Responsiveness Summary
Proposed Rule 17P-015, GMCB Rule 5.000: Oversight of Accountable Care Organizations

#	Comment	Recommended Language	Sec.	From	Amendment	Rationale
1	Section 5.208(g) requires ACOs to establish and maintain a process that provides Enrollees with a reasonable opportunity for a full and fair review of complaints and grievances. The section then describes that the processes must include hearing complaints related to quality of care or services and also "for those ACOs that reimburse Providers, the handling of or reimbursement for such services." As ACO models expand across the State and encompass a growing percent of reimbursement to providers, having access to a complaint and grievance process related to reimbursement is critical for Providers, not only Enrollees.	Amend section 5.208(g) as follows: "In consultation with The Office of the Health Care Advocate and Provider organizations, an ACO must establish and maintain a process that provides Enrollees and Providers with a reasonable opportunity for a full and fair review of complaints and grievances, 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." Alternatively, add parallel language re: Provider grievance procedures to section 5.209 (Provider Payment).	5.208 or 5.209	VMS	Add the following language in section 5.209 requiring an ACO to have an appeals process regarding payments to Participants: "(d) An ACO 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."	Participants should be able to contest the accuracy of payments from the ACO. The ACO should be able to develop an appeals process that meets the needs of its network.
2	VMS recognizes the importance to ACOs of being able to access and analyze quality and cost data. Some amount of that information must be entered by clinicians, and clinicians must also have access to meaningful data in order to improve patient care. On the other hand, the impact on physician practices of reporting on the quality and cost of care has been documented in many reports, including a recent American Medical Association-funded study by researchers at Dartmouth-Hitchcock. The report, "Allocation of Physician Time in Ambulatory Practice," found that for every hour physicians provide direct clinical face time to patients, nearly two additional hours is spent on EHR and desk work during the clinical work day. Outside office hours, physicians spend another one to two hours of personal time each night doing additional computer and other clerical work. The increased time physicians are having to devote to non-clinical issues has been recognized as a major factor in the epidemic of physician burnout. In addition, the administrative and financial impact of implementing EHRs	Amend section 5.210(a)(1) as follows: "To the best of its ability, with the health information infrastructure available, and with the explicit consent of Enrollees (unless otherwise permitted by law), an ACO must use and support its Participants in using an electronic system that: . . . minimizes the administrative burden on Participants and accessible to Participants of all sizes." (sic)	5.210	VMS	Amend section 5.210(a) as follows: "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 ~~To~~ the best of its ability, with the health information infrastructure available, and with the explicit consent of Enrollees (unless otherwise permitted by law), ~~an ACO must~~ use and support its Participants in using an electronic system that: . . . C. is accessible to Participants of all sizes; and . . ."	This section was not meant to focus on the needs of the ACO and Enrollees to the exclusion of providers. Providers should benefit from an ACO's analytics capabilities and from increased access to relevant, timely data on their patients. The issue of provider burden is also addressed in the statutory budget review criteria. *See* 18 V.S.A. § 9382(b)(1)(G) (ACO's incentives for investments to strengthen primary care, including strategies "for 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.") As requested, the potential amendment would require an ACO to use and support the use of a system that is accessible to Participants of all sizes.

	and complying with reporting requirements is anecdotally contributing to practice consolidation, an issue of concern to the Board, the Primary Care Advisory Group and the Legislature. Currently, Section 5.210, outlining the health information technology that "an ACO must use and support its Participants in using" only focuses on the type of data that must be collected and meeting the needs of Enrollees and patients.					
3	We believe it is important for the ACO agreement to be deemed confidential from the start rather than deciding on confidentiality at a later date. We would argue that the interested parties should have confidence and stability in the process by which they are creating the ACO and that it will be negotiated in a confidential manner, knowing the functions of the ACO will be fully vetted before going before the GMCB to be certified.	None provided.	5.106	Cigna	Amend section 5.106 to give Payers standing to request confidential treatment of materials submitted to the Board.	A document must fit within a Public Records Act exemption to be "deemed confidential." The rule sets out a process by which the Board will determine whether a document fits one of these exemptions. Amending the rule to allow a Payer to request confidential treatment of materials submitted to the Board will partially address Cigna's concern.
4	As it relates to Section 5.208 regarding Patient Protections and Support, subsections (a) and (e), we are unclear as to how a provider's recommendation fits with "interference" or does not. Cigna requires all its network providers, whether in a Collaborative Accountable Care (CAC) arrangement or not, to refer participants to other in-network providers except in the case of an emergency. This participation requirement under subsection (a) could be viewed as "interference". We would argue there is a very good reason for referring patients to other in-network providers as we want to protect the patient from potential out of network spending that may very well result in them receiving a surprise out of pocket expense from the out of network provider. Not allowing an ACO to educate people regarding their in-network options is a real disservice to the patient. We ask that the GMCB consider clarifying these subsections of the proposed rule to allow for the ability to educate patients regarding cost, quality of care, transparency and education around potential out of pocket costs.	None provided.	5.208	Cigna	None.	18 V.S.A. § 9382(a)(12) uses the term "interference" (GMCB must ensure as part of certification that "the ACO does not interfere with patients' choice of their own health care providers under their health plan . . ."), as does the APM Agreement ("State shall ensure that a Vermont ACO shall not interfere with a patient's choice of health care providers under the patient's health plan, regardless of whether a provider is participating in the ACO."). The rule prohibits interference with the freedom of choice that Enrollees have under their health plan.
5	In the data sharing section of the proposed rule, 5.401 Reporting to the Board, we read the language to require certified	None provided.	5.401	Cigna	Amend section 5.106 to give Payers standing to request confidential treatment of materials submitted to the Board.	The change should partially address Cigna's concern.

