

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
Rule 5.000: OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

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GREEN MOUNTAIN CARE BOARD
RULE 5.000: OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

5.100 General Provisions

5.101 Authority

The Board adopts this Rule pursuant to 18 V.S.A. §§ 9375(b), 9380, and 9382, and Act 62 (2025 adj. sess.) §§ 5 and 8.

5.102 Purpose

This Rule establishes standards and processes the Green Mountain Care Board (Board) will use to certify Accountable Care Organizations (ACOs) and review, modify, and approve the budgets of ACOs. This Rule also establishes mechanisms by which the Board will monitor and oversee the activities and performance of ACOs, including enforcement mechanisms by which the Board may limit, suspend, or revoke the certification of an ACO or require an ACO to take remedial action. The Board adopts this Rule to comply with its duties under 18 V.S.A. §§ 9375 and 9382; to provide sufficient oversight of ACOs operating in Vermont to comply with antitrust laws; and to ensure any ACO in Vermont is operating in a manner that is consistent with the requirements of 18 V.S.A. § 9551 and the health care reform principles of 18 V.S.A. § 9371.

This Rule is adopted pursuant to Act 62 (2025), which amended the Green Mountain Care Board's authority with respect to the regulation of accountable care organizations (ACOs). The prior statutory and regulatory framework governing ACO oversight was designed primarily to align with the requirements of the All-Payer ACO Model and did not contemplate the participation of multi-state ACOs contracting exclusively with Medicare in Vermont. In light of existing federal oversight of such entities, this Rule has been drafted to minimize unnecessary regulatory duplication. Rather than prescribing specific models for reform, the Rule seeks to strike an appropriate balance between safeguarding providers and patients and preserving the flexibility of providers to contract with ACOs at their discretion.

5.103 Definitions

For purposes of this Rule:

1. "Accountable Care Organization" and "ACO" mean an organization of ACO Participants that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it.
2. "ACO Participant" and "Participant" mean a Health Care Provider that has, through a formal, written document, agreed to participate in a Payer program with the ACO and collaborate on one or more ACO programs designed to improve Quality of Care and patient experience, and manage costs.
3. "ACO Provider" means an individual or entity that bills for services under the billing number of an ACO Participant.

4. “Applicant” means an ACO that has submitted an application to the Board for certification pursuant to section 5.301 of this Rule.
5. “At-Risk Enrollee” means an Enrollee identified (e.g., through a validated risk adjustment methodology or an analysis of utilization data) as having a significant burden of illness and being someone for whom considerable future health care expenditures are highly likely.
6. “Benchmark” means a Payer-specific financial target against which expenditures for Enrollees will be assessed. Payer-specific Shared Savings and Shared Losses for an ACO will be determined based on this assessment.
7. “Benefit Enhancement Waiver” means authority or approval granted by the Centers for Medicare & Medicaid Services (CMS) under federal law, including but not limited to Section 1115 and Section 1115A of the Social Security Act, or approval by a commercial insurer, self-funded employer health plan, or the Vermont Department of Financial Regulation, that permits the provision of services, benefits, or flexibilities not otherwise available under the standard Medicare, Medicaid, or commercial benefit design.
8. “Board” means the Green Mountain Care Board established in Title 18, chapter 220 of the Vermont Statutes Annotated, and any designee of the Board.
9. “Budget Benchmark” means indicators the Board may set in budget review to be used by ACOs in developing and preparing proposed budgets.
10. “Budget Year” means the twelve-month period beginning on January 1 and ending on December 31.
11. “CMS” means the Centers for Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services.
12. “Contracted Services” means the services for which an ACO is financially responsible, as defined by the terms of its contract with a Payer.
13. “DVHA” means the Department of Vermont Health Access, a department within the Vermont Agency of Human Services.
14. “Enrollee” means an individual covered by a Payer holding a contract with an ACO for whom the ACO has, based on a contractually-defined attribution methodology, assumed responsibility for managing cost and Quality of Care.
15. “Health Care Provider” and “Provider” mean a person, partnership, corporation, unincorporated association, or other legal entity, including a health care facility, that is licensed, certified, or otherwise authorized by law to provide Health Care Services in Vermont to an individual during that individual’s medical care, treatment, or confinement.

16. “Health Care Services” has the same meaning as “health service” in 18 V.S.A. § 9373.
17. “HIPAA” means the Health Insurance Portability and Accountability Act of 1996 and its associated rules and regulations, including the Standards for the Privacy of Individually Identifiable Health Information (“Privacy Rule”) and the Security Standards (“Security Rule”) at 45 C.F.R. Parts 160 and 164.
18. “NCQA” means the National Committee for Quality Assurance.
19. “Office of the Health Care Advocate” means the Office established by Title 18, chapter 229 of the Vermont Statutes Annotated.
20. “Operate in Vermont” means to contract with one or more Vermont providers and have more than 50 Vermont residents attributed through Vermont providers.
21. “Payer” means a third-party health care payer, including, to the extent permitted under federal law, any (a) publicly funded health care benefit plan; (b) health insurance company, health maintenance organization, or nonprofit hospital or medical service corporation; (c) employer or employee organization that offers a “group health plan” as defined by the federal Employee Retirement and Income Security Act; or (d) administrator for one of the above.
22. “Primary Care Provider” means a Provider who, within that Provider’s scope of practice, principally provides Primary Care Services.
23. “Primary Care Services” are Health Care Services furnished by Providers specifically trained for and skilled in first-contact and continuing care for persons with signs, symptoms, or health concerns, not limited by problem origin (biological, behavioral or social), organ system, or diagnosis. Primary Care Services include health promotion, disease prevention, health maintenance, counseling, patient education, self-management support, care planning, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.
24. “Quality Evaluation and Improvement Program” means a set of policies, procedures, and activities designed to improve the Quality of Care and the quality of the ACO’s services to Enrollees and Participants by assessing the Quality of Care or service against a set of established standards and taking action to improve it.
25. “Quality of Care” means the degree to which services for individuals and populations increase the likelihood of desired health outcomes, decrease the probability of undesired health outcomes, and are consistent with current professional knowledge or, where available, clinical best practices.
26. “Shared Loss” means the monetary amount owed to a Payer by an ACO as determined by comparing the ACO’s expenditures for Enrollees against the Benchmark for that Payer and accounting for the ACO’s performance against any

quality measures.

