MEMORANDUM

TO: Owen Foster, Chair, GMCB
CC: Susan Barrett, Executive Director, GMCB; Michael Barber, General Counsel, GMCB
FROM: Marisa Melamed, Deputy Director of Health Systems Policy and Regulation, GMCB; Michelle Sawyer, Health Policy Project Director, GMCB
RE: OneCare Vermont "Return on Investment" Analysis
DATE: May 9, 2024

Background and Objective

The Green Mountain Care Board (GMCB) is tasked with oversight of ACOs operating in Vermont, which includes certification and annual budget review. The annual budget review process requires GMCB approval or modification of a proposed ACO budget and provides an opportunity to assess ACOs' programs, as well as the cost of administering such programs. GMCB has approved the OneCare Vermont (OneCare or OCV) submitted budgets subject to conditions since 2018. Since the FY2020 budget review, and earlier in some form, GMCB has mandated OCV's health care savings exceed OCV's administrative costs; specifically:

"Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the healthcare savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model."

To verify fulfillment of this budget order condition, a return-on-investment (ROI) analysis is required. An analysis was not run until 2023.[1] OneCare retained a consultant to conduct the analysis and submitted the results in November of that year. OneCare's assessment is included in this memo and attached hereto as Exhibit 1.

An ROI analyzes the cost or investment, and the resulting return or benefit. In all the analyses explored within this document, save one, OneCare's administrative expenses are one side of this equation: the required investment or cost. The other side of the equation, the return, is more difficult to calculate for this ACO due in part to the challenges of quantifying the health of the population, of isolating the impact of OneCare in Vermont, and of measuring external forces that have affected the recent health care landscape (e.g. COVID). Despite the inherent challenges and limitations to an ROI analysis in this context, this memo outlines several methodological approaches and provides an ROI under each approach. GMCB reviewed the June 2020 and June 2021 State Auditor's Office (SAO) reports related to OneCare, and GMCB has included ROI analyses consistent with the methodology utilized therein.

This memorandum does not assess the ROI of the All-Payer Model as a whole. Notably, the federal All-Payer Model evaluation, discussed below, is performed by nearly 20 consultants and experts from the University of Chicago with additional support from other organizations. Absent adequate

[1] The calendar year and fiscal year are used interchangeably as the ACO's fiscal year runs from January through December.

financial resources to conduct a similar analysis of the All-Payer Model from the state of Vermont's perspective, GMCB is unable to provide a Vermont-specific programmatic review at this time. GMCB would welcome the opportunity to independently lead such an evaluation should the State appropriate the necessary resources. GMCB is supportive of such an evaluation as it would inform current and future policy makers of the successes and failures of the All-Payer Model and allow the State to better design and implement future health care reform efforts.

These limitations notwithstanding, GMCB has dedicated some of its limited internal resources to transparently evaluate ways in which OCV's financial outcomes could be measured, as outlined in several GMCB Orders on the OCV Budget. This memorandum aligns not only with GMCB's budgetary conditions but overlaps in important respects with the State Auditor's recommendation that the GMCB perform an ROI of the All-Payer Model, since OCV is Vermont's only multi-payer ACO. Further, this memo outlines and includes costs and benefits external to OneCare Vermont's specific performance, including identification of additional costs borne by the State and benefits accrued from contractual terms with the federal government, such as Medicare funding for Blueprint and Supports and Services at Home (SASH). The following sections outline work by GMCB and OCV to comply with the Orders.

This GMCB staff memo reviews:

1. Note on the State Auditor's Office Report
2. Approaches/Methods for Analysis and Results
3. Discussion

Note on the State Auditor's Office Reports

In June 2020 the State Auditor's Office (SAO) issued a report on Vermont's All-Payer ACO Model,[2] which amongst other things found:

- ACO operating costs should be less than the healthcare savings the ACO generates. The GMCB has cited complexities in measuring 1) whether healthcare spending would have occurred absent the ACO's performance, and 2) incorporating quality of care into this measurement of healthcare savings.
- Six of the 22 quality measures in the All-Payer Agreement have updated baselines that are either the same or higher than their corresponding 2022 targets. That means the quality of care could decline and yet the quality targets may be achieved. Therefore, should this occur, the public could be misled if the GMCB emphasizes that a target was met without also acknowledging that quality had declined.