	ACOs, including other entities performing other functions related that ACO [sic] which would presumably be Cigna under its current CAC arrangement in Vermont, to provide the GMCB with certain data we believe to be proprietary to our CAC arrangements or otherwise protected (ex: PHI data). Should there be a public policy reason for us to share the data sought by the GMCB, we would hope the data would be kept confidential or other similar protections would be put in place that serves both the goals of the GMCB and those stakeholders apart of, or attached to certified ACOs.					
6	Improving population health outcomes is the third leg of the Triple Aim.	Amend subsection (a) as follows: "An ACO must have a leadership and management structure that aligns with and supports the ACO's mission of improving the Quality of Care for individuals and populations, and reducing the rate of growth in health care expenditures and improve population health outcomes."	5.203	VDH	Amend subsection (a) as follows: "An ACO must have a leadership and management structure that aligns with and supports the ACO's ~~mission of improving the~~ efforts to improve Quality of Care ~~for individuals and populations~~, improve population health, and ~~reducing~~ reduce the rate of growth in health care expenditures."	The amendment is a clarification.
7	"Substance use disorder" is the current terminology.	Replace the term "substance abuse" with "substance use disorder" in subsections (a) and (g) of section 5.206.	5.206	VDH	Change "substance abuse" to "substance use disorder" throughout.	The terminology should be current.
8	HHS's National Culturally and Linguistically Appropriate Services (CLAS) Standards are national standards for cultural competency and language assistance.	Amend the following sentence in section 5.206(a) regarding delivery of culturally competent care coordination services to say that these services should adhere to the CLAS standards: ". . . In order to support individuals and strengthen community support systems, an ACO's care coordination services must be culturally competent, accessible, and personalized to meet individuals' needs." Amend section 5.206(i)(1), which requires that the ACO initiate or support its Participants in engaging regarding engagement of Enrollees with limited English proficiency in the development of shared care plans to say the engagement should be done in accordance with CLAS standards.	5.206 and 5.208	VDH	Delete the last sentence of section 5.206(a) about culturally competent and accessible care coordination services. Delete the language in section 5.206(i)(1) about engaging Enrollees with limited English proficiency in the development of shared care plans. Amend section 5.206 by adding a new subsection to more globally address the issue of culturally and linguistically appropriate care coordination services: "(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	There are 15 CLAS standards, some of which do not directly relate to section 5.206. The amendment incorporates into section 5.206 those standards that are most relevant, namely the principal standard and standards regarding communication and language assistance. The amendment to section 5.208 incorporates CLAS standard 14 relating to a health care organization's conflict and grievance resolution process.

					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." Amend section 5.208(g) by adding the following sentence: "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."	
9	Require ACOs to develop policies and procedures regarding substance use disorder.	Amend the following sentence in section 5.206: "An ACO must develop policies and procedures regarding care coordination, including physical and mental health care coordination."	5.206	VDH	Amend section 5.206(c) to read: "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."	The amendment is a clarification.
10	None provided.	Add a new subsection (e) to section 5.207: "The Board encourages the ACOs to consider implementing evidence-based strategies found in the Clinical Guide to Preventive Services developed by the U.S. Prevention Services Task Force, or in the Guide to Community Preventive Services developed by the U.S. Department of Health and Human Services."	5.207	VDH	None.	The Board may ask an ACO about the degree of alignment between its clinical guidelines and the guidelines mentioned in the comment. However, mandating the use of these guidelines is outside the Board's expertise and it would not be enforceable to encourage their use.
11	Require that, as part of budget submission, the ACO have to report on progress on its quality evaluation and improvement program.	Amend section 5.503(a)(9) as follows: "progress on its Quality Evaluation and Improvement program, including information regarding the ACO's models of care, including its population health initiatives and the benefit enhancements it offers;"	5.503	VDH	Add a new subdivision to the section, as follows: "information on the progress made by the ACO through its Quality Evaluation and Improvement Program;"	It would be appropriate to get this information annually in the budget review process.
12	Concerned about how GMCB will ensure that the benefits of ACOs outweigh costs, specifically the new administrative costs to the system that come with ACOs. Duplication of administrative costs.	None provided.	5.400	Chris Veal	None.	The Board will be receiving information on an ACO's performance (both on cost and quality) and on an ACO's administrative costs. The Board will be scrutinizing the reasonableness of an ACO's administrative expense as part of the budget review process.

13	In my opinion, the proposed rule contains a glaring omission in that a person can be enrolled without their knowledge or consent. I think the rule should require that each Enrollee be notified at least annually that his or her health care coverage is being overseen by a company that is neither the insurance carrier nor the provider. This is a key difference between the old managed care of the 1990s and the ACOs of today. Under the old managed care HMOs, an Enrollee made an affirmative choice or was signed up with a plan through their employer. But they went in with their eyes wide open knowing that an insurance company would be regulating, to a certain extent, the type of care they would receive. There is no such transparency with ACOs as far as I can tell. And why is this important? Well, as an example, two physicians affiliated with OneCare testified to a group of legislators yesterday, and here I refer to a VT Digger article in which Dr. Jim Ulager, a Vice President at UVM Medical Center, is said to have and I quote Digger "used the example of a patient coming in with a bad cough and the Dr. who suspects the patient might have pneumonia. Ulager said insurance companies will pay him more to prescribe an antibiotic and issue a test for pneumonia when the best thing for the patient may to have a conversation about how the patient can take care of herself. Now number 1, I pity the poor pneumonia patient who ends up seeing Dr. Ulager and who goes home trying to treat herself with cough drops and ibuprofen, especially if it's an elderly person. We all know that pneumonia can be a killer. But number 2, if it's the ACO that's dictating to that Dr., causing that Dr. to avoid treating that pneumonia the way it's supposed to be treated, then I as the patient want to know which ACO I'm enrolled in so that I can file a complaint. But there's more. Dr. Mark Depman, Medical Director at CVMC in Berlin testified yesterday and I'm again quoting Vermont Digger, "a young woman who was pregnant and came in with stomach pain. He said that while it would be easy to refer her to an obstetrician and gynecologist, the woman's real	None provided.	5.208	Ethan Parke	Amend section 5.208 by adding a new subsection (i), as follows: "(i) An ACO must notify new Enrollees that they are attributed to the ACO or require the ACO's Participants to provide notification to their patients at the point of care that the Participant is participating in the ACO. This requirement does not apply if Enrollees will be notified by a Payer that they are attributed to the ACO."	Different payers deal with this issue differently. For example, Medicare requires that notice be provided but has requirements that differ by program. The Board understands that nationally, most commercial insurers do not provide notice or require an ACO to provide notice. The amendment establishes a default rule of notice but allows some flexibility to account for different payer requirements that currently exist.

