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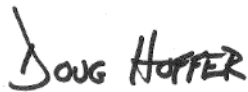
measures in the All-Payer Agreement have baselines that are the same or greater than their targets. Using this evaluation design, quality of care could worsen, and targets could still be achieved.

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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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]

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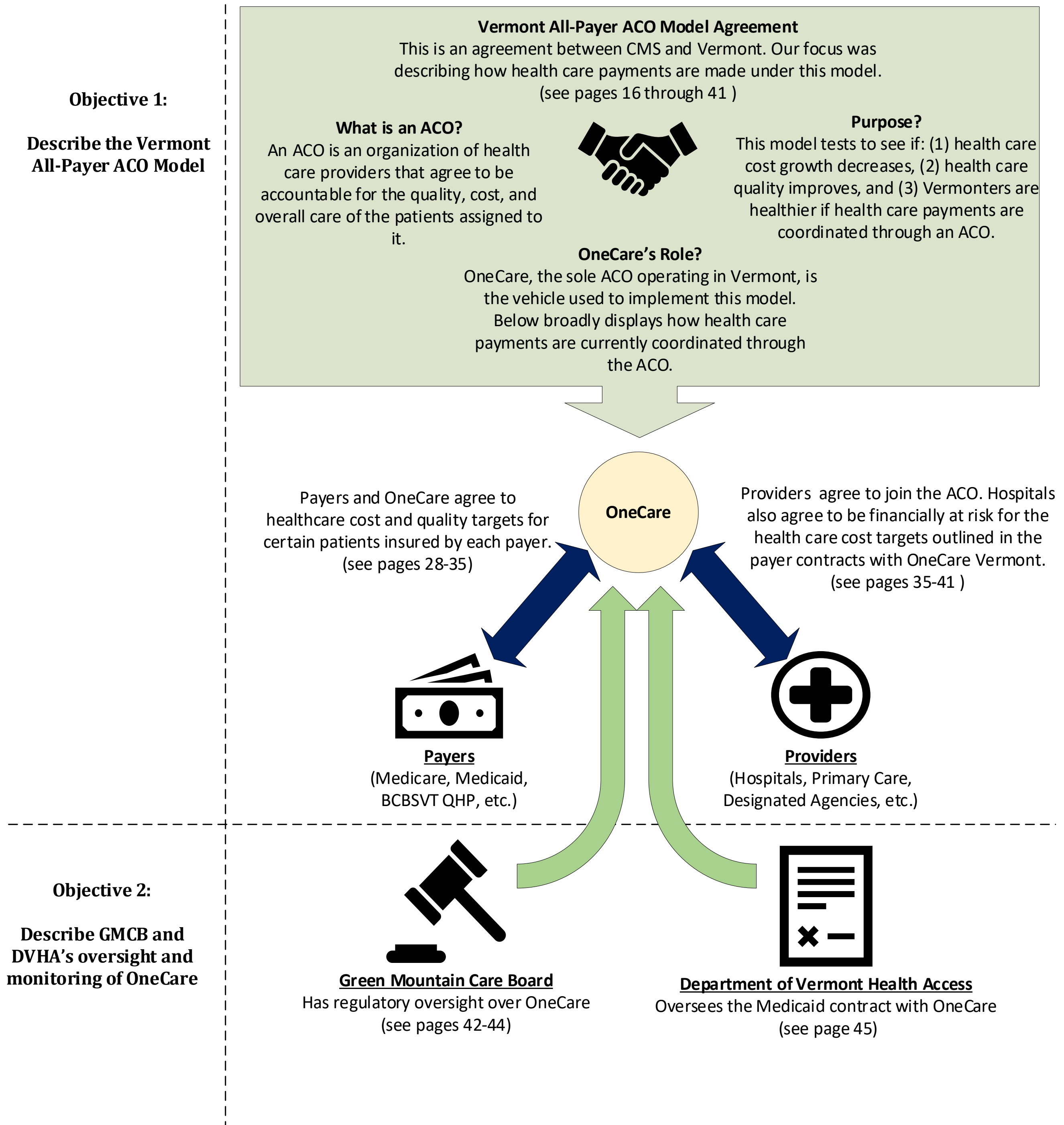
1 Vermont's Legislative Joint Fiscal Office and Legislative Council, Vermont: A Brief History of Health Care Reform.

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.