REPORT TO THE VERMONT LEGISLATURE

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Review of Accountable Care Organization Capabilities

In Accordance with Act 68 of 2025: An act relating to health care payment and delivery system reform

Submitted to: **The Vermont General Assembly, Health Reform Oversight Committee**

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VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access

Statutory Charge

The following is respectfully submitted to the Vermont General Assembly in accordance with Section 12 of Act 68 (2025). Per statute:

The Agency of Human Services shall explore opportunities to retain capabilities developed by or on behalf of a certified accountable care organization that were funded in whole or in part using State or federal monies, or both, and that have the potential to make beneficial contributions to Vermont's health care system, such as capabilities related to comprehensive payment reform and quality data measurement and reporting. On or before December 1, 2025, the Agency of Human Services shall report its findings and recommendations to the Health Reform Oversight Committee.

Introduction

OneCare Vermont ("OneCare") is an Accountable Care Organization (ACO) that began participating in payer programs in 2014 and has continuously operated since. Concurrent with the end of Vermont's All-Payer Accountable Care Organization Model (APM), OneCare will be sunsetting operations at the end of calendar year 2025. While OneCare has developed a multitude of capabilities and program offerings for participating providers during this decade of operation, many of these capabilities and innovative models were developed to support the health care system in participating in ACO-based reform. The ACO framework was a central, mandatory element of Vermont's APM, and required providers to work together under a multi-payer, population-based accountability model. Not all of OneCare's capabilities would continue to be beneficial to Vermont's health care system if providers are not engaging in a shared accountability model. Therefore, this summary focuses only on those that have the potential to be beneficial outside ACO and/or multi-payer models and notes where more information about future models would be important prior to making decisions about capabilities to continue supporting. The summary also acknowledges that the unique legal structure of an ACO enabled many of these valuable capabilities, and highlights where more legal analysis may be needed when considering future-state options.

At a high level, as an ACO operating under the All-Payer Model, OneCare has had unique legal authority, combined with extensive contracting expertise and capacity to manage complex financial transactions. Most notably, OneCare's participation under the All-Payer Model granted it and its participating providers certain waivers of fraud and abuse laws (including the physician self-referral law and federal anti-kickback statute).[1] This has allowed the organization to coordinate payer and provider payments in ways that are not easily replicable outside that structure. Instead of each individual payer contracting with individual providers, OneCare has been able to negotiate terms for multiple payers, on behalf of multiple providers, reallocating

[1] Centers for Medicare and Medicaid Services. (2018). *Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Vermont Medicare ACO Initiative Within the Vermont All-Payer ACO Model*. https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/downloads/vermont-medicare-aco-initiative-waivers.pdf.

funds across the system, such as to primary care. OneCare has been able to align quality measures across payers, providers, and the state, and establish and support cross-organizational financial accountability.

Findings

Capability 1: Development and Implementation of Innovative Payment Reform Models (including the Comprehensive Payment Reform (CPR) model)

Description of ACO Activities	OneCare has leveraged its contractual relationships with payers and providers across the health system to design innovative payment reform initiatives and enhance the health care delivery system through provider collaboration. Because of the ACO-payer contracts, OneCare has been able to develop payment model concepts, negotiate terms with payers to enable implementation, provide outcomes analysis, and perform centralized financial reconciliation activities. Examples include the Comprehensive Payment Reform (CPR) program for independent primary care practices and the Medicare and Medicaid fixed payment model for hospitals. Through these models (and its contractual relationships with providers), OneCare has been able reallocate funds across the healthcare system. This flexibility has resulted in OneCare making investments in primary care through enhancements to the fixed CPR payments. Having everything administered through an ACO also means that provider organizations have received support and guidance for participation, and payers have had a single partner with whom to develop and manage initiatives.
Continued Value to Vermont's Health Care System	Fixed payment arrangements have been of value to provider organizations because they allow for more predictable revenue and, because of the multi-payer model, make it possible for funds to be used more flexibly to support innovative care for full patient panels. These benefits would continue to exist to individual provider organizations beyond Vermont's All-Payer ACO model.
Legal & Structural Considerations for non-ACO-Based System	OneCare's legal and operational structure as an ACO have made it possible to conduct these innovative payment and delivery system reform-related activities. Absent an ACO or other multi-payer model structure, payment reform initiatives such as the Comprehensive Payment Reform program could be feasible, but would likely be more challenging to implement in a way that aligns expectations across payer populations. **Absent a single entity that can negotiate terms with multiple payers and synthesize funding streams to implement practice-level payments, payers would have to develop innovative payment models directly with provider practices**. These would have the potential to be more administratively burdensome for providers because they would have more entities with which to coordinate, and because there would be more potential for payer-to-payer variation in programmatic requirements and operational processes.

Future Considerations	Given robust provider interest in maintaining such innovative fixed payment models, the State should prioritize the development of replacement models to begin, at least in part, in CY 2027. Further analysis should determine whether existing multi-payer model structures (such as the Blueprint for Health) could be leveraged in the absence of an ACO to pursue coordinated payment reform efforts or innovative delivery system models. This should be done in conjunction with the State's continued negotiations regarding the AHEAD model, which is expected to feature opportunities for a *Medicare* capitated payment model for independent physician practices. Additional clarity about future multi-payer model participation would be useful to payers as they plan for models that are maximally aligned. In the short term, individual payers may consider how to implement fixed payments for different types of provider organizations as an interim step—for example, Vermont Medicaid is planning to offer and implement fixed payments for hospitals through the Medicaid Hospital Global Budget model in CY 2026, and is evaluating opportunities for Medicaid-only fixed payment models for primary care in CY 2027.