	problem was substance abuse. And quoting Dr. Depman directly from the Vermont Digger article, "She's really there because her drug addiction is treating her baby. I need to get her right now back to AA to talk to someone about her substance abuse." So lets recap. She's pregnant. She presents with abdominal pain. She's worried, rightfully, about her baby. It would be easy to get her prenatal care. In fact, CVMC has obstetricians and other providers right down the hall. But she's not going to get that referral because she's also a substance abuser. I find this astounding. I think every pregnant woman regardless of who they are or what other problems they might have should have uninhibited to prenatal care. The Dr. said her real problem is substance abuse. I think her real problem is the totality of her situation and I know many pregnant women go to their obstetrician and their obstetrician becomes their primary care provider throughout the term of their pregnancy and coordinates all of the needs of that patient. And I think that's what should have happened in this hypothetical case. I think the ACO's real problem is that in some cases they put lifestyle counseling in front of immediate clinical concerns. For instance is an obese person with hypertension going to be denied antihypertensive medicine until they join an aerobics class. Again, I want to know which ACO I'm in as a patient so that I can file a complaint. And the broader question is this where we're heading with ACOs. If so, I think the proposed rule needs to be far, far tougher with respect to patient protections and quality of care. We don't want to relive managed care of the 90s, which trumped up ways to deny care, so that insurance companies could make more money. Let's not turn back the clock.						
14	Definition of "health care provider" refers to "person, partnership, or corporation . . . ." Providers can form LLCs. Want to make sure we capture the full spectrum of providers and no limit it in any way.	Amend definition of "Health Care Provider".	5.103	VAHHS	Amend definition of "Health Care Provider" as follows: "'Health Care Provider' and 'Provider' mean a person, partnership, ~~or~~ corporation, <u>unincorporated association, or other legal entity,</u> including a health care facility, that is licensed, certified, or otherwise authorized by law to provide Health Care Services in Vermont	The definition came from 18 V.S.A. § 9571. The Board would interpret the term to include all business forms, including LLCs. *See* 1 V.S.A. § 128 (defining a "person" to include "any natural person, corporation, municipality, the State of Vermont or any department, agency, or subdivision of the State, and any partnership, unincorporated association, or other legal entity."). The amendment would add clarity.

					to an individual during that individual's medical care, treatment, or confinement."	
15	The American Academy of Family Physicians (AAFP) has established five definitions relating to primary care, which it believes must be taken together for a full understanding of the primary care framework. We recommend that the Board flesh out its definitions of "primary care provider" and "primary care services" to include additional important elements recognized by AAFP's primary care policy.	Amend definition of Primary Care Provider: "Primary Care Provider" means a Provider who, within that Provider's scope of practice, principally provides Primary Care Services. A primary care provider serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services." Amend definition of Primary Care Services: "'Primary Care Services' ~~include~~ are Health Care Services primarily and generally furnished by Providers specifically trained for and skilled in comprehensive 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 includes ~~(e.g.,~~ health promotion, disease prevention, health maintenance, counseling, patient education, care planning, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings~~)~~.	5.103	HCA	None re: definition of "Primary Care Provider." Amend definition of "Primary Care Services" as follows: "'Primary Care Services' ~~include~~ are Health Care Services furnished by Providers specifically trained for and skilled in comprehensive 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. ~~(e.g.,~~ 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~~)~~.	The amendment brings the definitions closer to those found in DFR Rule 3 (a.k.a. 09-03) and 33 V.S.A. § 1823.
16	Patient experience should be included in the definition of qualify of care.	Amend definition of "Quality of Care" "'Quality of Care' means the degree to which Health Care 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, and take into consideration the patient's experience, goals, priorities, and preferences."	5.103	HCA	None.	The definition was based on DFR Rule 3 (a.k.a. 09-03). At the HCA's request, language was added regarding "clinical best practices."
17	The definition of Risk Contract is difficult to read.	Amend definition of "Risk Contract" "'Risk Contract means a ~~contract~~ signed agreement between a Payer and an	5.103	HCA	Amend definition as follows: "'Risk Contract means a contract between a Payer and an ACO under which the ACO is responsible for ~~either~~ the full or	"Expense" is the appropriate term. "Contract" is the appropriate term. "Target" is not the right term.

		ACO under which the ACO is responsible for ~~either~~ the full or partial ~~expense~~ cost~~,~~ ~~(~~as defined by the ~~contract~~ agreement)~~,~~ of treating or arranging for the treatment of a group of patients, if that cost exceeds an agreed-upon target ~~certain amount (e.g., a Benchmark or Capitation Payment)~~.			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 ~~certain~~ amount ~~(e.g., a Benchmark or Capitation Payment)~~."	Deleting the reference to "benchmarks" and "capitation payments" does not change the meaning of the definition and is not objectionable.
18	Clarification.	Amend by adding the following: "All submissions to the Board must be copied to the Office of the Health Care Advocate."	5.105	HCA	Amend section 5.105 by adding the following sentence: "Each document submitted to or filed with the Board must be copied to the Office of the Health Care Advocate . . . ." Amend section 5.106 by deleting the following sentence: "A request for confidential treatment must be sent to The Office of the Health Care Advocate at the same time it is filed with the Board."	The HCA should get documents the Board gets. The language in section 5.106 requiring the HCA to be copied on any request for confidentiality is no longer necessary given the amendment to section 5.105.
19	We suggest revising subsection (e) to clarify the Board's separate responsibilities regarding written records and verbal deliberations. It is appropriate for the Board to refer to confidential material in its written decisions as long as any confidential contents are redacted. Likewise, the Board in public deliberations must not disclose confidential information but is not prohibited from referring by name or general description to a document which has been granted confidential treatment. The public is entitled to know that such a document exists and was relied upon by the Board, even though the public may not access its contents.	Amend subsection (e) as follows: "(e) 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. The Board will redact confidential information from any public written records. When engaging in public deliberations, the Board must not disclose the contents of any confidential materials."	5.106	HCA	None.	The existing language, which was based on GMCB Rule 2.000: Rate Review, is not contrary to or inconsistent with the HCA's comments. It does not suggest the Board would not identify the materials it is relying on.
20	Clarification. The current draft is confusing because the phrase "whose positions may not be filled by the same person" implies that the governing body must have two Enrollee members specified in item 4, *in addition to* those that may be required by items 1-3. We understand this was not the intent of the Board.	Amend subsection (b) as follows: (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 or represents 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 CMS;	5.202	HCA	Amend the language as suggested, except make (b)(4) a separate, non-numbered subdivision and refer to "subdivisions", not "items".	The amendment is a clarification.

