allowed OneCare to reduce the $8.4 million VBIF budget by $1.4 million to ease the financial pressures on hospitals.

Table 13: 2018 Distribution of VBIF Funds by Payer

Summary of 2018 VBIF Incentive Distribution		
Medicare	Quality Score Achieved	100%
	Amount to Primary Care Providers	$1.22 million
	Amount to Other Providers	$0.52 million
	Total	$1.74 million
Medicaid	Quality Score Achieved	85%
	Amount to Primary Care Providers	$1.05 million
	Amount to Other Providers	$0.45 million
	Total	$1.50 million
BCBSVT QHP	Quality Score Achieved	86%
	Amount to Primary Care Providers	$0.30 million
	Amount to Other Providers	$0.13 million
	Total	$0.43 million
UVMMC Self-Funded	Because mental health intervention data was not available, the 2018 VBIF was rolled forward into the 2019 VBIF program.	

The 2019 quality results and VBIF distribution are not known at this time. However, OneCare has changed its distribution methodology. Starting in 2019, 70 percent of any quality incentives earned by the network will continue to be given to attributing primary care providers, but only 20 percent will go to other providers in the ACO. OneCare will retain the remaining 10 percent for quality improvement investments that are approved by the Board of Managers.

Population health management programs may provide funding to entities other than health care providers. For example, OneCare provides funding to RiseVT which works with individuals, employers, schools, childcare providers, and municipalities to provide opportunities to make the healthy choices. Appendix IX on page 63 contains more detailed information about each of the population health management programs listed in OneCare's 2020 budget.

Objective 2: GMCB's and DVHA's Role in Overseeing and Monitoring OneCare

The GMCB and DVHA both monitor and oversee OneCare. In 2018, the GMCB certified that OneCare is eligible to receive payments from Medicaid or commercial insurers under the ACO Model, as required by statute. The GMCB also approved OneCare's 2018-2020 budgets. To perform these functions, the GMCB received and reviewed a wide variety of documentation

from OneCare and held public meetings in which OneCare was required to testify. DVHA, as the Medicaid payer, oversaw its Medicaid contracts with OneCare by obtaining and reviewing various reports and meeting with OneCare personnel in order to confirm that the ACO was meeting its contractual requirements.

The SAO plans to continue analyzing the State's oversight and monitoring of OneCare in future audits.

GMCB

Certification Process

The GMCB is responsible for certifying OneCare and annually verifying its certification eligibility.[57] The GMCB's certification process determines whether an ACO is eligible to receive payments from Medicaid or commercial insurance through the ACO Model. In addition, the statute includes specific criteria that GMCB must consider during the certification process, such as OneCare's governance structure, patient protections, financial stability, payment mechanisms, and population health management initiatives.

The GMCB's process of certifying OneCare primarily entailed reviewing documents provided by the ACO, meeting with OneCare officials, and requesting additional materials and descriptive responses from OneCare. For example, the GMCB obtained copies of OneCare's policies including those regarding conflicts of interest, compliance, network support and access, and care coordination. These were provided by OneCare along with narrative responses to GMCB staff's questions. GMCB staff also attended a demonstration of OneCare's care coordination and analytic systems. The GMCB also had other requirements, such as requiring OneCare to amend their provider appeals policy

COVID-19

Act 91 (2020) allows that during and for six months after a declared state of emergency in Vermont due to COVID-19, the Green Mountain Care Board may waive or permit variances from State laws, guidance, and standards with respect to OneCare's certification and budget review, to the extent permitted under federal law, as necessary to prioritize and maximize direct patient care, safeguard the stability of health care providers, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic. As of May 22, 2020 GMCB has not waived or permitted variances as allowed by Act 91.

[57] Act 113 (2016), made the certification requirement effective January 1, 2018.

to allow providers who have been denied the ability to participate in the ACO to make an appeal.

Ultimately, the GMCB was satisfied that OneCare met the statutory criteria and fully certified the ACO on March 21, 2018.[58] GMCB had documentation that supported that they considered each of the statutory requirements when making this decision.

To verify that OneCare continues to meet the statutory certification criteria, the GMCB conducts an annual recertification review. This process does not require OneCare to resubmit previously provided documentation. Instead, the GMCB requires that OneCare certify that they continue to meet the certification requirements and report any material changes that may impact continued eligibility such as material changes to OneCare's policies, programs, or organizational structure. For example, during the 2019 recertification process, OneCare reported that it had changed its participant appeals policy, which they provided to the GMCB for review.

Budget Approval Process

Starting in 2018, the GMCB became responsible for approving OneCare's budget.[59] Statute requires that when the GMCB reviews OneCare's budget, they evaluate a number of aspects of OneCare, including its expenditures for the previous year and proposed expenditures for the current year, its ability to assume financial risk, and to consider feedback from the Vermont Health Care Advocate and public comments about the proposed budget.[60]

We evaluated the GMCB's documentation of its 2018 and 2019 review of OneCare's budgets for these years and confirmed that the GMCB considered the relevant statutory requirements. For example, the GMCB:

- Reviewed OneCare's financial data submissions such as the trend rates used to construct payers' cost targets and the expected operating costs of OneCare. [61] For example, the GMCB compared OneCare's operating costs to benchmarks associated with companies in similar industries.

- Reviewed OneCare's ability to assume financial risk, including the hospitals' ability to cover those risks.

58 January 5, 2018 GMCB board meeting minutes page 1 and March 21, 2018 meeting minutes page 5.

59 Act 113 (2016), made the ACO budget approval requirement effective January 1, 2018.

60 18 V.S.A. § 9382(b)(1)(A-O).

61 When GMCB performed these reviews actual payer contracts had not been finalized. Therefore, cost and cost targets for the upcoming year were estimates only.

- Obtained input from the Vermont's Health Care Advocate.[62]
- Held public meetings to discuss the proposed budgets and requiring OneCare to testify and respond to questions from the GMCB, as well as allowing for public input. For example, as part of its 2019 budget approval process the GMCB required OneCare to testify about its budget proposal on October 24, 2018.[63]
- Considered public comments about the proposed budget. For example, in the 2018 Budget Order, the GMCB addressed a public comment related to OneCare lacking a plan for addressing provider pay disparities by requiring OneCare to report on how fixed payments made to independent primary care providers compare to those received by primary care providers from hospitals.[64]

The GMCB approved OneCare's budgets for 2018 – 2020 with conditions. For example, one condition requires that OneCare notify the GMCB if their operating costs exceed a specific threshold.[65] Another condition was that OneCare increase its reserves to $2.2 million by the end of the 2018 calendar year, and in its 2019 Budget Order, the GMCB increased this requirement to $3.9 million. GMCB's 2020 Budget Order placed limitations on the use of these reserves and required OneCare to notify the GMCB if they use them.

Medicaid Payment Review

The GMCB, as required by statute,[66] also reviews the payment arrangement between DVHA and OneCare for the upcoming year. The GMCB contracts with an actuary to perform this review. For example, GMCB's contractor reviewed DVHA's rates for 2019 and found no material errors. The GMCB posts the results of their contractor's review on its website.[67]

62 During the GMCB's 2019 budget review the Vermont's Health Care Advocate expressed a concern in a November 9, 2018 memo to the GMCB that OneCare failed to adequately answer questions posed by GMCB and by the advocate.

