



STATE OF VERMONT  
OFFICE OF THE STATE AUDITOR

Dear Vermonters,

The All-Payer Accountable Care Organization (ACO) Model Agreement is the signature element of Vermont's current health care reform efforts. In light of the substantial sums involved, not to mention the implications for the public's wellbeing, every Vermonter has a stake in knowing whether the model is delivering for them, and whether the State's contract with OneCare Vermont (OneCare) is working to successfully implement the model.

This is the second of two audit reports my office has completed relating to the Vermont All-Payer ACO Model, hereafter referred to as the ACO Model, to shed light on those questions. The ACO Model is currently scheduled to conclude in 2022. Before the end of 2021, the Green Mountain Care Board (GMCB), in collaboration with the Agency of Human Services (AHS) and the Governor's Office, may submit a proposal to the Centers for Medicare and Medicaid Services (CMS) to enter into a subsequent five-year agreement. Our two audit reports provide important information to help policymakers decide how to proceed as the end of the current agreement nears.

In the first report, found [here](#), we described how the ACO Model is structured and implemented. We also described the roles of the Green Mountain Care Board (GMCB) and the Department of Vermont Health Access (DVHA) in overseeing and monitoring OneCare, the State's only ACO and the entity with primary contractual responsibility for the model's performance.

An essential recommendation in that audit was that the GMCB 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. **In other words, is the model saving more money than it costs to operate?** We recommended that this be a prerequisite to agreeing to a new contract with CMS. The Board recognized the importance of such an analysis but has not established a methodology for it. That leads us to this second audit in our ACO series.

I would first like to say what this performance audit *is not*. It is *not* an audit of the concept of the All-Payer Model. And it is *not* an audit of the wisdom of moving away from a fee-for-service health care system in favor of so-called value-based payments.

A policymaker or State official can be completely invested in and supportive of the All-Payer Model **and** conclude, based upon the facts presented in this audit and elsewhere, that the implementation of the Model, as currently delivered, needs improving.

So, what *was* the performance audit about? It calculates and describes the use of State-controlled funds spent to implement the ACO Model. This resulted in answering the following questions:

1. How much have Vermonters spent supporting OneCare's operating budget as the ACO participating in the All-Payer Model?
2. Do any savings from OneCare's efforts exceed their operating costs?

These are relatively straightforward questions and ones Vermonters, be they patients, policymakers or providers, deserve to have answered.

Here's what we learned.

**We found that Vermont has spent at least \$29.8 million to implement the ACO Model since the State signed the agreement with CMS in October 2016** to create the model through the end of 2020. Most of that amount (84 percent) was DVHA payments to OneCare for operating costs through its Medicaid contract with the ACO.

**DVHA reports show that OneCare missed the financial targets for 2017 through 2019 by a combined \$11.1 million. During those same years DVHA also paid \$14.5 million of OneCare's operating costs. When including the operating costs, OneCare's estimated net Medicaid financial performance for those years collectively is -\$25.6 million.**

**Put simply, at this time the financial costs to run the model significantly exceed any Medicaid savings attributed to it.** This report does not analyze why, it is simply a fact.

In addition, when setting financial targets with OneCare and reporting the results, DVHA does not include OneCare's operating costs and suggests in their Management Comments that it would not be appropriate to do so. The GMCB's OneCare budget order, however, directs that OneCare's administrative expenses (which they use interchangeably with operating costs) "**must be less**" than the health care savings attributed to their efforts.

We find that DVHA is the only health care "payer" that financially supports OneCare's operating costs, and that DVHA paid a steadily increasing percentage of those costs each year from 2017 (28 percent) through 2020 (78 percent). At the exit interview for this audit report we asked the GMCB and AHS whether they are considering requiring other insurers to pay an administrative fee to OneCare. AHS indicated that this is not being planned for at this time. Only Vermont's taxpayer-funded Medicaid program is contributing.

We also found that gaps in DVHA's reporting provisions in their Medicaid contract with OneCare mean they cannot ensure that OneCare used all of the funds DVHA provided for their intended purposes. The total amount of unaccountable expenditures is \$12.7 million. Before issuing a draft of this report to DVHA, we confirmed with them that they never asked the ACO for a detailed accounting of how the funds were used. While it is disappointing that DVHA has not asked for a retroactive explanation of the spending, we are glad they have expressed intent to implement our recommendations to provide more accountability for the use of these funds moving forward.

In order to more completely account for all costs associated with operating OneCare, we also include information in this report about how the GMCB bills entities it regulates and how much the Board billed OneCare.

The AHS Management Comments state that "ACO operating costs – particularly in early years – should not be a leading factor in determining whether the State should enter into a subsequent All-Payer agreement."

There are two important and incorrect assumptions built into that statement – that this audit takes a position on whether Vermont should enter into a second All-Payer agreement (it doesn't), and that OneCare is the only potential option for AHS to contract with to carry out the ACO Model's work (it is not).

That AHS statement perfectly illustrates, though, the conundrum facing Vermont policymakers and citizens. If now is too soon, then when exactly *are* Vermonters entitled to call the question on whether their money-saving investments are actually going to save them money? Next year? In five years? Ten? Twenty?

**CMS estimates that NORC, their evaluation contractor, will not have a complete analysis of the ACO Model until April 2024. That is nearly three years *after* the GMCB, AHS, and the Governor's Office plan to propose a new five-year agreement. This guarantees that Vermont would be entering into a new agreement without any evidence that the current implementation plan is working. Because "early years" is not defined, it is easy to see how this logic – the program needs more time to produce benefits - could continue indefinitely.**

I hope the information within the report that follows, produced according to generally accepted government auditing standards, informs the decision-making process that confronts policymakers, health care providers, administration officials, and everyday Vermonters.

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

Sincerely,

A handwritten signature in black ink that reads "DOUG HOFFER". The signature is written in a cursive, slightly slanted style.

DOUGLAS R. HOFFER  
State Auditor



# *All-Payer ACO Model Implementation Costs*

Department of Vermont Health Access  
Provided Substantial Funding for OneCare's  
Operating Costs (Which Have Exceeded  
Reported Savings) But Has No Assurance that  
OneCare Used All Funds for Their Intended  
Purposes



## 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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# Contents

	<b>Page</b>
Highlights	1
Background	7
Objective: ACO Model Implementation Costs	10
Monthly Administrative Fees	11
Information Technology Related Payments	13
Population Health Investments	14
Total DVHA Payments to OneCare for Operating Costs	15
Other Vendor Costs Related to Implementing the ACO Model	17
GMCB Billback	19
Conclusions	20
Recommendations	20
Management's Comments	21
Appendix I: Scope and Methodology	22
Appendix II: Abbreviations	25
Appendix III: ACO Model Diagram	26
Appendix IV: GMCB Billbacks for Fiscal Year 2020 (July 1, 2019 – June 30, 2020)	27
Appendix V: Management's Comments from the Green Mountain Care Board	29
Appendix VI: Management's Comments from the Agency of Human Services	31
Appendix VII: SAO Evaluation of Management's Comments	35

# Highlights

In 2016, Vermont entered into an agreement with the federal government called the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement (hereafter referred to as the All-Payer Agreement). The goal is to limit the growth in health care spending and improve the quality of care for and the health of Vermonters.

The model outlined in the All-Payer Agreement relies on health insurers paying providers through an ACO<sup>1</sup> using risk-based payment arrangements tied to health care cost targets and quality measures. However, the All-Payer Agreement is silent on how to pay for the operational costs of ACO(s) that facilitate this arrangement.

Due to the Vermont All-Payer ACO Model's (hereafter referred to as the ACO Model) potentially profound effect on the delivery and cost of health care to Vermonters, the State Auditor's Office (SAO) decided to begin a series of audits pertaining to this model. This is our second audit in that series.<sup>2</sup>

Our first audit described the ACO Model and the roles of the Green Mountain Care Board (GMCB) and the Department of Vermont Health Access (DVHA) in overseeing and monitoring OneCare Vermont (hereafter referred to as OneCare),<sup>3</sup> which is Vermont's sole ACO.<sup>4</sup> During that audit, we found that as the State prepares to make the important decision of whether to enter into a subsequent All-Payer Agreement with the federal Centers for Medicare and Medicaid Services (CMS), GMCB had not developed a methodology to determine if the financial outcomes of the ACO Model outweigh OneCare's operating costs.

OneCare's operating costs are not the only costs associated with implementing the ACO Model. Therefore, we conducted an audit to calculate the amounts and describe the use of State controlled funds spent on implementing the Vermont All-Payer ACO Model since the State and the federal government entered into an agreement to create the model. State controlled funds includes those expenditures that are reimbursed by the federal government such as the federal share of Medicaid expenditures. Our focus was limited to payments made to OneCare that support the ACO's operating costs and payments to other vendors hired by the State that performed work pertaining to the implementation of the ACO Model.

<sup>1</sup> An ACO is a group of health care providers that agree to be accountable for the cost, quality, and overall care of its assigned patients.

<sup>2</sup> Appendix I on p. 22 details the scope and methodology of the audit. Appendix II on p. 25 contains the list of abbreviations used in this report.

<sup>3</sup> Appendix III contains an overview of how the ACO Model works and GMCB and DVHA's roles in overseeing and monitoring OneCare.

<sup>4</sup> [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](#), Rpt No. 20-02, dated June 26, 2020.

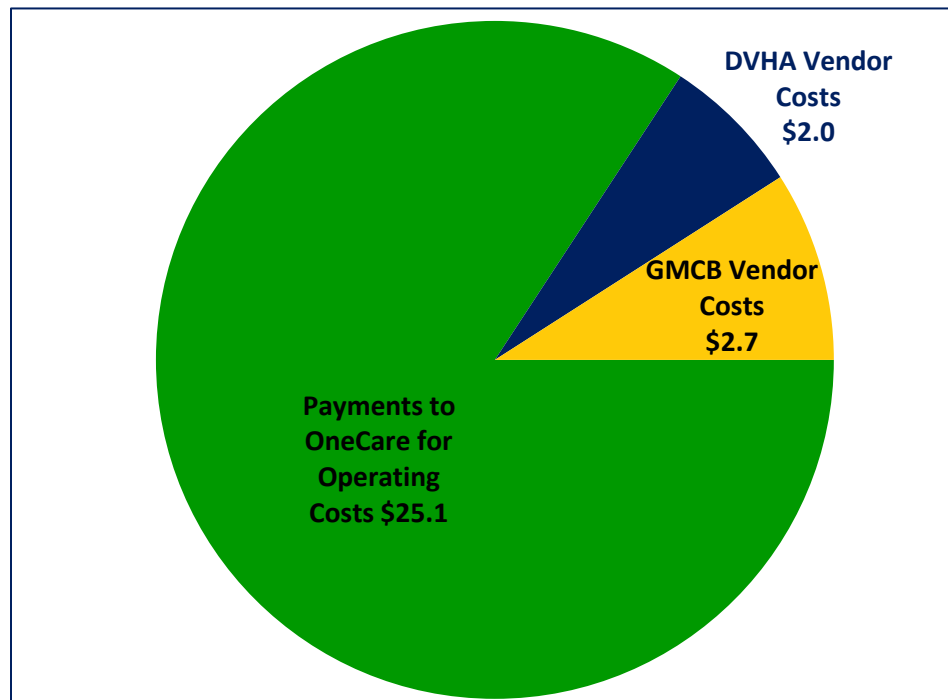
## What We Found

The State has spent at least \$29.8 million in the four years from the October 27, 2016 effective date of the agreement with CMS to implement the ACO Model through December 31, 2020. This includes payments to OneCare to support the ACO's operating costs and payments to other vendors used by the State to assist in implementing the model. In addition to these costs, the State incurred payroll costs associated with State employee work on implementing the model. However, neither Agency of Human Services (AHS) Central Office, DVHA, nor GMCB were able to provide us with a reliable estimation of employee time spent on implementing the ACO Model. Therefore, State employee costs are not included within the scope of this audit, and for that reason this audit does not reflect all administrative costs related to implementing the ACO Model. **Also not included is the substantial work performed under a \$45 million grant from CMS that led up to the Agreement.**<sup>5</sup>

DVHA's payments to OneCare through its Medicaid contract are the vast majority of the expenditures as shown in Figure 1 below.