27. “Shared Savings” means the monetary amount owed to an ACO by a Payer as determined by comparing the ACO’s expenditures for Enrollees against the Benchmark for that Payer and accounting for the ACO’s performance against any quality measures.
28. “Vermont Commercial Insurer” means any entity that finances or administers private health benefit coverage for Vermont residents, whether through a fully insured health insurance product regulated by the Department of Financial Regulation or through a self-funded employer health benefit plan. The term does not include Medicare or Medicaid programs.
29. “Vermont Medicaid” means the program of medical assistance benefits established under Title XIX of the Social Security Act, as amended, including any demonstration waivers approved by the Centers for Medicare and Medicaid Services, and administered by the DVHA within the Agency of Human Services.

5.104 Applicability

- (a) This rule applies to ACO certifications that will take effect on or after January 1, 2027. For an ACO seeking certification that will take effect prior to January 1, 2027, the rule that was in effect as of January 1, 2026, shall continue to apply.
- (b) An ACO subject to this rule must be certified by the Board to operate in Vermont. All ACOs wishing to operate in Vermont are subject to the certification requirements, certification procedures, and monitoring and enforcement procedures outlined below. An ACO is subject to the Board’s budget review authority at Rule 5.400 if it contracts with Vermont Medicaid, a Vermont Commercial Insurer, or both, on behalf of attributed lives in Vermont. These ACOs are subject to additional certification requirements and procedures as identified throughout Rule 5.200 and Rule 5.300.

5.105 Filing

Unless otherwise specified in this Rule, all documents submitted to or filed with the Board under this Rule must be transmitted electronically, pursuant to Board instructions and processes, except where doing so would cause undue hardship to the person submitting or filing the document or where the document cannot readily be converted to electronic form. Each document submitted to or filed with the Board under this Rule must be copied to the Office of the Health Care Advocate.

5.106 Confidentiality

- (a) For purposes of this section, “materials” means written or recorded information, regardless of physical form or characteristics.
- (b) The Board will make all materials provided to it under this Rule that are not confidential available to persons upon request, consistent with the Vermont Public Records Act.

(c) If an ACO believes that materials provided to the Board under this Rule are exempt from public inspection and copying under Vermont's Public Records Act, the ACO must submit to the Board a written request that the Board treat certain materials as confidential. A request for confidential treatment must be included with the materials filed with the Board and include the following:

1. a cover letter that supports the claim and which includes references to the applicable provisions of 1 V.S.A. § 317(c) and other law;
2. one copy of the materials, marked as confidential, with highlighted text marking any portion that the ACO proposes to keep confidential; and
3. one copy of the materials, marked as redacted, with redactions applied to any portion that the ACO proposes to keep confidential.

(d) An ACO requesting confidential treatment bears the burden of establishing that the materials are exempt from public inspection and copying.

(e) The Board will issue a written decision on the request. The Board's decision to grant or deny a request for confidential treatment will be based on the Board's determination as to whether the information identified in the request meets the statutory requirements. The Board will send a copy of its decision to the ACO and the Office of the Health Care Advocate. Pending a final decision by the Board, the materials identified in the request will be treated as confidential and will not be made available for public inspection and copying.

(f) If the Board grants in full or in part a request for confidential treatment under this section, the Board will not make the confidential materials available for public inspection and copying and will omit references to the materials in the records of any public deliberations.

(g) Notwithstanding anything to the contrary in this section, the Board may disclose confidential and non-confidential materials submitted by a hospital to the Office of the Health Care Advocate or other state or federal agencies, departments, offices, boards, or commissions as required by law.

5.107 Time

In computing any time period established or allowed by this Rule or by order of the Board or its Chair, the day of the act or event from which the designated time period begins to run shall not be included, nor shall weekends or federal or state holidays be included in the calculation if the last day in the time period falls on such weekend or holiday.

5.200 ACO Certification Requirements

5.201 Legal Entity

(a) An ACO must be a legal entity that is identified by a unique Taxpayer Identification Number and authorized to conduct business in Vermont for purposes of complying with this Rule and performing ACO activities.

(b) An ACO formed by two or more ACO Participants, each of which is identified by a unique Taxpayer Identification Number, must be formed as a legal entity separate from any of its ACO Participants.

5.202 Governing Body

(a) An ACO must maintain an identifiable governing body that:

1. is the same as the governing body of the legal entity that is the ACO;
2. is separate and unique to the ACO and not the same as the governing body of any ACO Participant, except where the ACO is formed by a single ACO Participant;
3. has sole and exclusive authority to execute the functions of the ACO and to make final decisions on behalf of the ACO; and
4. has ultimate authority and responsibility for the oversight and strategic direction of the ACO and for holding management accountable for the ACO's activities.