The SAO report included recommendations for GMCB. The GMCB responded to the Auditor's 2020 recommendations with a letter dated September 8, 2021, and a 1-year follow-up was reported to the Legislature via the Auditor in December 2021. In November 2023, the SAO requested a 3-year follow-up on implementation of its recommendations. The SAO's 2023 follow-up recommended that the GMCB analyze the cost of implementing the All-Payer ACO Model in comparison to the Model's savings. The federal government analyzes the Medicare performance of the All-Payer ACO Model. The federal Medicare analyses are attached hereto as Exhibits 2, 3, and 4. The final federal evaluation of the Model is expected later this year. Importantly, the federal evaluations *do not* evaluate Vermont-specific impacts of OCV on the All-Payer Model. In connection with implementing the All-Payer Model, the State of Vermont did not plan for, require, or resource a Vermont-specific evaluation.

In June 2021, the SAO issued another report on the ACO and its relationship with Vermont's Medicaid agency, the Department of Vermont Health Access (DVHA).[3] Findings from this report include:

- The State (DVHA and GMCB) spent at least $29.8 million from 2016-2020 on implementation of the All-Payer ACO Model.
- From 2017 through 2020, DVHA made $25.1 million in payments to OneCare to support ACO operations. Medicaid was the only payer to provide this type of support for the ACO. Some of this funding was intended for specific waiver-based uses; however, oversight of this funding was insufficient to ensure it was used for its intended purposes.

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[2] "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." 26 June 2020. https://auditor.vermont.gov/sites/auditor/files/documents/ACO%20Model%20Final%20Report_0.pdf

[3] "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." 18 June 2021. https://auditor.vermont.gov/sites/auditor/files/documents/ACO%20Implementation%20Costs%20with%20Letter%202.pdf

- From 2017 to 2019, the amount of OneCare's performance against Medicaid targets assessed against the operating costs funded by DVHA shows a net loss of $25.6 million for DVHA.

The 2021 report did not include recommendations for GMCB, but some of the analyses within this report addressed costs and returns associated with DVHA's involvement with and support of the ACO. Two of these analyses are expanded upon later in this memorandum with updated figures.

Approaches/Methods for Analysis

It should be noted and should be a caveat for all ROI-related considerations during the term of the All-Payer ACO Model (the agreement) from 2018-2022, that the COVID-19 pandemic significantly impacted health care spending. Disentangling the effects of the pandemic from the ROI is not something explored in this document, but a consideration readers should keep in mind when interpreting any of these analyses. *See* Exhibits 1, 2, 3, and 4 for further discussion on the effects of the COVID-19 pandemic on the health care landscape.

Because health care utilization was heavily impacted by the pandemic during most of 2020, there were large amounts of "savings" realized for the ACO. These results are outliers; the extreme 2020 savings are likely due to pandemic-induced reduction of health care spending. Including 2020 performance inflates experienced savings and lessens losses during the period of the APM. Thus, for each analysis there is a version in which 2020 is included, and a version where 2020 is excluded.

OneCare's administrative expenses during the agreement totaled $70.35 million. The sources of these funds varied from year to year but largely consisted of hospital participation fees. Hospital participation fees are the cost of entry into the ACO network for participating hospitals. The fees provide the operating revenue for the ACO and are calculated proportionally based on the hospital's net patient service revenue, CAH or non-CAH[4] designation, and an adjustment for population health payments. The amount of administrative spending each year varied as well. For each year in this analysis – 2018, 2019, 2020, 2021, and 2022 – the GMCB approved the amounts submitted in OneCare's budget. In FY23 and FY24, the GMCB ordered OneCare to reduce its proposed budgets by $303,799 and $957,245 respectively. FY23 and FY24 are identified and described in this memo, but not included in this analysis (FY18-FY22). Preliminary performance results for FY23 show varying performance among payer programs. Once the final settlement amounts have been determined and released, the information for FY23 can be applied to most of the analyses included in this document.