		2. at least one Enrollee member who is a Medicaid beneficiary if the ACO contracts with AHS or a department of AHS; and 3. for each 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.~~; and~~ 4. Notwithstanding items 1 through 3 above, the ACO's governing body must have at least two Enrollee members, regardless of the number of Payers the ACO contracts with.				
21	The last sentence of this subsection guards against conflicts of interest. We are concerned that the proposed language is not broad enough to carry out the intent of the provision, which we support. The current language seems to assume that an ACO Provider will be an individual, but in fact an ACO Provider could be a corporation or a partnership.	Amend subsection (c) as follows: "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."	5.202	HCA	Amend the language as suggested.	The change is appropriate.
22	We suggest adding a requirement that an ACO create, maintain, and publish on its website a general email address for its consumer advisory board. This will allow consumers and members of the public to suggest topics or submit concerns to an ACO's consumer advisory board.	Amend subsection (g) as follows: "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 members and caregivers. An ACO must create, monitor, and publish on its website a general email address for its consumer advisory board to which consumers and members of the public may submit suggested topics and concerns for the consumer advisory board."	5.202	HCA	Amend subsection (g) by adding the following sentence: "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."	An ACO's consumer advisory board may benefit from having an easy means of receiving input from consumers.
23	A previous draft of the proposed rule included the following text, which we believe should be included in the final rule.	Amend subsection (a) by adding the following sentence: "An ACO's finances, including its debt structure, executive compensation, and Participant compensation, shall be arranged and conducted to support the ACO's mission of improving the quality of	5.204	HCA	None.	No change is necessary. The section of the rule re: ACO budget decisions is sufficiently broad to allow the Board to amend an ACO's proposed budget if the ACO's finances, debt structure, executive compensation, or Participant compensation do not support the ACO's mission.

		care, achieving better health for populations, and reducing the rate of growth in health care expenditures."				
24	Subsections (g) and (h) are unclear and duplicative.	Combine subsections (g) and (h) as follows: "(g) ~~Population Stratification for Care Coordination:~~ 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 abuse conditions (within the limits of current data sharing requirements), high cost or high utilization, poorly controlled or complex conditions, or referrals by outside organizations. ~~(h) Risk Stratification: An ACO must use or support Participants in using an evidence-based risk adjustment tool to help identify Enrollees who might benefit from care coordination services.~~ 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."	5.206	HCA	Amend the language as suggested.	There is some duplication.
25	It is essential that practice guidelines be provided to patients, the Board, the HCA, and the public.	Amend subsection (d) as follows: "An ACO must promote evidence-based medicine, including through the adoption, implementation, and periodic assessment and	5.207	HCA	Amend section 5.207(d) as follows: "An ACO must promote evidence-based medicine, for example by requiring Participants to observe applicable professional standards, facilitating the	The issue of not reducing or limiting covered services is adequately covered in section 5.208 (Patient Protections and Support). The amendment better reflects the various ways an ACO can promote evidence-based medicine.

		updating of evidence-based practice guidelines for its Participants covering diagnoses with significant potential for the ACO to achieve quality improvements. Practice guidelines or other methods of promoting evidence-based medicine shall not include changes to or limitations on Enrollees' covered services under their health benefit plans. All practice guidelines shall be shared with Enrollees, the Board, and the Office of the Health Care Advocate and made available to the public."			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. ~~including through the adoption, implementation, and periodic assessment and updating of evidence-based practice guidelines for its Participants covering diagnoses with significant potential for the ACO to achieve quality improvements.~~	If the Board requests and receives guidelines or best practices from an ACO, the ACO must also send the guidelines to the HCA under section 5.105 (Filing). With respect to Enrollee access to guidelines and best practices, CMS must approve all communications with Medicare beneficiaries. Additionally, certain guidelines may be proprietary to a third-party vendor.
26	A previous draft of the proposed rule included language similar to the following. We request that this language be restored as it provides an important patient protection.	Amend subsection (a) by adding the following: "An ACO shall ensure that its operations do not diminish access to any appropriate health care or community-based service or increase delays in access to care for the population and area it serves."	5.208	HCA	Amend section 5.208(a) by adding the following sentence: "An ACO may not provide incentives to restrict access to Health Care Services solely on the basis of cost."	The language is statutory language and does not need to be restated. Section 5.207(b) requires ACOs to regularly evaluate care delivered to Enrollees against defined measures and standards, including standards re: access. The Board anticipate these measures and standards will be developed in concert with Payers and be informed by any access standards they operate under. The Board also has the ability under section 5.401 of the Rule to require reports from ACOs re: access. The amendment addresses the issue by getting at the concern re: provider incentives to reduce cost by limiting access. Section 5.209(b) also gets at the issue by requiring "that any Alternative Payment Methodologies implemented by the ACO with respect to Participants (e.g., capitation or fixed revenue budgets for hospitals) [be] coupled with mechanisms to improve performance or maintain a high level of performance on measures . . . including measures of quality and access."
27	Providers must be able to advocate for patients in appeals processes without penalty. We request specific language to make that clear in the rule.	Amend subsection (e) as follows: ". . . providing information to Enrollees about their health or decisions regarding their health, including the treatment options available to them; 2. advocating on behalf of an Enrollee, including within any utilization review, grievance, or appeal processes; or	5.208	HCA	Amend the language as suggested.	The change is appropriate.

