25-P042

FINAL PROPOSED RULE # _____.

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

GMCB Rule 5.000: Oversight of Accountable Care Organizations.

/s/ Owen Foster , on 1/26/2026
(signature) (date)

Printed Name and Title:
Owen Foster, GMCB Chair

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

1. TITLE OF RULE FILING:
   GMCB Rule 5.000: Oversight of Accountable Care Organizations.
2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   25P042
3. ADOPTING AGENCY:
   Green Mountain Care Board
4. PRIMARY CONTACT PERSON:
   (A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

   Name: Angela Pellegrino-Wood

   Agency: Green Mountain Care Board

   Mailing Address: 112 State St. 5th floor Montpelier, VT 05602

   Telephone: 802-461-5740 Fax:

   E-Mail: Angela.Pellegrino-Wood@vermont.gov

   Web URL *(WHERE THE RULE WILL BE POSTED)*:
   https://gmcboard.vermont.gov/aco-oversight
5. SECONDARY CONTACT PERSON:
   (A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

   Name: Mark Hengstler

   Agency: Green Mountain Care Board

   Mailing Address: 112 State St. 5th floor Montpelier, VT 05602

   Telephone: 8022490519 Fax:

   E-Mail: Mark.Hengstler@vermont.gov
6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
   (DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) No

   IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

   PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:
7. LEGAL AUTHORITY / ENABLING LEGISLATION:

(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

18 V.S.A. §§ 9375(b)(13), 9380, and 9382, and Act 62 §§ 5(a) (eff. Jan. 1, 2027), 5(b)-(g) (eff. Jan. 1, 2026), and 8 (eff. July 1, 2025).

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:

In 2016, the Green Mountain Care Board (GMCB) was given authority to develop rules and standards to regulate Accountable Care Organizations (ACOs). (Act 113 of 2016, §§ 6 and 8.) The GMCB then adopted Rule 5.000 to establish standards and processes to certify ACOs and review, modify, and approve ACO budgets. Act 62 of 2025 amends the GMCB's oversight of ACOs to account for the end of the Vermont All-Payer Model, the winding down of OneCare Vermont, and the entrance of more Medicare-only ACOs into the state. These amendments require revisions to GMCB Rule 5.000.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

This rule establishes revised standards and processes, consistent with Act 62 of 2025, that the GMCB will use to certify ACOs and review, modify, and approve the budgets of ACOs. First, as of January 1, 2026, the GMCB will no longer review the budgets of all ACOs operating in Vermont, as required by the current GMCB Rule 5.000. Instead, the GMCB will only review the budgets of ACOs that contract with Vermont Medicaid and/or Vermont

commercial payers. The GMCB will not review the budgets of ACOs that contract only with Medicare. Second, as of January 1, 2027, all ACOs operating in Vermont must be certified by the GMCB. This is a revision from the current GMCB Rule 5.000, which requires certification only for ACOs that contract with Vermont Medicaid and/or Vermont commercial payers. Third, this revised rule includes revisions to ACO certification and budget review criteria, consistent with Act 62 of 2025.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

Revision to Rule 5.000 is necessary because Act 62 of 2025 amends the GMCB's oversight authority over ACOs. Amendment to the GMCB's authority to review ACO budgets takes effect January 1, 2026. Amendment to the GMCB's authority to certify ACOs takes effect January 1, 2027.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

This revised rule sets out rational standards and processes by which the GMCB will certify ACOs and review ACO budgets. These revisions are consistent with the amendments made to the GMCB's oversight of ACOs under Act 62 of 2025.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

1. ACOs
2. Vermont health care providers
3. Vermont Medicaid and commercial payers
4. The Office of the Health Care Advocate
5. Vermont patients attributed to ACOs

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

This revised rule does not meaningfully alter the economic impact of the GMCB's oversight of ACOs. However, Act 62 of 2025 amended the manner by which ACOs make payments to the GMCB. Under prior law, ACOs paid a portion of the expenses of the GMCB under 18 V.S.A. § 9374(h)(1). Under Act 62, ACOs are instead subject to an initial certification fee of $10,000, an annual verification fee of $2,000, and, where applicable, an annual budget review fee $125,000. This revised rule does not meaningfully alter the economic

impact of GMCB oversight of ACOs to the other entities and people listed above.

19. A HEARING WAS HELD.

20. HEARING INFORMATION
(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 1/14/2026
Time: 10:30 AM
Street Address: 112 State St. 5th floor Montpelier, VT
Zip Code: 05602
URL for Virtual: https://gmcboard.vermont.gov/2026-meetings

Date:
Time: PM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: PM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: PM
Street Address:
Zip Code:
URL for Virtual:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
January 23

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

Accountable Care Organization (ACO)

Budget Review

Certification

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

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1. TITLE OF RULE FILING:
   GMCB Rule 5.000: Oversight of Accountable Care Organizations.
2. ADOPTING AGENCY:
   Green Mountain Care Board
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE .**

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):
   State Rule Log #17-060

Vermont Agency of Administration

Interagency Committee on Administrative Rules (ICAR) Minutes

Date/Time: December 8, 2025, 2:00 PM

Location: Virtually via Microsoft Teams

Members Present: Nick Kramer, Jared Adler, John Kessler, Natalie Weill, Michael Obuchowski, John Kessler, Jennifer Mojo

Members Absent: Diane Sherman, Nicole Dubuque

Minutes By: Chrissy Gilhuly

- 2:02 p.m. meeting called to order
- Review and approval of minutes from the November 17, 2025 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments were made.
- Presentation of Proposed Rules with recommended changes on pages to follow:

1). Vermont Department of Labor (VDOL) – Vermont Workers' Compensation and Occupational Disease Rule 1-27.
   a. These rules are for the purpose of carrying out the provisions of the Workers' Compensation Act and are consistent with the Act's processes and procedures.

2) Vermont Department of Labor (VDOL) – Unemployment Insurance Self-Employment Assistance Program
   a. The rule adds procedure for application of benefits through the Employment Assistance Program, as well as what criteria will be considered by the Commissioner in determining eligibility and whether to approve the program.

3) Agency of Natural Resources (ANR) – Vermont Use of Public Waters Rules
   a. These rules clarify the petition submission and review process and clarifies the procedures for municipal delegation under 10 V.S.A. § 1424 by authorizing full or partial delegation of State oversite, auditing, and revocation authority.

4) Green Mountain Care Board (GMCB) GMCB Rule 3.000: Hospital Budget Review
    a. This rule amends the existing rule to conform statutory amendments made by the passage of Act 29 (2025), Act 62 (2025), and Act 68 (2025), which set forth revised standards and processes by which hospital budgets are reviewed, established, and monitored by the GMCB.

- Other business – Advice for completing APA forms discussion moved to January 12, 2025, meeting.
- Next scheduled meeting is January 12, at 2:00 p.m.
- 3:28 p.m. meeting adjourned.

Proposed Rule: Vermont Department of Labor (VDOL) – Vermont Workers' Compensation and Occupational Disease Rule 1-27

Presented By: Dirk Anderson, Esq., Director of Worker's Compensation and Safety

Motion was made to accept the rule by Jennifer Mojo, seconded by Natalie Weill, and passed with one abstention from Jared Adler, with the following recommendations:

1) Proposed Filing – Coversheet:
    a. #11 – include same details that are provided in the Economic Impact portion of the filing.
    b. #8 – more descriptive, expand on the narrative/overview that was verbally presented to the committee.

Proposed Rule: Vermont Department of Labor (VDOL) – Unemployment Insurance Self-Employment Assistance Program Rule

Presented By: Robert Depper, General Counsel

Motion was made to accept the rule by John Kesslier, seconded by Jennifer Mojo, and passed with one abstention from Jared Adler, with the following recommendation:

1) Adopting Page:
    a. #4 – Add clarifying language that explains that the board rules are being amended with the addition of one rule.

Proposed Rule: Agency of Natural Resources (ANR), Department of Environmental Conservation (DEC) – Vermont Use of Public Waters Rules

Presented By: Laura Dlugolecki, Environmental Analyst/Policy and Outreach and Saige Culbertson, Attorney

Motion was made to accept the rules by John Kesslier, seconded by Jared Adler, and passed with one abstention from Jennifer Mojo.

Proposed Rule: Green Mountain Care Board (GMCB) - Rule 3.000: Hospital Budget Review Rule

Presented By: Mark Hengstler, Attorney

Motion was made to accept the rule by Jared Adler, seconded by John Kessler, and passed unanimously, with following change flagged by Mark Hegstler:

1) Proposed Filing Coversheet: Conformed signature will replace current signature.

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

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1. TITLE OF RULE FILING:

   GMCB Rule 5.000: Oversight of Accountable Care Organizations.

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   1. ACOs: This revised rule does not meaningfully alter current economic impact to ACOs. However, Act 62 of 2025 amended the manner by which ACOs make payments to the GMCB. Under prior law, ACOs paid a portion of the expenses of the GMCB under 18 V.S.A. § 9374(h)(1). Under Act 62, ACOs are instead subject to an initial

certification fee of $10,000, an annual verification fee of $2,000, and, where applicable, an annual budget review fee $125,000. This statutory amendment is not included in this revised rule because rulemaking is not necessary to implement this amendment.

2. Vermont health care providers: Currently, providers can contract with Medicare ACOs that do not need to be certified by the GMCB. These ACOs coordinate care with Vermont providers. Participation with these ACOs can lead to shared savings (or losses) based on performance benchmarks. Although not anticipated, certification of Medicare ACOs could potentially limit the total number of Medicare ACOs operating in Vermont. This could lead to less economic opportunity for Vermont providers. However, certification of Medicare ACOs ensures that all ACOs operating in Vermont meet certain quality, safety, and operational standards. These could have a positive economic impact on Vermont providers.

3. Vermont Medicaid and commercial payers: If Vermont Medicaid or commercial payers contract with future ACOs, these ACOs will be subject to both certification and budget review requirements. This is consistent with the current Rule 5.000.

4. The Office of the Health Care Advocate (HCA): The HCA participates in GMCB public hearings, including any hearings regarding ACO certification and budget review. These revisions to Rule 5.000 are not expected to have a substantial economic effect on the HCA.

5. Vermont patients: When an ACO contracts with a Vermont provider, certain patients of that provider get attributed to the ACO. These patients do not incur any costs for being attributed to the ACO. However, in some instances, ACOs provide certain in-kind benefits to attributed patients. Although not anticipated, if GMCB certification requirements reduce the number of ACOs that would otherwise operate in Vermont, this could limit the number of in-kind benefits to Vermont patients.

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact anticipated.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Not applicable.