***MOST STATE  
SPENDING ON  
IMPLEMENTING  
THE ACO  
MODEL GOES  
TOWARDS  
SUPPORTING  
ONECARE'S  
OPERATING  
COSTS.***

**Figure 1: State Spending on Implementing the ACO Model from October 27, 2016 to December 31, 2020 (in Millions)**



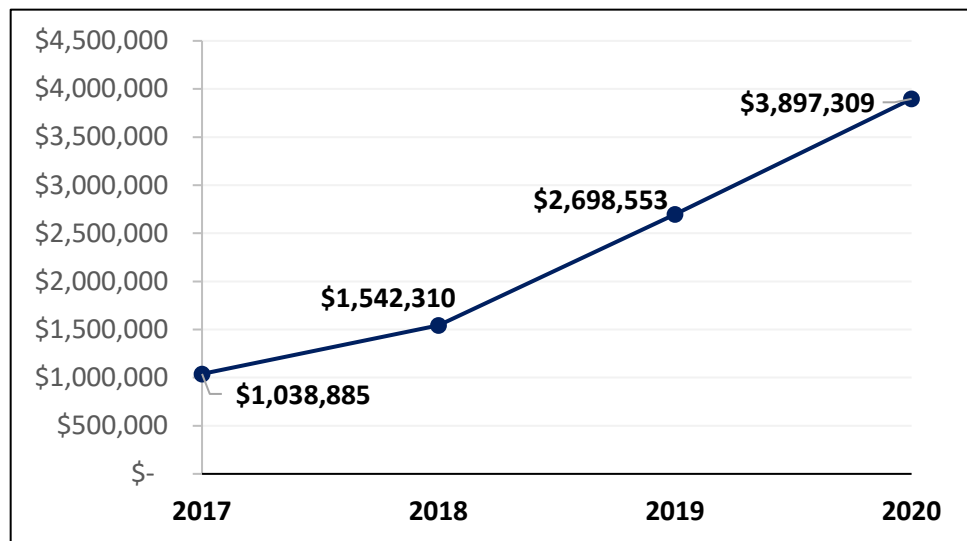
<sup>5</sup> Vermont received a State Innovation Model (SIM) grant in 2013 from the Center for Medicare and Medicaid Innovation. The SAO determined that it would be impracticable for the SAO to identify costs associated with developing the ACO Model due to the passage of time and the various projects undertaken with the grant.



DVHA, through its Medicaid contract with OneCare, provides a monthly payment to OneCare to help support the ACO's ongoing operating costs. The payment amount is \$3.25 per month for each Medicaid patient that the ACO has agreed to be accountable for. Neither of the other two major payers (CMS for Medicare and Blue Cross Blue Shield of Vermont) provided an administrative payment to OneCare because they were not contractually required to do so. Each year the amount that DVHA pays OneCare has increased, as shown in Figure 2 below, because the ACO has become accountable for more Medicaid patients.

**DVHA IS THE ONLY PAYER THAT PROVIDES SUPPORT TO ONECARE FOR ONGOING OPERATING COSTS.**

**Figure 2: Annual amount of Administrative Fees Paid by DVHA to OneCare from 2017 through 2020**



The administrative fees are not the only funding from the Medicaid contract that supports OneCare's operating costs. From 2017 through 2020, DVHA also paid another \$16 million to the ACO for operating costs for other programs outlined in the Medicaid contract. Specifically, DVHA paid \$12.1 million for information technology (IT) activities.<sup>6</sup>

- **However, DVHA was unable to provide us with financial detail as to how the ACO spent the vast majority of the IT payments because DVHA never required OneCare to provide such information. Therefore, DVHA has no assurance that the ACO used those funds solely for their intended purposes.**

<sup>6</sup> IT expenditures funded by DVHA are included in OneCare's operating costs.

## Recommendation

The Commissioner of DVHA should add financial reporting requirements in the Medicaid contract with OneCare for the ACO to provide detailed financial reporting on how the ACO used funds provided by DVHA for information technology programs.

DVHA also provided funding for programs OneCare refers to as population health investments. This includes funding for OneCare's RiseVT program and complex care coordination program, and some of the funding supported OneCare's operating costs. Specifically, all of the \$3.9 million DVHA paid in complex care coordination payments in 2020 went to the ACO's operating costs. However, DVHA was unable to account for all of the funds provided for population health investments in previous years, and therefore it is possible that OneCare may have used more of these funds for operating costs.

- **DVHA paid \$1.1 million to OneCare in 2019 for their RiseVT program and does not know how the ACO spent the vast majority of those funds either. Here again, DVHA never required such financial reporting. Therefore, DVHA has no assurance that the funds were used within the terms of contract.** DVHA received reports from OneCare showing that the ACO distributed \$189,608 to community organizations under the RiseVT program. Other than that, DVHA does not know how OneCare's used the funding and how much went to the ACO's operating costs.
- **DVHA does not know how OneCare used \$330,412 of the complex care coordination payments they gave the ACO in 2017 and therefore has no assurance that the funds were used within the terms of contract.** From 2017 through 2019 OneCare passed the majority of the complex care coordination funding they received on to health care providers. DVHA recouped funds not passed on to providers in 2018 and 2019 but in 2017 did not recoup \$330,412 in funds not passed on to providers because DVHA had not established a contractual requirement to do so that year. DVHA does not know how OneCare used those undistributed funds because DVHA did not require the ACO to report how they used undistributed funds.

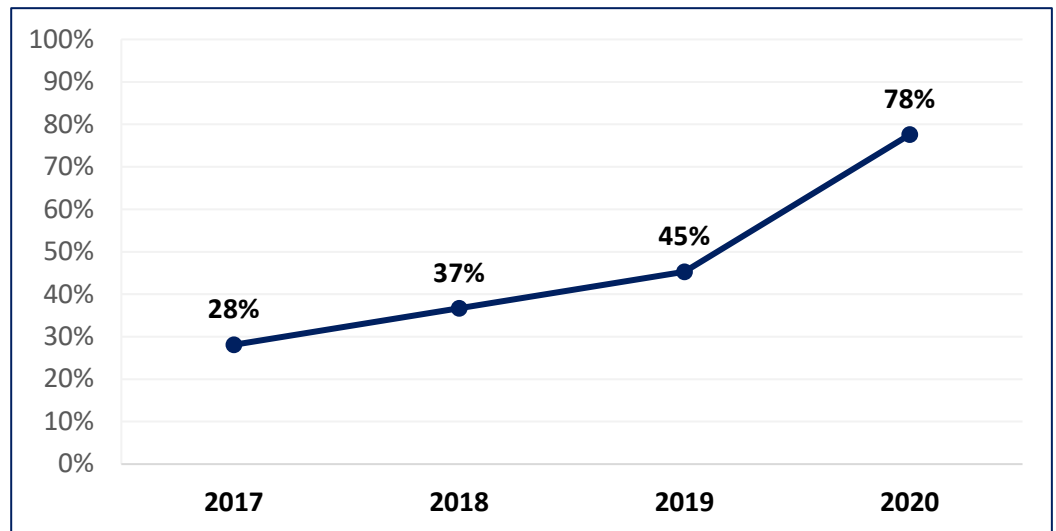
## Recommendation

The Commissioner of DVHA should add financial reporting requirements in the Medicaid contract with OneCare for the ACO to provide detailed financial reporting on how the ACO used all funds provided by DVHA for population health investments.

The additional investments combined with the increasing amount of administrative fees paid by DVHA have resulted in an annual increase in the percent of OneCare's operating costs supported by the Medicaid contract as shown in Figure 3 below.

**THE PERCENT  
OF ONECARE'S  
OPERATING  
COSTS  
SUPPORTED BY  
THE MEDICAID  
CONTRACT HAS  
BEEN  
INCREASING.**

**Figure 3: Percent of OneCare's Operating Costs Paid by DVHA Through the Medicaid Contract from 2017 to 2020**



The Medicaid contract contains financial targets for health care costs for each year. If OneCare is able to keep health care costs under that target, this is referred to as a savings. If actual health care costs exceed the target, then this is referred to as a loss. OneCare is eligible to receive savings or liable to pay the losses up to a maximum limit which are referred to as shared savings and losses.<sup>7</sup> Throughout this report, we discuss OneCare's financial performance relative to the targets before the calculation of shared savings or losses. This is because shared savings and losses have a maximum limit and actual financial performance may be outside those limits. For example, in 2019, OneCare had a -\$11.9 million loss against the target but the maximum financial liability OneCare had to pay DVHA for that loss was -\$6.6 million.

When DVHA sets the financial targets with OneCare, DVHA does not consider the payments they provided to OneCare for the ACO's operating costs. Therefore, when DVHA reports OneCare's financial performance with respect to the Medicaid contract the results do not factor in payments for ACO operating costs. Table 1 on the next page shows the reported financial results from 2017 to 2019, which are the most current reported results, along with our assessment of net performance when considering payments for operating costs. **After factoring in DVHA's payments to OneCare for operating costs, the ACO did not provide a net**

<sup>7</sup> For more information regarding cost targets and how the ACO agrees to share in savings and/or loss see pages 30-33 of our previous audit report [here](#).

savings relative to its Medicaid targets during those years.

**Table 1: OneCare’s Financial Performance Relative to the Medicaid Targets from 2017 to 2019 and Assessment Against OneCare’s Operating Costs Paid by DVHA (Rounded to Nearest \$100,000)<sup>a</sup>**

Year	Performance Against Financial Target	By How Much?	ACO Operating Costs Paid by DVHA	Assessment of Net Performance Relative to Target After Operating Cost Payments <sup>b</sup>	Assessment of Performance Relative to Target After Operating Cost Payments
2017	Savings	\$2,400,000	-\$2,500,000	-\$200,000	Loss
2018	Loss	-\$1,500,000	-\$5,000,000	-\$6,600,000	Loss
2019	Loss	-\$11,900,000	-\$6,900,000	-\$18,800,000	Loss
<b>Net<sup>c</sup></b>	<b>Loss</b>	<b>-\$11,100,000</b>	<b>-\$14,500,000</b>	<b>-\$25,600,000</b>	<b>Loss</b>

<sup>a</sup> This table does not include shared savings DVHA paid to OneCare or shared losses OneCare paid to DVHA. According to reports from DVHA, in 2017 OneCare was entitled to \$2.4 million in shared savings from DVHA. In 2018 and 2019, OneCare was liable to repay DVHA \$1.5 million and \$6.6 million in shared losses, respectively.

<sup>b</sup> Amounts in this column may differ from the sum of the two previous columns due to rounding.

<sup>c</sup> Amounts in this row may not match the sum of the column due to rounding.

# Background

## Efforts leading up to the All-Payer ACO Model Agreement

Vermont received a \$45 million grant<sup>8</sup> from CMS starting in 2013 which enabled the State to develop new efforts intended to advance health care delivery and payment reform. The central payment reform effort was development and implementation of a program that ran from 2014 to 2016 where ACOs could receive a savings for staying under cost targets and meeting performance expectations for quality measures from Medicaid<sup>9</sup> and Blue Cross Blue Shield of Vermont.<sup>10</sup> The intent was to incentivize providers to deliver high quality, efficient health care.

In 2015, the State began to explore ways to evolve its efforts towards an all-payer model, and in January 2016, began to engage with CMS on the design of the Vermont All-Payer ACO Model. The All-Payer Agreement became effective between Vermont and CMS on October 27, 2016.

## All-Payer Agreement Implementation

The State is in its fourth performance year of the Vermont All-Payer Accountable Care Organization (ACO) Model Agreement with CMS.<sup>11</sup> This agreement ends December 31, 2022, and if the State wishes to continue a subsequent agreement it must submit a proposal to CMS by the end of 2021.