The amounts used in the calculations for the ROI are actuals and thus vary from the budgeted amounts that appear in the ACO budget submissions and budget orders.

[4] CAH = Critical Access Hospital

1. Administrative expenses compared to performance against financial targets.

The most straightforward and reliable measurement of ROI is ACO administrative expenses compared to the ACO's performance (over or under) against financial targets during the course of the agreement. This is consistent with the approach taken in Table 3 in the State Auditor's 2021 Report but does have some methodological differences.

Savings occur when the ACO network spends less on providing care to Vermonters than the preset benchmark or target, which is negotiated between the ACO and the payer prior to the start of the program year. A higher negotiated benchmark makes it easier for the ACO to achieve savings, while a lower benchmark makes it more difficult to achieve savings. The ACO has the ability to deduct amounts designated for budgeted expenses from the savings (e.g., administrative costs, Population Health Management Expenses, and contributions to reserves) if determined appropriate by OneCare's Board of Managers before distributions to the network are made. The amount of those savings released back to the ACO network is called the settlement amount. This memorandum explains the impact of the ACO deducting amounts from distributed shared savings (settlement) in Section 2, *infra*.

For the purposes of this first section, ROI is calculated in three ways. The first, in Table 1a, is inclusive of all payer programs for each performance year and does not include funding for Blueprint for Health and SASH, the rationale for which is discussed below. The second, in Table 1b, omits the Medicare benchmark and only includes a combined total of the Medicaid and commercial benchmarks from each performance year. This calculates savings or losses for Vermont-based payers (i.e. Medicaid and commercial payers). The third, in Table 1c, is a closer look at the Medicaid performance of the ACO and includes ACO operating costs paid by Medicaid for each program year. This analysis is the only calculation included in this document in which OneCare's full administrative budget amount is not the input used to calculate the return, instead focusing strictly on the experience of a single payer.

The Medicare benchmark is set to incorporate the annual Blueprint for Health and SASH funding that flow through the ACO to the designated recipients. Because of this pass-through funding, when calculating the targets for each year in Table 1a, the amount of funding for Blueprint and SASH were deducted from the overall benchmark. Blueprint and SASH funding provided by Medicare as a function of the All-Payer Model are noted in this memorandum as an additional, non-ACO performance-based benefit of the Model.

A note about the formatting of the tables in this memo: because negative numbers can mean both performance under a target (which is desirable) and overall losses (which is not desirable), the cells are color-coded in an attempt to clarify desirable and undesirable results. Green cells indicate savings and performance under targets, while red cells indicate losses or performance over targets.

Table 1a: OneCare's Administrative Expenses Compared to Performance against Combined All-Payer Targets.

	2018	2019	2020	2021	2022	**TOTAL**	**TOTAL omitting 2020**
OneCare's Administrative Expenses	$13.74M	$15.34M	$14.04M	$13.61M	$13.61M	$70.35M	$56.30M
Over/Under Target*	-$6.15M	$17.80M	-$79.93M	-$1.13M	-$15.60M	-$85.02M[5]	-$5.09M
Savings	-$7.59M	-$33.14M	$65.89M	-$12.47M	$1.99M	**$14.67M**	**-$51.22M**

*Negative amounts indicate savings for performance under target in this row.

The method in Table 1a is the most closely aligned to the Net Financial Performance calculation in the second SAO report (6/18/2021, Table 3) carried forward through 2022. However, some figures vary due to differences in data sources, availability of actuals, and the lack of data available to GMCB staff regarding the UVMMC Self-Funded payer program. It should be noted that the SAO's calculation included funding for Blueprint and SASH, which totaled over $42M between 2018 and 2022. While the $42M was an important benefit the State received as part of the All-Payer Model for Blueprint and SASH, the authors of this memo are of the opinion that analysis of *OneCare's* performance should not include this benefit.