Capability 2: Quality reporting, improvement and accountability

Description of ACO Activities	OneCare manages quality data collection, medical chart abstraction, patient surveys, and reporting to payers on behalf of participating providers. This alleviates providers from federal Merit-based Incentive Payment System reporting requirements and creates efficiencies for payers through aggregated quality reporting submissions. OneCare negotiates and ensures alignment of quality measures across payers, providers, and the state, and promotes and facilitates quality improvement initiatives across its provider network. This aligns focus on specific quality measures, standardizes financial incentives, creates space for provider input, enables micro- and macro-level monitoring of quality improvement, and drives statewide improvement.
Continued Value to Vermont's Health Care System	An aligned quality framework and centralized quality metric collection apparatus have been of high value to provider organizations, as they indicate a clear set of quality measurement and improvement expectations across payers and significantly reduce the administrative burden on providers to collect and report metrics to multiple payers. Such an aligned quality framework across provider organizations and payers would continue to be of value for providers absent an ACO, as would the reduced administrative burden of centralized quality data collection and reporting.
Legal & Structural Considerations for non-ACO-Based System	An ACO's legal structure enables a level of data aggregation and sharing that may be difficult to replicate for non-ACO entities. While it may be legal for each payer to provide this kind of data sharing for providers, those products would not be aligned across payers or aggregated for full provider panels, meaning they could be more burdensome for providers to use. An ACO's role as an

	umbrella organization for many organizations in the health care system also enables it to convene groups of providers to develop focused, targeted quality improvement (QI) initiatives. Absent this type of coordinating structure or entity, provider organizations and specialties would remain siloed from each other in their respective quality improvement efforts.
Future Considerations	Vermont has a history of working to ensure quality measure alignment across payer initiatives, and could continue to do so in the future absent an ACO. Ensuring aligned focus on quality performance is something that could be incentivized through future payment model design, wherein different types of providers that can play a role in a member's outcome may all have some shared accountability. Additional information from continued negotiations about AHEAD model participation will be helpful for understanding areas of quality focus that may be prioritized by federal partners under a new multi-payer model.

Capability 3: Data Aggregation, Sharing, and Analysis

Description of ACO Activities	OneCare currently aggregates, validates, and securely warehouses financial, utilization, medical risk, and social risk data from all payers with which it contracts. This gives provider participants access to claims data for their patients and enables comparative reporting and analysis. The data are made available through an analytics platform that enables self-service analytics, standardized reporting, and ad-hoc requests at varying levels of aggregation. Example outputs include periodic financial performance reports, access to patient-level information to identify care gaps, and customized reports to identify progress and opportunities in panel management and quality performance.
Continued Value to Vermont's Health Care System	This functionality has been of high value to providers. While having access to total cost of care data, comparative analyses, opportunity analyses, panel management analytic support, and ad hoc analytic support was undoubtedly valuable for participation in a shared-accountability model, these types of reports would also be useful to provider organizations individually as they seek to make data-driven determinations about how best to care for the Vermonters they serve while operating sustainably.
Legal & Structural Considerations for non-ACO-Based System	An ACO's legal structure enables a level of data aggregation and sharing that would likely be difficult to replicate for non-ACO entities, and it is not possible for the ACO to 'transfer' this current functionality to any other entity because of their own payer-, provider-, and vendor-specific contractual requirements around data stewardship and destruction once they cease to operate. While it may be legal for each payer to provide this kind of data sharing for providers, those products would not be aligned across payers or aggregated for full provider panels, meaning they could be more burdensome for providers to use. Furthermore, different payers may have varying capabilities to provide this kind of data and analysis directly to providers.

Future Considerations	In order to maximize the utility to providers, having the data aggregated across payers and reporting customized to a full practice panel would be ideal, but the barriers to doing so may be challenging to address in the short term. Analyzing the feasibility of longer-term replacement options should be done in consultation with a wider range of organizations, including provider organizations that use data, payers that supply the data, and other organizations knowledgeable about data privacy and security considerations.

Other Potentially Valuable Capabilities

There are two other capabilities of the ACO that have been beneficial to providers in Vermont's health care system to support their participation in the population-based accountability model that were central to Vermont's All-Payer ACO Model: payment processing, and financial risk management. Because of OneCare's status as a risk-bearing ACO, they are legally able to manage complex financial transactions within their network of participating providers, and they are able to establish and support cross-organizational financial accountability through risk sharing and management. Not enough information is available at this time to determine whether these capabilities would continue to be valuable to Vermont's health care system, because the utility of either or both would depend on whether Vermont participates in another multi-payer population-based accountability model, and on the features of such a future model.

Summary

Several of the capabilities that OneCare Vermont has developed during its years of operation would continue to be valuable to Vermont's health care system beyond 2025. Planning for potential replacements of these capabilities would benefit from additional clarity around the State's possible participation in a new federal multi-payer model, particularly because such participation would dictate the parameters for Medicare's flexibility for innovative payment models (such as fixed payments for primary care), expectations around quality performance, and participation in data sharing and analytic activities. As the State continues to seek that clarity, smaller steps may be taken in the interim, such as Vermont payer-specific work on fixed payments for primary care providers, and more intensive legal analyses on the structures that could enable future data aggregation, sharing, and analysis for providers.