63 OneCare's presentation slides for that public meeting are here and the transcript for that meeting is here.

64 2018 Budget Order, pages 19 -20.

65 For 2020 GMCB ordered that OneCare's operating costs may not exceed 1.35 percent if their revenues increase, and must not exceed 1.60 percent if their revenues decrease, unless otherwise approved by the GMCB.

66 18 V.S.A. § 9573.

67 2018 rate review here; 2019 rate review here; 2020 rate review here.

DVHA

DVHA is the State department responsible for managing Medicaid[68] and in 2019 had a $252 million contract with OneCare.[69] DVHA required regular reporting from OneCare as part of overseeing this contract. As such, the contract contained a wide variety of reporting requirements supplemented by DVHA's ACO reporting manual. This manual contained descriptions of the purposes of the required reports and how frequently OneCare was to submit them to DVHA. For example, OneCare must regularly submit reports on topics like utilization, operational costs, care management processes, grievances and appeals, and other indicators of ACO performance.

DVHA has established a process to monitor their OneCare contract. As part of this process, DVHA (1) ensured that required reports were submitted and reviewed by applicable DVHA personnel, (2) met with OneCare personnel, and (3) compared DVHA's claims information to that submitted by OneCare to confirm their accuracy. For example, DVHA's provider and member relations unit monitored OneCare's provider and members communications by reviewing OneCare's monthly reports on the number of complaints, grievances, and appeals they received.

Conclusions

The Vermont All-Payer ACO Model is a test involving the federal government, State of Vermont, and the private sector. It tests whether a health care network using similar risk-based contracts among the payers can improve the value of health care for Vermonters. OneCare Vermont, LLC, which was created by the University of Vermont Medical Center and Dartmouth Hitchcock Health is the ACO operating under this model. OneCare facilitates ACO health care expenditures and delivery across all Vermont hospitals but one, and the company also works with other providers, such as independent physicians and Federally Qualified Health Centers.

The ACO Model promotes risk-based contracts between payers and providers using both fee-for-service and fixed payment structures. By OneCare entering into these agreements with payers, OneCare is held financially responsible for meeting health care cost and quality targets. OneCare then distributes this risk to participating hospitals. Ultimately, the

[68] Under Vermont's Medicaid waiver (Global Commitment to Health) AHS is the state agency responsible for ensuring that Medicaid services are delivered in accordance with federal statutes and the waiver agreement. AHS delegates most of its Medicaid responsibilities to DVHA.

[69] Contract # 32318 Amendment #3.

model aims to decrease the growth in health care expenditures and improve the quality and access of care for Vermonters.

The GMCB is responsible for regulating OneCare. The GMCB has recognized that the ACO Model should result in net health care savings for Vermonters. That means OneCare's operating costs should be less than any health care savings generated. However, the GMCB has not devised a method to make this determination.

By the end of 2021, the State must decide whether to enter into a subsequent agreement for another five years. The ACO seems to add new costs to the health care system. Thus, to make an informed decision about a new agreement, the GMCB would need to determine whether quality benefits and savings of the ACO Model outweigh OneCare's operating costs. In the absence of this determination, the State cannot identify whether the All-Payer Agreement increases costs for Vermonters without achieving at least an equivalent benefit.

Recommendations

We make the following recommendation in Table 14 to the GMCB.

Table 14: Recommendation and Related Issue

Recommendation	Report Pages	Issue
1. The GMCB should design and deploy a transparent method to measure the financial outcomes of the Vermont All-Payer ACO Model and determine whether they outweigh OneCare's operating costs. This method and determination should be established prior to agreeing to a subsequent agreement and contain a consideration of available quality results.	22-23	The GMCB has recognized that ACO operating costs should be less than the health care savings the ACO generates. However, the GMCB has not devised a method to make such a determination, citing complexities in both (1) measuring spending that would have occurred but did not due to the ACO and (2) incorporating quality of care into this measurement.
2. The GMCB should devise an alternate method to assess quality improvement for those quality measures in the All-Payer Agreement that have a baseline that is higher than or equal to the target.	24-27	Six of the 22 quality measures in the All-Payer Agreement have updated baselines that are either the same or higher than their corresponding 2022 targets. That means quality of care could decline and yet the targets achieved. Therefore, should this occur, the public could be misled if the GMCB emphasizes that a target was met without also acknowledging that quality had declined.

Management's Comments

On June 22, 2020, the Chair of the GMCB provided written comments to the draft of this report (reprinted in Appendix XI). These comments did not explicitly address our recommendations. That same day, both AHS and DVHA notified the SAO that they would not provide comments to the draft of this report because the SAO addressed the recommendations to the GMCB.

Appendix I
Scope and Methodology

We focused our work in Objective 1 on both describing the All-Payer ACO Model Agreement and how health care payments are coordinated through an ACO under this model. To address our first objective, we gained an understanding of the ACO Model by reviewing the Vermont All-Payer ACO Model Agreement, Section 1115A of the United States Social Security Act, and sections of the Global Commitment to Health Section 1115 Demonstration Waiver. We also interviewed officials from the GMCB and AHS, and we corresponded with the Vermont All-Payer ACO Model Lead at CMS. We discussed continuation of the ACO model with officials from AHS and CMS. We also reviewed various GMCB staff presentations to GMCB regarding the ACO Model and reports from the GMCB to CMS regarding the State progress on attribution targets and the All-Payer total cost of care target.

We reviewed payer contracts with OneCare for 2018 and 2019, which were with Medicare, Medicaid, BCBSVT QHP, and UVMMC's self-funded plan to gain an understanding of attribution methodologies, reporting requirements, payment structure arrangements, quality measures, and calculation methodologies for cost of care targets. We discussed various contractual items with officials from CMS, DVHA, and BCBSVT.

We reviewed OneCare's budget documents for 2018, 2019, and 2020 to determine cost of care targets, health population management program expenses, OneCare operating costs, and revenue sources. We also reviewed other documents such as OneCare's operating agreement, board of managers' meeting minutes, and organization charts to gain an understanding of OneCare's organizational structure and oversight by its board of managers. We interviewed OneCare officials to gain an understanding of various information contained in OneCare documents.

We reviewed the OneCare provider contract templates and contract addendums between OneCare and participating hospitals for 2019 to gain an understanding of how hospitals agreed to be financially accountable to cost targets by payer and the payment structures they agreed to. We also reviewed the contract template for independent primary care providers who agree to receive fixed payments instead of fee-for-service payments for attributed patients and reports regarding that project.

We reviewed Medicare and Medicaid shared savings and shared loss reconciliations with OneCare for 2018. We also reviewed the Medicare, Medicaid , BCBSVT QHP quality scorecard results for 2018.

Throughout the report, we provide examples of information reported by OneCare and the GMCB to help readers understand the ACO and its role. We relied on this information for descriptive purposes only and therefore did not assess its reliability and do not make any assertions to its accuracy.