Table 1b: OneCare's Administrative Expenses Compared to Performance against Aggregate Medicaid and Commercial Insurer Targets (Medicare omitted)

	2018	2019	2020	2021	2022	**TOTAL**	**TOTAL omitting 2020**
OneCare's Administrative Expenses	$13.74M	$15.34M	$14.04M	$13.61M	$13.61M	$70.35M	$56.30M
Over/Under Target*	$3.09M	$21.26M	-$61.33M	$12.42M	-$3.51M	-$28.07M	$33.26M
Savings	-$16.83M	-$36.60M	$47.29M	-$26.03M	-$10.10M	**-$42.28M**	**-$89.56M**

*Aggregate targets of Medicaid and Commercial payers. Negative amounts indicate savings for performance under target in this row.

From 2017 through 2021 Medicaid contributed funds towards the operating costs of the ACO. Since 2022, all funds provided by Medicaid to the ACO flow directly to providers per the contract. Table 1c expands upon an analysis in the SAO Report that explored OneCare's financial performance in the Medicaid program and assesses this performance against funds contributed to the ACO's operating

[5] Preliminary performance results for FY23 are available for three of four payer programs. Final results will be available in the fall of 2024. Preliminary results indicate the ACO will experience modest savings, breakeven, and small losses across these payer programs.

costs. The SAO Report included the years 2017 through 2019. While not included in Table 1c, the 2017 experience resulted in a $2.4 million savings for Medicaid.

Table 1c: Expansion of SAO Report Table 1

	2018	2019	2020	2021	2022	**TOTAL**	**TOTAL omitting 2020**
Administrative Costs funded by Medicaid	$3.08M	$5.40M	$5.40M	$3.89M	$0	$17.77M	$12.37M
Over/Under Medicaid Target*	$1.54M	$13.49M	-$16.83M	-$21.60M	-$15.8M	-$39.20M	-$22.37M
Savings	-$4.62M	-$18.89M	$11.44M	$17.70M	$15.80M	**$21.43M**	**$9.99M**

*Negative amounts indicate savings for performance under target in this row.

2. Administrative expenses compared to settlement payments.

A second method to calculate the ACO's ROI during the agreement would be to compare the ACO's administrative expenses to the settlement payments made to the ACO's network. These amounts, referred to as "settlement," are closely related to how the ACO performed against its set benchmark target in the first ROI calculations. As described in Section 1, the amount that the ACO saved with its performance under its benchmark is not the amount distributed to the ACO network. The settlement is a representation of what the network experiences as savings and is the result of the ACO's financial performance, any quality adjustments and risk corridors, as well as any sequestration amounts that are in the ACO's contracts with the payers. Based on the ACO's performance in specific quality metrics as specified in the payer contracts, the settlement amount can be adjusted up or down. When quality performance is high, the shared savings earned would be higher than if the ACO had saved the same amount but had lower quality performance.[6]

Settlement amounts as calculated in the Medicare program include funding for Blueprint and SASH. Table 2 below omits this funding for reasons previously discussed.

It should be noted that risk corridors are subject to negotiation between the ACO and payers. In the case of the Medicare payer program, the ACO is able to choose the risk corridor for each year from a set of options outlined by CMS. Savings have been realized every year under the Medicare program. However, due to the ACO choosing a narrower risk corridor, the settlement amounts experienced by the network have been smaller than they could have been had the ACO chosen to take on more risk.

Table 2: OneCare's Administrative Expenses Compared to Performance against All-Payer Settlement Amounts

	2018	2019	2020	2021	2022	**TOTAL**	**TOTAL omitting 2020**
OneCare's Administrative Expenses	$13.74M	$15.34M	$14.04M	$13.61M	$13.61M	$70.35M	$56.30M
Settlement*	$3.12M	-$5.03M	$20.71M	$5.46M	$6.57M	$30.83M	$10.12M
Savings	-$10.62M	-$20.37M	$6.67M	-$8.15M	$7.04M	**-$39.52M**	**-$46.18M**

*Not including Blueprint and SASH funding.

