STATE OF VERMONT Contract # 27060

STANDARD CONTRACT FOR SERVICES

1. ***Parties.*** This is a contract for services between the State of Vermont, Green Mountain Care Board (hereafter called "State"), and The Lewin Group, Inc., with principal place of business in 3130 Fairview Park Drive, Suite 550, Falls Church, Virginia 22042, (hereafter called "Contractor"). Contractor's form of business organization is corporation. It is the contractor's responsibility to contact the Vermont Department of Taxes to determine if, by law, the contractor is required to have a Vermont Department of Taxes Business Account Number.

2. ***Subject Matter.*** The subject matter of this contract is services generally on the subject of analytics and calculations. Detailed services to be provided by the contractor are described in Attachment A.

3. ***Maximum Amount.*** In consideration of the services to be performed by Contractor, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed $2,200,000 for the life of the contract.

4. ***Contract Term.*** The period of contractor's performance shall begin on July 1, 2014 and end on September 30, 2017.

5. ***Prior Approvals.*** If approval by the Attorney General's Office or the Secretary of Administration is required, (under current law, bulletins, and interpretations), neither this contract nor any amendment to it is binding until it has been approved by either or both such persons.

- Approval by the Attorney General's Office is required.
- Approval by the Secretary of Administration is required.
- Approval by the CIO/Commissioner is not required.

6. ***Amendment.*** This agreement represents the entire agreement between the parties; No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and Contractor.

7. ***Cancellation.*** This contract may be canceled by either party by giving written notice at least 30 days in advance.

8. ***Attachments.*** This contract consists of this Standard Contract for Services and the following attachments which are incorporated herein:

Attachment A - Specifications of Work to be Performed

Attachment B - Payment Provisions

Attachment C – "Standard State Provisions for Contracts and Grants" a preprinted form (revision date 6/09/2014), except that the following numbered paragraphs which differ: Section 15: Sub-Agreements: Request for added language (See Memo)

Notwithstanding the foregoing, the State agrees that the Party may assign this agreement, including all of the Party's rights and obligations hereunder, to any successor in interest to the Party arising out of the sale of or reorganization of the Party.

Attachment D - Other Contract Provisions

Attachment E – Business Associate Agreement

Attachment F - ACO Standards

Attachment G - Timeline for Measure Generation and Reporting

Attachment H - Timeline for Process of ACO Calculation of Financial Performance and Payment Distribution

Attachment I - ACO Shared Savings Methodology Worksheet (Excel)

9. ***Order of Precedence***. Any ambiguity, conflict or inconsistency in the Contract Documents shall be resolved according to the following order of precedence:

(1) Standard Contract

(2) Attachment C (Standard Contract Provisions for Contracts and Grants)

(3) Attachment D (if applicable)

(4) Attachment A

(5) Attachment B

(6) Attachment E

(7) Attachment F

(8) Attachment G

(9) Attachment H

(10) Attachment I

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

By the State of Vermont:

Date: 7/14/14

Signature: Susan J. Barrett

Name: Susan Barrett

Agency: Green Mountain Care Board

By the Contractor:

Date: July 8, 2014

Signature: [illegible]

Name: Lisa Chimento

Title: Chief Executive Officer

Vermont Analytics Contract
Attachment A
Scope of Work

Background

The State received a $45 million SIM Model Testing Grant from the federal government. This grant funds activities inside and outside of state government over the next four years to implement and evaluate three alternatives to fee-for-service payment:

- Shared savings accountable care payments, under which a single network of providers takes responsibility for managing the costs and quality of care/services for a group of Vermonters;
- Episodes of care, which provide a single reimbursement amount to a group of providers for treatment of a patient's acute or chronic care episode; and
- Pay-for-performance models, which incorporate the total costs and quality of services in provider compensation

In January 2014, the State launched two Shared Savings Programs: Commercial and Medicaid. The design of these programs requires determination and evaluation of both financial and quality performance of participating Accountable Care Organizations (ACOs). This contract is for those services.

The Contractor will perform statewide activities related to the implementation, monitoring, reporting, and evaluation of the Commercial and Medicaid Shared Savings Accountable Care Programs.

The Contractor will perform seven major activities for the State:

1. Project Management
2. Work Plan Development
3. Data Collection and Assessment
4. Calculation of ACO Financial Performance
5. Calculation of ACO Quality Measures
6. Calculation of the impact of Quality Measures on Shared Savings
7. Reports

The Contractor will engage in several tasks within each of these activities as described below. The Contractor will engage the payers and ACOs in all of the activities listed below.

Scope of Work

The Contractor will build a model for multiple ACOs that accepts key inputs, such as total shared savings, quality scores and scoring criteria, and calculate the final shared savings to be delivered to each ACO. The Contractor will detail key calculations in a series of Excel workbook tabs. There will be a quality measure tab in which the user can enter the quality score percentile. There will be a scoring assumption tab which will map ranges of quality scores to actual points. These tabs will both be easily updatable, should the scoring criteria change. There will be a scoring tab which will calculate both the total points available and the points achieved by the specific ACO. On the scoring assumption tab, Contractor will provide a table to translate the percentage of total points to a percentage of total savings. Finally, there will be a savings distribution tab, in which the user can enter the total shared savings, which will calculate the earned savings by multiplying the total shared savings by the percentage of total savings earned.

The Contractor will provide the State with opportunities to review the model and the results during and after model development and after the calculation of the shared savings distribution. The assumptions, input values, and calculations will be reviewed by the Contractor and the State on a consistent basis to ensure accuracy.

The Contractor will automate the current steps defined by the State, review the methodology and review the initial results. This will be described in the work plan. The Contractor will test the assumptions. The Contractor will make any changes requested by the State based on the State's methodology review.