(b) An ACO must have a governance structure that reasonably and equitably represents ACO Participants, including a governing body over which at least seventy-five percent (75%) control is held by ACO Participants or representatives of ACO Participants. An ACO's governing body must also include the following Enrollee members, whose positions may not be filled by the same person:

1. at least one Enrollee member who is a Medicare beneficiary if the ACO contracts with Medicare;
2. at least one Enrollee member who is a Vermont Medicaid beneficiary if the ACO contracts with Vermont Medicaid; and
3. for each Vermont Commercial Insurer the ACO contracts with that has a Vermont market share of greater than five percent (5%), at least one Enrollee member who is a beneficiary of that commercial insurer.

An ACO's governing body must have at least one Enrollee member, regardless of the number of Payers the ACO contracts with.

(c) For subdivision 2 and 3 above, an ACO must consult with local advocacy groups (e.g., the Office of the Health Care Advocate) and Provider organizations when recruiting Enrollee members of its governing body. An ACO must make a good faith attempt to recruit and select Enrollee members who are representative of the diversity of consumers served by the ACO, taking into account demographic and non-demographic factors, including gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services utilized. Each Enrollee member must have experience or training advocating for consumers on health care issues or be provided training on the subject. No Enrollee member may be an ACO Provider, an employee of an ACO Provider, or an owner of an ACO Provider. In addition, no Enrollee member may have an immediate family member who is an ACO Provider, an employee of an ACO Provider, or an owner

of an ACO Provider.

(d) An ACO must, on an ongoing basis, assist the Enrollee members of its governing body in understanding the processes, purposes, and structures of the ACO, as well as specific issues under consideration by the governing body.

(e) An ACO contracting with the Vermont Medicaid program must have a transparent governing process that includes:

1. posting the names of each governing body member on the ACO's website;
2. holding public meetings of the ACO's governing body in accordance with 18 V.S.A. § 9572(a), (b), and (e);
3. making the governing body's meeting schedule available to the public in accordance with 18 V.S.A. § 9572(c);
4. making recordings or minutes of governing body meetings available to the public in accordance with 18 V.S.A. § 9572(d);
5. providing a publicly accessible mechanism for explaining how the ACO works, including by posting on the ACO's website.

(f) An ACO must have a conflict of interest policy that applies to members of the ACO's governing body and that:

1. imposes on each member of the governing body a continuing duty to disclose relevant financial interests, including relevant financial interests of immediate family members;
2. provides a procedure to determine whether a conflict of interest exists, including a conflict of interest arising from the financial interests of an immediate family member, and sets forth a process to address any conflicts that arise; and
3. addresses remedial action for members of the governing body that fail to comply with the policy.

5.203 Leadership and Management

(a) An ACO must have a leadership and management structure that aligns with and supports the ACO's efforts to improve Quality of Care, improve population health, and reduce the rate of growth in health care expenditures.

(b) An ACO's operations must be managed by an executive officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to facilitate improvements in clinical practice that will lead to greater efficiencies and improved health outcomes.

(c) An ACO's clinical management and oversight activities must be managed by a

clinical director who is:

1. part of the ACO's senior management team; and
2. a board-certified physician actively licensed to practice medicine.

(d) An ACO must have a compliance plan that is updated periodically to reflect changes in applicable laws, regulations, and guidance, and that includes at least the following elements:

1. An independent compliance officer who:
 - A. is neither legal counsel to the ACO nor subordinate to legal counsel to the ACO;
 - B. reports directly to the ACO's governing body; and
 - C. is responsible for developing and implementing policies, procedures, and standards of conduct designed to ensure the ACO's compliance with all applicable laws, regulations, and guidance;
2. Mechanisms for identifying, investigating, and addressing compliance problems related to the ACO's operations and performance, including mechanisms for internal monitoring and auditing of compliance risks;
3. A method for anonymously reporting compliance concerns to the compliance officer;
4. Compliance training for the ACO, ACO Participants, and ACO Providers; and
5. For an ACO that contracts with Vermont Medicaid, a requirement to report probable violations of law to the Medicaid Fraud Unit of the Vermont Attorney General's Office and concurrently to any other appropriate governmental agency or official, and identification of the individual or individuals responsible for making such reports.

5.204 Solvency and Financial Stability

(a) An ACO must conduct ongoing assessments of its legal and financial vulnerabilities and have a process for reporting the results of these assessments to the ACO's governing body.

(b) An ACO must ensure that it maintains at all times an adequate level of financial stability and solvency.

5.205 Provider Network

(a) An ACO must execute written agreements with Participants who agree to adhere to the policies of the ACO. The written agreements between an ACO and its Participants must permit the ACO to take remedial actions to address Participants' noncompliance with the ACO's policies, procedures, and standards of conduct, as well as applicable laws and regulations.

(b) An ACO must have appropriate mechanisms and criteria for accepting Providers to be Participants. An ACO's Participant selection mechanisms and criteria may not

unreasonably discriminate against Providers by, for example, excluding Providers because they:

1. treat or specialize in treating At-Risk Enrollees;
2. provide a higher-than-average level of uncompensated care; or
3. treat a higher proportion of Medicaid or Medicare beneficiaries than the ACO prefers.

(c) Nothing in this section shall be construed to prohibit an ACO from declining to select a Provider to be a Participant, or from terminating or failing to renew the contract of a Participant, based on the Provider's failure to adhere to other legitimate selection criteria established by the ACO or the Participant's failure to conform to or comply with the ACO's established policies, procedures, or standards of conduct.