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   It is not clear whether any of the ACOs currently operating in Vermont would qualify as a "small business" under 3 V.S.A. § 801(b). However, the GMCB attempted to revise the rule to accommodate a range of ACO models and sizes, as required by 18 V.S.A. § 9382. This revised rule also maintains parts of the original rule that were designed to reduce the cost and burden to ACOs. For example, the rule allows an ACO to ask the GMCB as part of the certification process to deem the ACO's compliance with the NCQA's ACO accredidation standards as compliance with eligibility requirements of the rule.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   An ACO can reduce the cost or burden of complying with this revised rule by submitting certification materials or budget review materials that are complete, accurate, and do not require additional follow-up by the GMCB. To assist ACOs, this rule details certification and budget review processes in as detailed a manner as possible. Separately, the GMCB issues annual guidance to ACOs to identify all necessary forms and reporting requirements.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING

SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
Economic Impact of Rule: This revised rule is designed, in part, to reduce the regulatory burdens to ACOs with the end of the Vermont All-Payer Model and the winding down of OneCare, the state's sole participating ACO in the All-Payer Model. By reducing the scope of oversight over ACOs, including the end to budget oversight for an ACO contracting only with Medicare, this rule attempts to simplify the requirements for operating in Vermont. This rule attempts to balance efficient certification processes with the amended statutory requirements at 18 V.S.A. § 9382(a).
Economic Impact of No Rule: The GMCB is required to adopt this rule to carry out its duties consistent with 18 V.S.A. § 9382, Act 113 of 2016, and Act 62 of 2025.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
The GMCB's economic impact analysis considered the requirements of 18 V.S.A. § 9382 and Act 62 of 2025. Prior to pre-filing this rule, the GMCB sent a draft proposed rule to stakeholders, posted the draft rule for a special public comment period, and held hearings to take public comment on the proposed rule. The GMCB received comments from ACOs and from the Office of the Health Care Advocate, which informed changes to this proposed rule as pre-filed here.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

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1. TITLE OF RULE FILING:

   GMCB Rule 5.000: Oversight of Accountable Care Organizations.

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact anticipated.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact anticipated.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact anticipated.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACTS RECREATION IN THE STATE:*
   No impact anticipated.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact anticipated.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact anticipated.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   The GMCB's environmental impact analysis was limited to review of Act 62 of 2025 and the proposed revision to GMCB Rule 5.000, which do not concern any regulatory standards or processes that have a reasonable nexus to the environmental factors listed above.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   GMCB Rule 5.000: Oversight of Accountable Care Organizations.

2. ADOPTING AGENCY:

   Green Mountain Care Board

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   In order to maximize public involvement in the development of the proposed rule, the GMCB posted the draft proposed rule to a public webpage with up-to-date information about the rule and public comment. The GMCB emailed this information to all ACOs operating in Vermont, ACOs that have expressed interest in operating in Vermont, provider groups, the HCA, CMS, the Governor's office, AHS, and the Blueprint for Health. The GMCB then held two public meetings with time for public comment on October 8 and October 22, with a special public comment period running through October 2025. GMCB board members voted publicly on the draft proposed rule, after taking opportunity for comment. The GMCB will email the entities identified above when the next opportunity for public comment becomes available.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

   No other organizations or people are involved in the development of this proposed rule.

VERMONT
GREEN MOUNTAIN CARE BOARD

112 State Street, 5th Floor
Montpelier, VT 05633-3601
802-828-2177

DELIVERED ELECTRONICALLY

January 26, 2026

Rep. Trevor Squirrell, Chair
Legislative Committee on Administrative Rules
Vermont State House
Montpelier, Vermont

Dear Representative Squirrell and Committee Members:

In 2017 the Green Mountain Care Board (GMCB) adopted its rule concerning oversight of Accountable Care Organizations (ACOs). On November 25, 2025, following the passage of Act 62 (2025), which modifies the GMCB's oversight responsibilities, the GMCB filed its proposed amendment to this rule with the Secretary of State. The GMCB held hearings and took public comment as it considered a draft proposal before filing the proposed amendment. After filing with the Secretary of State, the GMCB then held a public hearing to discuss the proposed amendment and discuss changes. The GMCB held a public comment period through January 23, 2026.

Please find a summary of public comments and GMCB responses, as well as clerical errors that have been corrected from the filed proposed rule.

Sincerely,

Mark Hengstler, Staff Attorney
Green Mountain Care Board

cc: Secretary of State

Public Comments and GMCB Responses:

Comment: The rule should continue to require ACOs to integrate their work with the Blueprint for Health to obtain and maintain certification and to demonstrate compliance with the GMCB's annual budget review criteria.

Response: These requirements, which currently exist in the GMCB's ACO oversight rule at Sections 5.000, §§ 5.206(b) and 5.403(a), arise from the obligation to integrate ACO efforts with the Blueprint for Health that existed before the passage of Act 62 (2025) at 18 V.S.A. §§ 9382(a)(2) and 9382(b)(1)(F). This Act streamlined and simplified ACO certification and budget review requirements following the end of the Vermont All-Payer Model and the winding down of OneCare Vermont to accommodate the increase of Medicare-only ACOs now operating in the state. Current Medicare-only ACOs operating in Vermont exist

within a range of federal models and sizes, operate in multiple states, and conduct most business outside of Vermont. As such, it would be inconsistent with the requirement at 18 V.S.A. § 9382(a)(1) to "ensure these rules anticipate and accommodate a range of ACO models and sizes" to require Blueprint for Health coordination to obtain certification. However, ACOs subject to budget review must show that they will not duplicate existing community-based services. *See* Final Proposed Rule 5.000, § 5.403(a)(2). The rationale is that with the passage of Act 62 budget review applies only to ACOs contracting with Vermont Medicaid or Vermont commercial insurers. 18 V.S.A. § 9382(b). The GMCB must adopt rules that establish standards for these ACOs, including that these ACOs efficiently use Medicaid or commercial funds and that they collaborate with a range of provider types. 18 V.S.A. §§ 9382(b)(2) and 9382(b)(4).

Comment: Deadlines for initial certification applications and annual eligibility verification forms should be changed from September 1 to November 1 to align with ACO participant deadlines imposed by the Centers for Medicare & Medicaid Services (CMS).

Response: This comment responded to a draft proposed rule that the GMCB sent to stakeholders before its November 2025 filing with the Secretary of State. The suggestion of a November 1 deadline is not possible considering the GMCB's regulatory calendar and the need to issue certification decisions by December 31. *See* Final Proposed Rule 5.000, § 5.303(c). However, to better align with CMS deadlines, the GMCB has adjusted the September 1 deadline to October 1, with the option for ACOs to submit participant information by November 1. *See* Final Proposed Rule 5.000, §§ 5.301(a), 5.301(d)(3)(B). This addresses the underlying concern raised by this comment.

Comment: In rare circumstances Medicare-only ACOs may have limited Vermont provider contracts with minimal Vermont residents assigned to the ACO. Will these ACOs be subject to certification requirements?

Response: It was not the GMCB's intent to require certification for ACOs with minimal Vermont contacts, as this would require unnecessary administrative burden for the GMCB and result in possibly prohibitory certification fees, which are set out at 18 V.S.A. § 9382(g). To address this issue the GMCB has added the definition "operate in Vermont" to its final proposed rule to include only ACOs that contract with Vermont providers and have more than 50 Vermont residents attributed through these Vermont providers. *See* Final Proposed Rule 5.000, § 5.103(20).

Comment: Commenter expressed concern that ACOs are not necessary.

Response: The GMCB does not have authority to unilaterally prohibit ACO operations in Vermont. The GMCB must certify ACOs and approve or modify ACO budgets consistent with 18 V.S.A. § 9382.

Corrections to Clerical Errors:

In addition to the changes made in response to public comments, the GMCB made the following clerical edits in this final proposed rule:

- 5.103: Fixed definition not placed in alphabetical order.
- 5.106: Removed affirmative statement that the GMCB will post ACO materials to its website. Although this is existing practice, the GMCB is exploring future use of an electronic portal for ACO submissions, which would not require affirmative posting.
- 5.301(d): Fixed errors to internal references.
- 5.301(e): Fixed error to internal reference.

- 5.303(d): Clarified that provisional ACO approval for payments from Medicaid or a commercial insurer is limited to ACOs that have applied for such payments.

VERMONT Blueprint for Health

MEMORANDUM

Date: Oct. 3, 2025

From: John M. Saroyan, Executive Director, Vermont Blueprint for Health

To: Michelle Sawyer, GMCB Health Policy Project Director, Green Mountain Care Board

RE: GMCB ACO Oversight and Blueprint

Rule 5.000, adopted in 2017, established standards and processes for certifying ACOs and annually reviewing, modifying, and approving ACO budgets. In response to Act 62, Green Mountain Care Board is rewriting Rule 5.000 to reflect the changes in how the board will regulate ACOs going forward.

The Blueprint feels strongly that it is important to continue requiring ACOs to align their work with Blueprint initiatives. Many ACO functions, such as care coordination, quality improvement, and quality payments overlap directly with the functions of the Blueprint. Without a requirement to coordinate, entities might offer differing incentives and activities, creating a fractured system that is duplicative, difficult to participate in for providers, and higher cost for patients. We propose the following language be included:

5.206
(a) Any ACO operating in Vermont shall work with the Blueprint for Health to align and integrate the ACO's population health management and care coordination activities with Blueprint for Health functions. To ensure that Vermonters receive equal standards of care, administrative burdens are minimized, duplication of services is prevented, and the financial sustainability of primary care providers is maintained, the ACO shall collaborate with the Blueprint on the following:

- Orienting to the Blueprint program and initiatives
- Reporting on practices participating in the ACO, practice attribution, and practices impacted by down-side risk arrangements
- Quality alignment and ACO reinforcement of PCMH requirements and Vermont Advanced PCP Criteria
- Establishing reasonable reporting requirements, and/or supporting investments in primary care practice EMR infrastructure to automate reporting
- ACO investment in Blueprint for Health Network infrastructure
- Data sharing and collaborative collection efforts with Blueprint for Health Network
- Participation in statewide standard of care discussion and development
- Investment in and coordination with Community Health Team and team-based care infrastructure

5.400
(13) 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, as well as the ACO's integration of efforts with the Blueprint for Health and Blueprint's regional care collaboratives;

VERMONT Blueprint for Health

Thank you for the opportunity to provide input.

John M. Saroyan M.D.

John M. Saroyan, MD
Executive Director, Blueprint for Health
Vermont Agency of Human Services

220 5th Avenue, 17th Floor
New York, NY 10001

Green Mountain Care Board
% Michelle Sawyer, GMCB Health Policy Project Director
144 State Street
Montpelier, VT 05602

October 7, 2025

Re: Comments on Proposed Rule 5.000 – Oversight of Accountable Care Organizations

Dear Ms. Sawyer and the members of the Green Mountain Care Board:

Pearl Health, Inc. ("Pearl") appreciates the opportunity to provide comment to the Green Mountain Care Board ("Board") on proposed Rule 5.000 governing the oversight of Accountable Care Organizations ("ACOs") in Vermont. Pearl participates in the Centers for Medicare and Medicaid ("CMS") Medicare Shared Savings Program ("MSSP") and the Realizing Equity, Access, and Community Health ("REACH") Model programs. Pearl will operate Medicare-only ACOs in Vermont during Performance Year 2026: one MSSP ACO and one REACH ACO.

Pearl is appreciative of the Board's efforts to establish a framework for Medicare-only ACOs operating in Vermont that minimizes regulatory duplication due the federal oversight of such entities. We respectfully submit the following comments for your consideration:

Extension of Timelines for Rule 5.301- Application for Certification and Rule 5.305- Annual Eligibility Certifications

Pearl respectfully requests that the Board amend the proposed deadline for both initial certification applications under Rule 5.301(a) and annual eligibility verifications under Rule 5.305(a) from September 1 to November 1.

The proposed September 1 deadline creates significant operational challenges for Medicare ACOs. While the CMS deadline to add participants in CMS ACO programs is in August, the CMS deadline to drop participants in these ACOs is after September 1st. Therefore, the list of participants in a Medicare-only ACO is finalized after September 1st.

The proposed Rule 5.301(d)(1) requires ACOs to provide in their application "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." The proposed Rule 3.505(a)(2) requires ACOs to detail in their annual eligibility verifications any material changes to the ACO's provider network.