Current State entities that perform regular ACO Model work are (1) Agency of Human Service (AHS) Central Office, (2) DVHA, and (3) GMCB, as discussed in Table 2 below.

**Table 2: State Entities with Regular ACO Model Responsibilities**

State Entity	Examples of ACO Model Responsibilities
AHS Central Office	<ul style="list-style-type: none"> <li>• Signatory to the All-Payer Agreement and collaborates with GMCB to accomplish the reporting required by the agreement.</li> <li>• Responsible for the Medicaid implementation of the ACO Model.</li> </ul>

<sup>8</sup> State Innovation Model (SIM) grant. The CMS webpage regarding this grant is [here](#).

<sup>9</sup> Medicaid is a government-funded health insurance program for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. DVHA is responsible for administering Medicaid in Vermont, and it is funded jointly by the State and the federal government.

<sup>10</sup> The program was known as the ACO Shared Savings Program. Blue Cross Blue Shield’s participation in the program was extended into 2017.

<sup>11</sup> 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.

State Entity	Examples of ACO Model Responsibilities
DVHA	<ul style="list-style-type: none"> <li>• Enters into and oversees the Medicaid payer contract with OneCare.</li> <li>• Evaluates OneCare's actual Medicaid cost and quality performance to annual targets outlined in the Medicaid contract.</li> </ul>
GMCB	<ul style="list-style-type: none"> <li>• Regulates ACOs.</li> <li>• Signatory to the All-Payer Agreement and monitors and reports All-Payer Agreement progress annually.</li> <li>• Assists CMS in setting annual health care spending targets for the Medicare contract with OneCare.</li> <li>• Reviews the Medicaid rates used in DVHA's contract with OneCare.</li> </ul>

Both GMCB and DVHA use vendors to assist them in carrying out their responsibilities pertaining to the ACO Model. According to the AHS Director of Health Care Reform, the AHS Central Office did not contract with any vendors pertaining to ACO Model implementation and monitoring.

## OneCare Vermont’s Operating Costs

OneCare is Vermont’s sole ACO and participates in the ACO Model. Annually, OneCare submits a budget to GMCB for review and approval. The ACO’s budget contains three primary components: (1) provider reimbursements for health care services given to patients assigned to OneCare in the upcoming year; (2) population health investments<sup>12</sup> which are funding programs the ACO provides to the health care community and others as part of various health investment programs;<sup>13</sup> and (3) OneCare’s operating costs.

GMCB’s 2021 budget order<sup>14</sup> for OneCare notes 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.

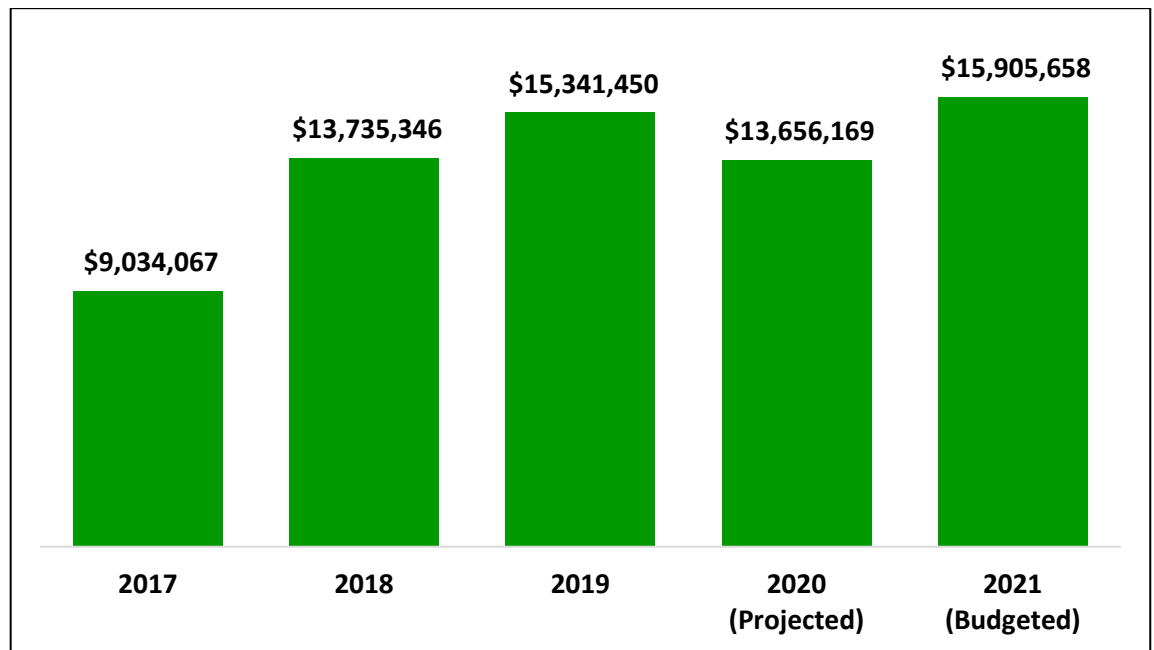
**The total cost of the ACO’s operations from 2017, which is the first year Medicaid began participating in the ACO Model, through the end of 2021 is expected to be approximately \$68 million.** With the exception of 2020, OneCare’s operating budget has increased annually, as shown in Figure 4 on the next page.

<sup>12</sup> OneCare also refers to these programs using other names such as population health initiatives or population health management programs.

<sup>13</sup> See slide 23 and 24 of [OneCare’s October 28, 2020 budget presentation to GMCB](#) for more information about the 2021 investment areas and who receives the funding respectively.

<sup>14</sup> See page 25 of GMCB’s 2021 budget order for the ACO [here](#).

**Figure 4: OneCare’s Operating Budget Since 2017<sup>a</sup>**



<sup>a</sup> OneCare’s operating budget for 2020 was originally \$19.3 million. In response to the COVID-19 pandemic, OneCare took cost cutting measures to reduce its operating costs.

OneCare’s operating costs such as salaries and fringe benefits, software, and supplies are primarily funded by DVHA through the Medicaid contract and by payments received from hospitals. In 2017, \$2 million of the ACO’s operating costs were also paid by CMS.<sup>15</sup>

### OneCare Vermont’s Financial Performance Since 2018

While Medicaid began participating in the ACO Model in 2017, Medicare and commercial payers<sup>16</sup> did not start participating until 2018, which is known as performance year 1 under the ACO Model. Each of these payers sets an annual cost target for health care services that the ACO is to try to stay below. If OneCare stays below that target, then it is referred to as a savings. If health care costs exceed the target, then that is referred to as a loss. OneCare may also agree with the payers to share in these savings or losses, which are referred to as shared savings or shared losses. These shared savings and losses may not be the same as the savings or loss amounts due to the terms of

<sup>15</sup> As part of the Vermont All-Payer ACO Model Agreement, CMS made \$9.5 million available to AHS for start-up funding. According to the AHS Director of Health Care Reform, \$7.5 went to providers participating in the Blueprint program, and \$2 million went to OneCare for efforts that would benefit Medicare patients. DVHA received these funds from CMS and then paid OneCare through contract #34070 found [here](#).

<sup>16</sup> The commercial payers that participated in 2020 were BlueCross BlueShield of Vermont and MVP Health Plan, Inc.

the payers’ contracts with the ACO because there are maximum limits on shared savings and losses. Actual financial performance may be outside the maximum sharing limits.<sup>17</sup>

When payers set health care targets and measure the actual results, they do not include the operating costs of the ACO. Table 3 below shows the gross savings and loss under each payer contract for 2018 and 2019 as well as a net total after accounting for OneCare’s operating costs.<sup>18</sup>

**In our previous audit we made a recommendation that GMCB 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.<sup>19</sup> The financial aspects of this Model to date show that the costs have exceeded savings since performance year 1 and highlight the importance of this analysis.**

**Table 3: OneCare’s Net Financial Performance For 2018 and 2019 (in Millions)<sup>a</sup>**

Payer	2018		2019 <sup>b</sup>		Net	
Medicaid	-\$1.5	Loss	-\$11.9	Loss	<b>-\$13.4</b>	<b>Loss</b>
Medicare	\$17.0	Savings	\$11.3	Savings	<b>\$28.3</b>	<b>Savings</b>
BCBSVT QHP	-\$1.6	Loss	-\$7.8	Loss	<b>-\$9.3</b>	<b>Loss</b>
UVMHC Self-Funded	-\$2.9	Loss	-\$3.9	Loss	<b>-\$6.8</b>	<b>Loss</b>
<b>Subtotal of Financial Performance</b>	<b>\$11.0</b>	<b>Savings</b>	<b>-\$12.2</b>	<b>Loss</b>	<b>-\$1.2</b>	<b>Loss</b>
Minus OneCare’s Operating Cost	-\$13.7		-\$15.3		<b>-\$29.1</b>	
<b>Net After Operating Costs</b>	<b>-\$2.7</b>	<b>Loss</b>	<b>-\$27.6</b>	<b>Loss</b>	<b>-\$30.3</b>	<b>Loss</b>

<sup>a</sup> Totals may differ in this table due to rounding.

## Objective: ACO Model Implementation Costs

DVHA, through its Medicaid contract with OneCare, paid \$25.1 million of the ACO’s operating costs from 2017 through 2020. Medicaid was the only payer that provided OneCare with ongoing funding for the ACO’s operating costs, and that amount increased annually during those years. However, **DVHA lacked the proper financial oversight of some of this funding to ensure it was used for its intended purposes.** DVHA also spent \$2 million during that time on other vendors that assisted them in carrying out their ACO Model responsibilities. Similarly, GMCB spent at least \$2.7 million from 2017 to

<sup>17</sup> For more information regarding cost targets and how the ACO agrees to share in savings and/or losses see pages 30-33 of our previous audit report [here](#).

<sup>18</sup> The gross amount is before any adjustments allowed under the payer contracts for calculating the amount of savings or loss that OneCare should share in.

<sup>19</sup> [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](#), Rpt No. 20-02, dated June 26, 2020.

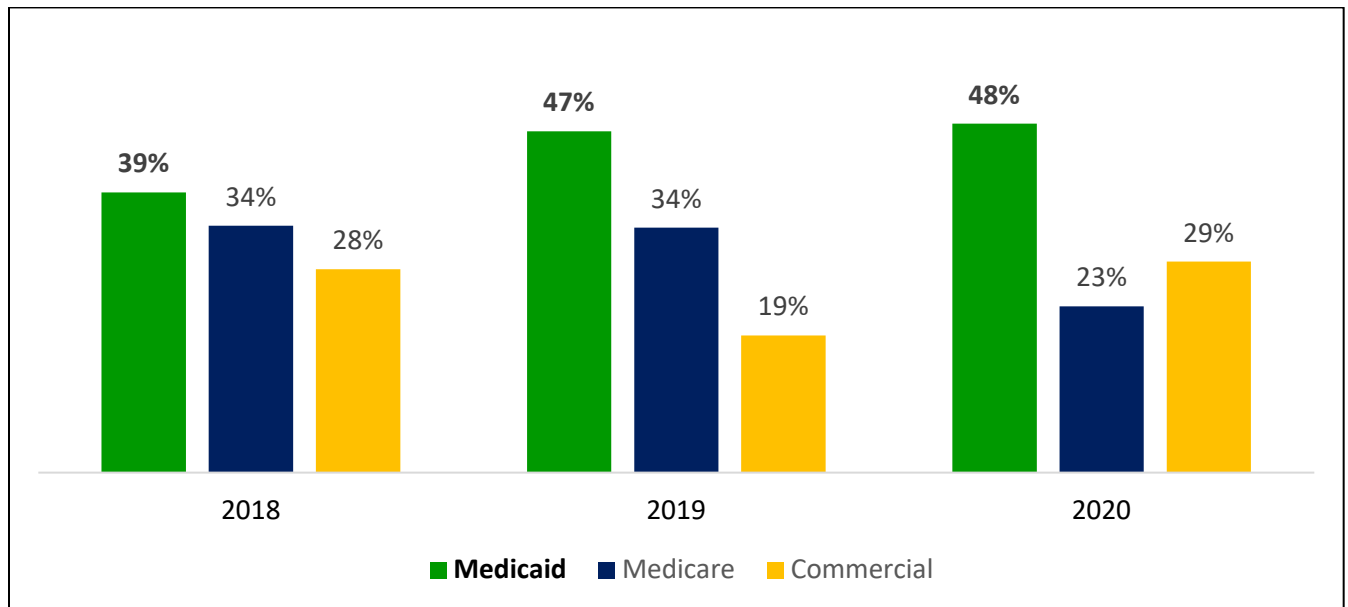


2019 on vendors that assisted GMCB in carrying out their ACO Model responsibilities. GMCB is allowed to bill entities it regulates to help support a portion of the Board’s operating costs. Between July 2018 and June 2020 GMCB billed OneCare \$574,256, which became part of the ACO’s operating budget.