To address our second objective, we reviewed statutes and rule to gain an understanding of GMCB's responsibilities to regulate and oversee OneCare. We compared GMCB's 2018 and 2019 documentation supporting its certification and budgetary reviews to the criteria outlined in statutes and rule and confirmed by documentation review that GMCB considered all appropriate criteria.

We reviewed CMS's contract with OneCare and interviewed GMCB officials to gain an understanding of GMCB's role and responsibilities for setting Medicare cost-of-care targets. We reviewed correspondence between CMS and GMCB regarding submission of and approval for cost-of-care targets for Medicare.

We reviewed DVHA's contracts with OneCare for 2018, 2019, and 2020. We also reviewed DVHA's ACO operations and ACO reporting manuals, reports from OneCare to DVHA and interviewed DVHA personnel to gain an understanding of how DVHA carried out its oversight of its Medicaid contract with OneCare.

Generally accepted government auditing standards (GAGAS) require that we identify internal control components and principles that are significant to our audit objective and perform procedures to evaluate those that are significant. The Department of Finance and Management recommends to State entities that they use the Committee of Sponsoring Organizations of the Treadway Commission (COSO) model,[70] so we used this same model in our consideration of internal control. As required by GAGAS, Table 15 identifies the internal control components and principles that we determined were significant to our audit objectives and briefly describes the work we performed.

[70] 2013 Internal Control – Integrated Framework© Committee of Sponsoring Organizations of the Treadway Commission (COSO). All rights reserved. Used with permission. COSO is a joint initiative of accountants, financial executives, and internal auditors dedicated to providing guidance to improve organizational performance.

Table 15: Summary of Internal Control Work

Objective #	Internal Control Component	Internal Control Principle	Description of Work Performed
1	Control Environment: This is the set of standards, processes, and structures that provide the basis for carrying out internal control across the organization.	The oversight body demonstrates independence from management and exercises oversight of the development and performance of internal control.	• We reviewed OneCare's Board of Managers public meeting documents and other OneCare documents pertaining to the Board's composition and responsibilities to gain an understanding of the composition and roles and responsibilities of the board.
2	Risk Assessment: This involves a dynamic and iterative process for identifying and assessing risks to the achievement of objectives.	The organization considers the potential for fraud in assessing risks to the achievement of objectives.	• We reviewed OneCare's compliance plan. • We discussed fraud considerations with officials from DVHA's Program Integrity Unit and gained an understanding of their oversight of OneCare.
2	Control Activities: These are the actions established through policies and procedures that help ensure that management's directives to mitigate risks to the achievement of objectives are carried out.	The organization selects and develops control activities that contribute to the mitigation of risks to the achievement of objectives to acceptable levels.	• We reviewed documentation pertaining to GMCB's 2018 and 2019 certification of OneCare and compared them to the requirements in statute and rule. • We reviewed documentation pertaining to GMCB's 2018 and 2019 budget approval for OneCare and compared them to the requirements in statute and rule. • We reviewed DVHA's 2019 Medicaid contract with OneCare and determined whether DVHA paid for those deliverables and had validated that the deliverables satisfied the contract terms.

We conducted our audit work between July 2019 and May 2020. We also met with various officials at various locations including GMCB officials in Montpelier, DVHA officials in Waterbury, and OneCare officials in Colchester. We conducted this performance audit in accordance with GAGAS, which require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II
Abbreviations

ACO	Accountable Care Organization
AHS	Agency of Human Services
BCBSVT QHP	BlueCross BlueShield of Vermont's Qualified Health Plan
CHT	Community Health Teams
CMS	Centers for Medicare and Medicaid Services
COSO	Committee of Sponsoring Organizations of the Treadway Commission
DVHA	Department of Vermont Health Access
GAGAS	Generally Accepted Government Auditing Standards
GMCB	Green Mountain Care Board
HSA	Health Service Area
PCMH	Patient Centered Medical Homes
SAO	State Auditor's Office
SASH	Supports and Services at Home
UVMMC	University of Vermont Medical Center
VBIF	Value Based Incentive Fund
V.S.A.	Vermont Statutes Annotated

Additional Budgetary Information

OneCare's overall budget has increased greatly between 2018 and 2020. The budgeted number of Vermonters expected to be attributed to the ACO has also increased greatly during the same period. Table 16 shows how both the budget and the expected attribution have grown between 2018 and 2020.

Table 16: OneCare's Budget Growth From 2018 to 2020

Initial Budget Submission	2018	2019	2020	% Change (2018 – 2020)
Overall Budget Request (includes population health programs and operating costs)	$639 million	$896 million	$1,425 million	123%
Budgeted Population Health Management Programs	$27 million	$37 million	$43 million	59%
Operating Costs	$13 million	$16 million	$19 million	58%
Number of Lives Expected to be Attributed	122,590	172,365	249,646	103%

Wages and benefits entail the majority of OneCare's operating costs. Table 17 provides a brief explanation of the various functions that OneCare groups their employee wage expenses into.

Table 17: OneCare Employee Functions

Function	Description
Clinical	Providing support to OneCare's network of providers, including training about OneCare tools and advising on best practices.
Quality	Identifying areas for improvement and facilitating sharing of methods from providers who are performing well. Providing support in areas that contribute to improving quality measures.
Analytics	Gathering network data pertaining to quality, cost, and utilization.
Primary Prevention	Creating long term goals for changing population health and working to prevent the factors that lead to poor health. This includes work with RiseVT, which is a program that promotes making healthy choices.
Other Support[a]	Handling appeals/grievances, maintaining a provider hotline, and sending patient mailings.
Regulatory/Government	Interacting with the GMCB and other regulatory entities.
General Admin	Providing administrative support services and performing other tasks that not included in other functional areas.

[a] OneCare refers to this functional area as Patient Support. We used the term Other Support since it includes some work for providers too.

According to OneCare's 2020 budget submission, most of the wages and benefits for employees are allocated to the clinical, analytic, and general administration functions.

OneCare's Board of Managers

OneCare is overseen by Board of Managers that can have up to 21 members.[71] By rule,[72] at least 75 percent of its membership must be participants in the ACO or their representatives. As of April 2020, 85 percent of the Board of Managers are participants in the ACO, with the remaining 15 percent of seats held by consumer members who have health coverage through one of OneCare's contracted payers (i.e., Medicare, Medicaid, and commercial insurance).

The Board of Managers is responsible for oversight, strategic direction, and holding management accountable for OneCare's activities. The Board of Managers makes employment decisions about members of OneCare's management team and approves the ACO's operating budget and changes to its policies. They also adopt and approve the shared savings allocation and any financial decision that has an impact on OneCare of more than $100,000.

OneCare does not financially compensate the board members for serving on the Board of Managers. The Board of Managers also does not have any responsibilities for resolving disputes between OneCare and providers.