[6] OneCare's Quality Performance can be found at https://www.onecarevt.org/aco-results/#scorecardsbyyear

3. OneCare's Submitted ROI Memo

The FY21 and FY22 OCV ACO Reporting Manuals designated the ROI analysis report to the FY23 Reporting Manual, following the conclusion of the original APM Agreement in effect 2018 through 2022. OneCare submitted a memo to the GMCB on November 14, 2023, "Return on Investment Analysis for OneCare Vermont." The memo reviewed how ACOs are assessed for ROI elsewhere, proposed methods for calculating ROI or similar metrics, discussed limitations on an analysis of ROI for the ACO, and presented recommendations for future analysis. Notably, the memorandum does not propose a calculation, nor calculate results for the GMCB to assess fulfillment of the Budget Order requirement, except for one metric: ROI Calculation Using Shared Savings Compared with OneCare's Administrative Expenses.

GMCB staff identified errors in calculations within the memo and notified OneCare of these findings. The staff found that an incorrect amount was in the "Shared Savings/Losses" box for 2019, and that the "Administrative Expenses" amount in 2021 was a budgeted amount rather than an actual amount. It should be noted that not all calculations within the memo were verified for accuracy by GMCB staff and additional corrections may need to be made. The memo was reissued to GMCB on April 15, 2024, with the 2019 correction made. This corrected report is attached as Exhibit 1. *See* Table 6 below from the reissued OCV memo.

Table 6. ROI Calculation Using Shared Savings Compared with OneCare's Administrative Expenses

	2019	2020	2021	Total
Shared Savings/Losses*	$12,800,000	$73,060,000	$17,040,000	$102,900,000
Administrative Expenses	$15,341,450	$14,044,262	$15,905,658	$45,291,370
Net Savings (Row 1-2)	($2,541,540)	$59,015,738	$1,134,342	$57,608,630

*Rounded to the nearest ten thousand

This calculation results in a total of $57.6 million in savings from 2019-2021. This is an incomplete analysis as it omits data from 2018 and 2022. There were also some differences in the vendor's choice of methodology and language as follows:

1) The Administrative Expenses included in this table are actuals for 2019 and 2020, but the budgeted amount was used for 2021 rather than the actual expense. The actual amount of administrative expense for 2021 is $13,608,548. As mentioned, GMCB staff notified OneCare of this discrepancy, but the memo was reissued with this figure unchanged.
2) "Shared Savings and Losses" in this table are network settlement amounts plus the fixed prospective payment (FPP) benefit amount for each year. The FPP benefit amount is associated with the Medicaid payer program, which provides unreconciled FPP to the network. If the amount spent by the network is less than what they were paid in FPP, that amount is retained by the network, and the difference is the benefit amount.
3) Over $42 million in Blueprint and SASH funding are included in OneCare's calculations of shared savings amounts. These funds are not a reflection of OneCare performance or programmatic efforts as it is a contract term negotiated between the State of Vermont and

CMMI. Nor did OneCare deduct other costs borne by the State of Vermont in establishing, implementing, and regulating the All-Payer Model. The GMCB staff chose not to include the Blueprint and SASH funds in most of the calculations discussed earlier in this document.

To complete the analysis started by OneCare's vendor, FY2018 and FY2022 must be included. The result of expanding this is seen below in Table 3, but excludes Blueprint and SASH funding, and includes only actual administrative expenses and not budgeted expenses for all years.

Table 3. OneCare Vermont's Table 6, expanded and corrected with actual administrative expenses.

	2018	2019	2020	2021	2022	TOTAL	TOTAL omitting 2020
OneCare's Administrative Expenses	$13.74M	$15.34M	$14.04M	$13.61M	$13.61M	$70.35M	$56.30M
Shared Savings and Losses*	$3.42M	$4.78M	$64.66M	$8.27M	$7.45M	$88.58M	$23.92M
Savings	-$10.32M	-$10.56M	$50.61M	-$5.34M	-$6.16M	**$18.23M**	**-$32.38M**

*Not including Blueprint and SASH funding.