### Monthly Administrative Fees

Since 2018, Medicaid has accounted for less than half of all the patients attributed<sup>20</sup> to OneCare, as shown in Figure 5 below. However, Medicaid is the only health insurance payer that provided annual funding support to OneCare for the ACO’s operating costs. Medicare and commercial payers were not contractually required to pay OneCare an administrative fee for operating costs.

**Figure 5: Percentage of Medicaid Patients Attributed to OneCare Compared to Other Participating Payers from 2018-2020**

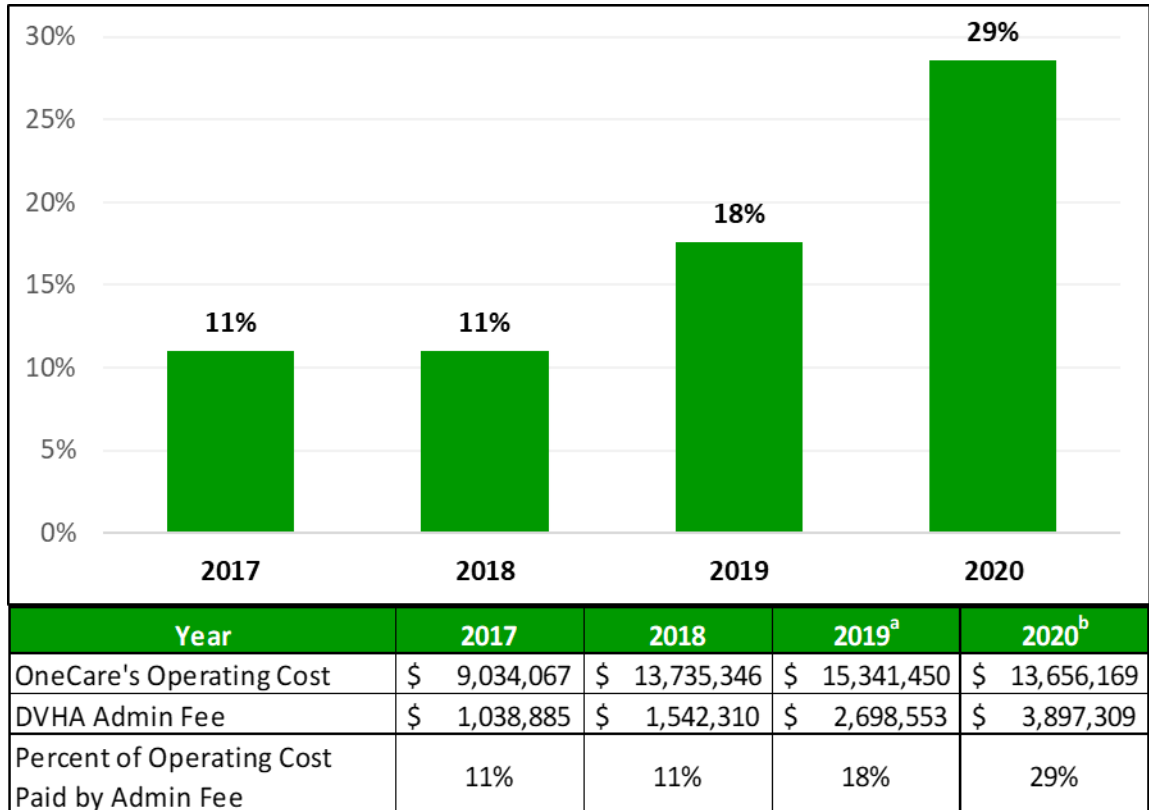


Medicaid began participating in the ACO Model in 2017, and since then DVHA has paid a monthly \$3.25 administrative fee to OneCare for every Medicaid patient that is attributed to the ACO that month. This has amounted to \$9.2 million in administrative fees paid to OneCare from 2017 to 2020.

<sup>20</sup> Attribution is the process used to identify the patients for which OneCare will be accountable for. Patients attributed to OneCare are not limited to seeing only providers that are part of the ACO’s network.

As more Medicaid patients became attributed to the ACO each year, DVHA paid more administrative fees for OneCare’s operating costs. Figure 6 below shows that not only has the amount of administrative fees paid by DVHA increased but the proportion of OneCare’s operating costs supported by these fees has also increased.<sup>21</sup>

**Figure 6: Percent of OneCare’s Operating Costs Funded by Monthly Administrative Fees Paid by DVHA from 2017 through 2020**



- <sup>a</sup> OneCare originally budgeted an operating cost of \$19.3 million for 2020 but later reduced the budget due to COVID-19. The budget reduction reduced the amount of fees the hospitals in the ACO had to pay but it did not reduce the administrative fee DVHA paid to OneCare.
- <sup>b</sup> OneCare’s operating costs for 2020 are projected.

These administrative fees were not included in DVHA’s assessment of OneCare’s annual financial performance. As such, they were not included in the ACO’s annual shared savings and losses calculation under the Medicaid contract.

<sup>21</sup> The SAO does not have access to detailed operating costs data for OneCare and makes no assertion as to whether the additional attributed lives warranted the additional amount of administrative fees paid by DVHA.

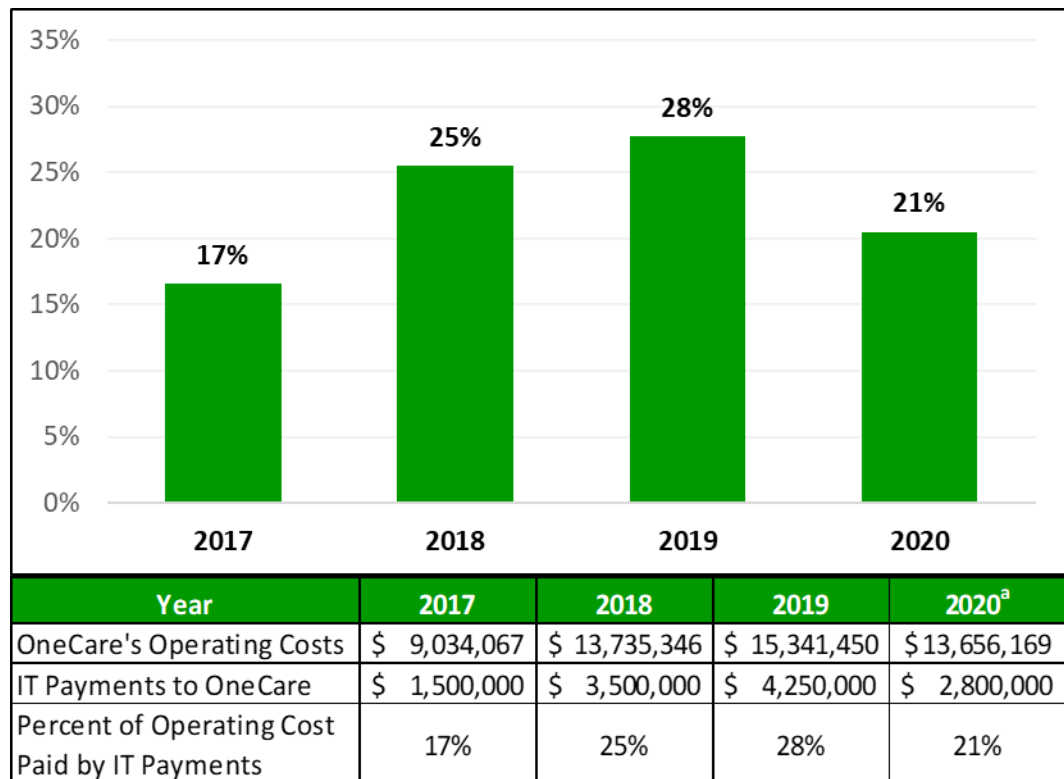
## Information Technology Related Payments

DVHA gave funding to OneCare for information technology (IT) activities which are components of OneCare’s operating costs. These payments are for what is referred to in the Medicaid contracts as quality and health management measurement improvement. These funds were for OneCare to improve its data analytics platform (referred to as WorkBenchOne), care coordination software (referred to as Care Navigator), and to provide training and technical assistance to providers. **In total, DVHA provided \$12.1 million in funds for the IT related costs from 2017 to 2020.**

These payments are also not included in DVHA’s assessment of OneCare’s annual financial performance. As such, they are not included in the ACO’s annual savings and losses calculation under the Medicaid contract.

The IT funding DVHA provided to OneCare has varied since 2017 and at times has exceeded 25 percent of the ACO’s operating costs as shown in Figure 7 below.

**Figure 7: Percent of OneCare’s Operating Costs Funded by DVHA IT Payments from 2017 through 2020**



<sup>a</sup> OneCare’s operating costs for 2020 are projected.

From 2017 through 2020, DVHA used \$10.9 million in special Medicaid funds for the majority of the IT payments. Specifically, DVHA used \$7 million in health information technology for economic and clinical health (HITECH) funds and \$3.9 million in delivery system reform (DSR)<sup>22</sup> investment funds.<sup>23</sup> According to a health information exchange program director at DVHA, HITECH funds could be used to design and implement WorkBenchOne and Care Navigator but not for the on-going operational and maintenance expenses. CMS also allowed DVHA to use DSR investment funds for activities related to WorkBenchOne and Care Navigator but that costs be supported by adequate source documentation.

**However, DVHA's Medicaid contracts did not require detailed financial reporting on how OneCare actually expended the funding they received for these IT activities. And, DVHA was unable to provide us with a breakout of how OneCare spent the vast majority of the IT funds that they received under the Medicaid contract (e.g., Care Navigator software costs, salaries and fringe benefits for analytics staff, etc.). Therefore, DVHA has no assurance that these funds were used solely for their intended purposes, and that the expenditures were within the conditions imposed by the federal government on both the HITECH and DSR investment funds.**

## Population Health Investments

DVHA also provided OneCare with funding for population health investments. Specifically, primary prevention, which supported RiseVT<sup>24</sup> and complex care coordination (referred to as advanced community care coordination in the Medicaid contracts), which supported care coordination for high and very-high risk patients. DVHA does not know whether any of the RiseVT funding was used by OneCare for operating costs but knows that OneCare used some of the complex care funding for operating costs.

### RiseVT

Since 2018, OneCare has employed RiseVT staff to coordinate the program at a State level. In 2019, DVHA paid \$1.1 million using Medicaid DSR investment funds to OneCare to support the RiseVT program.

In AHS's application to CMS to use DSR investment funding, the agency indicated that the ACO was contractually required to submit financial reports detailing their distribution of investment funds and that through financial

<sup>22</sup> Also referred to as delivery system-related.

<sup>23</sup> The HITECH and DSR amounts include the State's match to the federal funds.

<sup>24</sup> RiseVT is OneCare's lead primary prevention program and partners with individuals, schools, childcare providers, and municipalities to implement opportunities to make healthy choices.

monitoring, the State will ensure that the funds are not duplicative of other federal funds being paid to OneCare through the Medicaid contract with OneCare. However, the Medicaid contract with OneCare did not require such financial reporting.