OneCare's Network Assignments

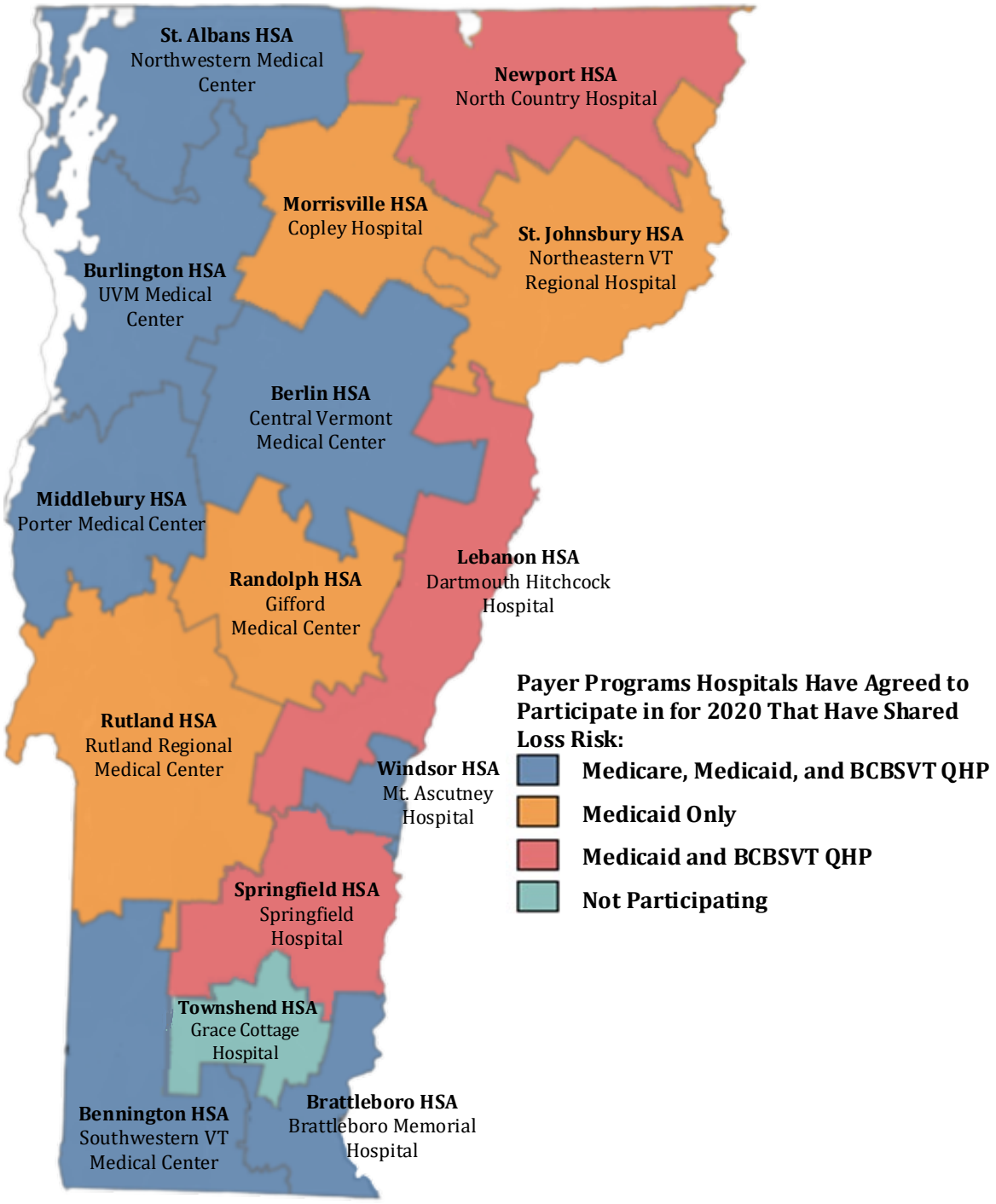
Figure 8 on the following page is a map of OneCare's HSA which are territories that the network is divided into. The different colors indicate which hospitals in that HSA have agreed to participate in the Medicare, Medicaid, or BCBSVT QHP payer programs for 2020.[73]

[71] As of April 23, 2020, OneCare had 20 board members listed on their website.

[72] GMCB Rule 5.202.

[73] These payer programs are the only ones that pose a risk to the hospitals of having to pay a penalty if they exceed cost targets.

Figure 8: 2020 Hospital Assignment by HSA and Payer Risk Program[74]



[74] GMCB provides participation maps here and here.

Appendix IV
Questions and Answers

Health care and the ACO Model are complex, and these subjects raise many questions. The following are answers to questions people may have regarding patients that are not explicitly covered in our audit objectives.

Patients' Rights

Q- Can Vermonters opt out of being attributed to OneCare?

A- Vermonters may not opt out of being attributed to the OneCare network unless they select providers who are not participating in the network.

Q- Are Vermonters attributed to OneCare only allowed to see providers in that network?

A- No, they may continue to see the provider of their choice, as allowed by their health plan, and are not limited to seeing only OneCare network providers. Similarly, providers do not need to join OneCare to be compensated for services provided to Medicare, Medicaid, and commercially insured patients.

Q- Can Vermonters opt out of having their health information shared with OneCare if they are attributed to OneCare?

A- Yes, Vermonters may opt out of having their health information shared with OneCare. OneCare will still receive aggregated de-identified claims information from payers for those Vermonters who have chosen to opt out of data sharing.

Appendix V
Summary of 2018 Vermont Attributed and Non-attributable Population by Payer

Table 18 summarizes Vermont's 2018 population and categorizes them into payer programs that were either included or excluded in the All-Payer attribution target for that year.

Table 18: Vermonters by Attribution Status and Payer in 2018

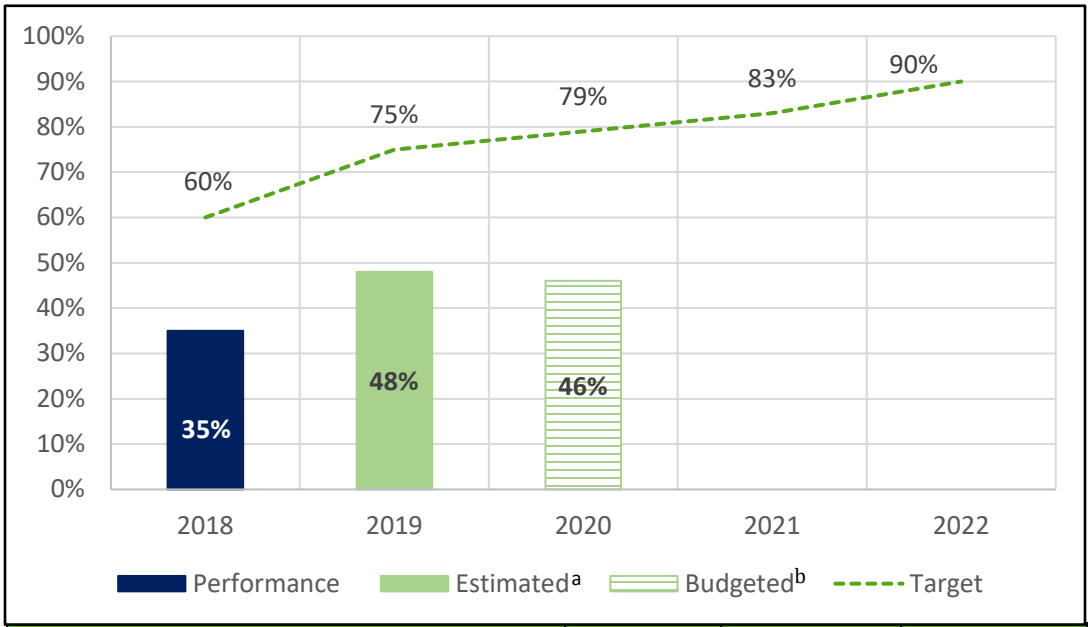
Payer	2018 Vermont Population	Percent of All Vermonters	Number Attributed to OneCare	Percent of All Attributed
Included in the All-Payer Attribution Target				
Medicare	115,029	18%	39,702	35%
Medicaid	136,407	21%	42,342[a]	38%
Commercial: Self-funded Employers	182,151	28%	9,874	9%
Commercial: Fully Insured	105,473	16%	20,838	18%
Commercial: Medicare Advantage	11,749	2%	0	0%
Subtotal	**550,809**	**84%**	**112,756**	**100%**
Excluded from the All-Payer Attribution Target				
Medicare: Part A or B Only	4,524	1%	Not Applicable	Not Applicable
Medicaid: Limited Coverage or Third-Party Insurance	4,943	1%	Not Applicable	Not Applicable
Commercial Insurance: No comprehensive coverage or certificate of authority	43,720	7%	Not Applicable	Not Applicable
Military Health Insurance	16,900	3%	Not Applicable	Not Applicable
Federal Employees	14,594	2%	Not Applicable	Not Applicable
Uninsured	19,800	3%	Not Applicable	Not Applicable
Total	**655,290**	**100%[b]**		

