Overview of Act 113 of 2016: An act relating to implementing an all-payer model and oversight of accountable care organizations

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Act 113: All-Payer Model

- All-payer model: A value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments
- Medicare participation in all-payer model requires the Centers for Medicare and Medicaid Services (CMS) to waive provisions under Title XVIII (Medicare) of the Social Security Act

Act 113: All-Payer Model

- Establishes parameters for a permissible Medicare waiver agreement with the federal government
  - Must be consistent with Act 48 principles
  - Must preserve Medicare consumer protections
  - Must allow providers to chose whether to participate in an ACO
  - Must allow Medicare patients to choose their providers
  - Must include outcome measures for population health
  - Must continue to provide Medicare payments directly to providers or ACO without State involvement

Act 113: All-Payer Model

- Establishes criteria for all-payer model, including:
  - Consistent with Act 48 criteria
  - Continues to provide Medicare payments directly to providers or ACO without State involvement
  - Maximizes alignment between Medicaid, Medicare, and commercial payers
  - Strengthens and invests in primary care
  - Incorporates social determinants of health
  - Provides parity of mental health and substance abuse treatment and integrates these treatment systems into the overall health care system
  - Includes process to integrate community-based providers
  - Evaluates access to care, quality of care, patient outcomes, and social determinants of health
  - Provides robust patient grievance and appeal protections

Act 113: ACOs

- Accountable care organization (ACO): organization of health care providers with formal legal structure and federal Taxpayer Identification Number that agrees to be accountable for the quality, cost, and overall care of the patients assigned to it
- Act requires ACOS to get and maintain certification from Green Mountain Care Board
  - Requires GMCB to adopt rules by January 1, 2018 establishing standards for certifying ACOs

Act 113: ACOs

- Specifies 16 criteria that GMCB must ensure are met in order to certify an ACO, including that:
  - ACO's governance, leadership, and management structure is transparent, represents its providers and patients, and includes consumer advisory board and consumer input
  - ACO has appropriate mechanisms to provide, manage, and coordinate high-quality health care services for its patients
  - ACO collaborates with providers outside financial model
  - ACO has a financial guarantee sufficient to cover potential losses
- Requires GMCB to adopt rules by January 1, 2018 for reviewing, modifying, and approving ACO budgets

Act 113: Additional Provisions

- GMCB must establish primary care professional advisory group for two years to help GMCB address administrative burden on primary care professionals
- Agency of Human Services must report by January 1, 2017 on its funding and evaluation of contracts with designated agencies, specialized service agencies, and preferred partners

Act 113: Additional Provisions

- "Medicaid pathway" – AHS must create a process for payment and delivery reform for Medicaid-participating providers and Medicaid services
- GMCB must conduct a Medicaid advisory rate case for ACO services by December 31, 2016
- Consideration of multi-year budgets:
  - By GMCB for ACOs
  - By JFO and Dept. of Finance and Management for Medicaid
- Requires Dept. of Health to establish minimum nutrition procurement standards for all food and beverages purchased, sold, or served by or on behalf of the State
  - Nutritional labeling must be displayed for all State-owned or operated vending machines, food/beverage vendors, cafeterias