DVHA received reports from OneCare showing that the ACO distributed \$189,608 to community organizations under the RiseVT program. Other than that, **DVHA was unable to provide us with a detailed breakout of how OneCare spent the remainder of the \$1.1 million, including how much was used by the ACO for operating costs. Therefore, DVHA has no assurance that these funds were used solely for their intended purposes, and that the expenditures were within the purpose of the DSR investment.**

### Complex Care Coordination

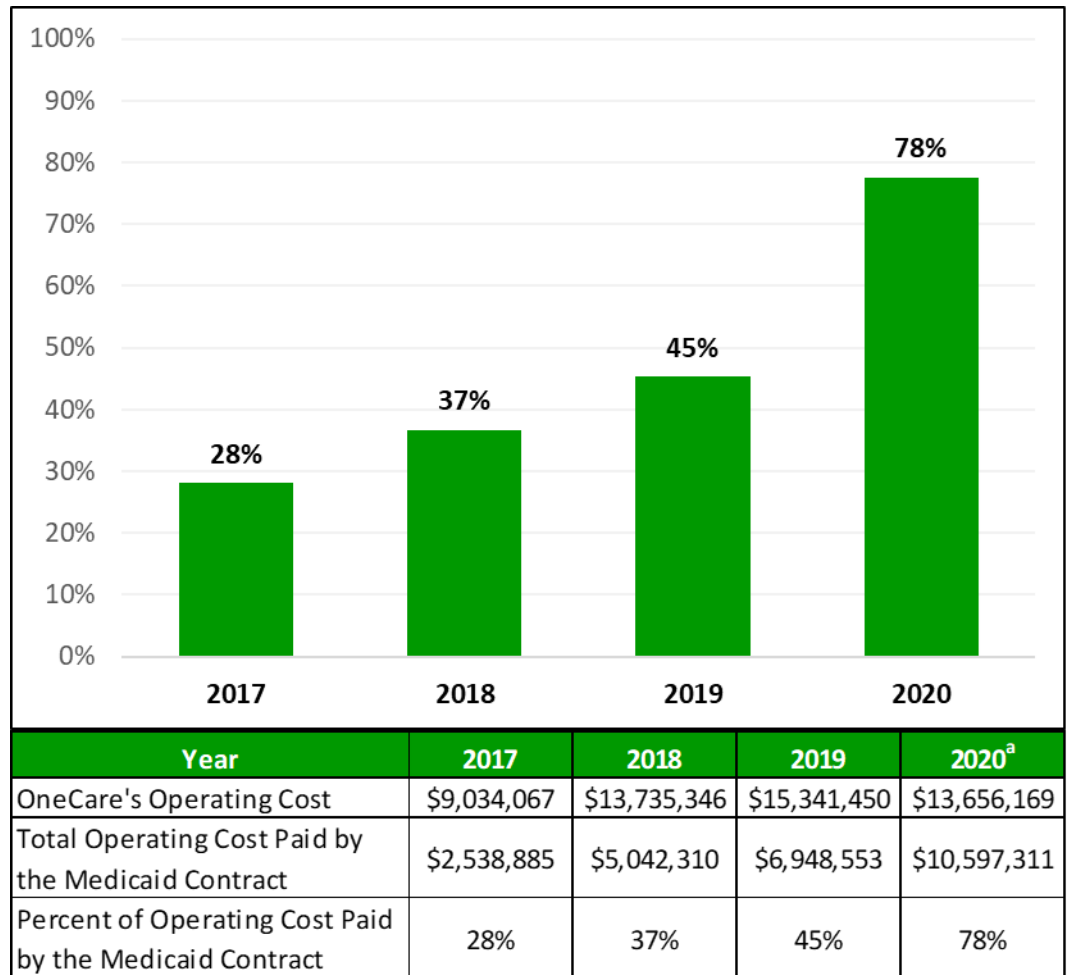
From 2017 through 2019, DVHA provided funding to support OneCare's complex care coordination model. Generally, OneCare passed the funds on to the health care providers that provided care coordination services, and DVHA recouped the funds that OneCare did not pass along. **However, in 2017 OneCare retained \$330,412 that was not passed on to health care providers because DVHA did not require the ACO to return undistributed funds that year. DVHA does not know how OneCare used the unspent funds and whether OneCare used it to pay for operating costs because DVHA never required the ACO to report that information.**

Additionally, in 2020 DVHA gave OneCare \$3.9 million to support their complex care coordination model, and all of that funding went to OneCare's operating costs to support the program. For example, \$1.9 million paid for health information technology costs such as data platform expenses and software expenses. Another \$1.2 million paid for salary and fringe benefit costs of OneCare employees.

## Total DVHA Payments to OneCare for Operating Costs

DVHA, through the Medicaid contract with OneCare, has paid an increasing proportion of the ACO's operating expense since 2017. Figure 8 on the next page, shows the percent of OneCare's operating costs paid under the Medicaid contract when combining the administrative fee, IT, and population health investment payments previously discussed.

**Figure 8: Percentage of ACO Operating Costs Paid by the Medicaid Contract From 2017 through 2020**



<sup>a</sup> OneCare’s operating costs for 2020 are projected.

DVHA publishes annual reports about the performance results of the Medicaid contract with OneCare.<sup>25</sup> The reports include an assessment of OneCare’s financial performance against the health care cost targets set under the Medicaid contract with the ACO for the reported year. Table 4 on the next page shows the amount that OneCare was able to keep health care costs under the agreed upon cost target or by how much the ACO exceeded the target for the reported years from 2017 to 2019. It also includes our assessment of net performance after payments to OneCare for operating costs, **which shows that OneCare has not provided a net savings to**

<sup>25</sup> The 2017 annual report is [here](#), the 2018 annual report is [here](#), and the 2019 annual report, which is the most recent annual report, is [here](#).

**Medicaid relative to the financial targets.** This table does not account for shared savings paid by DVHA to OneCare or shared losses paid by OneCare to DVHA.

**Table 4: OneCare’s Financial Performance Relative to the Medicaid Targets from 2017 to 2019 and Assessment Against OneCare’s Operating Costs Paid by DVHA (Rounded to Nearest \$100,000)<sup>a</sup>**

Year	Performance Against Financial Target	By How Much?	ACO Operating Costs Paid by DVHA	Assessment of Net Performance Relative to Target After Operating Cost Payments <sup>b</sup>	Assessment of Performance Relative to Target After Operating Cost Payments
2017	Savings	\$2,400,000	-\$2,500,000	-\$200,000	Loss
2018	Loss	- \$1,500,000	-\$5,000,000	-\$6,600,000	Loss
2019	Loss	-\$11,900,000	-\$6,900,000	-\$18,800,000	Loss
<b>Net<sup>c</sup></b>	<b>Loss</b>	<b>-\$11,100,000</b>	<b>-\$14,500,000</b>	<b>-\$25,600,000</b>	<b>Loss</b>

<sup>a</sup> This table does not include shared savings DVHA paid to OneCare or shared losses OneCare paid to DVHA. According to reports from DVHA, in 2017 OneCare was entitled to \$2.4 million in shared savings from DVHA. In 2018 and 2019, OneCare was liable to repay DVHA \$1.5 million and \$6.6 million in shared losses, respectively.

<sup>b</sup> Amounts in this column may differ from the sum of the two previous columns due to rounding.

<sup>c</sup> Amounts in this row may not match the sum of the column due to rounding.

## Other Vendor Costs Related to Implementing the ACO Model

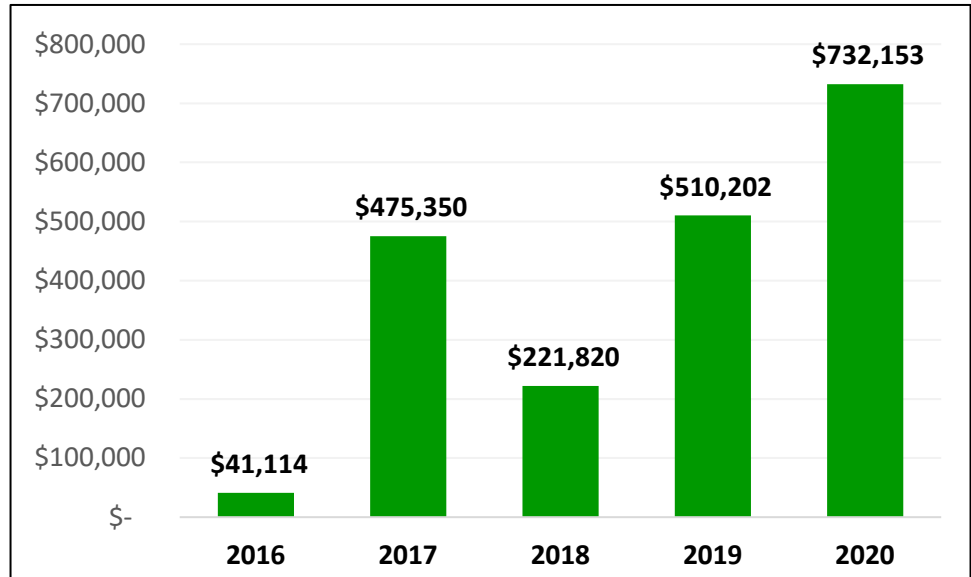
Both DVHA and GMCB contracted with vendors to assist them in carrying out their responsibilities for implementing the ACO Model.

### DVHA

DVHA paid vendors \$2 million<sup>26</sup> for work that pertained to implementing the ACO Model. Examples of ACO Model work performed by vendors included, but was not limited to: (1) making changes to the Medicaid payment system to allow for ACO payment processing and tracking, (2) assisting with rate development for the Medicaid contract with OneCare, and (3) ACO related quality measurement. Figure 9 on the next page shows the expense amounts for each year.

<sup>26</sup> DVHA paid 54 percent of the \$2 million using federally reimbursed funds and 46 percent using State funds.

**Figure 9: DVHA Vendor Expenses from October 27, 2016 through December 31, 2020 Related to the ACO Model**



These vendors often assisted DVHA in other areas of responsibilities; their work was not limited to the ACO Model. Costs for the vendors’ work in areas unrelated to the ACO Model are not included in the in \$2 million amount and therefore the amount does not reflect the total paid under the vendors’ contracts.

**GMCB**

GMCB has paid vendors at least \$2.7 million<sup>27</sup> from 2017 through 2020 to assist them in carrying out the Board’s various ACO Model responsibilities, which are more than just regulating ACOs. Examples of vendor work GMCB contracted for were: (1) actuary services for reviewing Medicaid rates in DVHA’s contract with OneCare, (2) analytic work regarding the ACO Model, and (3) work regarding the cost targets for CMS’s Medicare contracts with OneCare.

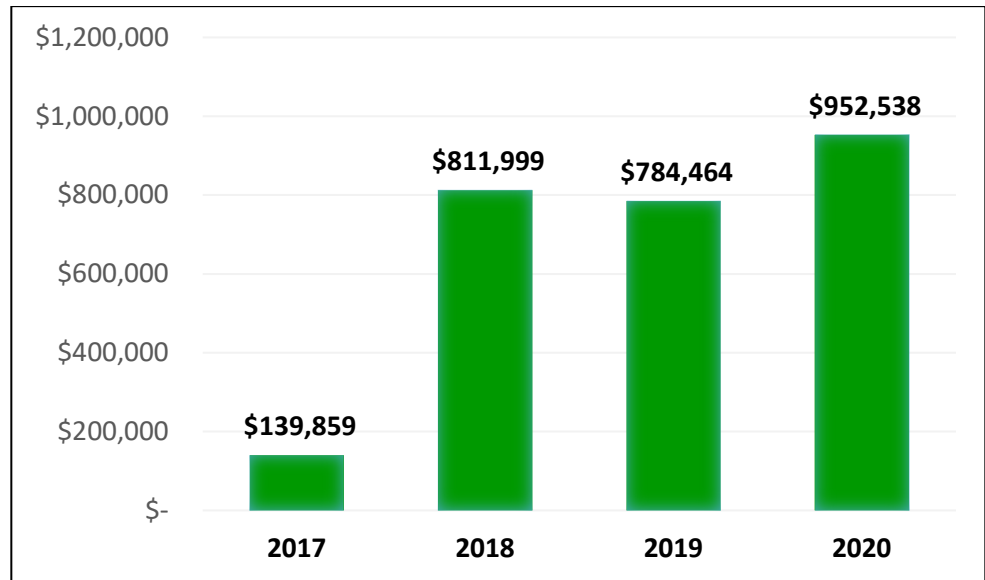
Similar to DVHA’s use of vendors, GMCB vendors often assisted the Board in other areas of responsibilities. Therefore, their work was not limited to the ACO Model. Costs for vendor work in areas unrelated to the ACO Model are not included in the \$2.7 million and does not reflect the total paid under these vendor contracts.

