OneCare Vermont

To: Jenney Samuelson, Secretary, AHS; Brendan Krause, Director of Health Care Reform, AHS
From: OneCare Vermont
CC: DVHA; GMCB; OneCare Board of Managers; Provider Organizations; Legislators; General Public
Date: June 23, 2025
Subject: Retaining the Capabilities of Certified ACOs

As articulated in recent legislation, the Agency of Human Services is tasked with exploring opportunities to sustain the benefits of certified accountable care organizations (ACOs). Additionally, other state and private entities have requested information to help guide future initiatives they may pursue. In support of these aims, we write to highlight some of the functions OneCare Vermont, a certified ACO, currently performs on behalf of patients and providers. With hope, some, if not all, of this work can be recreated in the future.

While the loss of funding in 2026 is more obvious and quantifiable, it is important that healthcare participants, payers, and government entities are aware of other supports OneCare provides that may be less visible. The purpose of this letter is to enhance readiness for all parties and to advocate for future solutions as this work is valuable to our healthcare system and the patients they serve.

As you may know, if this work cannot be replicated, the statewide progress being made to enhance patient care efficiency and outcomes will suffer. For example:

- Patients will lose the benefit of waivers that enable more efficient care pathways.
- Patients with high medical and/or social risks will not be as reliably prioritized without provider access to data and reports on their patient panels.
- Patients will experience a less flexible and customized care model as providers are forced to revert to fee-for-service (FFS), resulting in operations focused on volume rather than innovative team-based care approaches.
- Providers will face greater administrative burden as they independently negotiate and manage value-based initiatives, potentially adding to provider burnout.
- Vermonters will lose the benefits of population health strategies and interventions that impact their health outcomes in the absence of coordinated statewide quality improvement activities.
- Patients will experience less coordination across their providers, leading to a frustrating patient experience, reduced access, and/or worsened health outcomes as cross-organizational care coordination activities dissolve.
- Patients are at risk of experiencing less valuable care to meet their needs as providers lose access to funding that supports team-based care, integrated mental health services, and other best practices in high-value care that is unreimbursed, or under-reimbursed, by FFS.
- Vermonters will face greater financial pressures as overall accountability for healthcare costs and outcomes dissipate.

The following list catalogues bodies of work OneCare currently manages in support of our healthcare system and the patients they serve. Some of this work can be facilitated through different means, and these explanations will help Vermont pick up where OneCare left off. Not included are the many business functions necessary to operate the company and make these benefits possible.

Quality Improvement and Accountability: 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. This work is exemplified by the Population Health Model (PHM) program, which combines care coordination and quality improvement targets with financial incentives to generate outcomes. OneCare also partners with other entities, such as the Blueprint for Health, to agree on priorities and align initiatives.

> **Value:** Provider organizations are accountable for standardized quality outcomes, and quality improvement priorities are aligned throughout the system of care, enhancing statewide progress.
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> **Key Tasks:** Negotiation and alignment of quality measures; standardizing varying national benchmarks; establishing aligned standards for provider quality targets, quality analysis and assessment; design, development, and management of quality improvement initiatives; funding for quality improvement incentives, quality reporting; quality measure prioritization; education, training and support.

Quality Reporting: OneCare manages quality data collection, chart abstraction, patient surveys, and reporting to payers on behalf of participating providers. This alleviates providers from MIPS reporting requirements and creates efficiencies for payers through aggregated quality reporting submissions.

> **Value:** Providers do not need to individually develop systems and invest resources to gather and submit quality results data to payers. Results are aggregated across provider organizations and payers to enable micro- and macro-level trend and progress monitoring.
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> **Key Tasks:** Aggregating provider quality data; chart abstraction; claims data validation and analysis; unified quality reporting to payers; blending results across payers; provider education and technical support; monitoring quality trends and opportunities.

Regional Clinical Representative (RCR) Model and Practice Support: OneCare supports participants to improve population health quality outcomes and meet targets. This happens through monthly meetings with value-based care team members, data sharing, and facilitation of the Regional Clinical Representative (RCR) model. These supports help focus participant effort, monitor progress, and drive positive outcomes. Examples of this work include monthly data-review meetings with participants, performance improvement planning, and regular connections between RCRs and the organizations they support.

> **Value:** Participants have resources and support to help manage their efforts rather than developing their own isolated strategies, which requires significant administrative effort.