As noted earlier, preliminary performance for 2023 shows varying performance among payer programs. Using OneCare's methodology in Table 6, this will likely result in a small positive return for 2023. Once the final settlement amounts have been determined and released, this information can be included in any of the analyses provided in this document.

4. Other: Administrative expenses compared to the value of shared services with the ACO; administrative expenses compared to the value of improved health and/or improved quality of care delivery

As discussed here and in OneCare's submitted ROI analysis, there is no standard way of calculating an ROI for an ACO at the entity-level. This section attempts to document some additional potential "returns" that the ACO might have produced during the agreement, that may or may not have materialized into financial savings or costs reflected in the above calculations. This section does not attempt to calculate financial gain or loss due to the nature of these returns.

One potential advantage of the ACO is the value of shared services for its network. OneCare Vermont offered its network data analytics, data reporting, and a universal care coordination software platform during the agreement. In theory, these services are a benefit to the network as they have the potential to save providers the expense associated with producing these services in-house. The associated benefit would vary depending on the provider, given each provider's pre-existing data abilities and the perceived value of Care Navigator, the care coordination tool ultimately discontinued by the ACO. The value of the ACO's shared services is not readily amenable to a mathematical formula. It is unclear whether any financial savings were accrued or if they are demonstrated in performance as against the benchmark targets.

Another potential advantage of the ACO is the value of improved health for patients in Vermont. While better health outcomes are important to Vermonters, it is difficult to assign a dollar amount to these outcomes for the purpose of conducting an ROI. Four potential ways to review the "return" to Vermont in health outcomes would be through 1) analyzing the ACO's quality performance during the agreement, 2) analyzing the change in chronic disease burden, 3) measuring changes in life expectancy, and 4) measuring changes in hospitals' actual versus expected mortality rates. The first two methods are discussed in OneCare's submitted ROI document along with the associated shortfalls and data-related difficulties. Improvements, if any, in health may also be a result that can be observed many years later; increased preventative care today may not show a decrease in chronic illness until decades later. Health outcomes could additionally be a function of myriad factors unrelated to the ACO, such as a change in state demographics, broader environmental factors, accessibility of health care, costs of health care, improvements in pharmaceuticals, other reforms, and numerous other factors.

As discussed above, the State additionally benefited from the All-Payer Model through Medicare funding $42.04M for Blueprint and SASH.

5. Other: Additional costs incurred implementing and regulating the ACO

The main purpose of this memorandum is to analyze compliance with the budget order condition which instructed OneCare to ensure that its administrative costs were less than the savings that its programs produced. However, these administrative costs are far from the only ones that have been incurred in supporting the efforts of the ACO during the APM. This section discusses additional costs incurred while implementing and regulating the ACO, and includes actuals wherever data was available.

GMCB Regulatory Costs

The GMCB is funded in part from the State's General Fund and in part from assessments on the entities that GMCB regulates through a practice known as "billback." The following table shows the amounts that OneCare was assessed from 2019 – 2022, and the commensurate State share of the costs covered by these assessments. ACOs were not part of the billback prior to 2019.

Table 4: Costs associated with GMCB regulation of OneCare Vermont

	2019	2020	2021	2022	TOTAL
General Fund (40%)	$138,764	$244,074	$265,611	$293,914	$942,363
Billback paid by OneCare (60%)	$208,145	$366,111	$398,416	$440,872	$1,413,544
Total (100%)	$346,909	$610,185	$664,027	$734,786	**$2,355,907**

*18 V.S.A. § 9374(h) did not authorize GMCB to include Accountable Care Organizations in billback until 2019.

Mathematica Contract

Since 2017, GMCB has contracted with the vendor Mathematica to fulfill the State's reporting requirements under the All-Payer Model. Through the GMCB the State pays Mathematica approximately $1M annually for these services, and the State expended approximately $5M between 2018-2022. The total amount paid to Mathematica will total approximately $7M at the conclusion of State FY26.