<sup>27</sup> GMCB paid 89 percent of the \$2.7 million using State funds and the remaining 11 percent using federally reimbursed funds.



Starting in 2018, GMCB contracted with a vendor to perform analytics and reporting to support the implementation of the ACO Model. This vendor accounts for \$2.1 million (78 percent) of GMCB’s vendor costs. This is why Figure 10 below shows a significant increase in vendor costs from 2017 to 2018.

**Figure 10: GMCB Vendor Expenses from 2017 through 2020 Related to the ACO Model**



### GMCB Billback

Vermont statute<sup>28</sup> allows GMCB to assess and collect fees from regulated entities, and they used this authority to charge fees for eligible expenses to hospitals and health insurance companies. GMCB refers to these fees as billbacks and uses them to support a portion of the Board’s operating costs.<sup>29</sup>

Starting in 2018, statute also authorized GMCB to charge these fees to OneCare.<sup>30</sup> Since then the ACO has been the third highest charged entity, with Blue Cross and Blue Shield of Vermont and the University of Vermont Medical Center being the first and second, respectively. According to an Administrative Services Director at GMCB, the Board calculated the overall amount that they could bill back to regulated entities, and then apportioned

<sup>28</sup> [18 V.S.A. § 9374\(h\)](#).

<sup>29</sup> See [here](#) for GMCB’s annual billback reports dating back to 2013.

<sup>30</sup> [Act 167 \(2018\) § 17](#).

six percent of that amount to charge to OneCare as allowed under statute.<sup>31</sup> See Appendix IV for a table of GMCB’s most recently reported billings.

Table 5 shows the amounts that GMCB has billed OneCare since it received statutory authority to do so in 2018. GMCB uses the State fiscal year, which runs July 1<sup>st</sup> to June 30<sup>th</sup>, to calculate billback amounts.

**Table 5: Amounts GMCB Billed OneCare in Fiscal Years 2019 and 2020**

Fiscal Year	Billback Amount
Fiscal Year 2019 (July 1, 2018 – June 30, 2019)	\$208,145
Fiscal Year 2020 (July 1, 2019 – June 30, 2020)	\$366,111
<b>Total</b>	<b>\$574,256</b>

GMCB expects that the upcoming billback amount to be similar to fiscal year 2020 amount, and these costs are part of OneCare’s operating budget.

## Conclusions

The State spent at least \$29.8 million from October 27, 2016 to December 31, 2020 on implementing the ACO Model. Of this amount \$4.7 million was for payments made by DVHA and GMCB to vendors other than OneCare that they contracted with. The remaining \$25.1 million were payments DVHA made to OneCare through the Medicaid contract that went towards the ACO’s operating costs. Some of the Medicaid funding that DVHA provided was for specific investments allowed under the State’s Medicaid waiver with CMS. However, DVHA lacked the proper financial oversight to ensure that OneCare used the funding for its intended purposes.

**The known financial aspects of the Model to date indicate that OneCare’s operating costs have greatly exceeded any savings achieved by the ACO.**

## Recommendations

We make the following recommendations in Table 6 on the next page to the Commissioner of the Department of Vermont Health Access.

<sup>31</sup> [18 V.S.A. § 9374\(h\)\(2\)\(A\)\(iv\)](#).

**Table 6: Recommendations and Related Issues**

Recommendation	Report Pages	Issue
1. Add financial reporting requirements in the Medicaid contract with OneCare for the ACO to provide detailed financial reporting on how the ACO used funds provided by DVHA for information technology programs.	16-17	DVHA was unable to provide us with a breakout of how OneCare spent the majority of the IT funds that they received under the Medicaid contract (e.g., software costs, salaries, and fringe benefits for analytics staff, etc.). DVHA’s Medicaid contracts did not require detailed financial reporting on how OneCare used those funds. Therefore, DVHA has no assurance that these funds were used solely for their intended purposes.
2. Add financial reporting requirements in the Medicaid contract with OneCare for the ACO to provide detailed financial reporting on how the ACO used funds provided by DVHA for population health investments.	17-18	DVHA was unable to provide a detailed breakout of how OneCare spent the \$1.1 million DVHA gave the ACO for the RiseVT program in 2019. And, DVHA’s Medicaid contract with OneCare did not require such financial reporting. Similarly, OneCare retained \$330,412 that was not passed on to health care providers. DVHA does not know how OneCare used the unspent funds and whether OneCare used it to pay for operating costs. Therefore, DVHA has no assurance OneCare used the funds solely for their intended purposes.

## Management’s Comments

On June 11, 2021, the Chair of the Green Mountain Care Board provided written comments on a draft of this report. These comments are reprinted in Appendix V. The Chair disagreed with one of our findings in the report. Our evaluation of their comment is in Appendix VII.

On June 14, 2021, the Secretary of the Agency of Human Services and the Interim Commissioner of DVHA provided written comments on a draft of this report, which are reprinted in Appendix VI. They agreed to implement both audit recommendations in their entirety but disagreed with some of the report findings. Our evaluation of their comments is in Appendix VII.

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## Appendix I

### Scope and Methodology

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We focused our work on payments made to OneCare that support the ACO's operating costs and payments to other vendors hired by the State that performed work pertaining to the implementation of the ACO Model. We originally intended to capture the cost of State employee time spent on implementing the ACO Model. However, when we asked the Agency of Human Services, DVHA, and GMCB for information regarding employee time spent on implementing the Model, they were unable to do so citing that they could not provide a reasonably reliable estimate of employee time. Therefore, State employee time is not included within the scope of this audit.

To gain an understanding of the efforts that led up to the Vermont All-Payer ACO Model Agreement, we reviewed State and federal reports regarding Vermont's work performed under Vermont's State Innovation Model (SIM) grant awarded by the Center for Medicare and Medicaid Services Innovation Center. We also reviewed various information contained on the [Vermont Health Care Innovation Project website](#), which is the name of the State's SIM initiative.

We reviewed OneCare budget documents to identify OneCare's annual operating costs since 2017. To identify OneCare's gross savings or loss under the payer contracts, we reviewed DVHA's reports about OneCare's performance on the Medicaid contract for 2017, 2018, and 2019, Medicare shared savings and shared loss reconciliations for 2018 and 2019, BCBSVT and UVMMC program settlements with OneCare for 2018, and a presentation to GMCB regarding financial performance under the payer contracts for 2019.

To address our objective, we obtained and reviewed DVHA's contracts with OneCare from 2017 to 2020 to identify authorized payment amounts to the ACO. We obtained Medicaid attribution data for 2017 through 2020 from DVHA to calculate the amount of administrative fees DVHA paid to the ACO. We confirmed the 2017 through 2019 amounts by comparing them to the amounts listed in DVHA's annual performance reports for the Medicaid contract for those years. We obtained and reviewed payment documentation for the deliverables outlined in the Medicaid contracts, and we obtained confirmation from the DVHA payment reform unit as to the amount of these funds used to pay OneCare's operating costs.

To determine that the payment information in the Medicaid payment system was sufficiently reliable for our audit purposes, we traced a selection of payments to OneCare's invoices to verify that the amounts matched.

To gain an understanding of DSR investments we reviewed pertinent sections of the Global Commitment to Health Section 1115 Demonstration Waiver. We reviewed reports from AHS to the legislature regarding these DSR

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## Appendix I

### Scope and Methodology

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investments. We also obtained and reviewed the DSR investment applications that CMS approved for the following investments:

- OneCare Vermont Accountable Care Organization Quality and Health Management Measurement Improvement Investment (this pertains to funding for IT investments)
- OneCare Vermont Accountable Care Organization Primary Prevention Development Investment (this pertains to funding for RiseVT)
- OneCare Vermont Accountable Care Organization Advanced Community Care Coordination

We reviewed DVHA's Medicaid contracts with OneCare to identify whether the contracts contained financial reporting requirements for the investments listed above to determine whether DVHA had verification internal controls over these investments.

To identify and calculate the vendor costs we discussed with DVHA and GMCB officials which vendors they used to assist them in implementing the ACO Model. We obtained and reviewed the relevant vendor contracts. We queried the State's accounting system to identify payments made to these vendors under the contracts. For vendors that performed more than just ACO Model work we obtained vendor invoices, and additional information from DVHA and GMCB as to what parts of the invoices pertained specifically to implementing the ACO Model in order to calculate those amounts specific to the model. We also confirmed chartfield information in the State's accounting system with DVHA and GMCB used to identify whether federally reimbursed or state funds were used in payments to vendors.

To determine that the vendor payment information contained in the State's accounting system was sufficiently reliable for our audit purposes we reviewed the query results for blank information in the payment amount or any other illogical data. We also traced a selection of payments in the State's accounting system to vendor invoices to determine whether the amounts matched. For those invoices, we also reviewed whether DVHA or GMCB approved those invoices for payment to determine whether approval internal controls were in place.

To gain an understanding of GMCB's billback authority and the amounts they bill to regulated entities we reviewed [18 V.S.A. § 9374\(h\)](#), [Act 167 \(2018\) § 17](#), and GMCB reports to the Legislature for fiscal years 2018, 2019, and 2020, and discussed this process with GMCB staff.

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## Appendix I

### Scope and Methodology

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We met with various officials remotely including AHS Central Office, DVHA, and GMCB officials. We conducted this performance audit in accordance with GAGAS, which requires 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.