(d) An ACO contracting with Vermont Medicaid or a Vermont Commercial Insurer must establish an appeal process through which a Provider who is denied participation in the ACO, and a Participant whose contract has been terminated or not renewed by the ACO, may obtain a review of those decisions. The ACO's appeal process must require the ACO to give the Provider or Participant a written statement of the reasons for the ACO's decision. The ACO's appeal process must also include reasonable time limits for taking and resolving appeals and provide a reasonable opportunity for Providers and Participants to respond to the ACO's statement of the reasons supporting its decision. An ACO must communicate the requirements of its appeal process to Providers who have been denied participation in the ACO and Participants whose contracts have been terminated or not renewed by the ACO.

5.206 Quality Evaluation and Improvement

(a) An ACO must develop and implement a Quality Evaluation and Improvement Program that is actively supervised by the ACO's clinical director or designee and that includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution, and follow-up of potential and actual problems in health care administration and delivery, as well as opportunities for improvement.

(b) The ACO's Quality Evaluation and Improvement Program must regularly evaluate the care delivered to Enrollees against defined measures and standards regarding access to care, Quality of Care, Enrollee and caregiver/family experience, utilization, and cost, for the overall Enrollee population and for key subpopulations (e.g., medically or socially high-needs individuals or vulnerable populations). The ACO must, to the extent possible, align its quality standards and measures with those established by state and national entities.

(c) An ACO must utilize ACO- and Participant-level performance evaluations to provide feedback to Participants and to maintain or improve access to care and Quality of Care for Enrollees.

(d) An ACO must promote evidence-based medicine, for example by requiring Participants to observe applicable professional standards, facilitating the dissemination of guidelines or best practices to Participants, and organizing or supporting educational

programs for Participants. If requested by the Board, an ACO must describe for the Board its efforts to promote evidence-based medicine and provide the Board with any guidelines or best practices disseminated by the ACO. An ACO must also, upon the request of an Enrollee, provide the Enrollee with its guidelines or best practices, unless prohibited under federal law or regulation or contractual arrangement.

5.207 Patient Protections and Support

(a) An ACO may not interfere with Enrollees' freedom to select their own Health Care Providers, consistent with their health plan benefit, regardless of whether the Providers are ACO Participants. An ACO may not provide incentives to restrict access to Health Care Services solely on the basis of cost.

(b) An ACO may not reduce or limit the services covered by an Enrollee's health plan. An ACO may not offer an inducement to a Provider to forego providing medically necessary Health Care Services to an Enrollee or referring an Enrollee to such services.

(c) An ACO may not increase an Enrollee's cost sharing under the Enrollee's health plan.

(d) An ACO must ensure that no Enrollee or person acting on behalf of an Enrollee is billed, charged, or held liable for Contracted Services provided to the Enrollee which the ACO does not pay the Provider for, or for the ACO's debts or the debts of any subcontractor of the ACO in the event of the entity's insolvency. Nothing in this subsection shall prohibit a Provider from collecting coinsurance, deductibles, or copays, if specifically allowed by the Provider's agreement with a Payer.

(e) An ACO may not prohibit any individual or organization from, or penalize any individual or organization for, reporting any act or practice of the ACO that the individual or organization reasonably believes could jeopardize patient health or welfare, or for participating in any proceeding arising from such report. For the purpose of this subsection an individual or organization includes any Provider, Participant, or Enrollee.

(f) An ACO may not prohibit a Participant from, or penalize a Participant for:

1. providing information to Enrollees about their health or decisions regarding their health, including the treatment options available to them; or
2. advocating on behalf of an Enrollee, including within any utilization review, grievance, or appeal processes.

(g) An ACO contracting with Vermont Medicaid or a Vermont Commercial Insurer must maintain a consumer telephone line for receiving complaints and grievances from Enrollees. An ACO must post the number for this line on its public website together with contact information for the Office of the Health Care Advocate. If an ACO cannot resolve an Enrollee's complaint, it must provide the Enrollee with contact information for the Office of the Health Care Advocate and, if appropriate given the nature of the complaint, the appropriate Payer's member services line.

(h) In consultation with the Office of the Health Care Advocate, an ACO contracting with Vermont Medicaid or a Vermont Commercial Insurer must establish and maintain a

process that provides Enrollees with a reasonable opportunity for a full and fair review of complaints and grievances regarding the ACO's activities, including complaints and grievances regarding the quality of care or services received and, for those ACOs that reimburse Providers, the handling of or reimbursement for such services. The Enrollee complaint and grievance process must be culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by Enrollees. An ACO must respond to, and make best efforts to resolve, complaints and grievances in a timely manner, including by providing assistance to Enrollees in identifying appropriate rights under their health plan. An ACO must maintain accurate records of all grievances and complaints it receives, including, at a minimum:

1. the detailed reason for and nature of the grievance or complaint;
2. the date the grievance or complaint was received by the ACO;
3. the date the grievance or complaint was reviewed and the individual or individuals that reviewed the grievance or complaint;
4. the manner in which the grievance or complaint was resolved;
5. the date the grievance or complaint was resolved; and
6. copies of all communications between the ACO and the Enrollee or the Enrollee's representative regarding the grievance or complaint.

(i) An ACO must provide complaint and grievance information to the Board and to the Office of the Health Care Advocate at times and in a manner specified by the Board under section 5.401 of this Rule, but in no event less than twice per year. An ACO must ensure that such information is deidentified in accordance with 45 C.F.R. § 164.514.

(j) An ACO must provide new Enrollees with a written, plain language notice that they are attributed to the ACO. This requirement does not apply with respect to Enrollees attributed to an ACO under a Medicare ACO program or to Enrollees who will be notified by a Payer that they are attributed to the ACO.

5.208 Provider Payment

(a) If an ACO will be responsible for reimbursing Participants for delivering Health Care Services, the ACO, or any contractor performing this function on the ACO's behalf, must maintain the required functionality for, and demonstrated proficiency in, administering payments on behalf of Enrollees.

