Section by section summary of H.812, An act relating to implementing an all-payer model and oversight of accountable care organizations

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Sec. 1. All-payer model; Medicare agreement

- The Green Mountain Care Board (GMCB) and Agency of Administration can only enter into an agreement with CMS to waive Medicare provisions if the agreement:
  - is consistent with the Act 48 principles of health care reform
  - preserves Medicare consumer protections
  - allows providers to choose whether to participate in an ACO
  - allows Medicare patients to choose their providers
  - includes outcome measures for population health
  - continues to provide Medicare payments directly to providers or ACOs without State involvement

Sec. 2. All-payer model

- In order to implement an all-payer model, the GMCB and Agency of Administration must ensure that the model:
  - maintains consistency with the Act 48 principles
  - continues to provide Medicare payments directly to providers or ACOs without State involvement
  - maximizes alignment between Medicare, Medicaid, and commercial payers, including:
    - what is included in the calculation of total cost of care
    - attribution and payment mechanisms
    - patient protections
    - care management mechanisms
    - provider reimbursement processes
  - strengthens and invests in primary care
  - incorporates social determinants of health
  - follows federal and State laws on parity of mental health and substance abuse treatment, integrates them into the overall health system, and does not manage their care separately from other health care
  - includes a process for integrating community-based providers and their funding streams into a transformed, fully integrated health care system
  - continues to prioritize local and regional health care provider collaboratives
  - pursues integrated approach to data collection, analysis, exchange, reporting
  - allows providers to choose whether to participate in ACOs
  - evaluates access to care, quality of care, patient outcomes, and social determinants of health
  - requires processes and shared protocols for shared decision making
  - supports coordination of care and care transitions through use of technology
  - ensures, with the Office of the Health Care Advocate (HCA), that robust patient grievance and appeals processes are available

Sec. 3. Definition of "accountable care organization" or "ACO"

- Adds a definition of "accountable care organization" or "ACO" to GMCB statutes

Sec. 4. Duty to adopt ACO standards

- Adds to GMCB duties the adoption by rule of ACO standards, including reporting requirements, patient protections, solvency, and ability to assume financing risk

Sec. 5. Oversight of ACOs

- Requires ACOs with at least 10,000 attributed lives in Vermont to obtain and maintain GMCB certification in order to be eligible to receive payments from Medicaid or commercial insurance through a payment reform program or initiative
- Requires the GMCB to adopt rules to establish standards for certifying ACOs
    - May include accepting NCQA or other accreditation for any of the criteria
- In order to certify an ACO, GMCB must ensure the following criteria are met:
    - the ACO's governance, leadership, and management structure is transparent, represents its providers and patients, includes a consumer advisory board and consumer input
    - the ACO has appropriate mechanisms to provide, manage, and coordinate high-quality health care services for its patients
    - the ACO has appropriate mechanisms to receive and distribute payments to its providers
    - the ACO has appropriate mechanisms and criteria for accepting providers to participate in the ACO
    - the ACO has appropriate mechanisms to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies
    - the ACO can have meaningful participation in health information exchanges
    - the ACO has performance standards and measures to evaluate quality and utilization of care
    - the ACO does not restrict information its providers can give to their patients
    - the ACO's providers engage patients in shared decision making
    - the ACO has an accessible mechanisms to explain how ACOs work, provides contact information for the HCA, has a consumer phone line, responds and resolves complaints, shares deidentified information with the HCA at least twice each year
    - the ACO collaborates with providers outside its model
    - the ACO does not interfere with patients' choice of their own providers under their health plan, does not reduce covered services, and does not increase patient cost-sharing
    - the ACO's governing body meetings include a public session
    - establishment and operation of the ACO does not diminish access to any health care service for the population or area served
    - the ACO has a financial guarantee sufficient to cover its potential losses
- The GMCB must adopt rules to establish standards and processes for reviewing, modifying, and approving ACO budgets, including reviewing and considering:

  - information about utilization of health care services delivered by the ACO's participating providers
  - goals and recommendations of the health resource allocation plan (HRAP)
  - expenditure analysis for the prior year and for the year under review
  - character, competence, fiscal responsibility, and soundness of the ACO and its principals
  - reports from professional review organizations
  - ACO's efforts to prevent duplication of high-quality services being provided by community-based providers
  - extent to which the ACO provides incentives for systemic investments to strengthen primary care
  - extent to which the ACO provides incentives for system investments in social determinants of health
  - public comment on the ACO's costs and use and on its proposed budget
  - information from meetings with the ACO about its proposed budget
  - information on the ACO's administrative costs
  - Medicaid cost-shift
  - extent to which the ACO makes its costs transparent and easy to understand
- The HCA has the right to intervene in any ACO budget review
- Information filed by an ACO must be made available to the public upon request
- GMCB must supervise the parties as necessary to avoid federal antitrust violations

Sec. 6. GMCB rulemaking

- The GMCB must adopt rules by January 1, 2018 governing the oversight of ACOs
- By January 15, 2017, GMCB must provide an update on the rulemaking process and its vision for their implementation to the committees of jurisdiction

Sec. 7. DFR and DVHA rulemaking; denial of service

- The Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) must ensure their rules protect against wrongful denial of services for covered individuals attributed to an ACO.
- DFR and DVHA may amend their rules to ensure that the Medicaid and insurance grievance and appeals processes are appropriate to an ACO structure.

Sec. 8. Transition and implementation

- Prior to January 1, 2018, if the GMCB and Agency of Administration pursue an all-payer model, they must do so in a manner that works toward meeting the criteria in the bill for an all-payer model.
- By January 1, 2018, if the GMCB and Agency of Administration pursue an all-payer model, they must implement it in accordance with the criteria in the bill.
- Prior to January 1, 2018, the GMCB must oversee ACOs to encourage them to comply with the criteria in the bill and establish budgets that reflect the bill.
- By January 1, 2018, the GMCB must begin certifying ACOs that meet criteria in the bill and only approve budgets after review and consideration of criteria in the bill.

Sec. 9. Effective dates