As the names and addresses of Vermont Participants will not be finalized by September 1st, this timing mismatch would force Medicare-only ACOs to submit applications for certification based

on incomplete or speculative information. This timing also will not allow Medicare-only ACOs to complete their annual eligibility verification, as ACOs will not be able to determine whether there have been material changes to the ACO's provider network by September 1st. Providers may withdraw participation in the ACO until the CMS drop deadline that occurred later in September for PY 2026. Furthermore, contracting often occurs up until the CMS deadline, and an earlier due date for the Vermont Participant listing will require an ACO to list potential Vermont Participants who have yet to complete contracts with the ACO, resulting in the prospect of inaccuracy in the listings.

Furthermore, the proposed Rule 5.301(d)((3)(B) requires that the application for certification include "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." CMS requires new MSSP ACOs to finalize their governing board composition by the end of October. Therefore, requiring the application for certification to be submitted before the CMS deadline for MSSP governing body formation risks non-final information to be submitted on the application, and overall creates unnecessary administrative burden.

Due to the above considerations, Pearl recommends a November 1st deadline for the application for certification at Rule 5.301(a) and the annual eligibility verification at Rule 3.305(a).

A November 1 deadline for both submissions has the following benefits:

- Aligns with CMS deadlines, allowing ACOs to submit applications for certifications and annual eligibility certifications based on finalized provider networks for the upcoming performance year;
- Improves data accuracy, ensuring the Board receives complete and reliable information about ACO operations rather than preliminary estimates;
- Reduces administrative burden, eliminating the need for potential amendments; and
- Provides adequate lead time for the Board to review applications for certification and annual eligibility certifications before the start of the performance year on January 1.

We appreciate the Green Mountain Care Board's consideration of these comments. Pearl looks forward to working collaboratively with the Green Mountain Care Board for its Medicare-only ACO oversight in Vermont.

Respectfully submitted,

Gabriel Drapos

Gabriel Drapos
Chief Operating and Compliance Officer
Pearl Health, Inc.

Hengstler, Mark

From: Krzyzewski, Kristen <kristenk@ltcaco.com>
Sent: Thursday, December 4, 2025 5:09 PM
To: GMCB - ACO
Subject: Re: [EXTERNAL SENDER] RE: MSSP-pnly ACO in VT

Thanks for your response. I've included responses to your questions below in red font. I will also forward my prior correspondence with Michelle Sawyer from 2023, via separate email.
Thank you.
Kristen

On Thu, Dec 4, 2025 at 4:44 PM GMCB - ACO <GMCB.ACO@vermont.gov> wrote:

> Hi Kristen,
>
> Thank you for reaching out. I have a few follow-up questions/clarifications that will help me assist you with your request.
>
> - In the third sentence of your email , "We do NOT participate in Medicare or commercial value-based care contracts", do you mean Medicaid rather than Medicare? Thank you, yes. I meant to write Medicaid or commercial.
> - What year did you begin contracting with providers in Vermont? We've had a few providers in Vermont since the ACO's inception in 2016, but there was only 1 year that we had minor MSSP attribution in the state of 9 lives. I corresponded with Michelle Sawyer in 2023 about this.
> - What entities and/or providers are you contracting with in Vermont? Are these providers or entities contracting with LTC in bordering states as well? The providers are part of Genesis Eldercare Physician Services, LLC and AlignMed Partners, PC, which are affiliated organizations. Yes, most of their activity is in bordering states.
> - Can you help me understand the exclusion of lives you mentioned? Does this mean the providers are not included on the ACO participant list, or is there some other mechanism you're referring to? The group did not bill their VT patients through the TIN participating in our ACO as a result of the complicating circumstances in VT and the small number of lives involved.
>
> Thank you,
>
> Marisa

Marisa Melamed, MPH (she/her)

Health Systems Policy, Deputy Director

Green Mountain Care Board

112 State Street, 5th Floor

Montpelier, VT 05633-3601

p: 802-377-0194 | e: marisa.melamed@vermont.gov

http://gmcboard.vermont.gov/

From: Krzyzewski, Kristen <kristenk@ltcaco.com>
Sent: Wednesday, November 26, 2025 10:22 AM
To: GMCB - ACO <GMCB.ACO@vermont.gov>
Subject: MSSP-pnly ACO in VT

I have some questions about the requirements necessary for our Medicare Shared Savings Program ACO to operate in Vermont in 2026 and 2027.

Our ACO, LTC ACO, and our participating providers serve Medicare FFS beneficiaries residing in long-term care nursing facilities in 30 states across the country. We do NOT participate in Medicare or commercial value-based care contracts. Our participating providers currently see about 80 Medicare FFS beneficiaries residing in two nursing facilities located in Vermont, with 30-40 individuals expected to attribute to our ACO on an annual basis, but we've excluded these lives from our ACO historically since the small number of lives didn't justify the reporting and certification requirements in Vermont.

Based on our latest review of information on your website, it appears that MSSP-only ACOs do NOT need to be certified to do business in Vermont and no budget or other reporting is otherwise required. Is that a correct interpretation? If so, we plan to add the VT lives back to our MSSP ACO for 2026 and thereafter.

Thank you for your response and guidance on these questions.

Kristen

This e-mail and any attachments may contain information which is confidential, proprietary, privileged or otherwise protected by law. The information is solely intended for the named addressee (or a person responsible for delivering it to the addressee). If you are not the intended recipient of this message, you are not authorized to read, print, retain, copy or disseminate this message or any part of it. If you have received this e-mail in error, please notify the sender immediately by return e-mail and delete it from your computer.

Hengstler, Mark

From:	LaJeunesse, Kristen
Sent:	Wednesday, January 14, 2026 11:59 AM
To:	GMCB - ACO; Foster, Owen; Murman, David; Walsh, Thom; Holmes, Jessica A.; Sawyer, Michelle; LaJeunesse, Kristen; Teachout, Sara; Brown, Emily; Parker, Abigail
Subject:	Public Comment: Accountable Care Organization (ACO) 2026-01-14T16:59:21Z

A new GMCB Public Comment has been received.

Submit Time: 2026-01-14T16:59:21Z

Name: Walter Carpenter
Affiliation: Vermont Health Care for All
Town/City: Montpelier

Topic: Accountable Care Organization

Comment: In regards to the draft oversight rule (5.000), do we really need ACOs anymore, now that they've showed themselves to be spectacular failures and not accountable at all?

Post Comment: Yes

Annotated Text

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

5.504 Limitation, Suspension, and Revocation of Certification

5.600 Other Matters

5.601 Waiver of Rules
5.602 Conflict
5.603 Severability
5.604 Effective Date

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, ~~Act 113 (2015 adj. sess.), §§ 6 and 8(b)~~ 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 ~~all-payer, ACO-based payment reform model~~ACO in Vermont is ~~implemented~~ 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. ~~"Actuary" means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.~~

~~5. "Alternative Payment Methodologies" means methods of paying for Health Care Services that are alternatives to traditional fee for service reimbursement, such as Shared Savings and Shared Savings/Shared Loss arrangements, bundled payments, and global or partial Capitation Payment Arrangements.~~

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.

~~. "Blueprint for Health" means the State program established in Title 18, chapter 13 of the Vermont Statutes Annotated.~~

8.~~10~~. "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~~1~~. "Budget Year" means the twelve-month period beginning on January 1 and ending on December 31.

~~12. "Capitation Payment" and "Capitation Payment Arrangement" mean a contractually based payment or prepayment made to an ACO, or an arrangement for such a payment or prepayment to be made, on a per-member per-month or percentage-of-premium basis, in exchange for one or more Contracted Services to be rendered, referred, or otherwise arranged by the ACO.~~

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~~2~~ C.F.R. Parts 160 and 164.

18. "NCQA" means the National Committee for Quality Assurance.

19~~2~~. "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.

~~27. "Risk Cap" means the maximum amount of risk an ACO may assume during a given Budget Year.~~

~~28. "Risk Contract" means a contract between a Payer and an ACO under which the ACO is responsible for the full or partial expense, as defined by the contract, of treating or arranging for the treatment of a group of patients, if that expense exceeds an agreed-upon amount.~~

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 ~~Department of Vermont Health Access~~DVHA within the Agency of Human Services.

5.104 Applicability

Starting January 1, 2027, an~~An~~ ACO 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~~s~~ is subject to the Board's budget review authority at Rule 5.400 ~~that~~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. ~~contract with Vermont Medicaid and/or one or more Vermont-based commercial payers that wish to be certified by the Board are subject to all sections of this Rule. ACOs that do not contract with these payers but wish to be certified by the Board are subject to [enter something here]… all sections of this Rule except sections 5.201~~

~~5~~

~~5.210 (ACO Certification Requirements), sections 5.301 – 5.305 (Certification Procedures), and section 5.505 (Limitation, Suspension, and Revocation of Certification).~~

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 ~~and to those Payers to whom the submission or filing relates~~.

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 ~~or a Payer~~ 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 ~~or Payer~~ must submit to the Board a written request that the Board treat ~~the~~ certain materials as confidential. A request for confidential treatment must be included with the materials filed with the Board and include the following:~~specifically identify the materials claimed by the requestor to be exempt from public inspection and copying and must include~~

1. a~~a~~ cover letter ~~detailed explanation supporting~~that supports th~~e~~at claim and which ~~,~~ includ~~inges~~ references to the applicable provisions of 1 V.S.A. § 317(c) ~~and~~ and other law;~~. The request must be submitted no later than three (3) days after the~~at the same ~~time that~~ materials sought to be kept confidential are filed with the Board.~~

2. one copy of the materials, marked as confidential, with highlighted text marking any portion that the ACO proposes to keep confidential; and

~~1.~~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 ~~or Payer~~ requesting confidential treatment ~~of materials submitted to the Board under this Rule~~ bears the burden of establishing that the materials are exempt from public inspection and copying.

(e) ~~Within ten (10) days of receiving a complete and accurate request for confidential treatment, t~~The Board will issue a written decision on the request~~, except the Board may shorten or lengthen this period for good cause~~. 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 ~~pertaining to materials exempt from public inspection and copying under Vermont's Public Records Act~~. 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. ~~The Board may implement the provisions of this section by issuing a confidentiality order, executing a confidentiality agreement, or both.~~

(g) Notwithstanding anything to the contrary in this section, the Board may disclose confidential and non-confidential materials provided to it under this Rule to the Office of the Health Care Advocate, the State Auditor's Office, and other state or federal agencies, departments, offices, boards, or commissions, subject to any confidentiality order, confidentiality agreement, or other protections deemed appropriate by the Board.

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~~, registered with the Vermont Secretary of State,~~ 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~~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.

Notwithstanding subdivisions 1 through 3 above, an ACO's governing body must have at least ~~two~~ one Enrollee member~~s~~, regardless of the number of Payers the ACO contracts with.

(c) ~~An~~ 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) Members of an ACO's governing body must have a fiduciary duty to the ACO, including the duty of loyalty, and must act consistent with that fiduciary duty.~~

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

1. posting the names ~~and contact information~~ 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. ~~posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website; and~~
5. providing a publicly accessible mechanism for explaining how the ACO works, including by posting on the ACO's website.