(b) An ACO contracting with Vermont Medicaid or a Vermont Commercial Insurer must establish and maintain an appeals process that provides Participants with a reasonable opportunity for a full and fair review of complaints regarding payments from the ACO, including reimbursements for delivering Health Care Services.

5.209 Health Information Technology

(a) Data Collection and Integration. Recognizing the critical role of information

technology to an ACO's effectiveness and also recognizing the burden associated with inputting and accessing data, an ACO must, to the best of its ability, with the health information infrastructure available, and with the explicit consent of Enrollees (unless otherwise permitted by law), use and/or support its Participants in using an electronic system that meets the requirements of a Certified Electronic Health Record Technology (CEHRT), which includes compliance with HIPAA.

(b) Data Analytics.

1. An ACO must apply health information technology to consolidate, standardize, and analyze the data collected from Participants.
2. An ACO must have in place information systems to measure care process improvements, quality improvements, and costs of care, including the ability to retrieve information about Participant performance.
3. The financial data systems of a risk-bearing ACO must be sufficient for assessing and managing financial risk and be integrated with clinical data systems.

5.210 Public Reporting and Transparency

(a) An ACO contracting with Vermont Medicaid, a Vermont commercial insurer, or both, must report on a publicly accessible website maintained by the ACO the following:

1. Organizational information, including:
 - A. the name and location of the ACO;
 - B. the primary contact information for the ACO;
 - C. the identity of each ACO Participant;
 - D. each joint venture between or among the ACO and any of its Participants; and
 - E. the identity of the ACO's key clinical and administrative leaders.
2. Information on Shared Savings and Shared Losses, broken down by line of business, including:
 - A. the amount of Shared Savings or Shared Losses for any performance year;
 - B. the proportion of savings distributed to ACO Participants and the bases for determining how the savings were distributed.
3. The ACO's performance on quality measures as specified by the Board.

5.300 Certification Procedures

5.301 Application for Certification

- (a) An ACO that wishes to operate in Vermont must submit an Application for Certification, in a format prescribed by the Board, by October 1 of the year preceding its planned operation in Vermont.
- (b) An ACO must include with its application a filing fee, paid to the Green Mountain Care Board, consistent with 18 V.S.A. § 9382(g)(1).
- (c) An ACO executive (e.g., chief executive officer or president) with authority to legally bind the ACO must sign the application on behalf of the ACO and verify under oath that the information contained in the application is accurate, complete, and truthful to the best of his or her knowledge, information, and belief.
- (d) An ACO must provide as part of its application:
1. the names and addresses of the Applicant's actual or expected Vermont Participants and a description of the services provided or expected to be provided by each and the Payer programs they will be participating in;
 2. any pretermination notice(s) received from CMS in the prior three budget years, including but not limited to a warning regarding noncompliance with program requirements, a request for a corrective action plan, or a notice of a special monitoring plan;
 3. evidence that the Applicant satisfies the requirements of 18 V.S.A. § 9382(a) and sections 5.201 – 5.210 of this Rule, examples of which may include:
 - A. copies of the bylaws, operating agreement, and other authoritative documents that regulate the internal affairs of the Applicant;
 - B. a list of the Applicant's governing body members that identifies which members are Enrollee members, which members represent Participants, and, for those members that represent Participants, which Participants they represent. This information may be submitted before November 1 if the ACO's governing body membership has not been finalized by the date of application.
 - C. a description of, or documents sufficient to describe, how the ACO identifies, nominates, and elects members to its governing body;
 - D. a copy of the conflict of interest policy that applies to members of the Applicant's governing body;
 - E. a description of, or documents sufficient to describe, the mechanisms the Applicant utilizes or will utilize to assess its legal and financial vulnerabilities and report the results of these assessments to the Applicant's governing body;
 - F. the Applicant's Participant selection criteria and a description of how these criteria relate to the needs of the Applicant's patient population;

- G. for an ACO contracting with Vermont Medicaid or a Vermont Commercial Insurer, a description of, or documents sufficient to describe, the Provider appeals processes required by sections 5.205(d) and 5.208(b) of this Rule;
 - H. illustrative copies of the Applicant's agreements with Participants;
 - I. written descriptions of, or documents sufficient to describe, the Applicant's:
 - i. population health management and care coordination program;
 - ii. use of benefit enhancement waivers;
 - iii. quality evaluation and improvement program, including the measures and standards the Applicant will utilize to measure the Quality of Care delivered to Enrollees;
 - iv. enrollee grievance and complaint process;
 - v. compliance plan;
 - vi. plans for aligning Participant payment and compensation and other mechanisms utilized to influence Participants' performance with the ACO's performance incentives and for distributing shared savings; and
 - vii. health information technology systems and how these systems are used by the Applicant, for example, to coordinate Enrollees' care and measure Participants' performance;
 - J. a certification that the ACO will comply with all applicable patient protections set forth in section 5.207 of this Rule;
 - K. any request for deeming under section 5.302 of this Rule;
 - L. any request for confidential treatment of application materials under section 5.106 of this Rule; and
 - M. any other documents or materials requested by the Board for the purpose of reviewing the application.
- (e) An application must conform to any guidance or bulletins issued by the Board regarding the certification requirements in sections 5.201 through 5.210 of this Rule.
- (f) Within thirty (30) days of receiving an application, the Board will review the application and notify the Applicant in writing whether the application is complete or additional information is needed. If the Board notifies an Applicant that it must submit additional information in connection with its application, the Board will specify the deadline for submitting the additional information. The Board's decision to request additional information or allow an Applicant to amend a deficient or incomplete

application is discretionary. It is the Applicant's burden to establish that it is eligible for certification.