		3. reporting in good faith to state or federal authorities any act or practice of the ACO that jeopardizes patient health or welfare."				
28	Please clarify when HCA contact information should be provided.	Amend subsection (f) as follows: "Enrollees that contact the ACO to make a complaint or grievance, or to file an appeal of a provider decision must be provided with contact information for The Office of the Health Care Advocate and the appropriate Payer's member services line. Contact information for the Office of the Health Care Advocate must be provided to any ACO Enrollee who expresses dissatisfaction with the ACO's Enrollee services and to all ACO Enrollees upon request."	5.208	HCA	Amend section 5.208(f) as follows: "An ACO must maintain a consumer telephone line for receiving complaints and grievances from Enrollees~~, and, at a minimum,~~ 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. ~~Enrollees that contact the ACO to appeal a benefit decision must be provided with contact information for The Office of the Health Care Advocate and the appropriate Payer's member services line.~~"	ACOs do not handle "appeals" and will need to refer these issues to Payers. The amendments ensure Enrollees will be provided contact information for the HCA at appropriate times.
29	A previous version of the proposed rule included a subsection (d), which we believe should be included in the rule.	Add the following sentence: "An ACO shall present to the Board for review at least annually as part of its proposed budget under section 5.503 of this rule, and more frequently if requested by the Board, the ACO's methods for paying primary care providers, hospitals, specialists, and community-based service and social service agencies; and a description of the risk arrangements."	5.209	HCA	None.	The language was deleted from the certification standards part of the rule because it is addressed in the budget review part, which applies to all ACOs. The Board will get provider payment information annually under section 5.503(a)(7) (requiring an ACO to file information regarding the ACO's Provider payment strategies and methodologies). The Board will specify in guidance exactly how it wants to receive this information.
30	Under HIPAA, business associates are only required to report HIPAA violations to the covered entity that holds the data that was compromised. Then, the covered entity decides whether to report the business associate to the Office for Civil Rights. This process makes sense when the business associate does straightforward contractual work for the covered entity, such as accounting work. However, the process is insufficient for entities such as ACOs that have a lot of power over the covered entities.	Add the following language: "In addition to complying with HIPAA, an ACO must establish and implement policies, standards, and procedures to protect the confidentiality, security, and integrity of individually identifiable health care information that it uses or possesses. Policies and procedures must address corrective action in response to sharing of incorrect information and improper sharing of protected health information when the sharing was facilitated directly or indirectly by the	5.210	HCA	None.	An ACO must comply with HIPAA. Violations of law may be grounds for taking corrective action or limiting, suspending, or revoking certification.

		ACO. An ACO must report any suspected or confirmed HIPAA violations and other privacy or security breaches to the Board and to the Office of the Health Care Advocate in addition to any reporting required by their business associate agreements."				
31	There is a typo in section 5.301(c)(2)(L)(iii) that changes the meaning of the section, corrected below. Also, this section should include appeals.	Amend section 5.301(c)(2)(L)(iii) as follows: "L. written descriptions of, or documents sufficient to describe, the Applicant's: i. population health management and care coordination program; ii. quality evaluation and improvement program, including the measures and standards the Applicant will utilize to measure the Quality of Care delivered to Enrollees; iii. grievance, ~~compliant~~ complaint, and appeals processes;"	5.301	HCA	Amend the language as follows: "iii. Enrollee grievance and ~~compliant~~ complaint process;"	The word change is a technical correction. ACOs do not handle "appeals" from Enrollees, so the reference to an appeals process is inappropriate.
32	The HCA does not agree that NCQA accreditation could be sufficient for ACO certification in Vermont. NCQA accreditation is awarded by a private entity. As a consequence, the accreditation process is not open to the public. The process is also subject to change. Finally, it is our understanding that NCQA certification does not encompass all of the requirements for ACO certification set out in 18 V.S.A. § 9382.	Unclear.	5.302	HCA	None.	Section 5.302 does not say that NCQA accreditation is sufficient for ACO certification. Rather, it says that if a certification standard in the rule is substantially similar an accreditation standard set by the NCQA, for example, the Board can deem the certification standard satisfied if the ACO is accredited. The intent is to prevent unnecessary duplication of effort. NCQA accreditation is not a stand-in for Board certification.
33	The rule should require the Board to conduct a complete annual recertification process for all ACOs to ensure that ACOs form and grow in a manner consistent with Vermont's goals for health care reform and that patients benefit from, and are not hurt by, the model. It is difficult to predict all of the consumer protection issues that may arise as ACOs are developed and implemented. An annual recertification should be required, at a minimum, for the first five years of an ACO's certification.	None provided.	5.305	HCA	None.	The Board will be getting information each year during the budget review process on an ACO's model of care and care management processes; governance and leadership, health information technology, provider payment strategies, etc. A certified ACO will have to report annually to the Board on changes to any of the issues addressed in the rule and certain matters must be reported sooner, within 15 days of their occurrence. The Board also has strong monitoring provisions and broad authority to get information from an ACO. Annual re-certification would be a significant burden on both the Board and ACOs for little return given the above.
34	None provided.	Amend subsection (a) as follows: "Subjects on which the Board may require an ACO to report include Quality of Care, access to care, cost, attribution, utilization, population health	5.401	HCA	Amend the language as suggested.	The list is meant to be illustrative, not exhaustive, but the additions makes sense.

