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TO: House Committee on Health Care
FROM: Vicki Loner, VP Operations
CC: Amy Cooper, Todd Moore, and Joyce Gallimore
DATE: March 8, 2016
RE: H.812

Vermont's three (3) Accountable Care Organizations; Vermont Physicians Collaborative LLC (Healthfirst), Community Health Accountable Care LLC, and OneCare VT LLC have met to review the draft Bill of H.812. Although this response is from OneCare Vermont, we have general consensus on certain aspects of the Bill as it currently exists. If the Committee wishes, and as time permits, any of us could provide further testimony at a later date about other aspects of H.812. Thank you again for the opportunity to provide feedback.

Recommendations:

I. Addition

1. For ACO certification and ongoing oversight requirements, we would propose that a regulated ACO either:
    - Achieves and maintains NCQA accreditation for ACOs; or
    - Complies with state developed standards as set by GMCB under this statute

II. Modifications

1. Section 1, p. 2, lines 3-5, subsection 6 and Section 2, p. 2, Line 16 #2 (identical language) – continues to provide payments from Medicare directly to health care providers without conversion, appropriation, or aggregation by the State of Vermont
    - **Proposed Language:** continues to provide payments from Medicare directly to health care providers or Accountable Care Organizations without conversion, appropriation, or aggregation by the State of Vermont.

    - Rationale for the modification- The language as written could be interpreted to prohibit the GMCB's ability to agree with CMS to any arrangement that does not include Medicare payments going directly to health care providers.

2. Section 5, p. 7, line 16-20, subsection 10 – the ACO notifies each of its attributed patients of their attribution, including an explanation of how an ACO works, patients' rights, grievances and appeals processes, including the availability of grievance and appeals processes through both the ACO and the patients' health insurer, and contact information for the offices of the Health Care Advocate
    - **Proposed Language:** the ACO maintains a website that explains how ACOs work as well as contact information for the Office of the Health Care Advocate and maintains a consumer call in line for complaints and grievances from attributed patients, responds and makes best efforts to resolve such complaints and grievances including assistance in identifying appropriate rights under the patients'

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health plan, and shares complaint and grievance information, in de identified form, with the Office of the Health Care Advocate on a biannual basis.

- Rationale for the modification- The language introduces another layer that already exists under existing managed care laws and has the potential to confuse and exhaust the consumer in a time of need. To establish to all patients an implied ACO role of "one stop shopping" for consumer protections outside of those specifically and uniquely set for an ACO entity may draw unrealistic consumer expectations of the ACO and require significant operational expenses if significant patient rights navigation services become an expectation.

3. Section 5, p. 8, Lines 7-9, subsection 13 – meetings of the ACO governing body include a public session at which all business that is not confidential or proprietary is conducted and members of the public are provided an opportunity to comment
    - **Proposed Language:** meetings of the ACO's governing body include a portion of time set aside to hear comments from members of the public who have signed up before the meeting and to provide brief public updates of the ACO's activities.

    - Rationale for the modification - The current Board requirements already call for broad representation, including public representation through required consumer seats. The proposed language is consistent with current ACO provisions under existing State and Federal ACO programs (e.g., Shared Savings and Next Generation models).

4. Section 5, p. 10 start, Line 14, subsection e – to the extent possible to avoid federal antitrust …costs modifying payment methods

    - **Proposed Language:** Consistent with the purposes of 18 V.S.A. §9377, and to the extent required to avoid federal antitrust violations through the state action immunity doctrine, the Board shall supervise the participation of health care professionals, health care facilities and other persons operating or participating in an accountable care organization . . . . . (continue without change)

    - **Rationale for the modification:** Better match the legal standard by which state action immunity to anti-trust is assessed.

5. Section 2, p. 4, subsection 12, lines 8-15 (see also Section 5, subsection (9) page 7, lines 13-15) - requires processes and protocols for shared decision making between the patient and his or her health care providers that take into account a patient's unique needs, preferences, values, and priorities" and "the ACO's participating health care providers engage their patients in shared decision making to ensure their awareness and understanding of their treatment options and the related risks and benefits of each.

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- **Proposed Language:** requires implementation of processes that support the ACO's providers to engage their patients in shared decision making to ensure their awareness and understanding of their treatment options and the related risks and benefits of each;

- Rationale for the modification- Supports the relationship between the provider and the patient v. ACO and patient. Setting of concrete protocols disempowers the health care provider in determining the best approach to shared decision making conversations based on individual patient situations and treatment options.

6. Section 5, p. 5, subsection a, start on line 18 – In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization with 5,000 or more attributed lives in Vermont shall obtain and maintain certification from the Green Mountain Care Board.

    - **Proposed Language:** change from 5,000 or more to 10,000 or more

    - Rationale for the modification- Align with Medicare Next Generation ACO program standards which require that number of minimum lives for a risk bearing ACO

7. Section 4, p. 5, subsection (b)(13) - Adopt by rule pursuant to 3 V.S.A. chapter 25, standards for accountable care organizations, including reporting requirements, patient protections, and other matters the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter.

    Proposed Language: Adopt by rule pursuant to 3 V.S.A. chapter 25, standards for accountable care organizations, including reporting requirements, patient protections, solvency and financial ability to assume risk and other matters the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter.

    - Rationale for the modification- Address solvency and financial ability to assume risk and provides clear and complete regulation of all material elements of ACOs to the GMCB.