§ 9551. All-Payer Model: All-Payer Model and Accountable Care Organizations

In order to implement a value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments and increased financial predictability for providers, the Green Mountain Care Board and Agency of Administration shall ensure that the model:

(1) maintains consistency with the principles established in section 9371 of this title;

(2) continues to provide payments from Medicare directly to health care providers or accountable care organizations without conversion, appropriation, or aggregation by the State of Vermont;

(3) maximizes alignment between Medicare, Medicaid, and commercial payers to the extent permitted under federal law and waivers from federal law, including:

(A) what is included in the calculation of the total cost of care;

(B) attribution and payment mechanisms;

(C) patient protections;

(D) care management mechanisms; and

(E) provider reimbursement processes;

(4) strengthens and invests in primary care;

(5) incorporates social determinants of health;

(6) adheres to federal and State laws on parity of mental health and substance abuse treatment, integrates mental health and substance abuse treatment systems into the overall health care system, and does not manage mental health or substance abuse care through a separate entity; provided, however, that nothing in this subdivision (6) shall be construed to alter the statutory responsibilities of the Departments of Health and of Mental Health;

(7) includes a process for integration of community-based providers, including home health agencies, mental health agencies, developmental disability service providers, emergency medical service providers, adult day service providers, and area agencies on aging, and their funding streams to the extent permitted under federal law, into a transformed, fully integrated health care system that may include transportation and housing;
(8) continues to prioritize the use, where appropriate, of existing local and regional collaboratives of community health providers that develop integrated health care initiatives to address regional needs and evaluate best practices for replication and return on investment;

(9) pursues an integrated approach to data collection, analysis, exchange, and reporting to simplify communication across providers and drive quality improvement and access to care;

(10) allows providers to choose whether to participate in accountable care organizations, to the extent permitted under federal law;

(11) evaluates access to care, quality of care, patient outcomes, and social determinants of health;

(12) requires processes and protocols for shared decision making between the patient and his or her health care providers that take into account a patient's unique needs, preferences, values, and priorities, including use of decision support tools and shared decision making methods with which the patient may assess the merits of various treatment options in the context of his or her values and convictions, and by providing patients access to their medical records and to clinical knowledge so that they may make informed choices about their care;

(13) supports coordination of patients' care and care transitions through the use of technology, with patient consent, such as sharing electronic summary records across providers and using telemedicine, home telemonitoring, and other enabling technologies; and

(14) ensures, in consultation with the Office of the Health Care Advocate, that robust patient grievance and appeal protections are available.