Key Tasks: Meetings with OneCare staff to review data and results; consultative support for workflow evolution; RCR strategy development; progress monitoring; sharing learnings and best practices.

Waiver Management: OneCare researches, educates, and champions the use of benefit enhancement and fraud, waste and abuse waivers to facilitate timely and appropriate patient care. Waivers are inherently complex, and centralized expertise helps promote utilization, assess impact, manage risks, and develop opportunities for expansion. Examples of this work include rollout of the Medicare 3-Day SNF benefit enhancement waiver, Payment for Ambulance Field Treatment Without Transport waiver, Mobility Assistance Devices waiver, ED Transport waiver, and Home Health Wound Care Services waiver.

Value: Providers have the legal pathway to invoke waivers, and access to the expertise and resources needed to research and understand waiver specifications, support and manage initiatives, and monitor compliance.

Key Tasks: Researching and understanding legal and compliant waiver opportunities and rules; provider education and training; development of waiver initiatives; upfront funding; utilization monitoring; impact analysis; payer reporting.

Innovation and Evolution: Through provider collaborations as well as independent assessment and analysis, OneCare identifies opportunities and supports creative initiatives designed to enhance patient care. This leads to pilot initiatives that can be replicated and scaled if successful. Examples of this work include creating the Comprehensive Payment Reform program, developing the Mental Health Screening Initiative, promoting and requiring health-related social needs (HRSN) screening, adjusting the PHM program to improve effectiveness, and partnerships to launch Innovation Fund programs such as Psychiatric Urgent Care for Kids (PUCK).

Value: Providers and payers have support and resources to design, develop, negotiate, monitor, and evaluate new innovations and initiatives; programs are adjusted based on participant feedback and input; new ideas are explored collaboratively.

Key Tasks: Developing initiatives; soliciting ideas for initiatives; facilitating pilot projects; start-up funding; data support; results monitoring; sharing outcomes; adjusting program designs; expanding successful initiatives.

Provider Collaborations: OneCare serves as the platform for cross-organizational provider collaborations, information sharing, data review, and relationship building. This helps to de-silo the healthcare provider system and create synergy and collegiality between separate healthcare entities. Examples of this work include HSA Consultations, e-Learn trainings, and co-leading a statewide hypertension collaborative.

Value: Provider organizations have facilitated opportunities to collaborate, build relationships, learn from each other, generate alignment, reduce competition, and use data to support initiatives.

Key Tasks: Clinical collaborations; joint advocacy; information sharing; partnerships; provider education; networking; sharing best practices.

Data Aggregation, Sharing, and Analysis: OneCare currently aggregates, validates, and warehouses total cost of care, medical risk, and social risk data. This provides participants with 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 PHM performance reports, financial performance reports, access to patient-level information to identify care gaps, and customized reports to identify progress and opportunities.

> **Value:** Providers have access to total cost of care data, comparative analyses, opportunity analyses, panel management analytic support, and ad hoc analytic support.
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> **Key Tasks:** Data warehousing; data quality control; data infrastructure management; data security; data use compliance; dashboard development; reporting; provider access; opportunity analysis; performance monitoring; ad hoc analysis; financial reporting.

Payment Processing: OneCare's ACO contracts allow for flexible funds flow between payers and provider organizations to improve delivery and coordination of care. OneCare aggregates payer and hospital investments, distributes funds in an aligned fashion according to program and contractual terms, and reallocates funds between segments of the provider system. As an example, OneCare blends funding sources so that providers have equal PMPM payments and financial opportunity across payer lines within the PHM program.

> **Value:** Provider collaborations in spirit of cost and quality improvement goals are compliant with Stark and Anti-Kickback laws, and payer or governmental investments are aggregated and aligned.
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> **Key Tasks:** Collecting payer and provider investments; aligning payment models and incentives; safe harbor for cross-provider incentives; pass-through funding management; distribution of shared savings and/or losses; accounting and reporting.

Payment Reform Development and Management: OneCare designs and manages payment reform initiatives on behalf of payers and providers. Arrangements are formalized through contracts, payment models are developed with provider input, rates are negotiated, outcomes are analyzed, adjustments are made, and reconciliations are centralized. Examples include operating the Comprehensive Payment Reform program, developing the Medicare and Medicaid fixed payment model for hospitals, and managing the Global Payment Program in partnership with DVHA.