[a] 21,488 of these were young Vermonters in the child eligibility group.
[b] Percentages in column will not add up to 100 percent due to rounding.

Medicare Attribution Target Progress

Figure 9 shows Medicare attribution target performance as reported by the GMCB, including the projected results for 2019 and budgeted results for 2020.

Figure 9: Performance Against the Medicare-Only Attribution Target



	2018	2019 (Estimated[a])	2020 (Budgeted[b])
Number of Vermont Medicare patients with Medicare Parts A and B	115,029	113,272	117,356
Target for the year	69,017	84,954	92,711
Number of Vermonters attributed	39,702	54,210	53,842
Target Shortfall	**(29,315)**	**(30,744)**	**(38,869)**

[a] The GMCB does not yet know the number of Vermont Medicare patients with Parts A and B in 2019. Therefore, this number and the target for the year are estimates.

[b] The GMCB has not received final attribution numbers for all the payers. Therefore, all numbers are estimates, with attribution based on OneCare's 2020 budget.

Medicare-only Cost Growth Target Leeway

While the Medicare-only cost growth target is to stay under 0.2 percent of the national projected Medicare growth rate,[75] CMS provides some leeway for that target. Specifically, CMS will determine that the State is not on track to meet the Medicare-only cost growth target if the average growth rates exceed

[75] Both the Medicare-only cost growth and the national projected Medicare growth rate are calculated as the annually compounded growth from 2017 to the most recently completed year.

0.1 percent of the national projected amount for each year. Table 19 provides the Medicare growth limits Vermont must conform to before CMS determines the State is not on track to achieve the targets outlined in the All-Payer Agreement.

Table 19: Maximum Medicare-only Growth Limits Before CMS Issues Warning Notice

Year	Maximum Acceptable Medicare-only Growth	Medicare Population Included in the Growth Calculation
2018	3.8%	Only members attributed to an ACO.
2019	4.0%	Only members attributed to an ACO.
2020	4.1%	If at least 65 percent of Medicare members are attributed to an ACO, then all Medicare members. Otherwise, only members attributed to an ACO.
2021	4.2%	All Medicare members.
2022	Not known at the time.	All Medicare members.

The Medicare-only cost growth results are not known at this time because of issues with the codes GMCB's contractor used for determining results.

Appendix VII
Attribution Information for Each Payer In 2019

Table 20 shows the factors and process used to determine which patients should be attributed to OneCare in 2019 under each payer program.

Table 20: Factors and Process to Determine Who is Attributed by Payer for 2019

Factors Used for Determining Who Should Be Attributed by Payer				
Factor	**Medicare**	**Medicaid[a]**	**BCBSVT QHP**	**UVMMC**
Attributing Providers	Primary care providers. Non-primary care providers, including specialists such as cardiologists and psychiatrists.	Primary care providers.	Primary care providers.	Primary care providers.
Qualifying Services	Office and other outpatient services. Domiciliary, rest home, or custodial care services. Domiciliary, rest home, or home care plan oversight services. Home services. Transitional care management services. Chronic care management services. Wellness visits.	Office and other outpatient services. Nursing facility services. Domiciliary, rest home, or custodial care services. Domiciliary, rest home, or home care plan oversight services. Home services. Preventative care/ wellness visits. Child and maternal health. Federally Qualified Health Center/Rural Health Center clinical visit. Other prolonged direct and indirect services.	Office or other outpatient services. Nursing facility services. Domiciliary, rest home, or custodial care services. Home services. Prolonged physician services with or without direct patient contact. Preventative medicine services. Counseling risk factor reduction and behavior change intervention. Newborn care services. Federally Qualified Health Center visit.	Office or other outpatient services. Nursing facility services. Domiciliary, rest home, or custodial care services. Home services. Prolonged physician services with or without direct patient contact. Preventative medicine services. Counseling risk factor reduction and behavior change intervention. Newborn care services. Federally Qualified Health Center visit.

Appendix VII
Attribution Information for Each Payer In 2019

Factors Used for Determining Who Should Be Attributed by Payer				
Factor	**Medicare**	**Medicaid[a]**	**BCBSVT QHP**	**UVMMC**
Attribution Time Period	Patient had qualifying services during the two years before July 1, 2018.	Patient had qualifying services during the two and a half years before July 1, 2018.	Patient had qualifying services during the two years before the start of 2019.	Patient had qualifying services during the two years before the start of 2019.
Ineligible Patients	Patients covered under only Medicare Part A or under only Medicare Part B during the attribution time period. Patients who had Medicare as secondary health coverage during the attribution time period. Patients who were enrolled in a Medicare Advantage plan or other Medicare managed care plan during the attribution time period. Patients who were not residents of the United States during the attribution time period.	Patients who did not receive qualifying health care services during the attribution time period. Patients enrolled in Medicaid for less than one month during attribution time period. Patients with commercial health insurance or who are eligible for Medicare. Patients who have evidence of any other insurance that DVHA would retroactively bill to ensure that Medicaid is the payer of last resort. Patients who receive a limited Medicaid package. Patients born since the end of the attribution time period.	Patients who did not live in Vermont on the last day of the attribution time period. Patients for whom BCBSVT QHP was not their primary insurer.	None specified.