		management and care coordination processes, capabilities, activities, and results, complaints and grievances, 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."				
35	The rule should include additional information about ACO-level quality measures that will be reported to and monitored by the Board. This is an essential component of the ACO model and one of the only ways in which ACOs will be accountable to the State of Vermont and the public for quality of care and patient experience.	None provided.	5.402	HCA	None.	Consistent with the All-Payer Model ACO Agreement, ACO-level quality measures may evolve and are not appropriate for inclusion in the rule.
36	We suggest adding a description of VHCURES and the statutory citation to section (a)(3).	Amend subsection (a)(3) as follows: ". . . analyses of information in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database established in 18 V.S.A. § 9410; or"	5.403	HCA	Amend the language as follows: ". . . analyses of information in ~~the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES),~~ Vermont's all-payer claims database established in 18 V.S.A. § 9410."	The name of the database has changed in the past and may change in the future. The descriptive reference is better.
37	We suggest to following edit to subsection (c) for clarity:	Amend subsection (c) as follows: "…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."	5.404	HCA	Amend the language as suggested.	The amendment is a clarification.
38	In general, we support the options for interim sanctions in addition to revocation of certification, but the rule needs to clarify what it means to limit certification.	None provided.	5.405	HCA	None.	The Board cannot foresee at this point all the kinds of "limitations" that may be appropriate and does not want to circumscribe its authority in any way. However, potential examples might be limiting the services an ACO can contract for or limiting the payment mechanisms it can use.
39	None provided.	Amend (a) as follows: "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. imminent and/or substantial harm to patients;"	5.405	HCA	Amend (a) as follows: "~~imminent~~ harm to patients that is imminent, substantial, or both;"	The term "and/or" is ambiguous, but the addition may be appropriate. Attempts may be made to address non-imminent harms through less drastic actions, such as implementation of a corrective action plan.

40	We suggest adding the following to section 5.503(a) after current item #1, to include entities such as the Vermont Care Organization, which has been serving Vermont's two ACOs in an advisory capacity.	Amend subsection (a) by adding a new paragraph, as follows: "2. information on all non-governmental organizations that have influence over an ACO's decision-making in a material way;"	5.503	HCA	None.	If the Board needs this information, it can obtain it under the catch-all provision of section 5.503(a).
41	None provided.	Amend subsection (a) by adding a new paragraph, as follows: "6. information on the ACO's complaint, grievance, and appeal processes for consumers and providers;"	5.503	HCA	Amend the language as suggested, except use the terms "Enrollees" instead of "consumers" and capitalize the term "providers."	The Board will likely want this information as part of the annual budget submission.
42	An ACO that does not assume risk and/or has fewer than 10,000 lives should still be fully and transparently reviewed for its impact on health care costs and quality; specifically, how much money it takes from the system to run the business, how much money it saves the system, and whether quality of care has improved or declined as a result of the ACO's work. A full and transparent review should include a public hearing.	Amend subsection (a) as follows: The Board shall hold a public hearing 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~~.	5.601	HCA	None.	The Board must review the budgets of all ACOs, regardless of size or risk profile. Information that can be released will likely be posted on the Board's website. The hospital budget review process also allows for the Board to make exemptions.
43	Sections (a) and (b) need to be edited to clarify when an ACO must apply for a budget adjustment and what the consequences are of a Board determination that the budget has varied substantially. It is not clear what the Board's enforcement authority is.	None provided.	5.701	HCA	Amend the sections as follows: (a) The Board may conduct an independent review of an ACO's performance under ~~the~~ an established budget ~~established for it by the Board~~ 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 ~~such~~ 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 ~~factors~~ facts the Board considered. (b) After determining that an ACO's performance has varied substantially from its budget, and upon ~~Upon~~ application of the ~~an~~ ACO, the Board may adjust ~~an~~ the ACO's budget. In considering an adjustment of an ACO's budget, the Board will consider the	This section should be read in concert with the sections regarding remedial actions and limitation, suspension, and revocation of certification. An ACO may apply for a budget adjustment when the Board determines its performance has varied substantially from its budget. Absent an adjustment, the Board can compel compliance with established budget by requiring remedial action. Revoking certification is available if remedial actions are not taken. Enforcement of a budget order through the courts may be a possibility, but does not need to be addressed in the rule.

					financial condition of the ACO and any other factors it deems appropriate. … (d) The Board may take any and all actions within its power to compel compliance with an established budget.	
44	Section 5.102 states that the Board is adopting this Rule to comply with its duties to provide sufficient oversight of ACOs operating in Vermont to comply with antitrust laws. Yet there is not a single provision in the Rule relating to antitrust laws or laws concerning other similar unfair trade practices. The "state action doctrine" is the legal standard that essentially immunizes states and private participants from antitrust liability when a state chooses to regulate conduct that could be considered anti-competitive under federal standards. The basic requirement of the state action doctrine is that the state act. At a bare minimum, the state needs to monitor the activity in question. It does not appear that any instrumentality of Vermont government is monitoring the market impact of ACOs in Vermont. While accountable care organizations are not required to seek mandatory antitrust review in order to participate in Medicare's ACO programs, the Department of Justice and the Federal Trade Commission have made available a free Voluntary Expedited Antitrust Review. Any newly formed ACO that desires antitrust guidance can submit a request for an evaluation of its proposed arrangement to the reviewing agency. Other states are taking actions to evaluate the market impact and unfair trade practices of their ACOs. Texas, for instance, requires ACOs to submit a market impact evaluation as part of its certification process. The Rule should require an ACO to submit to an antitrust review as a condition of certification. The review should be updated annually. It is in the public interest to understand and mitigate the impact of ACOs on Vermont's health care market. Vermont cannot protect	None provided.	5.102	DDC	None.	The state action doctrine, also known as *Parker* immunity, shields private anticompetitive conduct from antitrust liability if a state has 1) clearly articulated and affirmatively expressed a policy to allow the conduct and 2) actively supervised the conduct. *Parker* immunity is grounded in notions of federalism and state sovereignty and the purpose of the two-part test is to determine if the conduct of a private party should be deemed "state action". The comment asserts that the "active state supervision" prong is not adequately addressed in the rule and no agency in Vermont will be monitoring the impact of ACOs. This is not accurate. The Board will be regularly receiving information necessary to weigh the impact of an ACO and the pros and cons of provider collaboration under the ACO. The question under the active state supervision prong is whether the state has exercised sufficient independent judgment and control to ensure that the details of the anticompetitive conduct were established as a product of deliberate state intervention, not simply by agreement among private parties. Through the rule, and particularly through the budget review process, the Board will be exercising a great deal of independent judgment and control over ACOs to ensure the State's health care payment and delivery system reform goals are furthered. For example, the Board will be reviewing proposed ACO-Payer rates to ensure cost growth across all payers is constrained within certain targets set *by the State* and it will be reviewing the quality incentives between Payers and ACOs and between ACOs and participating providers to ensure that they align with and further the population health goals set *by the State*.