~~(g) An ACO must have regularly scheduled processes for inviting and considering consumer input regarding ACO policy, including a consumer advisory board that meets at least quarterly. The membership of an ACO's consumer advisory board must be drawn from the communities served by the ACO, including Enrollees of each participating Payer and Enrollees' family~~

~~8~~

~~members and caregivers. An ACO must create, monitor, and publish on its website a general email address to which consumers and members of the public may submit suggested topics and concerns for the consumer advisory board. Members of an ACO's management team and governing body must regularly attend consumer advisory board meetings and report back to the ACO's governing body following each such meeting. The results of any other consumer input activities undertaken by an ACO (e.g., hosting public forums or soliciting public comments) must be reported to the ACO's governing body at least annually.~~

~~(h) At least once per year, an ACO must arrange for the members of its consumer advisory board to meet with representatives of the Office of the Health Care Advocate to discuss their experiences serving on the consumer advisory board and providing input to the ACO. The Office of the Health Care Advocate may report its findings from this meeting to the ACO.~~

(~~i~~) 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 ~~in the State of Vermont.~~;

~~3. an ACO Provider; and~~

~~4. physically present on a regular basis at any of the clinics, offices, or other locations participating in the ACO.~~

(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~~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. ~~In addition to any other reporting the Board may require of an ACO and any monitoring activities it may undertake under other sections of this Rule, 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.~~

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~~, including Primary Care Providers and specialists,~~ to be Participants. ~~The ACO's Participant selection criteria must relate to the needs of the ACO and the Enrollee population it serves, including access to care and Quality of Care.~~ 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 Population Health Management and Care Coordination**~~

~~(a) A primary function of an ACO is to improve Enrollees' Quality of Care by enhancing coordination and management of the services Enrollees receive. An ACO must collaborate with Payers, Participants, and non-Participant Providers, including community-based provider organizations (e.g., home health and hospice providers, mental health and substance use disorder providers, and disability and long-term care providers) and dental providers, as necessary to enhance coordination of services for Enrollees and reduce duplication of services already being provided effectively and efficiently.~~

~~(b~~a~~) An ACO must work closely with the Blueprint for Health to integrate the ACO's population health management and care coordination activities with the following Blueprint for Health functions~~

~~c) An ACO must develop policies and procedures regarding care coordination, including physical and mental health care coordination and coordination of care for Enrollees with a substance use disorder. An ACO must submit these policies and procedures to the Board and make them available to the public. An ACO must monitor and evaluate the effectiveness of its policies and procedures and develop and implement mechanisms to improve coordination and continuity of care based on such monitoring and evaluation. An ACO must encourage and~~

~~11~~

support Participants in using data for measuring and assessing care coordination activities and their effectiveness, to inform program management and improvement activities.

(d) An ACO must consult with and solicit feedback from its consumer advisory board regarding the ACO's care coordination goals, activities, and policies and procedures.

(e) Enrollees may already be receiving care coordination services from another entity or entities when they are attributed to an ACO. In order to maintain or improve Enrollees' access to care and Quality of Care during their transition to the ACO, an ACO must work with or support Participants in working with the Enrollee and the other entity or entities providing care coordination services to determine how the Enrollee should receive care coordination services across organizations.

(f) An ACO must coordinate or support Participants in coordinating Enrollees' care and care transitions (e.g., through the sharing of electronic summary records across providers and the use of telehealth, remote patient monitoring, care management software, electronic shared care planning, and other enabling technologies) across the continuum of care.

(g) An ACO must maintain and utilize or support Participants in maintaining and utilizing a data-driven, evidence-based method for evaluating the needs of the ACO's Enrollee population and individual Enrollees. As part of its population health strategy, an ACO must have a method of systematically identifying Enrollees who need or would benefit from care coordination services, the types of services they should receive, and the entity or entities that should provide those services. The identification process must include risk stratification and screening, and take into consideration factors such as social determinants of health, mental health and substance use disorders (within the limits of current data sharing requirements), high cost or high utilization, poorly controlled or complex conditions, or referrals by outside organizations. An ACO must develop or support Participants in developing descriptions of the various care management levels, and must design or support Participants in designing interventions, methods of communication, frequency of communications, and qualifications of staff for each care management level.

(h) Care Plan Development: An ACO must use or support Participants in using an evidence-based process to develop person-directed shared care plans for those Enrollees participating in complex case management. An ACO must:

1. engage or support Participants in engaging Enrollees and others chosen by the Enrollee in the development of the care plan;
2. use or support Participants in using data from multiple sources in the development of each Enrollee's care plan;
3. coordinate or support Participants in coordinating the services called for in the care plan, in consultation with any other care managers already assigned to an Enrollee by another entity;
4. develop or support Participants in developing a process for reviewing and updating care plans with Enrollees on an as-needed basis;
5. develop or support Participants in developing a protocol for re-evaluating Enrollees who have moved across care management levels; and

6. ensure that the ACO's clinical director or designee is available to consult with clinicians on an Enrollee's complex case management team as needed and with Payers' medical or clinical directors as appropriate.

(i) Enrollee Engagement and Shared Decision-Making: An ACO must apply or support Participants in applying Enrollee and caregiver engagement and shared decision-making processes that take into account Enrollees' unique needs, preferences, values, and priorities. Such processes must:

1. provide Enrollees access to their own medical records and to information on their diagnoses, treatments, and options for future treatment in ways that are understandable to them, so that they can make informed choices about their care;

2. use decision support tools and other methods that enable Enrollees to assess the merits of various treatment options and their relative risks and benefits in the context of their own values and convictions; and

3. act to foster health literacy in Enrollees and their families.

(j) Enrollee Self-Management: An ACO must assist Participants in supporting Enrollee self-management by:

1. offering Enrollees and their families plain language educational resources to assist them in the self-management of their health and disability, if applicable;

2. adopting procedures to help Enrollees and their caregivers understand and implement any self-management plans;

3. offering Enrollees and their families self-management tools that enable them to record self-care results; and

4. facilitating the connection of Enrollees and their families with self-management support programs and resources.

(k) Provision of Culturally and Linguistically Appropriate Services: An ACO must take steps to ensure that the services and activities described in this section are delivered or undertaken in a way that is responsive to Enrollees' diverse cultural health beliefs and practices, preferred language, health literacy, and other communication needs. An ACO must implement or support Participants in implementing strategies for engaging Enrollees with limited English proficiency in the activities and processes described in this section, for example, by offering them language assistance services at no cost, clearly informing them verbally and in writing of the availability of language assistance services in their preferred language, and providing easy-to-understand print materials and signage in the languages commonly used by populations in the service area.

(lb) Reporting Requirements: An ACO must provide the Board with information on its population health management and care coordination processes, capabilities, activities, and results, at times and in the manner specified by the Board.

5.2076 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-, ~~community~~ 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.

5.2078 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.

(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.

5.2089 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 must ensure that any Alternative Payment Methodologies implemented by the ACO with respect to Participants (e.g., capitation or fixed revenue budgets for hospitals) are coupled with mechanisms to improve performance or maintain a high level of performance on measures identified by the ACO and Participants and communicated to the Board, including measures of quality and access.~~

~~(c) Any performance incentives incorporated into the payment arrangements between a Payer and the ACO must be appropriately reflected in the mechanisms that the ACO utilizes to influence the performance of its Participants. The ACO must report to the Board as part of its application under section 5.301 of this Rule, and thereafter as part of the annual budget review process, the ACO's written plans for:~~

~~1. aligning Participant payment and compensation and other mechanisms utilized to influence Participants' performance with ACO performance incentives for cost and quality; and~~

~~2. distributing any earned shared savings.~~

(b~~d~~) 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.

5.2091~~0~~ 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 ~~Tehnology~~Technology (CEHRT) .

(b) Data Analytics.

1. An ACO must apply health information technology to consolidate, standardize, and analyze the data ~~described in subsection (a) of this section.~~collected from Participants.

~~2. An ACO must integrate data collected from multiple sources to make it~~

~~actionable, including for:~~

~~A. detecting practice or physician patterns (e.g., referrals, high costs, and variations from best practices);~~

~~B. predictive modeling and patient risk stratification;~~

~~C. identifying variations in care provided to Enrollees; and~~

~~D. understanding Enrollee population characteristics.~~

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 ~~individual Provider~~Participant ~~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~~1~~ 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~~Each~~ ACO that wishes to operate in Vermont ~~be certified~~ must submit an

~~complete application~~ Application for Certification~~to the Board~~, in a format~~on forms or in a format~~ prescribed by the Board, by ~~October~~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 ~~ACO~~ 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;

~~information on the ACO's structure, composition, ownership, governance, and management;~~
~~information on actions, investigations, or findings involving the ACO or its agents or employees;~~
~~information on the ACO's complaint, grievance, and appeal processes for Enrollees and Providers;~~
~~information regarding the ACO's models of care, including its population health initiatives and the benefit enhancements it offers;~~
~~any reports from professional review organizations or Payers;~~

3. ~~2.~~ 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. a certificate of good standing or certificate of status from the Vermont Secretary of State;~~

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;~~F. a description of the Applicant's consumer advisory board, its composition, and its relationship to the Applicant's governing body, as well as a description of any other methods utilized or to be utilized by the Applicant to obtain input from consumers;~~

~~G. materials documenting the Applicant's organization and leadership and management structure, which must include a list of members on the Applicant's executive leadership team and a description of their qualifications, an organizational chart, and descriptions of the purpose and composition of each of the Applicant's committees, advisory boards, councils, and similar groups;~~

~~H. materials documenting the Applicant's staffing, including a list of all staff members, a brief description of the functions performed by each staff member, and, for those staff members not employed by the ACO, a statement identifying who employs them;~~

~~I. a description of, or documents sufficient to describe, the qualifications and experience of the Applicant's management team, including the Applicant's clinical director;~~

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. ~~a~~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 5.2089(b~~d~~) 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~~ii~~. enrollee grievance and complaint process;

~~iv~~. 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 ~~the~~ all applicable patient protections set forth in section 5.207~~8~~ 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 ~~(e.g., NCQA accreditation standards or CMS requirements for participation in the Medicare Next Generation ACO program).~~.

(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 ~~than sixty (60) days after notifying the ACO that the application is complete~~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(~~a~~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~~, unless specifically exempted~~.