5.302 Deeming

(a) The Board may, in its discretion, deem any requirement of 18 V.S.A. § 9382 or this Rule satisfied based on the determination of an accrediting entity (e.g., NCQA) or a state or federal agency (e.g., CMS) that the Applicant satisfies substantially equivalent standards.

(b) An Applicant must make a written request for deeming to the Board as part of its application. The ACO's request must:

1. specifically identify each of the requirements the Applicant wishes to be deemed;
2. specifically identify the standards of the accrediting entity or state or federal agency that the Applicant considers to be substantially equivalent to each requirement specified in subdivision 1 of this subsection;
3. identify the entity that determined the Applicant met the standards specified in subdivision 2 of this subsection and provide documentation of the determination; and
4. identify the date the entity made the determination specified in subdivision 3 of this subsection and describe any relevant changes that have occurred since the determination was made.

(c) An Applicant that makes a request under subsection (b) of this section must cooperate with the Board in obtaining any other information the Board may require in its consideration of the request. The Board may deny the request of an Applicant that fails to completely and timely supply any materials required by the Board in its consideration of the request.

5.303 Review of Applications; Decisions

(a) An Applicant bears the burden of establishing that its application should be granted.

(b) Failure by an Applicant to provide the Board with complete, accurate, and timely information during the Board's review process may result in rejection of an application.

(c) The Board must evaluate an application and, no later than December 31st of the year the application was submitted, either approve, provisionally approve with conditions, or deny the application based on the Board's determination of whether the Applicant satisfies the requirements of 18 V.S.A. § 9382 and this Rule. The review period may be extended with the consent of the Applicant or for good cause.

(d) If the Board approves or provisionally approves an application with conditions, the legal entity described in section 5.201 of this Rule will be eligible to receive payments from Medicaid or a commercial insurer as specified in the application and subject to 18 V.S.A. § 9382(b).

(e) An ACO may seek relief from any condition imposed as part of a provisional certification by filing a written request to the Board. Within sixty (60) days of receiving a request for relief from a condition, the Board will issue a written decision on the request. Failure of an ACO to conform to a condition within any timeframe established by the Board will result in a denial of the ACO's application.

(f) The following will be considered final actions or orders of the Board, which may be appealed under 18 V.S.A. § 9381:

1. the denial of an application for certification;
2. the provisional approval of an application for certification with conditions; and
3. the denial of a request for relief from a condition imposed by the Board as part of a provisional certification.

5.304 Application Record

(a) The Board must consider each application based on the materials included in the record, as designated and maintained by the Board. The record includes:

1. all materials submitted by the Applicant in connection with the application, including the application and any attachments thereto, as well as any other materials submitted by the Applicant at the Board's request;
2. all written communications between the Board and the Applicant relating to the application;
3. any other materials relied upon by the Board in rendering its decision on the application;
4. the Board's final, written decision on the application; and
5. all materials submitted subsequent to the Board's decision that relate to the application, including any implementation reports required in connection with a provisional certification.

(b) Materials included in the record are public records pursuant to 1 V.S.A. § 317.

5.305 Annual Eligibility Verifications

(a) An ACO must annually submit to the Board by September 1 an eligibility verification which:

1. verifies that the ACO continues to meet the requirements of the 18 V.S.A. § 9382 and this Rule;
2. describes in detail any material changes to the ACO's policies, procedures, programs, organizational structures, provider network, health information infrastructure, or other matters addressed in sections 5.201 through 5.210 of this Rule that the ACO has not already reported to the Board; and
3. includes with its eligibility verification a filing fee, paid to the Green Mountain

Care Board, consistent with 18 V.S.A. § 9382(g)(2).

(b) The eligibility verification must be signed by an ACO executive with authority to legally bind the ACO, who must verify under oath that the information contained therein is accurate, complete, and truthful to the best of his or her knowledge, information, and belief.

(c) Within thirty (30) days of receiving an eligibility verification, the Board will notify the ACO in writing if additional information is needed to review the ACO's continued eligibility for certification. An ACO's certification remains valid while the Board's review process is pending.

5.400 Review of ACO Budgets and Payer Programs

5.401 Uniform Formats for Data Filings

An ACO must use the methods, formats, charts, and forms set forth in the annual reporting manual and budget guidance to report its budget and program-related data and information to the Board. The Board shall provide the manual to ACOs by March 1 and budget guidance by July 1 of each year.

5.402 Establishing Budget Benchmarks

The Board may establish budget benchmarks for any indicators to be used by ACOs in developing and preparing their proposed budgets. The Board will meet with ACOs and the Office of the Health Care Advocate to obtain input prior to establishing budget benchmarks. The established budget benchmarks will be included in the annual reporting and budget review manual and will assist the Board in determining whether to approve or modify an ACO's proposed budget.