Appendix VII
Attribution Information for Each Payer In 2019

Factors Used for Determining Who Should Be Attributed by Payer				
Factor	**Medicare**	**Medicaid[a]**	**BCBSVT QHP**	**UVMMC**
Process for Determining Whether a Patient Should be Attributed to ACO				
Basis of Comparison between ACO and Non-ACO Providers	Cost of qualifying services.	Cost of qualifying services.	If required to select a primary care provider by health plan, then attribution is determined by whether the selected primary care provider is participating in OneCare. Otherwise, number of qualifying services.	If required to select a primary care provider by health plan, then attribution is determined by whether the selected primary care provider is participating in OneCare. Otherwise, number of qualifying services.
Weighting Methodology	Services performed in most recent attribution year (July 1, 2017 to June 30, 2018) are given twice the weight of services performed in the previous attribution year (July 1, 2016 to June 30, 2017).	Providers who have provided services performed in most recent 15 months of the attribution time period are given twice the weight of the providers who gave services in previous 15 months of the attribution time period.	None specified.	None specified.
Tiebreaker	The provider who provided the most recent qualifying services.	The provider who provided the most recent qualifying services.	The provider who performed the most recent qualifying services.	The provider who performed the most recent qualifying services.

[a] Medicaid introduced an expanded attribution methodology for 2020 which includes, but is not limited to, attributing Medicaid members who have not received qualifying services, and allows for newborns born to these members before October 1, 2019 to also be attributed.

The payer contracts detail the financial savings OneCare may receive if health care costs remain under the target, known as shared savings, as well as the financial risk if costs exceed the targets, known as shared losses.[76] This risk is made up of two components:

(1) Risk corridor—the cap on the maximum percentage of the target for which OneCare may share in any losses or savings.

(2) Sharing rate—the rate within the risk corridor, which is the percent of the savings or loss that OneCare will share.

Table 21 is a hypothetical example of how the maximum potential savings or losses for OneCare are calculated using different sharing rates under a 5 percent risk corridor.

Table 21: Hypothetical Example of How Maximum Potential OneCare Savings / Losses are Calculated

Payer Cost of Care Target	X	Risk Corridor	=	Gross Financial Risk/Reward	X	Sharing Rate	=	Maximum Potential Savings / Loss
$ 100,000,000	X	5%	=	$ 5,000,000	X	100%	=	$ 5,000,000
$ 100,000,000	X	5%	=	$ 5,000,000	X	80%	=	$ 4,000,000
$ 100,000,000	X	5%	=	$ 5,000,000	X	50%	=	$ 2,500,000

[76] OneCare shares in savings only with the UVMMC self-funded plan, unlike the other payers with whom they share both savings and losses. OneCare Vermont does not take on risk for any losses with the UVMMC self-funded plan.

Appendix IX
Population Health Management Programs

In 2020, OneCare expects to support twelve population health management programs, three of which are included in the Vermont Blueprint for Health. Currently, the only mechanism CMS can use to provide Medicare funding for Blueprint is through advanced shared savings to OneCare.

OneCare's total 2020 budget for the population health management is $43.12 million. Table 22 provides a brief description of these programs and their 2020 budget amounts. Due to COVID-19, the amounts in the table below may change.

Table 22: Population Health Management Programs Funded by OneCare in 2020

Program	Description	2020 Budgeted Amount
Complex Care Coordination Program	Paid monthly to primary care practices, Designated Agencies, home health, and Area Agencies on Aging on a per qualifying patient basis. Program supports providers in better managing the care of the highest risk patients by ensuring communication among care teams.	$10,223,590
Basic OneCare Per Member Per Month	Paid monthly to attributing primary care practices who achieve certain criteria on a per patient basis. Encourages participation in ACO programs and program development and focuses on population health and high-quality care delivery.	$8,569,920
Value Based Incentive Fund	Rewards providers when the network performs well on ACO quality measures. Funded using hospital dues and paid in a lump sum.	$8,387,232
Specialist Program Payment	Paid monthly to specialist providers on a per patient basis for initiatives that increase access to and coordination of specialty care.	$3,144,500[a]
Comprehensive Payment Reform Program	Additional funding for independent primary care practices that are enrolled in a fixed payment program. Paid monthly on a per patient basis. Fixed payments instead of fee-for-service payments encourages more flexible health care delivery and helps shift funding away from the fee-for-service model.	$1,606,613
Innovation Fund	Paid as a grant for pilot projects that could be implemented across organizations and would benefit both cost and quality of care.	$1,367,580[b]
Primary Prevention Programs	Funding for programs designed to engage Vermont communities in wellness and prevention. Includes funding for RiseVT, which works with individuals, employers, schools, childcare providers, and municipalities to provide opportunities to make the healthy choices. RiseVT is OneCare's lead primary prevention program and is being expanded statewide.	$1,031,752

Appendix IX
Population Health Management Programs

Program	Description	2020 Budgeted Amount
Primary Care Engagement Investment	OneCare, in conjunction with the payers, intends to explore strategies for engaging Vermonters more proactively in their health care and facilitating sustained relationships between patient and primary care provider.	$375,000
VBIF Quality Initiatives	Funded using a portion of unearned value-based incentives to invest in initiatives to improve health care quality.	$167,505
Vermont Blueprint for Health Investments:	A state-led initiative for transforming health care delivery and payments. It designs community-led strategies for improving health and well-being. Consists of: **Supports and Services at Home (SASH)** Coordinates the resources of social-service agencies, community health providers, and nonprofit housing organizations to support Vermonters that choose to live independently at home. Provides an on-site Wellness Nurse and a SASH Care Coordinator for individualized support. Partners include: Home Health Agencies, Area Agencies on Aging, and Designated (mental health) Agencies. **Patient Centered Medical Homes (PCMH)** Investments in primary care that supports practices in achieving and maintaining recognition as a PCHM under the National Committee for Quality Assurance standards. Standards promote excellence in 6 areas including care coordination and transitions, performance measurement and quality improvement, and population health management. **Community Health Teams (CHT)** Designed to incorporate the full continuum of care into population health management initiatives. Supplements services from PCMHs and connects patients with social and economic services that makes healthy living possible.	Total: $8,242,374 SASH: $3,968,246 PCMH: $1,894,417 CHT: $2,379,711

[a] $1,394,500 of this amount is obligated from 2019 to continue projects into 2020.
[b] $617,580 of this amount is obligated from 2019 to continue projects into 2020.