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;~~ and~~

2. ~~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

~~2.~~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 ~~review manual~~ 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 ~~Benchmarks~~Budget benchmarks

The Board may establish ~~benchmarks~~budget benchmarks for any indicators to be used by ACOs in developing and preparing their proposed budgets. The Board will meet with ACOs and ~~other interested persons~~the Office of the Health Care Advocate to obtain input prior to establishing ~~benchmarks~~budget benchmarks. The established ~~benchmarks~~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 ~~June~~ 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 ~~annual reporting and~~ budget ~~review manual~~guidance. The Board may establish later deadlines for submitting certain information in the ~~annual reporting and~~ budget ~~review manual~~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;

~~1. information on the ACO's structure, composition, ownership, governance, and management;~~

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~~2. the ACO's proposed budget for the next Budget Year, including detailed information on the ACO's expected expenditures, costs of operation, and revenues;~~,~~ ~~as well as a description of how the ACO proposes to distribute Medicare funding for the Blueprint for Health and the Support and Services at Home programs;~~

~~4~~3. other financial information, ~~such as~~which may include information on the ACO's reserves, assets, liabilities~~, fund~~, fund balances, other income, short- and long-term investments, rates, charges, units of service, and administrative costs, including wage and salary data;

54. financial and quality performance results under Payer contracts;

~~6~~5. the ACO's use of a consumer advisory board and other mechanisms for inviting and considering consumer input;

~~5. information on the ACO's consumer input activities, including its consumer advisory board, and any feedback provided by the Office of the Health Care Advocate as a result of its annual meeting with members of the ACO's consumer advisory board;~~

~~6. information on actions, investigations, or findings involving the ACO or its agents or employees;~~

~~7. information on the ACO's complaint, grievance, and appeal processes for Enrollees and Providers;~~

~~8. information on the ACO's anticipated network for the next Budget Year, including the identity of ACO Participants and ACO Providers and the Payer programs they will be participating in;~~

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);~~14. a projected three-year capital expenditure budget;~~

9. any reports from professional review organizations or Payers;

~~16. information on the ACO's efforts to prevent duplication of high-quality services being provided effectively and efficiently by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;~~

~~17~~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;

~~(5) the ACO's use of a consumer advisory board and other mechanisms for inviting and considering consumer input; and~~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

~~18. information on the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;~~

~~19. information on the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;~~

~~20. information on the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;~~

~~21. information on the ACO's efforts or plans to make its costs transparent and easy to understand for the public; and~~

13~~2~~. 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 is expected to have fewer than 10,000 attributed lives in Vermont during the next Budget Year or~~ 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 ~~projected to have 10,000 or more attributed lives in Vermont during the next Budget Year,~~ contracting with Vermont Medicaid, ~~and/or~~ a Vermont ~~-based~~ commercial ~~payer~~insurer, or both, the Board will take into
consideration:

1. any ~~benchmarks~~budget benchmarks established under section 5.402 of this Rule;
2. the criteria listed in 18 V.S.A. § 9382(b)~~(1)~~; and
~~3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and~~
~~4~~3. any other issues at the discretion of the Board.

~~(c) In deciding whether to approve or modify the proposed budget of an ACO projected to have fewer than 10,000 attributed lives in Vermont during the next Budget Year, the Board will take into consideration:~~
~~1. any benchmarks established under section 5.402 of this Rule;~~
~~25~~
~~2. those criteria listed in 18 V.S.A. § 9382(b)(1) that the Board deems appropriate to the ACO's size and scope;~~
~~3. the elements of the ACO's Payer-specific programs and any applicable requirements of 18 V.S.A. § 9551 or the Vermont All-Payer Accountable Care Organization Model Agreement between the State of Vermont and CMS; and~~
~~4. any other issues at the discretion of the Board.~~

5.406 Establishment of ACO Budgets; Decisions
~~On or before~~ Th~~December~~ ~~February~~ 1, the Board will issue a written decision establishing each ACO's budget for the ~~next~~ 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) An ACO must request and receive an adjustment to its budget under subsection (b) of this~~

~~section prior to executing a Risk Contract that would cause the ACO to exceed a Risk Cap established by the Board as part of the ACO's budget.~~
(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. ~~1.~~ changes to the ACO's bylaws, operating agreement, or similar documents;

2. ~~.~~ changes to the ACO's provider selection criteria;

~~2.~~3. changes to the ACO's Vermont provider network;

~~3.~~4. ~~e~~for ACOs contracting with Medicaid or commercial insurers, changes to the ACO's Enrollee grievance and complaint process; ~~and~~

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. calculations required under the All-Payer Accountable Care Organization (ACO) Model Agreement between the State of Vermont and CMS;~~

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 Public Reporting and Transparency**~~

~~(a) An ACO 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 (i.e., commercial, Medicaid, and Medicare), including:~~

~~A. the amount of Shared Savings or Shared Losses for any performance year;~~

~~B. the proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce costs for Enrollees; and~~

~~C. 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 specified by the Board.~~

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

~~1.~~2.harm to patients that is imminent, substantial, or both;

32. financial fraud or abuse;

34. fiscal insolvency or significant threat of fiscal insolvency of the ACO;

45. 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;

56. 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

67. 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.; and

7. failure to adhere to established quality measures.

(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 November 17, 2017July 1, 2026.

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

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

Starting January 1, 2027, an ACO 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 provided to it under this Rule to the Office of the Health Care Advocate, the State Auditor's Office, and other state or federal agencies, departments, offices, boards, or commissions, subject to any confidentiality order, confidentiality agreement, or other protections deemed appropriate by the Board.

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.

Notwithstanding subdivisions 1 through 3 above, 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.

(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).

(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.

The Vermont Statutes Online

The Statutes below include the actions of the 2025 session of the General Assembly.

NOTE: The Vermont Statutes Online is an unofficial copy of the Vermont Statutes Annotated that is provided as a convenience.

Title 18 : Health

Chapter 220 : Green Mountain Care Board

Subchapter 001 : GREEN MOUNTAIN CARE BOARD

(Cite as: 18 V.S.A. § 9375)

§ 9375. Duties

(a) The Board shall execute its duties consistent with the principles expressed in section 9371 of this title.

(b) The Board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs that may include the participation of Medicare and Medicaid, which may include the creation of health care professional cost-containment targets, reference-based pricing, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(i) The Board shall work in collaboration with providers to develop payment models that preserve access to care and quality in each community.

(ii) The rule shall take into consideration current Medicare designations and payment methodologies, including critical access hospitals, prospective payment system hospitals, graduate medical education payments, Medicare dependent hospitals, and federally qualified health centers.

(iii) The payment reform methodologies developed by the Board shall

encourage coordination and planning on a regional basis, taking into account existing local relationships between providers and human services organizations.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the Board's proposed methodologies to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of State government to engage in additional cost-containment activities to the extent permitted by State and federal law.

(2) [Repealed.]

(3) Review and approve the Health Care Workforce Development Strategic Plan created in chapter 222 of this title.

(4) Publish on its website the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources in accordance with section 9405 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time beginning with reference-based pricing as soon as practicable, but not later than hospital fiscal year 2027, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4026, taking into consideration the requirements in the underlying statutes; changes in health care delivery; changes in payment methods and amounts, including implementation of reference-based pricing; protecting insurer solvency; and other issues at the discretion of the Board.

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, including establishing standards for global hospital budgets that reflect the implementation of reference-based pricing and the total cost of care targets determined in collaboration with federal partners and other stakeholders or as set by the Statewide Health Care Delivery Plan developed pursuant to section 9403 of this title, once established. Beginning not later than hospital fiscal year 2028, to the extent that resources are available, the Board shall establish global hospital budgets for one or more Vermont hospitals that are not critical access hospitals. By hospital fiscal year 2030, to the extent that resources are available, the Board shall establish global hospital budgets for all Vermont hospitals.

(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title.

(9) Review and approve, with recommendations from the Commissioner of Vermont Health Access, the benefit package or packages for qualified health benefit plans and reflective health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1. The Board shall report to the House Committee on Health Care and the Senate Committee on Health and Welfare within 15 days following its approval of any substantive changes to the benefit packages.

(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

(C) in consultation with the Department of Health and the Director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(D) for cost-containment and limiting the growth in health care expenditures;

(E) for determining the adequacy of the supply and distribution of health care resources in this State;

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the Board.

(11) Develop the health care spending estimate pursuant to section 9383 of this title.

(12) [Repealed.]

(13) Adopt by rule pursuant to 3 V.S.A. chapter 25 such standards as the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter, including reporting requirements, patient protections, and solvency and ability to assume financial risk.

[Subdivision (b)(14) repealed effective January 16, 2026.]

(14)(A) Collect and review annualized data from ambulatory surgical centers licensed pursuant to chapter 49 of this title, which shall include net patient revenues and which may include data on an ambulatory surgical center's scope of services, volume, payer mix, and coordination with other aspects of the health care system. The Board's processes shall be appropriate to ambulatory surgical centers' scale, their role in Vermont's health care system, and their administrative capacity, and the Board shall

seek to minimize the administrative burden of data collection on ambulatory surgical centers. The Board shall also consider ways in which ambulatory surgical centers can be integrated into systemwide payment and delivery system reform.

(B) In its annual report pursuant to subsection (d) of this section, the Board shall describe its oversight of ambulatory surgical centers pursuant to subdivision (A) of this subdivision (14) for the most recently concluded 12-month period of the Board's review, including the amount of each ambulatory surgical center's net patient revenues and, using claims data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), information regarding high-volume outpatient surgeries and procedures performed in ambulatory surgical center and hospital settings in Vermont, any changes in utilization over time, and a comparison of the commercial insurance rates paid for the same surgeries and procedures performed in ambulatory surgical centers and in hospitals in Vermont.

(15) Collect and review data from each community mental health and developmental disability agency designated by the Commissioner of Mental Health or of Disabilities, Aging, and Independent Living pursuant to chapter 207 of this title, which may include data regarding a designated or specialized service agency's scope of services, volume, utilization, payer mix, quality, coordination with other aspects of the health care system, and financial condition, including solvency. The Board's processes shall be appropriate to the designated and specialized service agencies' scale and their role in Vermont's health care system, and the Board shall consider ways in which the designated and specialized service agencies can be integrated fully into systemwide payment and delivery system reform.

(c) The Board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the Agency of Human Services, and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the Agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the Agency of Human Services shall present a report on the benefit package proposal to the House Committee on Health Care and the Senate Committee on Health and Welfare. The report shall describe the covered services to be included in the Green Mountain Care benefit package and any cost-sharing requirements. If the General Assembly is not in session at the time that the Agency makes its recommendations, the Agency shall send its report electronically or by first-class mail to each member of the House Committee on Health Care and the Senate Committee on Health and Welfare.

(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the Governor a three-year Green Mountain Care budget pursuant to 32

V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

[Subsection (d) effective until July 1, 2026; see also subsection (d) effective July 1, 2026 set out below.]

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

(A) any changes to the payment rates for health care professionals pursuant to section 9376 of this title;

(B) any new developments with respect to health information technology;

(C) the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications;

(D) the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations;

(E) the process and outcome measures used in the evaluation;

(F) the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates and any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

(G) any recommendations for modifications to Vermont statutes; and

(H) any actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs.

(2) The report shall identify how the work of the Board comports with the principles expressed in section 9371 of this title.

[Subsection (d) effective July 1, 2026; see also subsection (d) effective until July 1, 2026 set out above.]

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

(A) any changes to the payment rates for health care professionals pursuant to

section 9376 of this title;

(B) any new developments with respect to health information technology;

(C) the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications;

(D) the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations;

(E) the process and outcome measures used in the evaluation;

(F) the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates and any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

(G) the status of its efforts to establish methodologies for and begin implementation of reference-based pricing and development of global hospital budgets, and the effects of these efforts and activities on increasing access to care, improving the quality of care, and reducing the cost of care in Vermont;

(H) any recommendations for modifications to Vermont statutes; and

(I) any actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs.

(2) The report shall identify how the work of the Board comports with the principles expressed in section 9371 of this title.

(e)(1) The Board shall summarize and synthesize the key findings and recommendations from reports prepared by and for the Board, including its expenditure analyses and focused studies. The Board shall develop, in consultation with the Office of the Health Care Advocate, a standard for creating plain language summaries that the public can easily use and understand.

