§ 9382. OVERSIGHT OF ACCOUNTABLE CARE ORGANIZATIONS

(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;

(3) the ACO has established appropriate mechanisms to receive and distribute payments to its participating health care providers;

(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) meetings of the ACO's governing body include a public session at which all business that is not confidential or proprietary is conducted and members of the public are provided an opportunity to comment;

(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; and

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