> **Value:** Payment reform initiatives are aggregated between payers, provider organizations receive support and guidance, and payers have a single partner to develop and manage initiatives.
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> **Key Tasks:** Developing and negotiating payment reform opportunities with payers; designing payment reform models; piloting and scaling payment reform models for varying provider types; provider contracting; provider roster management; financial analysis; claims and results monitoring; troubleshooting; reconciliations and adjustments.

Risk Management: OneCare centrally manages value-based care program risk, develops risk sharing models, and facilitates financial settlement between payers and providers. This enables risk to be

apportioned across the provider system and enables smaller organizations to participate in two-sided programs. Examples include processing the annual settlement transactions, offering risk mitigation solutions, and managing the Medicare financial guarantee.

> **Value:** Financial risk and settlement transactions are centrally managed, risk is strategically apportioned across the provider system, and providers are accountable for cost outcomes.
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> **Key Tasks:** Risk model development; risk reporting; risk allocation; settlement transactions; risk mitigation arrangements; reinsurance; provider education.

Financial Negotiation and Settlement Validation: OneCare manages the actuarial process to establish total cost of care and other financial targets within value-based care agreements. Additionally, OneCare works with the payers to ensure final settlement calculations are accurate and fairly represent provider performance.

> **Value:** Providers can rely upon a shared entity to negotiate with payers and ensure accurate settlement calculations, and do not need to develop their own expertise independently.
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> **Key Tasks:** Total cost of care target negotiation; actuarial analysis; performance monitoring; financial reporting; advocacy; settlement reconciliations; results validation.

Contract Negotiation and Management: OneCare negotiates value-based care contracts and terms on behalf of its provider network and passes aligned and standardized accountabilities to provider participants. This creates efficiencies for payers and providers through standardization and drastically reduces the number of contracts entities need to manage. OneCare also assumes responsibilities on behalf of provider entities such as population health monitoring, quality measurement and reporting, and TCOC performance management. Examples of this work include negotiating ACO contracts, creating participant contracts, developing and negotiating RCR contracts, and managing contracts necessary to implement waivers.

> **Value:** Payers don't need to establish separate contracts and initiatives with each provider, and providers have an entity to negotiate on their behalf, manage separate contracts with each payer, and generate alignment.
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> **Key Tasks:** Aggregated contracting with payers; payer negotiations; provider negotiations; consolidated contracting with providers; contract management; dispute resolution.

Compliance: OneCare leads initiatives to ensure compliance with federal, state, and contractual requirements. This includes collaborative risk assessments, auditing, reporting, and investigations as needed. And example of this work is the program integrity work embedded in the Vermont Medicaid Next Generation contract that monitors for undesirable outcomes as providers transition into value-based care models.

> **Value:** Transitioning into value-based care creates new risks for fraud, waste and abuse. An independent third-party monitoring compliance on behalf of participants and payers helps to limit overall risk and alleviate provider administrative burden.
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> **Key Tasks:** Researching, understanding and following compliance requirements; negotiating compliance expectations in contracts; auditing; monitoring; training; risk assessments.

Value-Based Care Policy and Operations Expertise: OneCare monitors developments and changes within the value-based care landscape and applies its knowledge to advance clinical and financial innovations. This includes tracking federal and state developments, providing input, analyzing impact, communicating with providers, and integrating changes into new and existing programs. OneCare develops and maintains a highly skilled workforce with the knowledge and expertise to plan, develop, evaluate, and refine value-based care contracts.

> **Value:** Providers have access to a shared entity that monitors payer initiatives independently and keeps up with the ever-changing value-based care landscape.
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> **Key Tasks:** Maintaining expertise in value-based care programs and concepts; workforce training and development; model change evaluation; new model evaluation; provider inquiries; providing payer input.

Providers and provider organizations need support as the state pursues new healthcare delivery approaches and structures. Infrastructure to build connections, install and manage continuous improvement initiatives, provide data, alleviate provider organizations from administrative burden, and align priorities is a useful and replicable model. Our recommendation is that Vermont finds new ways to reproduce or sustain this work. Much has been learned over the last decade, and it is important that we continue moving forward.

Please feel free to reach out if you have questions about any of these functions or would like to discuss alternative ways to support similar efforts.