(2) All reports and summaries prepared by the Board shall be available to the public and shall be posted on the Board's website. (Added 2011, No. 48, § 3, eff. May 26, 2011; amended 2011, No. 171 (Adj. Sess.), § 12, eff. May 16, 2012; 2013, No. 79, § 5 I, eff. Jan. 1, 2014; 2013, No. 79, § 41; 2015, No. 54, § 7, eff. June 5, 2015; 2015, No. 113 (Adj. Sess.), § 4, eff. Jan. 1, 2018; 2017, No. 88 (Adj. Sess.), § 1, eff. Feb. 20, 2018; 2017, No. 113 (Adj. Sess.), § 105; 2017, No. 154 (Adj. Sess.), § 3, eff. May 21, 2018; 2017, No. 167 (Adj. Sess.), §§ 1, 8, eff. May 22, 2018; 2017, No. 187 (Adj. Sess.), § 4, eff. May 28, 2018; 2019, No. 19, § 3, eff. Jan. 1, 2020; 2019, No. 53, § 2; 2019, No. 55, § 4, eff. June 10, 2019; 2019, No. 63, § 10 eff. June 17, 2019; 2019, No. 140 (Adj. Sess.), § 1, eff. July 6, 2020; 2021, No. 167 (Adj. Sess.), § 9, eff. June 1, 2022; 2025, No. 11, § 19, eff. September 1, 2025; 2025, No. 62, § 4, eff. July 1, 2025; 2025, No. 68, § 2, eff. June 12, 2025; 2025, No. 68, § 16, eff. July 1, 2026.)

The Vermont Statutes Online

The Statutes below include the actions of the 2025 session of the General Assembly.

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Title 18 : Health

Chapter 220 : Green Mountain Care Board

Subchapter 001 : GREEN MOUNTAIN CARE BOARD

(Cite as: 18 V.S.A. § 9380)

§ 9380. Rules

The Board may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the provisions of this chapter. (Added 2011, No. 48, § 3, eff. May 26, 2011.)

The Vermont Statutes Online

The Statutes below include the actions of the 2025 session of the General Assembly.

NOTE: The Vermont Statutes Online is an unofficial copy of the Vermont Statutes Annotated that is provided as a convenience.

Title 18 : Health

Chapter 220 : Green Mountain Care Board

Subchapter 001 : GREEN MOUNTAIN CARE BOARD

(Cite as: 18 V.S.A. § 9382)

§ 9382. Oversight of accountable care organizations

[Subsection (a) effective until January 1, 2027; see also subsection (a) effective January 1, 2027, set out below]

(a) 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 shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations. To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

(1) The ACO's governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input.

(2) The ACO has established appropriate mechanisms and care models to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO. The ACO ensures equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care.

(3) The ACO has established appropriate mechanisms to receive and distribute

payments to its participating health care providers in a fair and equitable manner. To the extent that the ACO has the authority and ability to establish provider reimbursement rates, the ACO shall minimize differentials in payment methodology and amounts among comparable participating providers across all practice settings, as long as doing so is not inconsistent with the ACO's overall payment reform objectives.

(4) The ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination and are related to the needs of the ACO and the patient population served.

(5) The ACO has established mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care, where feasible.

(6) The ACO's participating providers have the capacity for meaningful participation in health information exchanges.

(7) The ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers.

(8) The ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health.

(9) The ACO's participating health care providers engage their patients in shared decision making to inform them of their treatment options and the related risks and benefits of each.

(10) The ACO offers assistance to health care consumers, including:

(A) maintaining a consumer telephone line for complaints and grievances from attributed patients;

(B) responding and making best efforts to resolve complaints and grievances from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan;

(C) providing an accessible mechanism for explaining how ACOs work;

(D) providing contact information for the Office of the Health Care Advocate; and

(E) sharing deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually.

(11) The ACO collaborates with providers not included in its financial model, including home- and community-based providers and dental health providers.

(12) The ACO does not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the

ACO; does not reduce covered services; and does not increase patient cost sharing.

(13) The meetings of the ACO's governing body comply with the provisions of section 9572 of this title.

(14) The impact of the ACO's establishment and operation does not diminish access to any health care or community-based service or increase delays in access to care for the population and area it serves.

(15) The ACO has in place appropriate mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities.

(16) The ACO has in place a financial guarantee sufficient to cover its potential losses.

(17) The ACO provides connections and incentives to existing community services for preventing and addressing the impact of childhood adversity. The ACO collaborates on the development of quality-outcome measurements for use by primary care providers who work with children and families and fosters collaboration among care coordinators, community service providers, and families.

[Subsection (a) effective January 1, 2027; see also subsection (a) effective until January 1, 2027, set out above.]

(a)(1) In order to be eligible to operate in Vermont, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations. To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

(A) The ACO's mechanisms and care models, taken as a whole, support and do not hinder the State's principles for health care reform as set forth in section 9371 of this title.

(B) The ACO's financial incentives for providers and patients are reasonably calculated to improve, or at a minimum, maintain, the quality of, access to, and affordability of care.

(C) The ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers in a fair and equitable manner.

(D) The ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination.

(E) The ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers.

(F) The ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health.

(G) The ACO offers assistance to health care consumers, including:

(i) maintaining a consumer telephone line for questions, complaints, and grievances from attributed patients;

(ii) responding and making best efforts to resolve complaints and grievances from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan;

(iii) providing an accessible mechanism for explaining how ACOs work;

(iv) providing contact information for the Office of the Health Care Advocate; and

(v) sharing deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually.

(H) The ACO has in place a financial guarantee sufficient to cover its potential losses.

(2) Notwithstanding subdivision (1) of this subsection, the Green Mountain Care Board may adopt rules in accordance with 3 V.S.A. chapter 25 to establish a streamlined process for certification as a Medicare-only ACO for an entity authorized by the Centers for Medicare and Medicaid Services to act as an accountable care organization under the Medicare program. The streamlined process may require a Medicare-only ACO to meet one or more of the criteria set forth in subdivision (1) of this subsection. Certification obtained pursuant to the streamlined process shall apply to the Medicare-only ACO's actions only as they relate to Medicare beneficiaries and only to the extent that the federal authorization allows.

[Subsections (b)–(e) effective until January 1, 2026; see also subsections (b)–(g) effective January 1, 2026, set out below.]

(b)(1) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with 10,000 or more attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;

(B) the Health Resource Allocation Plan identifying Vermont's critical health

needs, goods, services, and resources as identified pursuant to section 9405 of this title;

(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;

(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;

(E) any reports from professional review organizations;

(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;

(G) 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;

(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;

(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;

(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;

(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;

(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(M) information on the ACO's administrative costs, as defined by the Board;

(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;

(O) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and

(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.

(2) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with fewer than 10,000 attributed lives in Vermont. In its review, the Board may consider as many of the factors described in subdivision (1) of this subsection as the Board deems appropriate to a specific ACO's size and scope.

(3)(A) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to any ACO budget review and may:

(i) ask questions of employees of the Green Mountain Care Board related to the Board's ACO budget review;

(ii) submit written questions to the Board that the Board will ask of the ACO in advance of any hearing held in conjunction with the Board's ACO review;

(iii) submit written comments for the Board's consideration; and

(iv) ask questions and provide testimony in any hearing held in conjunction with the Board's ACO budget review.

(B) The Office of the Health Care Advocate shall not disclose further any confidential or proprietary information provided to the Office pursuant to this subdivision (3).

(c) The Board's rules shall include requirements for submission of information and data by ACOs and their participating providers as needed to evaluate an ACO's success. They may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

(d) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public upon request, provided that individual patients or health care providers shall not be directly or indirectly identifiable.

(e) To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other

persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

[Subsections (b)–(g) effective January 1, 2026; see also subsections (b)–(e) effective until January 1, 2026, set out above.]

(b) The Green Mountain Care Board shall adopt rules in accordance with 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs that receive payments from Medicaid or commercial insurers, or both, on behalf of attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

(1) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(2) the efficacy with which the ACO uses funds from Medicaid and commercial insurers, as applicable, to enhance and expedite the State's health care system transformation efforts;

(3) the ACO's reasonable use of State and commercial insurance funds for its own administrative costs, as defined by the Board;

(4) the ACO's collaboration with a range of provider types, such as home- and community-based providers, dental health providers, and mental health and substance use disorder treatment providers;

(5) the ACO's use of a consumer advisory board and other mechanisms for inviting and considering consumer input; and

(6) public comment on all aspects of the ACO's costs, operations, and proposed budget.

(c)(1) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to any ACO certification or budget review and may:

(A) ask questions of employees of the Green Mountain Care Board related to the Board's ACO budget review;

(B) submit written questions to the Board that the Board will ask of the ACO in advance of any hearing held in conjunction with the Board's ACO review;

(C) submit written comments for the Board's consideration; and

(D) ask questions and provide testimony in any hearing held in conjunction with the Board's ACO budget review.

(2) The Office of the Health Care Advocate shall not disclose further any confidential or proprietary information provided to the Office pursuant to this subsection.

(d) The Board's rules shall include requirements for submission of information and data by ACOs and their participating providers as needed to evaluate an ACO's success. The rules may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

(e) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public in accordance with 1 V.S.A. chapter 5, subchapter 3 (Public Records Act), provided that individual patients or health care providers shall not be directly or indirectly identifiable.

(f) To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

(g) The Board shall collect the following amounts from an accountable care organization:

(1) $10,000.00 for initial certification in accordance with subsection (a) of this section;

(2) $2,000.00 annually following initial certification to maintain certification; and

(3) $125,000.00 for each review of the accountable care organization's budget in accordance with subsection (b) of this section. (Added 2015, No. 113 (Adj. Sess.), § 5, eff. Jan. 1, 2018; amended 2017, No. 59, § 1; 2017, No. 167 (Adj. Sess.), §§ 2, 13a, eff. May 22, 2018; 2017, No. 200 (Adj. Sess.), § 15; 2017, No. 204 (Adj. Sess.), § 7; 2019, No. 14, § 54, eff. April 30, 2019; 2019, No. 52, § 2a; 2025, No. 62, § 5.)

No. 62. An act relating to modifying the regulatory duties of the Green Mountain Care Board.

(S.63)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 18 V.S.A. § 9351 is amended to read:

§ 9351. HEALTH INFORMATION TECHNOLOGY PLAN

(a)(1) The Department of Vermont Health Access, in consultation with the Department's Health Information Exchange Steering Committee, shall be responsible for the overall coordination of Vermont's statewide Health Information Technology Plan. The Plan shall be revised annually and updated comprehensively every five years to provide a strategic vision for clinical health information technology.

(2) ~~The Department shall submit the proposed Plan to the Green Mountain Care Board annually on or before November 1. The Green Mountain Care Board shall approve, reject, or request modifications to the Plan within 45 days following its submission; if the Board has taken no action after 45 days, the Plan shall be deemed to have been approved.~~ [Repealed.]

(3)(A) The Department, in consultation with the Steering Committee, shall administer the Plan.

(B) The Plan shall include the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. The Plan shall provide for each patient's

electronic health information that is contained in the Vermont Health Information Exchange to be accessible to health care facilities, health care professionals, and public and private payers to the extent permitted under federal law unless the patient has affirmatively elected not to have the patient's electronic health information shared in that manner.

(C) The Plan shall include standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, access to advance care planning documents, and, overall, a more efficient and less costly means of delivering quality health care in Vermont.

(D) A representative of the Green Mountain Care Board shall be a voting member of the Steering Committee.