5.403 ACO Duties and Obligations

(a) On or before October 1 of each year, an ACO must file the information set forth in this section with the Board in a manner specified in the budget guidance. The Board may establish later deadlines for submitting certain information in the budget guidance. The ACO must submit:

1. documentation reflecting the ACO's use of Medicaid and commercial insurer funds to enhance and expedite Vermont's health care system transformation efforts, including but not limited to efforts to reform health care following the principles for health care reform, defined at 18 V.S.A. § 9371, and efforts to implement Vermont's Statewide Health Care Delivery Strategic Plan, once established, defined at 18 V.S.A. § 9403;
2. information on the ACO's efforts to prevent duplication of services being provided effectively and efficiently by existing community-based providers in the same geographic area;

3. the ACO's proposed budget for the next Budget Year, including detailed information on the ACO's expected expenditures, costs of operation, and revenues;
4. other financial information, which may include information on the ACO's reserves, assets, liabilities, fund balances, other income, short- and long-term investments, rates, charges, units of service, and administrative costs, including wage and salary data;
5. financial and quality performance results under Payer contracts;
6. the ACO's use of a consumer advisory board and other mechanisms for inviting and considering consumer input;
7. information regarding the ACO's Provider payment strategies and methodologies;
8. information regarding each contract the ACO plans to execute with a Payer covering any portion of the next Budget Year (e.g., information on attribution, the scope of Contracted Services, payment rates and mechanisms, quality measures, and risk arrangements);
9. any reports from professional review organizations or Payers;
10. information on the extent to which the ACO provides incentives for systemic health care investments to strengthen primary care, including strategies for recruiting additional primary care providers, providing resources to expand capacity in existing primary care practices, and reducing the administrative burden of reporting requirements for providers while balancing the need to have sufficient measures to evaluate adequately the quality of and access to care;
11. should the ACO wish to bear risk during the next Budget Year, a full risk mitigation plan describing how the ACO would cover the losses it could incur under the Risk Cap (e.g., through reserves, collateral, or other liquid security; risk transfers to ACO Participants; or reinsurance, withholds, or other risk management mechanisms);
12. each risk-bearing ACO that contracts with Vermont Medicaid or a Vermont Commercial Insurer must submit quarterly financial reports or statements to the Board in a form or format specified by the Board to enable the Board to monitor the ACO's financial stability and solvency; and
13. such other information as the Board may require.

5.404 Public Hearing

(a) The Board shall meet with the ACO to review and discuss the ACO's proposed budget and the elements of its Payer programs. The Board shall hold one or more public hearings concerning a proposed budget submitted by an ACO, except that the Board may decline to hold a hearing concerning a proposed budget submitted by an ACO that will not be assuming risk during the next Budget Year. At a public hearing convened by the Board concerning an ACO's

proposed budget, the Board may require ACO representatives to provide testimony and respond to questions raised by the Board or the public.

(b) The Office of the Health Care Advocate has the right to receive copies of all materials submitted by an ACO under section 5.403 of this Rule and shall protect such information in conformity with any confidentiality orders or other protections that the Board may require. The Office of the Health Care Advocate may:

1. ask questions of Board employees related to the Board's review of an ACO's proposed budget;
2. submit written questions to the Board that the Board will ask of the ACO in advance of any hearing held under subsection (a) of this section;
3. submit written comments for the Board's consideration; and
4. ask questions and provide testimony in any hearing held under subsection (a) of this section.

5.405 Review Process

(a) The ACO shall have the burden of justifying its proposed budget to the Board.

(b) In deciding whether to approve or modify the proposed budget of an ACO contracting with Vermont Medicaid, a Vermont Commercial Insurer, or both, the Board will take into consideration:

1. any budget benchmarks established under section 5.402 of this Rule;
2. the criteria listed in 18 V.S.A. § 9382(b); and
3. any other issues at the discretion of the Board.

5.406 Establishment of ACO Budgets; Decisions

The Board will issue a written decision establishing each ACO's budget for the Budget Year by December 31st of the year the budget was submitted. The decision of the Board is a final action or order, which may be appealed pursuant to 18 V.S.A. § 9381.

5.407 Budget Performance Review and Adjustment

(a) The Board may conduct an independent review of an ACO's performance under an established budget at any time. Such a review need not be limited to financial performance and may cover any matter approved by the Board as part of the ACO's budget. The Board may request, and an ACO must provide, information determined by the Board to be necessary to conduct the review. If, after conducting a review, the Board determines that an ACO's

performance has varied substantially from its budget, the Board shall provide written notice to the ACO. The notice shall set forth the results of the Board's review, as well as a description of the facts the Board considered.

(b) After determining that an ACO's performance has varied substantially from its budget, and upon application of the ACO, the Board may adjust the ACO's budget. In considering an adjustment of an ACO's budget, the Board will consider the financial condition of the ACO and any other factors it deems appropriate.

(c) The Board may take any and all actions within its power to compel compliance with an established budget.

5.500 Monitoring and Enforcement

5.501 Reporting and Recordkeeping Requirements

(a) An ACO must completely, timely, and accurately report to the Board all data and analyses specified by the Board regarding the activities of the ACO, ACO Participants, ACO Providers, and any other individuals or entities performing functions or services related to ACO activities. Subjects on which the Board may require an ACO to report include Quality of Care; access to care; cost; attribution; utilization; population health management and care coordination processes, capabilities, activities, and results; patient experience; complaints, grievances, and appeals; Provider payments and incentives; solvency; and financial performance. An ACO must, if necessary, require ACO Participants to cooperate in preparing and submitting any required reports to the Board.

(b) An ACO must, upon request, assist the Board in defining data elements, reporting formats, and other reporting requirements.

(c) In addition to the reports an ACO may be required to submit to the Board under subsection (a) of this section, an ACO must report the following to the Board within fifteen (15) days of their occurrence:

1. changes to the ACO's bylaws, operating agreement, or similar documents;
2. changes to the ACO's provider selection criteria;
3. changes to the ACO's Vermont provider network;
4. for ACOs contracting with Medicaid or commercial insurers, changes to the ACO's Enrollee grievance and complaint process;
5. any notice to or discussion within the ACO's governing body of the ACO's potential dissolution or bankruptcy, the potential termination of a Payer program, or a potential new Payer program; and
6. any pretermination notice(s) received from CMS including but not limited to a warning

regarding noncompliance with program requirements, a request for a corrective action plan, or a notice of a special monitoring plan.