	Vermonters from unfair trade practices without substantive action.					
45	The term "Population Health" appears throughout the Rule. Indeed, the title of Section 5.206 is "Population Health Management and Care Coordination." Yet the Rule does not define Population Health. Is the Rule concerned with the health of the population in a geographic location, e.g., Chittenden County? Or is the Rule concerned with the health of a sub-population, e.g., the population of Vermonters who smoke? It appears the Rule is concerned primarily with the health of an ACO's panel of patients. If the term "population health" remains in the Rule it should be defined ant the use of the term restricted to that definition.	None provided.	5.103	DDC	None.	See comment 47.
46	An ACO should be required to identify and describe the members of its executive leadership team and provide a list of ACO employees and their titles in an organizational chart. In addition, ACOs should identify ACO employees who are also employed by the ACO's owner, investor, and/or affiliated provider. It is in the public's interest to know, for example, if the same person is serving as Medical Director for both OneCare and UVM.	None provided.	5.203	DDC	Amend section 5.301 (Application for Certification), subsection (c)(2) as follows: . . . G. materials documenting the Applicant's organization and leadership and management structure ~~(e.g.,~~ which must include a list of members on the Applicant's executive leadership team and a description of their qualifications, an organizational ~~charts~~ chart, and descriptions of the purpose and ~~makeup~~ composition of each of the Applicant's committee~~s~~, advisory board~~s~~, council~~s~~, ~~or~~ and similar group~~s~~; 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;"	This is information the Board will want in the application for certification.
47	The Rule does not define "Population Health." This term is widely used to refer to the health of a population of a specific geographic region. However, the Rule uses the term to refer to an ACO's panel of attributed patients. In this section, the use of the term "Population Health" in reference to an ACO's panel of patients is particularly misleading in that it creates the impression that an ACO's function is to improve the health	None provided.	5.206	DDC	None.	An ACO can only be held responsible for its attributed population. A definition is not necessary because the terms used in this section, "population health management" and "population health strategy," do not suggest the ACO is responsible for improving the health of all Vermonters. It is descriptive of the strategies and approaches outlined in section 5.206.

	of all Vermonters and not just the Vermonters attributed to it.					
48	Rule 5.206 requires an ACO to develop and use certain tools and procedures. An ACO applying for Certification should provide the GMCB with copies of its tools, including its decision support tools, shared care plan, and self-management tools. The ACO should indicate which tools were created with public funds and be required to make publicly-funded tools available for public use.	None provided	5.206	DDC	None.	Section 5.301(c) requires an ACO applying for certification to submit a written description of, or documents sufficient to describe, its population health management and care coordination program. The Board has authority to require more information and documents if needed.
49	While this section contains a lot of worthwhile protections, it is missing an essential first step. As required by ACOs participating in Medicare's ACO initiatives, an ACO should notify a person as soon as he or she becomes an ACO-attributed life. When an individual Vermonter does not have the right to opt out of being an ACO-attributed life, he or she has the right to choose a provider who is not affiliated with an ACO and/or a provider affiliated with the ACO of their choosing. Vermonters should know whether their providers' finances are impacted by the total cost of the care they receive.	None provided.	5.208	DDC	Amend section 5.208 by adding a new subsection (i), as follows "(i) An ACO must notify new Enrollees that they are attributed to the ACO or require the ACO's Participants to provide notification to their patients at the point of care that the Participant is participating in the ACO. This requirement does not apply if Enrollees will be notified by a Payer that they are attributed to the ACO."	See comment 13.
50	ACOs are required to submit "information of actions, investigations, findings involving the ACO or its agents or employees." ACOs are also required to submit "any reports from professional review organizations or Payers." An ACO ought to be required to provide the financial and quality performance results for each product line annually to GMCB and post the same in an accessible format on the ACO's website. The financial and quality performance results should include a disability sub-analysis, if one was performed.	None provided.	5.503	DDC	Amend section by adding the following: "financial and quality performance results under Payer contracts".	Final results may not be in by the time the proposed budget is submitted or by the time a budget is established for the ACO. However, the Board may want to understand an ACO's performance to date. As far as public reporting, a separate section already requires an ACO to publish performance information, broken out by line of business, on the ACO's website.
51	5.503(13) rolls at least five Act 113 requirements into one generalized catch-all request for an ACO to provide information on the efforts and incentives described in Act 113 for such things as an ACO's investments in home and community-based services. Act 113 requires ACOs to indicate the extent to which the ACO is investing in community services. As part of the certification and budget review processes, an ACO should be required to provide information regarding the extent of its financial support to the entities listed in Act 113. A break out of	None provided	5.503	DDC	Amend the language as suggested.	This will lengthen the rule, but makes the rule more readable by eliminating the need to refer to the statute.