* * *

(c) The Department of Vermont Health Access, in consultation with the Steering Committee ~~and subject to Green Mountain Care Board approval~~, may propose updates to the Plan in addition to the annual updates as needed to reflect emerging technologies, the State's changing needs, and such other areas as the Department deems appropriate. The Department shall solicit recommendations from interested stakeholders in order to propose updates to the Health Information Technology Plan pursuant to subsection (a) of this section and to this subsection, including applicable standards, protocols, and pilot programs, and ~~following approval of the proposed updates by the Green~~

~~Mountain Care Board,~~ may enter into a contract or grant agreement with appropriate entities to update some or all of the Plan. ~~Upon approval of the updated Plan by the Green Mountain Care Board, the~~ The Department of Vermont Health Access shall distribute the updated Plan to the Secretary of Administration; the Secretary of Digital Services; the Commissioner of Financial Regulation; the Green Mountain Care Board; the Secretary of Human Services; the Commissioner of Health; the Commissioner of Mental Health; the Commissioner of Disabilities, Aging, and Independent Living; the Senate Committee on Health and Welfare; the House Committee on Health Care; affected parties; and interested stakeholders. Unless major modifications are required, the Department may present updated information about the Plan to the legislative committees of jurisdiction in lieu of creating a written report.

(d) The Health Information Technology Plan shall serve as the framework within which the Green Mountain Care Board reviews certificate of need applications for information technology under section 9440b of this title. In addition, the ~~Commissioner of Information and Innovation~~ Secretary of Digital Services shall use the Health Information Technology Plan as the basis for independent review of State information technology procurements.

* * *

Sec. 2. 18 V.S.A. § 9352 is amended to read:

§ 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

* * *

(c) Health information exchange operation.

(1) VITL shall be designated in the Health Information Technology Plan ~~approved by the Green Mountain Care Board pursuant to section 9351 of this title~~ to operate the exclusive statewide health information exchange network for this State. The Plan shall determine the manner in which Vermont's health information exchange network shall be managed. ~~The Green Mountain Care Board shall have the authority to approve VITL's budget pursuant to chapter 220 of this title.~~ Nothing in this chapter shall impede local community providers from the exchange of electronic medical data.

* * *

(e) Report. On or before January 15 of each year, VITL shall file a report with the Green Mountain Care Board; the Secretary of Administration; the Secretary of Digital Services; the Commissioner of Financial Regulation; the Commissioner of Vermont Health Access; the Secretary of Human Services; the Commissioner of Health; the Commissioner of Mental Health; the Commissioner of Disabilities, Aging, and Independent Living; the Senate Committee on Health and Welfare; and the House Committee on Health Care. The report shall include an assessment of progress in implementing health information technology in Vermont and recommendations for additional funding and legislation required. In addition, VITL shall publish minutes of VITL meetings and any other relevant information on a public website. The

provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subsection.

* * *

(i) Certification of meaningful use and connectivity.

(1) To the extent necessary to support Vermont's health care reform goals or as required by federal law, VITL shall be authorized to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont.

(2) VITL, in consultation with health care providers and health care facilities, shall establish criteria for creating or maintaining connectivity to the State's health information exchange network. ~~VITL shall provide the criteria annually on or before March 1 to the Green Mountain Care Board established pursuant to chapter 220 of this title.~~

* * *

Sec. 3. 18 V.S.A. § 9374(h) is amended to read:

(h)(1)(A) Except as otherwise provided in subdivisions (1)(C) and (2) of this subsection (h), the expenses of the Board shall be borne as follows:

(i) ~~40.0~~ 40 percent by the State from State monies;

(ii) ~~28.8~~ 36 percent by the hospitals; and

(iii) ~~23.2~~ 24 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125, health insurance

companies licensed under 8 V.S.A. chapter 101, and health maintenance organizations licensed under 8 V.S.A. chapter 139~~; and~~

~~(iv) 8.0 percent by accountable care organizations~~.

(B) Expenses under subdivision (A)(iii) of this subdivision (1) shall be allocated to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this subdivision (1) shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care, limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(C) ~~Expenses~~ Amounts assessed pursuant to the provisions of ~~section~~ sections 9382 and 9441 of this title shall not be assessed in accordance with the formula set forth in subdivision (A) of this subdivision (1).

(2) The Board may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subdivision (1) of this subsection if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

(3) If the amount of the proportional assessment to any entity calculated in accordance with the formula set forth in subdivision (1)(A) of this subsection would be less than $150.00, the Board shall assess the entity a minimum fee of $150.00. The Board shall apply the amounts collected based on the difference between each applicable entity's proportional assessment

amount and $150.00 to reduce the total amount assessed to the regulated entities pursuant to subdivisions ~~(1)(A)(ii) (iv)~~ (1)(A)(ii) and (iii) of this subsection.

* * *

Sec. 4. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

* * *

(b) The Board shall have the following duties:

* * *

(2)~~(A) Review and approve Vermont's statewide Health Information Technology Plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the State to achieve the principles expressed in section 9371 of this title.~~

~~(B) Review and approve the criteria required for health care providers and health care facilities to create or maintain connectivity to the State's health information exchange as set forth in section 9352 of this title. Within 90 days following this approval, the Board shall issue an order explaining its decision.~~

~~(C) Annually review and approve the budget, consistent with available funds, of the Vermont Information Technology Leaders, Inc. (VITL). This review shall take into account VITL's responsibilities pursuant to section~~

~~9352 of this title and the availability of funds needed to support those responsibilities.~~ [Repealed.]

* * *

(12) ~~Review data regarding mental health and substance abuse treatment reported to the Department of Financial Regulation pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the Mental Health Technical Advisory Group established pursuant to subdivision 9374(e)(2) of this title.~~ [Repealed.]

(13) Adopt by rule pursuant to 3 V.S.A. chapter 25 such standards as the Board deems necessary and appropriate to the operation and evaluation of accountable care organizations pursuant to this chapter, including reporting requirements, patient protections, and solvency and ability to assume financial risk.

* * *

Sec. 5. 18 V.S.A. § 9382 is amended to read:

§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(a)(1) 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~~ operate in Vermont, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations.

To the extent permitted under federal law, the Board shall ensure these rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In order to certify an ACO to operate in this State, the Board shall ensure that the following criteria are met:

~~(1)~~(A) The ACO's ~~governance, leadership, and management structure is transparent, reasonably and equitably represents the ACO's participating providers and its patients, and includes a consumer advisory board and other processes for inviting and considering consumer input.~~

~~(2) The ACO has established appropriate~~ mechanisms and care models ~~to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO. The ACO ensures equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care~~, taken as a whole, support and do not hinder the State's principles for health care reform as set forth in section 9371 of this title.

(B) The ACO's financial incentives for providers and patients are reasonably calculated to improve, or at a minimum, maintain, the quality of, access to, and affordability of care.

~~(3)~~(C) The ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers in a fair and equitable manner. ~~To the extent that the ACO has the authority and ability to establish provider reimbursement rates, the ACO shall minimize differentials in payment methodology and amounts among comparable participating providers across all practice settings, as long as doing so is not inconsistent with the ACO's overall payment reform objectives.~~

~~(4)~~(D) The ACO has established appropriate mechanisms and criteria for accepting health care providers to participate in the ACO that prevent unreasonable discrimination ~~and are related to the needs of the ACO and the patient population served~~.

~~(5) The ACO has established mechanisms and care models to promote evidence-based health care, patient engagement, coordination of care, use of electronic health records, and other enabling technologies to promote integrated, efficient, seamless, and effective health care services across the continuum of care, where feasible.~~

~~(6) The ACO's participating providers have the capacity for meaningful participation in health information exchanges.~~

~~(7)~~(E) The ACO has performance standards and measures to evaluate the quality and utilization of care delivered by its participating health care providers.

~~(8)~~(F) The ACO does not place any restrictions on the information its participating health care providers may provide to patients about their health or decisions regarding their health.

~~(9) The ACO's participating health care providers engage their patients in shared decision making to inform them of their treatment options and the related risks and benefits of each.~~

~~(10)~~(G) The ACO offers assistance to health care consumers, including:

~~(A)~~(i) maintaining a consumer telephone line for questions, complaints, and grievances from attributed patients;

~~(B)~~(ii) responding and making best efforts to resolve complaints and grievances from attributed patients, including providing assistance in identifying appropriate rights under a patient's health plan;

~~(C)~~(iii) providing an accessible mechanism for explaining how ACOs work;

~~(D)~~(iv) providing contact information for the Office of the Health Care Advocate; and

~~(E)~~(v) sharing deidentified complaint and grievance information with the Office of the Health Care Advocate at least twice annually.

~~(11) The ACO collaborates with providers not included in its financial model, including home- and community-based providers and dental health providers.~~

~~(12) The ACO does not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the ACO; does not reduce covered services; and does not increase patient cost sharing.~~

~~(13) The meetings of the ACO's governing body comply with the provisions of section 9572 of this title.~~

~~(14) The impact of the ACO's establishment and operation does not diminish access to any health care or community-based service or increase delays in access to care for the population and area it serves.~~

~~(15) The ACO has in place appropriate mechanisms to conduct ongoing assessments of its legal and financial vulnerabilities.~~

~~(16)~~(H) The ACO has in place a financial guarantee sufficient to cover its potential losses.

~~(17) The ACO provides connections and incentives to existing community services for preventing and addressing the impact of childhood adversity. The ACO collaborates on the development of quality-outcome measurements for use by primary care providers who work with children and families and fosters collaboration among care coordinators, community service providers, and families.~~

(2) Notwithstanding subdivision (1) of this subsection, the Green Mountain Care Board may adopt rules in accordance with 3 V.S.A. chapter 25 to establish a streamlined process for certification as a Medicare-only ACO for

an entity authorized by the Centers for Medicare and Medicaid Services to act as an accountable care organization under the Medicare program. The streamlined process may require a Medicare-only ACO to meet one or more of the criteria set forth in subdivision (1) of this subsection. Certification obtained pursuant to the streamlined process shall apply to the Medicare-only ACO's actions only as they relate to Medicare beneficiaries and only to the extent that the federal authorization allows.

(b)~~(1)~~ The Green Mountain Care Board shall adopt rules ~~pursuant to~~ in accordance with 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs ~~with 10,000 or more~~ that receive payments from Medicaid or commercial insurers, or both, on behalf of attributed lives in Vermont. To the extent permitted under federal law, the Board shall ensure the rules anticipate and accommodate a range of ACO models and sizes, balancing oversight with support for innovation. In its review, the Board shall review and consider:

~~(A) information regarding utilization of the health care services delivered by health care providers participating in the ACO and the effects of care models on appropriate utilization, including the provision of innovative services;~~

~~(B) the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources as identified pursuant to section 9405 of this title;~~

~~(C) the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review by payer;~~

~~(D) the character, competence, fiscal responsibility, and soundness of the ACO and its principals;~~

~~(E) any reports from professional review organizations;~~

~~(F) the ACO's efforts to prevent duplication of high-quality services being provided efficiently and effectively by existing community-based providers in the same geographic area, as well as its integration of efforts with the Blueprint for Health and its regional care collaboratives;~~

~~(G) 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;~~

~~(H) the extent to which the ACO provides incentives for systemic integration of community-based providers in its care model or investments to expand capacity in existing community-based providers, in order to promote seamless coordination of care across the care continuum;~~

~~(I) the extent to which the ACO provides incentives for systemic health care investments in social determinants of health, such as developing~~

~~support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers that are participating providers of an accountable care organization;~~

~~(J) the extent to which the ACO provides incentives for preventing and addressing the impacts of adverse childhood experiences (ACEs) and other traumas, such as developing quality outcome measures for use by primary care providers working with children and families, developing partnerships between nurses and families, providing opportunities for home visits, and including parent-child centers and designated agencies as participating providers in the ACO;~~

~~(K) public comment on all aspects of the ACO's costs and use and on the ACO's proposed budget;~~

~~(L) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;~~

~~(M) information on the ACO's administrative costs, as defined by the Board;~~

~~(N) the effect, if any, of Medicaid reimbursement rates on the rates for other payers;~~

~~(O) the extent to which the ACO makes its costs transparent and easy to understand so that patients are aware of the costs of the health care services they receive; and~~

~~(P) the extent to which the ACO provides resources to primary care practices to ensure that care coordination and community services, such as mental health and substance use disorder counseling that are provided by community health teams, are available to patients without imposing unreasonable burdens on primary care providers or on ACO member organizations.~~

~~(2) The Green Mountain Care Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for reviewing, modifying, and approving the budgets of ACOs with fewer than 10,000 attributed lives in Vermont. In its review, the Board may consider as many of the factors described in subdivision (1) of this subsection as the Board deems appropriate to a specific ACO's size and scope~~

(1) information gathered from meetings with the ACO to review and discuss its proposed budget for the forthcoming fiscal year;

(2) the efficacy with which the ACO uses funds from Medicaid and commercial insurers, as applicable, to enhance and expedite the State's health care system transformation efforts;

(3) the ACO's reasonable use of State and commercial insurance funds for its own administrative costs, as defined by the Board;

(4) the ACO's collaboration with a range of provider types, such as home- and community-based providers, dental health providers, and mental health and substance use disorder treatment providers;

(5) the ACO's use of a consumer advisory board and other mechanisms for inviting and considering consumer input; and

(6) public comment on all aspects of the ACO's costs, operations, and proposed budget.