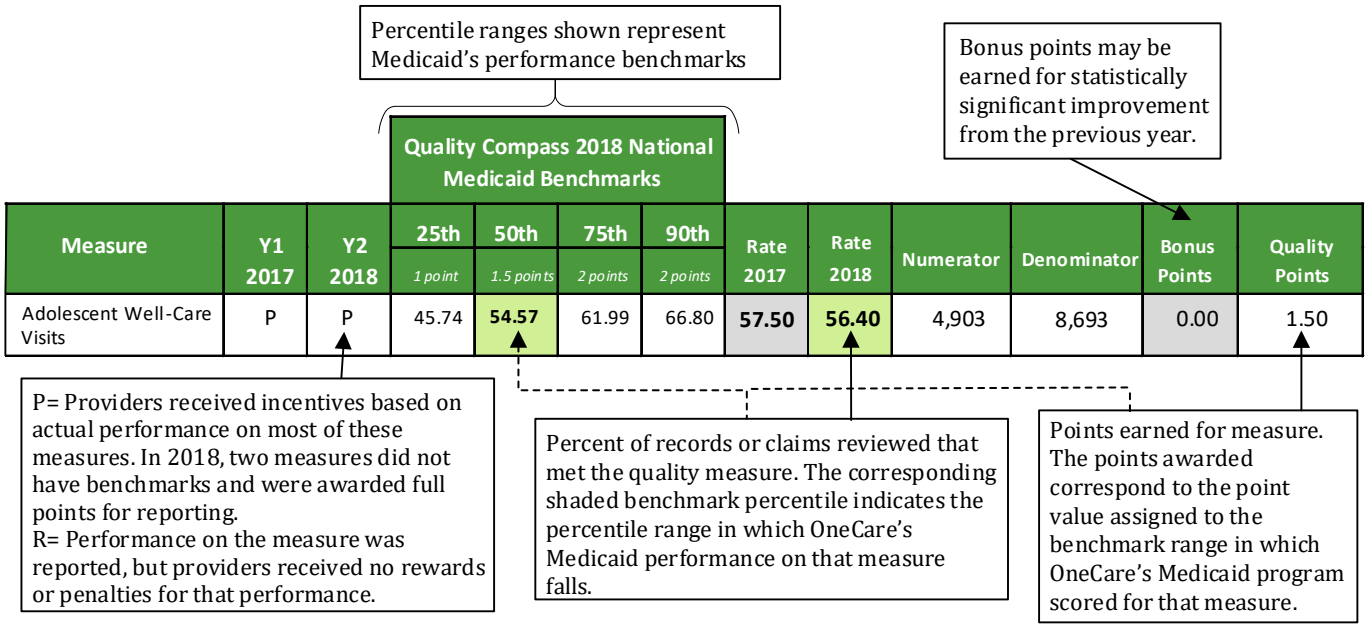
Appendix X
How to Read a Payer's Quality Measure Scorecard

The quality measure scorecards compare OneCare's performance for each payer with performance benchmarks for the measure. For example, in 2018, 56.40 percent of Vermont eligible adolescent Medicaid patients received a well-care visit. This placed the Medicaid program in the 50th percentile range in comparison to the national benchmark and earned OneCare 1.5 points out of 2 toward its total incentive score.

There are three methods used to calculate the quality measure scores that are reported on the scorecards: claims, clinical, and survey. The claims method uses all of the claims that meet certain criteria to determine the rate for that measure, while the clinical method uses a random sample of claims that meet the criteria. The survey method uses the results of patient experience surveys for the quality measure scores.

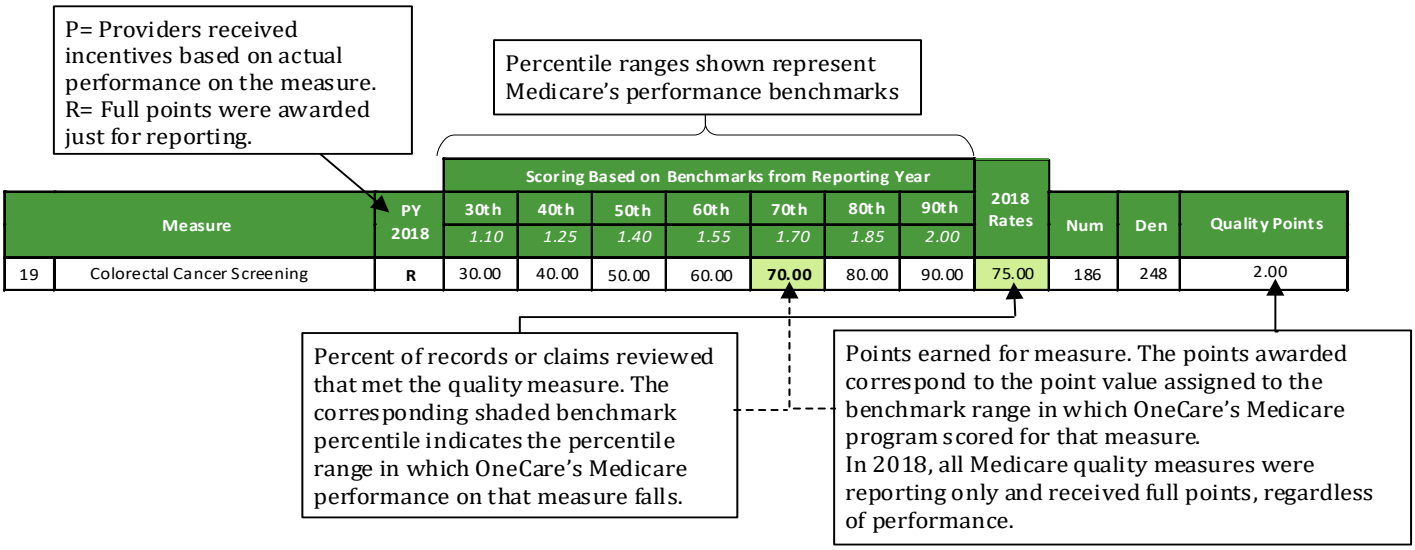
Figures 10 through 12 provide a brief explanation of the information contained in the 2018 quality measure scorecards for Medicaid, Medicare, and BCBSVT QHP using excerpts from the scorecards. Below each figure is a link to the full scorecard located on OneCare's website.

Figure 10: Explanation of Information Contained In the 2018 Medicaid Quality Scorecard



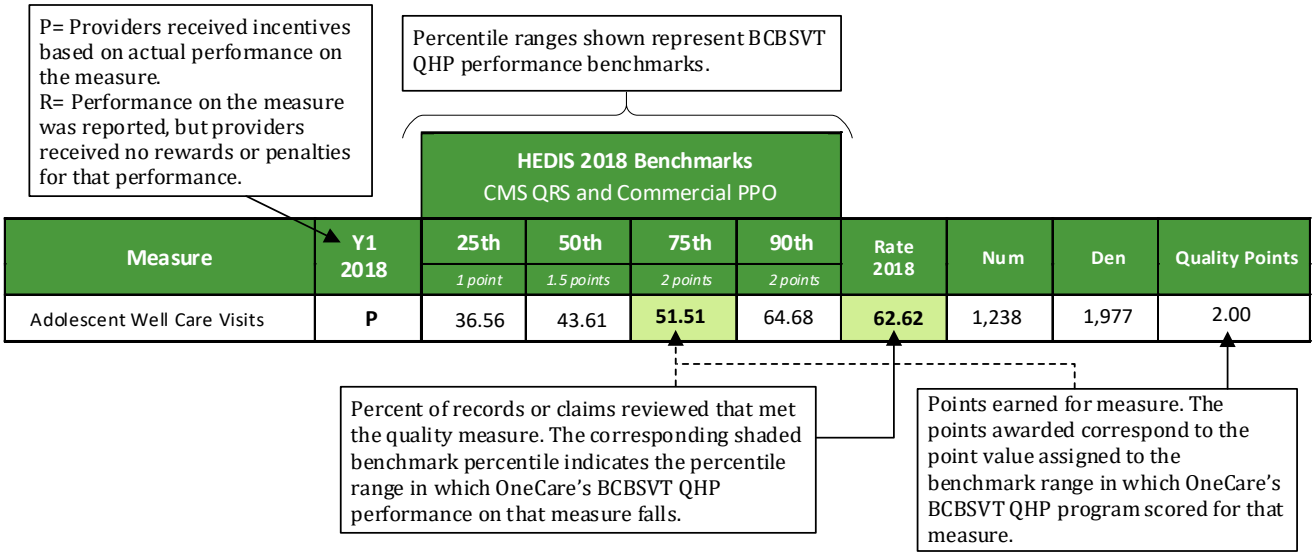
Click here for the 2018 Medicaid quality scorecard.