	the ACO's investments in each of the areas listed in Act 113 should be included in the Rule.					
52	The proposed rule states that ACOs shall submit provider contracts as requested by the GMCB. The provider contracts for Medicaid ACOs should be required. Further, the Healthcare Advocate's right to obtain provider contracts should be equal to that of the GMCB.	None provided	5.503	DDC	None.	The HCA will receive whatever the Board receives. The Board probably does not need to see each provider contract under the Medicaid contract if the contracts are standardized. Nevertheless, the Board can get the contracts under the catch-all provision if it needs to.
53	ACOs should provide copies of grants and/or contracts from governmental entities and instrumentalities. ACOs should report sources of income, including income from grants such as the State Innovation Model (SIM) grant; income provided in agreements such as the All Payer Agreement; and income provided by the state and/or federal government, such as Waiver Investments.	None provided	5.503	DDC	None.	An ACO will have to report sources of income, including income from grants, etc. This is adequately addressed in the rule. The Board has the ability to request those grants or contracts if it needs them.
54	ACOs should also report on funding, equipment, and services received as a third-party beneficiary of a contract or grant. ACOs should report on the value of information technology improvements, event notification systems, shared care plans, etc. paid for with public dollars, as well as contracts with VITL and others that directly benefit an ACO.	None provided	5.503	DDC	None.	The Board separately reviews VITL's budget and will have insight into VITL's spending through that process.
55	ACOs should provide tax returns.	None provided.	5.503	DDC	None.	Information contained in a tax return is limited, but the Board has the authority to obtain tax returns if it needs them.
56	ACO budgets should be broken down by line of business. What are the administrative costs for the VT/Medicaid ACO contract? If DVHA is OneCare's only payer, will VT Medicaid pay all of OneCare's administrative expenses, including I.T. and executive compensation? What percent of an ACO's CEO's salary is Vermont Medicaid paying and how will taxpayers know?	None provided	5.503	DDC	None.	The rule adequately addresses the types of financial and programmatic information the Board needs to evaluate an ACO's proposed budget. Detail as to how to report this information will be set forth in the reporting manual each year.
57	ACOs should break out provider member fees/dues by category- e.g. amount paid by hospitals, amount paid by DAs/SSAs, etc. This analysis should include raw numbers and percentages of provider income.	None provided.	5.503	DDC	None.	This is information the Board could obtain under the rule if needed.
58	Using SIM dollars, the Green Mountain Care Board and the Blueprint for Health produced a series of care coordination learning collaboratives. Participants in these publicly funded collaboratives developed a model of care that became	None provided.	5.103 5.206	DDC	None.	There are similarities between what is in section 5.206 of the rule and the "Vermont Model of Care". Section 5.206 is intended to address certain key issues while still allowing an ACO to be flexible and to make appropriate changes to its models of care.

	known as "the Vermont Model of Care." Vermont's ACOs should be required by rule to adopt the Vermont Model of Care. Short of that, an ACO should be required to compare its own Model of Care with the Vermont Model of Care. The Vermont Model of Care should be a defined term in section 5.103 and should be based on the outline provided in the SIM Sustainability Plan.					
59	ACOs should be required to report the number of attributed lives they have for each product line and/or payer. This report should include all relevant attribution targets – e.g. targets in the SIM grant and in the All-Payer agreement. The report should indicate the current number of attributed lives as well as the number of attributed lives for the prior three years.	None provided.	None	DDC	None.	The rule allows the Board to require reporting from an ACO on attribution. The Board will need this information to prepare reports to CMS re: state performance against scale targets.
60	We ask the Board to promote transparency and patient empowerment by ensuring that patients are well informed. Act 113 requires that the all-payer model ensure that "robust patient grievance and appeal protections are available." 18 V.S.A. 9551(14). The Board cannot ensure these protections if patients are not provided clear notice that they are attributed to an ACO. The current draft rule does not require that enrollees be notified about their attribution to an ACO. Notification posted at a provider's office that the *provider* is participating in an ACO is not sufficient, as it does not give individual patients information about the patient's attribution status.	Add the following language to the rule: "An ACO must ensure that Enrollees are notified annually in writing that they are attributed to the ACO. All ACO notices written by Vermont ACOs, providers, or insurers must be written in plain language in consultation with the Office of the Health Care Advocate."	5.208	HCA	Amend section 5.208 by adding a new subsection (i), as follows "(i) An ACO must notify new Enrollees that they are attributed to the ACO or require the ACO's Participants to provide notification to their patients at the point of care that the Participant is participating in the ACO. This requirement does not apply if Enrollees will be notified by a Payer that they are attributed to the ACO."	See comment 13. Requiring annual written notice would add expense and its value is unclear. Notification at the point of care that the provider is participating in an ACO has been deemed sufficient by CMS for Medicare beneficiaries attributed to an ACO participating in the shared savings program. *See* 42 C.F.R. § 425.312.
61	Act 113 requires the Board to ensure that the ACO has established appropriate mechanisms and care models to provide, manage, and coordinate high-quality health care services for its patients. 18 V.S.A. §9382(a)(2). The current draft rule requires ACOs to provide information on its models of care, and allows the Board and Enrollees to request an ACO's guidelines. We ask the Board to add additional specificity to the information the ACO must submit annually, in order to align with Act 113.	Add the following language (underlined) under § 5.403: (a) On or before June 1 of each year…The ACO must submit information regarding mechanisms the ACO has established to provide, manage, and coordinate health care services for its patients, including guidelines or best practices adopted, promoted, or implemented by the ACO.	5.403	HCA	None.	The Board can get this information under existing language.
62	We further ask the Board to require ACOs to provide copies of its guidelines and best	Add the following language (underlined) under §5.207:	5.207	HCA	See comment 25.	See comment 25.

	practices to the HCA upon request, as outlined above.	"(d) An ACO must promote evidence-based medicine, including through the adoption, implementation, and periodic assessment and updating of guidelines or best practices for its Participants covering diagnoses or conditions with significant potential for the ACO to achieve quality improvements. Upon request, an ACO must provide these guidelines to the Board, the Office of the Health Care Advocate, and, unless prohibited under federal law or regulation, to Enrollees."				
63	Because Vermont's payment reform model is new and untested, some results may be unforeseen. It is therefore vital that everyone involved is free to express concerns about any negative impact the changes may have on patient health and welfare without fear of retaliation. Open dialogue will allow issues to be identified and problematic practices to be improved.	Add the following language under §5.208: "An ACO may not penalize any individual or organization for reporting any act or practice of the ACO that an individual reasonably believes could jeopardize patient health or welfare or for participating in any proceeding arising from such report."	5.208	HCA	None.	Issue is adequately addressed by existing language. Section 5.208(e) already prohibits an ACO from prohibiting a Participant from (or penalizing a Participant for) "reporting in good faith to state or federal authorities any act or practice of the ACO that jeopardizes patient health or welfare" or "advocating on behalf of an Enrollee, including within any utilization review, grievance, or appeal processes."
64	We urge the Board to make sure that an independent entity with expertise in antitrust law, such as Vermont's Attorney General's Office, has reviewed the rule. The entity should ensure that the Board's review process, as reflected in the rule, provides sufficient antitrust oversight.	None	None	HCA	None.	See comment 44.