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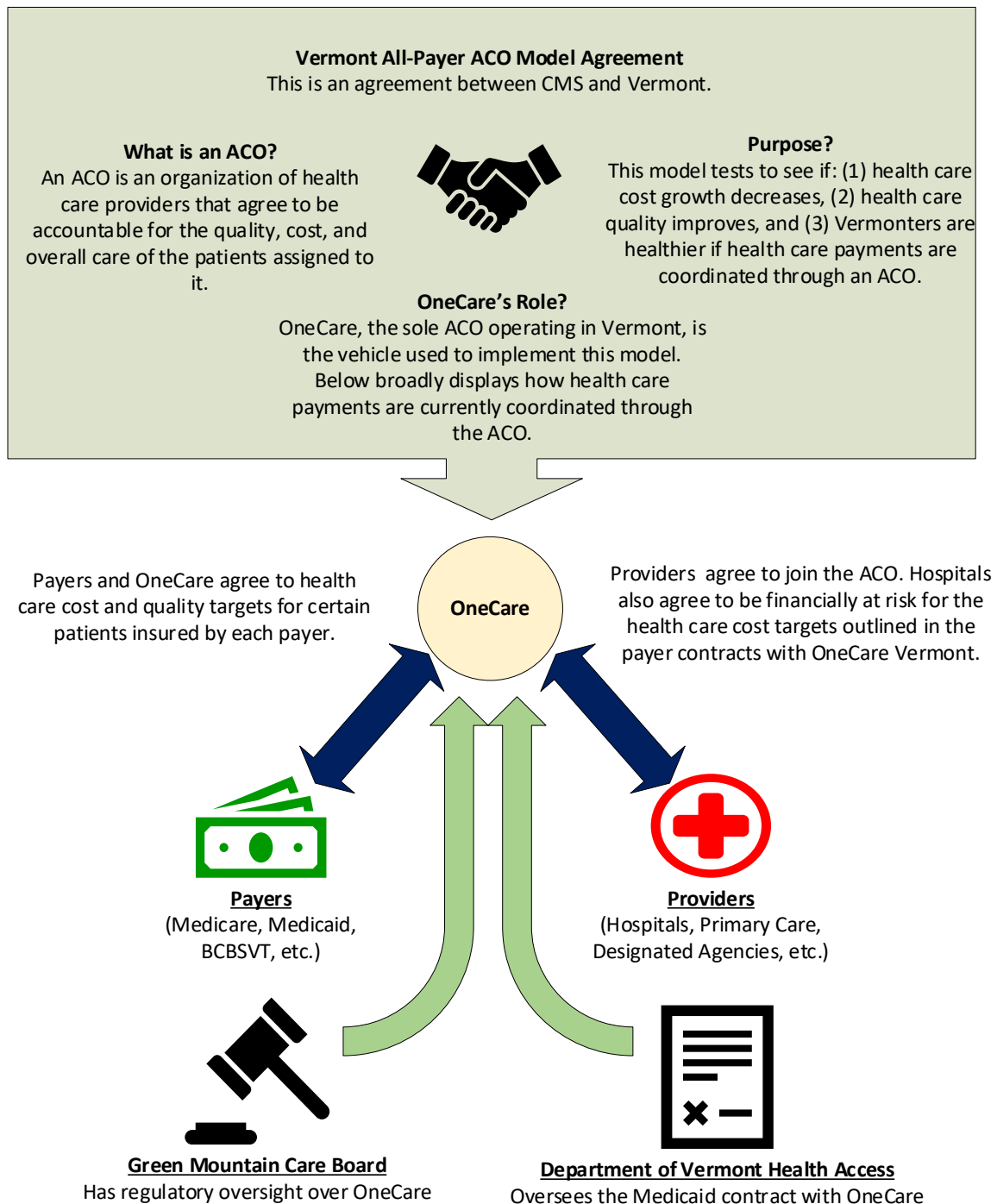
## Appendix II Abbreviations

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ACO	Accountable Care Organization
AHS	Agency of Human Services
CMS	Centers for Medicare and Medicaid Services
DSR	Delivery System Reform
DVHA	Department of Vermont Health Access
GMCB	Green Mountain Care Board
HITECH	Health Information Technology for Economic and Clinical Health
IT	Information Technology
SAO	State Auditor's Office
SIM	State Innovation Model
V.S.A.	Vermont Statutes Annotated

## Appendix III ACO Model Diagram

The following diagram is a broad overview of the ACO Model which we used in our previous audit report that described the ACO Model and GMCB and DVHA's role in overseeing and monitoring OneCare.<sup>32</sup>



<sup>32</sup> [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](#), Rpt No. 20-02, dated June 26, 2020.



## Appendix IV

### GMCB Billbacks For Fiscal Year 2020 (July 1, 2019 – June 30, 2020)

Table 7 shows the what GMCB reported that they billed regulated entities for fiscal year 2020 in order of highest to lowest. OneCare was the third highest entity billed.

**Table 7: Amount and Percent of Total Amount GMCB Billed to Regulated Entities in Fiscal Year 2020**

Entity	Type of Entity	Amount Billed	Percent of Total Amount Billed
Blue Cross and Blue Shield of Vermont	Insurance Company	\$1,249,916	31.2%
University of Vermont Medical Center	Hospital	\$966,372	24.1%
OneCare	ACO	\$366,111	9.1%
MVP Health Plan Inc	Insurance Company	\$205,807	5.1%
Rutland Regional Medical Center	Hospital	\$191,957	4.8%
Central Vermont Medical Center	Hospital	\$156,299	3.9%
Southwestern Vermont Medical Center	Hospital	\$123,498	3.1%
Northwestern Medical Center	Hospital	\$83,816	2.1%
MVP Health Insurance Company	Insurance Company	\$82,595	2.1%
Cigna Health and Life Insurance Company/Connecticut General Life Ins	Insurance Company	\$77,564	1.9%
Brattleboro Memorial Hospital	Hospital	\$63,185	1.6%
Porter Medical Center	Hospital	\$62,713	1.6%
Northeastern Vermont Regional Hospital	Hospital	\$62,546	1.6%
North Country Hospital	Hospital	\$59,943	1.5%
Copley Hospital	Hospital	\$52,083	1.3%
Mt Ascutney Hospital	Hospital	\$38,533	> 1%
Gifford Medical Center	Hospital	\$37,550	> 1%
Springfield Hospital	Hospital	\$35,045	> 1%
Aetna Life Insurance Company	Insurance Company	\$29,851	> 1%
The Vermont Health Plan, LLC	Insurance Company	\$28,792	> 1%
UnitedHealthcare Insurance Company	Insurance Company	\$15,005	> 1%
Grace Cottage Hospital (Carlos Otis)	Hospital	\$14,313	> 1%
Atlanta International Insurance Company	Insurance Company	\$2,151	> 1%
QCC Insurance Company	Insurance Company	\$1,753	> 1%
State Farm Mutual Automobile Insurance Company	Insurance Company	\$1,339	> 1%
AXA Equitable Life Insurance Company	Insurance Company	\$184	> 1%
United States Life Insurance Company in the City of New York	Insurance Company	\$163	> 1%

## Appendix IV

### GMCB Billbacks For Fiscal Year 2020 (July 1, 2019 – June 30, 2020)

Entity	Type of Entity	Amount Billed	Percent of Total Amount Billed
Sierra Health and Life Insurance Company, Inc.	Insurance Company	\$156	> 1%
Trustmark Insurance Company	Insurance Company	\$154	> 1%
MONY Life Insurance Company	Insurance Company	\$152	> 1%
American Progressive Life & Health Insurance Company of New York	Insurance Company	\$151	> 1%
Reserve National Insurance Company	Insurance Company	\$135	> 1%
New York Life Insurance Company	Insurance Company	\$131	> 1%
Unified Life Insurance Company	Insurance Company	\$128	> 1%
<b>Total</b>		<b>\$4,010,091</b>	

# Appendix V

## Management's Comments from the Green Mountain Care Board

The following is a reprint of management's response to a draft of this report.



144 State Street  
Montpelier, VT 05602  
802-828-2177

Kevin Mullin, Chair  
Jessica Holmes, Ph.D.  
Robin Lunge, J.D., MHCDS  
Tom Pelham  
Maureen Usifer  
Susan J. Barrett, J.D., Executive Director

DELIVERED ELECTRONICALLY

June 11, 2021

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 *All-Payer ACO Model Implementation Costs*. We are providing our comments below.

See comment  
1 on page 35

First, the costs incurred by the Green Mountain Care Board (GMCB) and cited in the report do not result solely from implementation of the Vermont All-Payer ACO Model. Those costs are driven by the GMCB's regulatory oversight of ACOs, which encompasses more than implementation of the APM. The GMCB's regulatory authority over ACOs was established under Act 113 of 2016, which became law prior to the signing of the Vermont All-Payer Accountable Care Organization Model Agreement.

Second, we think it important to note, as we previously stated in our comment letter of June 22, 2020, in response to 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*, that 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 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.

Sincerely,

Kevin Mullin  
Chair, Green Mountain Care Board



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## Appendix V Management's Comments from the Green Mountain Care Board

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cc: Mike Smith, Secretary, Agency of Human Services  
Adaline Strumolo, Interim Commissioner, Dept. of Vermont Health Access



# Appendix VI Management's Comments from the Agency of Human Services

The following is a reprint of management's response to a draft of this report.



**State of Vermont**  
**Agency of Human Services**  
Office of the Secretary  
280 State Drive  
Waterbury, VT 05671  
[www.humanservices.vermont.gov](http://www.humanservices.vermont.gov)

[phone] 802-241-0440  
[fax] 802-241-0450

Michael K. Smith, *Secretary*  
Jenney Samuelson, *Deputy Secretary*

DELIVERED ELECTRONICALLY

June 14, 2021

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

Dear Mr. Hoffer,

The Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) thank you for the opportunity to provide these comments in response to the draft audit report titled *All-Payer ACO Model Implementation Costs* and to indicate our agreement with the report's recommendations for DVHA. We will implement the two recommendations in their entirety.

Vermont is committed to moving away from fee-for-service reimbursement for health care services. We want a health care system that rewards providers for the high-quality care that they deliver instead of for every additional service rendered, regardless of the outcome. Vermont is a national leader in aligning Medicare, Medicaid, and commercial payers in a model that aims to curb health care cost growth and increase quality of care and population health outcomes for Vermonters.

Over three performance years (PYs), Vermont has observed promise in paying providers differently through Accountable Care Organizations (ACOs). The advantages of the model were particularly visible in DVHA's Vermont Medicaid Next Generation ACO program where providers can elect to be at risk for fixed prospective payments. Predictable payments from Medicaid have added stability for Vermont's system of care, especially considering unprecedented disruption from COVID-19.

In November 2020, AHS issued an Implementation Improvement Plan for the Vermont All-Payer Accountable Care Organization Model (All-Payer Model) that highlighted the high rate of participation in the Medicaid program and the need for other payers to keep pace and move more aggressively away from fee-for-service. We need more consistency and equity across the payers that are participating in the All-Payer Model. It is not surprising that DVHA, with its larger scale of participation in the Medicaid program as well as its more advanced payment model, would contribute more to ACO operating costs in the early years of model implementation. Moreover, the State of Vermont negotiated with the federal Center for Medicaid and CHIP Services (CMCS) to allow for Medicaid delivery system related investments to support the implementation of the All-Payer Model. These one-time,



## Appendix VI Management's Comments from the Agency of Human Services

start-up investments were a planned component of funding, agreed to by the federal government, to support delivery system reform within a transformed payment model.

AHS and DVHA believe that ongoing monitoring and evaluation are essential in determining the impact of Vermont's All-Payer Agreement and progress toward the Model's ambitious goals. As a result, performance measures related to quality, cost, scale, and population health outcomes are incorporated into the Model Agreement and DVHA's contract with the ACO, including for delivery-system related investments. The federal Centers for Medicare and Medicaid Services (CMS) share that view. The evaluation of the Model is also a priority and statutory responsibility for our federal partners at the Center for Medicare and Medicaid Innovation (CMMI) with whom the State of Vermont has an Agreement to implement the All-Payer Model. The All-Payer ACO Model Agreement and its impacts on health care quality, outcomes and cost growth are being independently evaluated through a CMMI contract with NORC at the University of Chicago. Per its website,

*The CMS Innovation Center continually monitors and evaluates its payment and service delivery models. Statute specifies the CMS Innovation Center evaluate quality of care (including patient-level outcomes, patient satisfaction and other patient-centeredness criteria) and changes in spending in each model. The CMS Innovation Center also gathers and reports on lessons-learned and best practices identified during model testing to support improvements across CMS and the health care system, at large. The CMS Innovation Center facilitates and accelerates the healthcare system's move to value-based care, which pays for healthcare based on outcomes.*

The results of the first annual evaluation report will be publicly available later in 2021.

The draft audit report takes a more narrow approach to understanding the impact of the All-Payer Model and instead presents several totals that combine ACO savings, losses, and operating costs. Although it is important to understand ACO operating costs over time as the ACO model achieves scale and makes start-up investments in infrastructure to support the transition from fee-for-service reimbursement to value-based care, evaluations of ACO financial performance nationally do not customarily include operating costs. For this reason, evaluations to date of ACO financial performance for each of the payer agreements related to the All-Payer Model Agreement have been specific to the costs of care for attributed Vermonters. Moreover, when delivery system transformation is an overarching goal of the All-Payer Model Agreement, whether financial outcomes outweigh ACO operating costs—particularly in early years—should not be a leading factor in determining whether the State should enter into a subsequent All-Payer agreement with the federal government.