State Innovation Model (SIM) Grant

As mentioned in the 2021 SAO Report, Vermont was the recipient of a $45 million SIM Grant in 2013 to, in part, set up the All-Payer Model. This grant required that the State experience savings equal to the amount of the grant; this requirement was met. The amount of money spent directly implementing the ACO is unknown as there were various projects funded by this grant.

Pre-APM DVHA-Funded Operation Costs

This memo previously described Medicaid's funding to support OneCare's operating costs. Because the analyses completed focused on the years of 2018 through 2022, any funds spent prior to this were not described. It should be noted that in 2017, Medicaid also contributed $2.5 million towards OneCare's operating costs, while OneCare saved $2.4 million against the Medicaid target, resulting in a net loss of approximately $200,000.

Other Potential Costs

GMCB staff have limited insight into additional State funds that may have been spent on the implementation or operation of the ACO but wish to acknowledge that there may be additional costs not captured within this memo.

Discussion

The analyses in this memo demonstrate a range of results, from $42.28 million in losses for Medicaid and commercial payers up to $21.43 million in savings for Medicaid. When removing 2020 from any of these analyses, savings significantly decrease, and losses significantly increase.

Table 5: Summary of Results

METHOD	Page	RESULT	RESULT w/o 2020
1a. OneCare's Administrative Expenses Compared to Performance against all-payer target	Pg 7	$14.67 million in savings	$51.22 million in losses
1b. OneCare's Administrative Expenses Compared to Performance against Medicaid and Commercial Insurer-blended target (Medicare omitted)	Pg 7	$42.28 million in losses	$89.56 million in losses
1c. Medicaid's contribution towards Administrative Expenses against Performance against Medicaid Target	Pg 8	$21.43 million in savings	$9.99 million in savings
2. OneCare's Administrative Expenses Compared to all-payer settlement	Pg 9	$39.52 million in losses	$46.18 million in losses
3. OneCare's Administrative Expenses Compared to all-payer settlement [OneCare's submission]	Pg 11	$18.23 million in savings	$32.38 million in losses

Continued analysis of any of these or other methods will require additional analytics support. One consideration that could be explored is the effect on health care pricing on the observed financial performance of OneCare. While reducing utilization and improving outcomes are two goals of the ACO, financial performance could ultimately be a reflection of, or at least impacted by, what providers are charging for health care services rather than a sign of decreased utilization and improved health.

It is the opinion of the staff authors of this memo that it is unlikely there will be consensus around a single metric that accurately measures the value of the ACO, and that any follow-up analysis should be financial performance-based in nature given the likely impossibility of parsing out OneCare's effect on health outcomes.

Exhibits

Exhibit 1: Return on Investment Analysis for OneCare Vermont

- Return on Investment Analysis for OneCare Vermont

Exhibit 2: First Evaluation Report, Performance Years 1-2 (2018-2019) (August 2021)

- First Evaluation Report: Evaluation of the Vermont All-Payer Accountable Care Organization Model
- Findings at a Glance: Vermont All-Payer Model Evaluation of the First Two Performance Years: 2018-2019
- Technical Appendices: First Evaluation Report, Evaluation of the Vermont All-Payer Accountable Care Organization Model

Exhibit 3: Second Evaluation Report, Performance Years 1-3 (December 2022)

- Second Evaluation Report: Evaluation of the Vermont All-Payer Accountable Care Organization Model
- Findings at a Glance: Vermont All-Payer Model Evaluation of the First Three Performance Years: 2018-2020
- Technical Appendices: Second Evaluation Report, Evaluation of the Vermont All-Payer Accountable Care Organization Model

Exhibit 4: Third Evaluation Report, Performance Years 1-4 (July 2023)

- Third Evaluation Report: Evaluation of the Vermont All-Payer Accountable Care Organization Model
- Findings at a Glance: Vermont All-Payer Model Evaluation of the First Four Performance Years: 2018-2021
- Technical Appendices: Third Evaluation Report, Evaluation of the Vermont All-Payer Accountable Care Organization Model