Figure 11: Explanation of Information Contained In the 2018 Medicare Quality Scorecard



Click here for the 2018 Medicare quality scorecard.

Figure 12: Explanation of Information Contained In the 2018 BCBSVT QHP Quality Scorecard



Click here for the 2018 BCBSVT QHP quality scorecard.

Appendix XI
Comments from Management

The following is a reprint of management's response to a draft of this report. Our evaluation of these comments is contained in Appendix XII on page 69.

VERMONT
GREEN MOUNTAIN CARE BOARD

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Kevin Mullin, Chair
Jessica Holmes, Ph.D.
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Tom Pelham
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June 22, 2020

Mr. Douglas R. Hoffer
Vermont State Auditor
Office of the State Auditor
132 State Street
Montpelier, Vermont 05633-5101

Dear Mr. Hoffer,

Thank you for the opportunity to comment on your office's draft audit report titled *Vermont's All-Payer Accountable Care Organization (ACO) Model: An Overview of the All-Payer ACO Model and the State's Oversight of Vermont's Only ACO, OneCare Vermont, LLC*. As more data become available, it will be important to build upon and integrate existing measurements and analyses to identify successes of the Vermont All-Payer ACO Model (APM or "the Model") and opportunities to improve. We welcome your recommendations on this subject and provide our comments below.

The APM – and Vermont's broader health care payment and delivery system reform efforts – seeks to change the way health care is delivered and paid for, with the goal of keeping health care cost growth in line with that of the overall economy and improving the health of Vermonters and the quality of care they receive. This is consistent with the federal government's priorities, as reflected in the U.S. Department of Health and Human Services' 2015 announcement that, by 2018, the majority of Medicare payments would be paid through "alternative payment models" that reward value, efficiency, and high quality care, rather than through the traditional "fee-for-service" system.[1] CMS has urged states to follow suit.

Vermont's All-Payer Model keeps Vermont moving in the same direction as Medicare while allowing the State to tailor Medicare's programs to Vermont's circumstances and needs. It also allows us to align Medicare's model with other Vermont payers, creating a unified set of incentives for providers which are more likely to achieve the desired outcomes. The COVID-19 pandemic has reinforced the pitfalls of fee-for-service reimbursement and highlighted the value of fixed payments, which can help providers maintain stable revenue during unpredictable times.

The Model was also instrumental in introducing targets for health care spending growth, health care quality, and population health outcomes. The APM contains statewide spending growth targets based on historical economic growth, including expenditures that are outside of the GMCB's traditional regulatory levers (e.g., non-hospital, out-of-state, and self-funded employer spending). The Model's Quality Framework includes ambitious long-term goals to improve the health of Vermonters. The Agreement also keeps Medicare dollars flowing to the Blueprint for Health and Support and Services at Home (SASH) programs, which otherwise would have lost Medicare funding after 2016.

Ongoing assessment of the Model is key to our shared goal of improving Vermont's health care system while increasing transparency. Any assessment of the APM must consider the Model holistically and

[1] *See* Centers for Medicare and Medicaid Services Fact Sheet, *Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume* (Jan. 26, 2015), https://www.cms.gov/newsroom/fact-sheets/better-care-smarter-spending-healthier-people-paying-providers-value-not-volume.

include the Model's impact on overall health care spending, health care quality, and population health outcomes. In addition, analysis of the Model's financial performance should not be limited to the ACO's ability to achieve savings relative to its operational costs: it should include an assessment of the value generated as a result of investments in population health and improved care integration, as well as economies of scale afforded by centralizing shared data infrastructure, analytics, and care coordination, among others. Success on these outcomes depends on collaboration across Vermont health care providers, State agencies, social service organizations, the ACO, and our Vermont communities, and a more simplistic return-on-investment analysis would not accurately evaluate the Model's costs and benefits.

In addition to the multitude of State monitoring and reporting required under the APM, the federal government is performing a comprehensive formal evaluation of the Model. As in most health services research projects, evaluation results are not immediate; standard health care data availability timelines and the federal clearance process mean that reports are typically available 12-30 months following the end of the performance period. While Vermont could consider undertaking a formal State-led evaluation, it would face the same timing constraints and would be highly expensive; without significant additional appropriations, the GMCB could not undertake such a project.

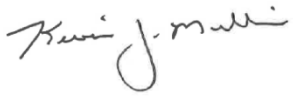
Per the Agreement, Vermont is expected to propose a subsequent model by December 2021. The State and its federal partners recognize that it is not possible to complete a comprehensive Model evaluation prior to this decision for the reasons indicated above; while unfortunate, this was known when the proposal deadline was set during Model negotiations. **For these reasons, the GMCB and its co-signatories will use all available data – including quantitative data and trends that incorporate pre-baseline data, as well as stakeholder input – in deciding whether or not to enter into a subsequent agreement.** The GMCB and our Model cosignatories have already begun contemplating lessons learned that could inform the design of a subsequent model. As noted in your report, proposal development will incorporate a robust stakeholder process to solicit input from providers, advocates, and Vermonters.

See comment 1 on page 69

In evaluating Vermont's performance on the APM's statewide health care quality and population health outcomes measures, it is important to remember that the APM Quality Framework was developed in partnership with Vermont stakeholders and was intensively negotiated with CMS. During these negotiations, 2022 performance targets for each measure were established using the most recent performance information that was then available. As noted in the report, there are areas where Vermont's Year 1 performance is already greater than or equal to the 2022 target, representing improvements over performance results that were available during the 2016 negotiations and/or sustained strong performance. We agree that it is imperative to continue to track performance and to make annual results transparent, both to identify continued success and any areas where performance declines.

As we continue to plan with our co-signatories and prepare to make a proposal for a subsequent agreement, we will continue to consult all available resources and to work with our stakeholders to ensure that we continue to act in the best interest of Vermonters.

Sincerely,



Kevin Mullin
Chair, Green Mountain Care Board

cc:
Mike Smith, Secretary, Agency of Human Services
Cory Gustafson, Commissioner, Dept. of Vermont Health Access

Appendix XII
SAO Evaluation of Management's Comments

In accordance with generally accepted government auditing standards, the following table contains our evaluation of management's comments.

Comment #	Management's Response	SAO Evaluation
1	*As noted in your report, proposal development will incorporate a robust stakeholder process to solicit input from providers, advocates, and Vermonters.*	We made no assertions about the subsequent proposal development including whether the stakeholder process was robust. We reported that according to the AHS Director of Health Care Reform, the State has begun preliminary work regarding a subsequent All-Payer Agreement with CMS. AHS and GMCB had expected to formally engage stakeholders in July 2020 to meet the December 31, 2021 deadline for a proposal for a subsequent five-year agreement, which would end in 2027. However, the timing of this planned stakeholder engagement has been postponed due to the COVID-19 pandemic and they are unsure when it will take place.