The draft audit report also omits an important contextual point: that investment funds that have supported ACO operations in the first several years of All-Payer Model implementation are time-limited in their availability. As such, it should be expected that proportionally more funding for Health Information Technology and population health would be expended up-front. Therefore, any conclusions from an evaluation of All-Payer Model implementation costs at this point in time are premature, both because the first period of performance is not yet complete, and distribution of investment funds was intentionally concentrated in the earliest years.

For each contract performance year, DVHA sets a price for health care services paid through the arrangement with OneCare Vermont. By setting the price for health care services in advance and by

2

See comment  
2 on page 35

See comment  
3 on page 36

See comment  
4 on page 36

## Appendix VI Management’s Comments from the Agency of Human Services

See comment  
5 on page 37

sharing financial risk with the ACO, both DVHA and the participating providers have more certainty about health care expenditures and revenues, respectively. The draft report is silent altogether on this fundamental component of the DVHA/OneCare Vermont contract. Additionally, the draft audit report excludes from the overall calculations any funds that the ACO has either been entitled to receive or liable to re-pay as a result of the risk-sharing arrangements present in the payer agreements. As a result of financial performance, the ACO repaid \$8.4M to DVHA between 2017-2019. These financial incentives are central to the model’s potential to modulate health care costs over time, and the corresponding values are necessary to include when representing the total dollars flowing between DVHA and the ACO in each performance year.

The draft report contains two recommendations for DVHA:

- *“The Commissioner of DVHA should add financial reporting requirements in the Medicaid contract with OneCare for the ACO to provide detailed financial reporting on how the ACO used funds provided by DVHA for information technology programs.”*
- *“The Commissioner of DVHA should add financial reporting requirements in the Medicaid contract with OneCare for the ACO to provide detailed financial reporting on how the ACO used all funds provided by DVHA for population health investments.”*

DVHA appreciates these recommendations regarding financial reporting of the use of information technology and population health investment funds and intends to implement them. Across all program years, these investment funds have accounted for less than 2% of the total funding from DVHA to the ACO and its providers to support the provision of health care services as part of the Vermont Medicaid Next Generation ACO program. Although this accounts for a small proportion of the overall programmatic funding, it is an important component, and understanding how these funds enable delivery system transformation is a priority. DVHA’s oversight approach in prior years has been focused on requiring the ACO to provide extensive information about the programs supported by these funds. Since the inception of this funding opportunity, DVHA has received reporting on the design, implementation, and results of those programs, as well as detailed financial information on investment funding that the ACO directly distributed to its network and affiliated providers in accordance with investment funding applications to the federal government. In 2020, DVHA augmented those efforts by requiring the ACO to provide additional financial detail on the use of investment funds, in the form of line-item budget information. In response to the recommendations in this report, DVHA plans to require the ACO to provide year-end financial information depicting actual versus budgeted expenditures of future investment funds.

See comment  
6 on page 37

See comment  
7 on page 38

The draft report includes the following text on the header of each page: *“Department of Vermont Health Access Provided Substantial Funding for OneCare’s Operating Costs (Which Have Exceeded Reported Savings) But Has No Assurance that OneCare Used All Funds for Their Intended Purposes.”* AHS and DVHA believe that this statement could be misleading without additional context. As described in the preceding paragraph, DVHA has evolved its oversight of investment funds included in DVHA’s contract and will continue to do so in future. In addition, as pointed out earlier, it is not surprising that DVHA, with its larger scale of participation in the Medicaid program as well as its more advanced payment model, would contribute more to ACO operating costs in the early years of model implementation. Just to reiterate, in November 2020, AHS issued an Implementation Improvement Plan for the All-Payer Model that highlighted the high rate of participation in the Medicaid program and the need for other payers to keep pace and move more aggressively away from fee-for-service.

3

## Appendix VI Management's Comments from the Agency of Human Services

See comment  
8 on page 38

See comment  
9 on page 38

Finally, the draft audit report compares public investments in implementation, health information technology, and delivery system transformation to the ACO's short-term financial performance only. The goal of the All-Payer Model, and these public investments, is to promote large-scale and long-term transformation of Vermont's health care system to support high-quality integrated care and improved population health outcomes, which should ultimately result in more efficient use of health care resources. A benefit of an ACO-based Model is that the ACO can serve as a coordinating entity for various health and community service providers, and provide centralized data infrastructure, analytic capacity, approaches to care coordination, and provider training. Although there is still much work to be accomplished in this area, it is fair to say that an assessment that does not highlight the complexity of the change that is being undertaken nor acknowledge realistic timeframes for measurable results may leave a reader without a clear picture of performance.

Sincerely,



Mike Smith  
Secretary, Agency of Human Services



Adaline Strumolo  
Interim Commissioner, Department of Vermont Health Access

cc:  
Kevin Mullin, Chair, Green Mountain Care Board

4



## Appendix VII

### 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 Comments	SAO Evaluation
1	<p><i>First, the costs incurred by the Green Mountain Care Board (GMCB) and cited in the report do not result solely from implementation of the Vermont All-Payer ACO Model. Those costs are driven by the GMCB’s regulatory oversight of ACOs, which encompasses more than implementation of the APM. The GMCB’s regulatory authority over ACOs was established under Act 113 of 2016, which became law prior to the signing of the Vermont All-Payer Accountable Care Organization Model Agreement.</i></p>	<p>Because the certification and budget review regulatory processes are intrinsically linked to the ACO Model we included those costs.</p> <p>OneCare is the sole ACO in Vermont and participates in the ACO Model. In order to participate in the model, OneCare must obtain and maintain GMCB certification in order to be eligible to receive payments from Medicaid and commercial insurers.</p> <p>GMCB would still have to review and approve OneCare’s budget regardless of whether an All-Payer Agreement existed. However, in GMCB’s ACO Oversight document they explain that the annual ACO budget review process provides an opportunity to assess the ACO’s programs, which are expected to facilitate Vermont’s shift toward value-based care, as well as the cost of administering these programs. This includes, but is not limited to, a review of ACO financial and quality performance to date, the ACO’s investments in infrastructure and direct programming for health improvement and payment reform, the ACO’s administrative and operational costs, the ACO’s contractual relationships with payers and providers, and the alignment of ACO activities and strategies with the state’s objectives as stated under the Vermont’s All-Payer Model Agreement with the federal government.</p>
2	<p><i>The results of the first annual evaluation report will be publicly available later in 2021.</i></p>	<p>The first evaluation will cover only 2018 and 2019. CMS estimates that NORC will have a complete analysis of the ACO Model by April 2024, which is more than three years after the State is required to decide whether to enter into a subsequent All-Payer Agreement. As a result, the State will not have the information necessary to determine whether the ACO Model is successful prior to entering into a new Agreement.</p>

Appendix VII  
SAO Evaluation of Management’s Comments

Comment #	Management’s Comments	SAO Evaluation
3	<p><i>Although it is important to understand ACO operating costs over time as the ACO model achieves scale and makes start-up investments in infrastructure to support the transition from fee-for-service reimbursement to value-based care, evaluations of ACO financial performance nationally do not customarily include operating costs. For this reason, evaluations to date of ACO financial performance for each of the payer agreements related to the All-Payer Model Agreement have been specific to the costs of care for attributed Vermonters.</i></p>	<p>Per GMCB’s 2021 budget order for OneCare:</p> <p>“Over the duration of the APM 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.”</p> <p>GMCB’s use of the term “OneCare’s administrative expenses” in its budget order has the same meaning as “OneCare’s operating costs.” Therefore, evaluations of the ACO Model must include OneCare’s operating costs consistent with GMCB’s budget orders.</p> <p>In addition, AHS’s characterization of “start-up investments in infrastructure” implies that infrastructure is not a continuing amortized element of the cost of operating the ACO. Moreover, it is entirely possible that there will be additional taxpayer-funded investments in the future.</p>
4	<p><i>For each contract performance year, DVHA sets a price for health care services paid through the arrangement with OneCare Vermont. By setting the price for health care services in advance and by sharing financial risk with the ACO, both DVHA and the participating providers have more certainty about health care expenditures and revenues, respectively. The draft report is silent altogether on this fundamental component of the DVHA/OneCare Vermont contract.</i></p>	<p>The objective of the audit was to calculate and describe the use of state-controlled funds spent on implementing the ACO Model which we had communicated to AHS, DVHA, and GMCB. As such, the SAO did not assess whether DVHA and participating providers have more certainty about health care expenditures and revenues as these were not within the scope of the audit.</p>

## Appendix VII

### SAO Evaluation of Management's Comments

Comment #	Management's Comments	SAO Evaluation
5	<p><i>Additionally, the draft audit report excludes from the overall calculations any funds that the ACO has either been entitled to receive or liable to re-pay as a result of the risk-sharing arrangements present in the payer agreements. As a result of financial performance, the ACO repaid \$8.4M to DVHA between 2017-2019.</i></p>	<p>The SAO added language to the report to make it clearer that throughout the report we discuss OneCare's financial performance relative to the targets before the calculation of shared savings or losses. This is because shared savings and losses have a maximum limit and actual financial performance may be outside those limits.</p> <p>We also updated the Table 1 and Table 4 headers to make it clearer that they are assessing financial performance relative to the Medicaid targets and added the following footnote to both tables: "This table does not include shared savings DVHA paid to OneCare or shared losses OneCare paid to DVHA. According to reports from DVHA, in 2017 OneCare was entitled to \$2.4 million in shared savings from DVHA. In 2018 and 2019, OneCare was liable to repay DVHA \$1.5 million and \$6.6 million in shared losses, respectively."</p>
6	<p><i>In 2020, DVHA augmented those efforts by requiring the ACO to provide additional financial detail on the use of investment funds, in the form of line-item budget information.</i></p>	<p>DVHA required this financial detail for the \$3.9 million they provided for OneCare's complex care coordination model in 2020, and OneCare's invoices contained line-item detail. However, DVHA did not have the same requirements for the \$2.8 million in HITECH funds for IT activities that DVHA paid to OneCare in 2020, and DVHA was unable to provide us with a breakout of how OneCare expended all of these funds. OneCare submitted two invoices each for \$1.4 million and they did not contain any detail.</p>

## Appendix VII

### SAO Evaluation of Management's Comments

Comment #	Management's Comments	SAO Evaluation
7	<p><i>The draft report includes the following text on the header of each page: "Department of Vermont Health Access Provided Substantial Funding for OneCare's Operating Costs (Which Have Exceeded Reported Savings) But Has No Assurance that OneCare Used All Funds for Their Intended Purposes." AHS and DVHA believe that this statement could be misleading without additional context. As described in the preceding paragraph, DVHA has evolved its oversight of investment funds included in DVHA's contract and will continue to do so in future.</i></p>	<p>We disagree. DVHA required financial detail for the \$3.9 million they provided for OneCare's complex care coordination model in 2020, and OneCare's invoices contained line-item detail. However, DVHA did not have the same requirements for the \$2.8 million in HITECH funds for IT activities that DVHA paid to OneCare in 2020, and DVHA was unable to provide us with a breakout of how OneCare expended all of these funds. OneCare submitted two invoices each for \$1.4 million and they did not contain any detail.</p>
8	<p><i>Finally, the draft audit report compares public investments in implementation, health information technology, and delivery system transformation to the ACO's short-term financial performance only.</i></p>	<p>The scope of this audit focused on state-controlled expenditures pertaining to implementing the ACO Model from 2017 to 2020 because that is the only data that exists.</p>
9	<p><i>Although there is still much work to be accomplished in this area, it is fair to say that an assessment that does not highlight the complexity of the change that is being undertaken nor acknowledge realistic timeframes for measurable results may leave a reader without a clear picture of performance.</i></p>	<p>The scope of this audit focused on the available data regarding state-controlled expenditures pertaining to the ACO Model.</p> <p>If the State wishes to continue a subsequent agreement it must submit a proposal to CMS by the end of 2021.</p> <p>In our previous ACO Model audit, found <a href="#">here</a>, we recommended that 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. We also said in that report that 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.</p>