(d) An ACO must maintain all records, including books, contracts, software systems, and other information, relating to:

1. information the ACO provides to the Board;
2. utilization and costs; and
3. quality performance measures, shared savings distributions, and other financial arrangements.

An ACO must maintain the records described in this subsection for a period of ten (10) years after the end of the calendar year to which the records relate or the completion of any audit, evaluation, inspection, or investigation, whichever is later. The Board may require an ACO to maintain records for a longer period by notifying the ACO prior to the end of the retention period.

(e) Upon request, an ACO must provide the records described in subsection (d) of this section to the Board and to the federal government, including CMS, the Department of Health and Human Services, the Department of Justice, the Government Accountability Office, and other federal agencies or their designees.

5.502 Monitoring

(a) The Board may use any and all powers granted to it by law to monitor an ACO's performance or operations or to investigate an ACO's compliance with the requirements of this Rule, other applicable laws or regulations, and decisions and orders of the Board. Such reviews may be performed at any time, including in response to:

1. a complaint or grievance from a patient or Health Care Provider or a pattern of such complaints or grievances, including information provided by the Office of the Health Care Advocate;
2. documents submitted by the ACO under section 5.501 of this Rule;
3. analyses of information in Vermont's all-payer claims database established in 18 V.S.A. § 9410; or
4. any other information that has come to the attention of the Board, including information from a Payer.

(b) The Board shall advise an ACO of the specific areas that will be reviewed and any statutory or regulatory provisions under examination.

(c) In monitoring an ACO's activities under this Rule, the Board may, in its discretion,

rely on any assessment conducted by or on behalf of CMS, DVHA, NCQA, or another entity. An ACO shall provide all such assessments to the Board within ten (10) days of receipt.

(d) If the Board has reason to suspect that an ACO, or any individual or entity working with or on behalf of an ACO, is engaging in anticompetitive behavior without the specific behavior creating a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs, the Board will provide written notice to the individual or entity of such concerns and may require the individual or entity to respond to the concerns in writing within a specified time period. After providing the individual or entity notice and an opportunity for a hearing, the Board may refer the matter to the Attorney General for appropriate action.

5.503 Remedial Actions; Corrective Action Plans

(a) If the Board determines that an ACO, its Participants, or its Providers are failing to meet any requirements of this Rule or an order or decision of the Board, 18 V.S.A. § 9382, or any other legal requirements that apply to the operations of the ACO, the Board may, in its discretion, take remedial action against the ACO, including placing the ACO on a monitoring or auditing plan or requiring the ACO to implement a corrective action plan.

(b) Before requiring an ACO to take remedial action, the Board will provide the ACO with a written explanation of the deficiency or deficiencies it has identified and any supporting data. Within thirty (30) days of receiving the Board's explanation and proposal, the ACO must submit a written response to the Board. If the Board's proposal for remedial action is that the ACO implement a corrective action plan, the ACO's written response must include a detailed description of the ACO's plan to correct the identified deficiencies, including the time in which the deficiencies will be corrected.

(c) Within five (5) days of receiving an ACO's written response, the Board will post the response on its website. Within thirty (30) days of receiving an ACO's written response, the Board may, in its discretion, hold a public hearing. The Board will accept public comments for ten (10) days after the ACO's written response has been posted or, if a hearing is held, for ten (10) days after the hearing has concluded.

(d) A decision of the Board requiring an ACO to take remedial action shall be considered a final action or order, which may be appealed under 18 V.S.A. § 9381.

5.504 Limitation, Suspension, and Revocation of Certification

(a) The Board may limit, suspend, or revoke the certification of an ACO after written notice and an opportunity for review or hearing. Bases for limiting, suspending, or revoking the certification of an ACO include:

1. failure to meet any requirement of 18 V.S.A. § 9382(a)(1);
2. harm to patients that is imminent, substantial, or both;

3. financial fraud or abuse;
4. fiscal insolvency or significant threat of fiscal insolvency of the ACO;
5. the imposition of sanctions or other actions against the ACO by an accrediting organization or a state, federal, or local government agency leading to an inability of the ACO to comply with the requirements of this Rule or other applicable law;
6. violations of the physician self-referral prohibition, civil monetary penalties law, anti-kickback laws, antitrust laws, or any other applicable federal or state laws, rules, or regulations, taking into account any waivers that may apply; and
7. failure to comply with the requirements a corrective action plan or other remedial actions required by the Board under section 5.504 of this Rule.

(b) Hearings under this section shall be conducted by the Board in accordance with 3 V.S.A. §§ 809, 809a, 809b, and 810. Decisions of the Board under this section shall comply with the requirements of 3 V.S.A. § 812 and may be appealed pursuant to 18 V.S.A. § 9381.

5.600 Other Matters

5.601 Waiver of Rules

In order to prevent unnecessary hardship or delay, in order to prevent injustice, or for other good cause, the Board may waive the application of any provision of this Rule upon such conditions as it may require, unless precluded by the Rule itself or by statute. Any waiver granted by the Board shall be issued in writing and shall specify the grounds upon which it is based.

5.602 Conflict

In the event this Rule or any section thereof conflicts with a Vermont statute or a federal statute, rule, or regulation, the Vermont statute or federal statute, rule, or regulation shall govern.

5.603 Severability

If any provision of this Rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remaining provisions of the Rule and the application of such provisions to other persons or circumstances shall not be affected thereby.

5.604 Effective Date

This Rule shall become effective July 1, 2026.