~~(3)(A)~~(c)(1) The Office of the Health Care Advocate shall have the right to receive copies of all materials related to any ACO certification or budget review and may:

~~(i)~~(A) ask questions of employees of the Green Mountain Care Board related to the Board's ACO budget review;

~~(ii)~~(B) submit written questions to the Board that the Board will ask of the ACO in advance of any hearing held in conjunction with the Board's ACO review;

~~(iii)~~(C) submit written comments for the Board's consideration; and

~~(iv)~~(D) ask questions and provide testimony in any hearing held in conjunction with the Board's ACO budget review.

~~(B)~~(2) The Office of the Health Care Advocate shall not disclose further any confidential or proprietary information provided to the Office pursuant to this ~~subdivision (3)~~ subsection.

~~(c)~~(d) The Board's rules shall include requirements for submission of information and data by ACOs and their participating providers as needed to evaluate an ACO's success. ~~They~~ The rules may also establish standards as appropriate to promote an ACO's ability to participate in applicable federal programs for ACOs.

~~(d)~~(e) All information required to be filed by an ACO pursuant to this section or to rules adopted pursuant to this section shall be made available to the public ~~upon request~~ in accordance with 1 V.S.A. chapter 5, subchapter 3 (Public Records Act), provided that individual patients or health care providers shall not be directly or indirectly identifiable.

~~(e)~~(f) To the extent required to avoid federal antitrust violations, the Board shall supervise the participation of health care professionals, health care facilities, and other persons operating or participating in an accountable care organization. The Board shall ensure that its certification and oversight processes constitute sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Board determines, after notice and an opportunity to be heard, may be in violation of State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

(g) The Board shall collect the following amounts from an accountable care organization:

(1) $10,000.00 for initial certification in accordance with subsection (a) of this section;

(2) $2,000.00 annually following initial certification to maintain certification; and

(3) $125,000.00 for each review of the accountable care organization's budget in accordance with subsection (b) of this section.

Sec. 6. 18 V.S.A. § 9454 is amended to read:

§ 9454. HOSPITALS; DUTIES

* * *

(b)(1) ~~Hospitals~~ General hospitals, as defined in section 1902 of this title, shall adopt a fiscal year that shall begin on October 1.

(2) Psychiatric hospitals, as defined in section 1902 of this title but excluding those conducted, maintained, or operated by the State of Vermont, shall adopt a fiscal year that shall begin on January 1.

Sec. 7. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

(a) The Board shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter and in accordance with a schedule established by the Board. Notwithstanding any provision of 3 V.S.A. chapter 25 to the contrary, the Board's review,

establishment, and enforcement of hospital budgets under this section shall not be construed to be a contested case. Any person aggrieved by a final Board action, order, or determination under this section may appeal as set forth in section 9381 of this title.

* * *

(d)(1)(A) Annually, the Board shall establish a budget for each general hospital, as defined in section 1902 of this title, on or before September 15, followed by a written decision ~~by~~ on or before October 1.

(B) Annually, the Board shall establish a budget for each psychiatric hospital, as defined in section 1902 of this title but excluding those conducted, maintained, or operated by the State of Vermont, on or before December 15, followed by a written decision on or before December 31.

(C) Each hospital shall operate within the budget established under this section.

* * *

(h)(1) If a hospital violates a provision of this section, the Board may maintain an action in the Superior Court of the county in which the hospital is located to enjoin, restrain, or prevent such violation.

(2)(A) After notice and an opportunity for hearing, the Board may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of ~~no~~ not more than $40,000.00, or in the case of a continuing violation, a civil

administrative penalty of ~~no~~ not more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

(B)(i) The Board may order a hospital to:

* * *

(ii) Orders issued under this subdivision (2)(B) shall be issued after notice and an opportunity to be heard, except where the Board finds that a hospital's financial or other emergency circumstances pose an immediate threat of harm to the public or to the financial condition of the hospital. Where there is an immediate threat, the Board may issue orders under this subdivision (2)(B) without written or oral notice to the hospital. Where an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. The hearing shall be held within 30 days after receipt of the hospital's request for a hearing, and a decision shall be issued within 30 days after conclusion of the hearing. The Board may increase the time to hold the hearing or to render the decision for good cause shown. ~~Hospitals may appeal any decision in this subsection to Superior Court. Appeal shall be on the record as developed by the Board in the administrative proceeding and the standard of review shall be as provided in 8 V.S.A. § 16.~~

Sec. 8. 18 V.S.A. § 9572 is amended to read:

§ 9572. MEETINGS OF AN ACCOUNTABLE CARE ORGANIZATION'S GOVERNING BODY

(a) Application. This section shall apply to all regular, special, and emergency meetings of the governing board of an accountable care ~~organization's governing body~~ organization that contracts with the Vermont Medicaid program, whether the meeting is held in person or by electronic means, as well as to any other assemblage of members of the ACO's governing body at which binding action is taken on behalf of the ACO. For purposes of this section, the term "ACO's governing body" shall also include the governing body of any organization acting as a coordinating entity for two or more ACOs that contract with Vermont Medicaid.

* * *

Sec. 9. REPEAL

18 V.S.A. § 9573 (Medicaid advisory rate case) is repealed.

Sec. 10. EFFECTIVE DATES

(a) In Sec. 5, (18 V.S.A. § 9382), subsection (a) shall take effect on January 1, 2027 and subsections (b)–(g) shall take effect on January 1, 2026.

(b) Secs. 6 (18 V.S.A. § 9454) and 7 (18 V.S.A. § 9456) and this section shall take effect on passage.

(c) The remaining sections shall take effect on July 1, 2025.

Date Governor signed bill: June 12, 2025

VERMONT

Proposed Rules Postings
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Deadline For Public Comment

Deadline: Jan 21, 2026

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	25P042
Title:	Green Mountain Care Board: Rule 5.000: Oversight of Accountable Care Organizations.
Type:	Standard
Status:	Proposed
Agency:	Green Mountain Care Board
Legal Authority:	18 V.S.A. §§ 9375(b)(13), 9380, and 9382.
Summary:	This rule establishes revised standards and processes, consistent with Act 62 of 2025, that the Green Mountain Care Board (GMCB) will use to certify Accountable Care Organizations (ACOs) and review, modify, and approve the budgets of ACOs. First, as

	of January 1, 2026, the GMCB will no longer review the budgets of all ACOs operating in Vermont, as required by the current GMCB Rule 5.000. Instead, the GMCB will only review the budgets of ACOs that contract with Vermont Medicaid and/or Vermont commercial payers. The GMCB will not review the budgets of ACOs that contract only with Medicare. Second, as of January 1, 2027, all ACOs operating in Vermont must be certified by the GMCB. This is a revision from the current GMCB Rule 5.000, which requires certification only for ACOs that contract with Vermont Medicaid and/or Vermont commercial payers. Third, this revised rule includes revisions to ACO certification and budget review criteria, consistent with Act 62 of 2025.
Persons Affected:	Accountable Care Organizations (ACOs), Vermont health care providers, Vermont Medicaid and commercial payers, The Office of the Health Care Advocate, and Vermont patients attributed to ACOs.
Economic Impact:	This revised rule does not meaningfully alter the economic impact of the GMCB's oversight of ACOs. However, Act 62 of 2025 amended the manner by which ACOs make payments to the GMCB. Under prior law, ACOs paid a portion of the expenses of the GMCB under 18 V.S.A. § 9374(h)(1). Under Act 62, ACOs are instead subject to an initial certification fee of$10,000, an annual verification fee of $2,000, and, where applicable, an annual budget review fee $125,000. This revised rule does not meaningfully alter the economic impact of GMCB oversight of ACOs to the other entities and people listed above.
Posting date:	Dec 03,2025

Hearing Information

Information for Hearing # 1

Hearing date:	01-14-2026 1:00 PM ADD TO YOUR CALENDAR
Location:	Green Mountain Care Board
Address:	112 State Street, 5th Floor
City:	Montpelier
State:	VT
Zip:	05602
Hearing Notes:	Also virtually see: https://gmcboard.vermont.gov/2026-meetings

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

Level:	Primary
Name:	Angela Pellegrino-Wood
Agency:	Green Mountain Care Board
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Fax:	
Email:	Angela.Pellegrino-Wood@vermont.gov SEND A COMMENT
Website Address:	https://gmcboard.vermont.gov/aco-oversight VIEW WEBSITE

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON.

Level:	Secondary
Name:	Mark Hengstler
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Keyword Information

Keywords:

Accountable Care Organization (ACO)
Budget Review
Certification

Back

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	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
	News & Citizen (mike@stowereporter.com)	Tel: 888-2212 FAX: 888-2173
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	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter
	VT Digger (legals@vtdigger.org)	Attn: Legals

FROM: APA Coordinator, VSARA **Date of Fax:** January 27, 2026

RE: The "Proposed State Rules " ad copy to run on **December 11, 2025**

PAGES INCLUDING THIS COVER MEMO: **2**

NOTE **8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

Green Mountain Care Board: Rule 5.000: Oversight of Accountable Care Organizations.

Vermont Proposed Rule: 25P042

AGENCY:

CONCISE SUMMARY: This rule establishes revised standards and processes, consistent with Act 62 of 2025, that the Green Mountain Care Board (GMCB) will use to certify Accountable Care Organizations (ACOs) and review, modify, and approve the budgets of ACOs. First, as of January 1, 2026, the GMCB will no longer review the budgets of all ACOs operating in Vermont, as required by the current GMCB Rule 5.000. Instead, the GMCB will only review the budgets of ACOs that contract with Vermont Medicaid and/or Vermont commercial payers. The GMCB will not review the budgets of ACOs that contract only with Medicare. Second, as of January 1, 2027, all ACOs operating in Vermont must be certified by the GMCB. This is a revision from the current GMCB Rule 5.000, which requires certification only for ACOs that contract with Vermont Medicaid and/or Vermont commercial payers. Third, this revised rule includes revisions to ACO certification and budget review criteria, consistent with Act 62 of 2025.

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