The Contractor will document the final results for quality and financial measures in a summary document for the State and individual documents for each ACO. The Contractor will include detail about the methodology used and include quality scores, scoring criteria and total shared savings.

1. Project Management, Organization and Communication Strategy:

This project shall start with an in-person kick-off meeting between the Contractor and the State. The purpose of the meeting, which will occur within two weeks of the contract signing, will be to establish a partnership between the Contractor and the State to support a shared understanding of State goals and the approach to completing project tasks. The Contractor will also clarify project objectives and priorities, refine the scope of work and technical approach, clarify contract requirements and expectations, establish an overall communication plan (including regularly scheduled calls with the State to provide project updates), and discuss timelines for completing each task. The kick-off meeting will provide an opportunity for the State to offer feedback on recommended technical approaches, share background information on Vermont's health care environment and providers participating in payment and delivery system reform pilots, and provide initial specifications of the content and time line for project deliverables. The Contractor's Project Director will participate in on-site meetings that pertain to this contract, as requested and will attend additional meetings either in person or via conference call or webinar as reasonably requested.

a. Key Personnel

Project Director: Steve Johnson, PhD, MS, Vice President
Subject Matter Expert: Nancy Walczak, FSA, PhD, Vice President
Actuarial Analysis:
Scott Smith (Lead), Senior Consultant
Colby Schaeffer, Actuarial Consultant
Lia Bunch, Consultant
Tanya Disney, Research Consultant
Michael Holcomb, Actuarial Analyst
Performance Measures:
Linda Shields (Lead), RN, BSN, Vice President
Tim Prinz, Senior Consultant
Julie Trottier, Senior Consultant
Dave Schafer, Solutions Manager OPTUM
Sailaja Prakriya, Senior Consultant
Dan Labson, Senior Research Analyst

Reporting:
Michael Cristiani (Lead), Senior Consultant
Matt Trott, Actuarial Research Consultant
Dan Labson, Senior Research Analyst

2. Work Plan Development

The Contractor will develop and provide a work plan that details contract deliverables and timelines. The work plan will be developed to meet the deadlines in the timeline provided in Attachment G. If the Contractor identifies a need to change some of the deadlines, the Contractor will notify the State and a new, mutually agreed upon date will be established. The work plan is due four weeks after the kick-off meeting.

3. Data Collection and Assessment

The Contractor will sign Data Use Agreements (DUAs) and comply with all applicable state requirements to obtain data. The Contractor will develop a data security plan and provide a secure file transfer protocol.

The Contractor will rely on the following data:

i. Claims data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)
ii. Claims member demographics and member term data from BlueCross & BlueShield of Vermont, MVP Health Care, Inc. and Vermont Medicaid
iii. Clinical measures (numerator and denominator) data from OneCare Vermont, Accountable Care Coalition of the Green Mountains, and Community Health

Accountable Care and the providers within each of those Accountable Care Organizations (ACOs).

iv. Survey data provided by the State including, but not limited to: patient experience survey data, BRFSS data and Household Health Insurance Survey Data.

a. Data Validity

The Contractor will ensure data are valid each year. The Contractor will detail measurement requirements, data availability, and alignment with project timelines. The Contractor's data validation process will identify any potential timing problems. The Contractor will begin data validation at contract execution and depending on the data issues identified, the Contractor expects this phase to take three months, including the preparation of the validation report. The Contractor's data validation process will include the following validations:

i. Standardized Data Checks

After loading the data and verifying control totals, the Contractor will run existing SAS programs to provide several standard validation analyses. These analyses will include:

- Date of Service Volume Analyses: The Contractor will trend claim volume by category of service and time to identify any potential gaps in submissions, as well as provide an initial view of data completeness.
- Analysis of Valid Values: The Contractor will generate simple frequencies for key fields by payer to potentially identify anomalies or differences in how fields are populated by payer.
- Claim to Provider and Member Linkage Analysis: The Contractor will ensure that all provider identifiers found in claims match to providers found in the corresponding provider table.
- Analysis of Quality of Diagnosis Reporting: A key driver of the risk scores computed for each payer will be the quality of the diagnosis information it reports on its claims. The Contractor will compute the percentage of claims for each major category of service with 1, 2, 3, and 4 or more diagnosis codes for each payer.
- Analysis of Risk Score Credibility: If the prior analyses raise data completeness or quality concerns for any payer, the Contractor will independently validate scores using the Symmetry Pharmacy Risk Grouper (PRG) using only pharmacy data.

ii. Actuarial Analyses

The Contractor will create standard actuarial measures of data completeness such as lag triangles on a category-of-service basis that measure the length of time from when a service was provided to when a service was paid. If variation in the data requires manual adjustments to lag factors for large claims, asymmetric information or other volatility in claims processing, the Contractor will make such adjustments. The Contractor will apply

professional judgment in assessing data completeness and making necessary adjustments to the claim lag triangles.

The Contractor will provide the State with a written report summarizing the primary data issues and the methodology used to select data for savings calculations, along with detailed supporting validation results. This report will summarize the standard data checks, show comparison to reference totals, and include actuarial analyses. The Contractor will provide payer-specific data validation results.

iii. Medical Coding Assessment

The Contractor will identify and evaluate the impact of improvements in medical coding practices on member risk scores. The Contractor will provide a proposed methodology for this analysis to the State for review and approval no later than December 1, 2014. The proposed methodology will incorporate three different testing strategies to determine the financial effect of changes in medical coding practices:

- Constant Cohort Test
- Pharmacy Risk Grouper (PRG)/ Episode Risk Grouper (ERG) Risk Score Test
- Diagnosis Frequency Test

For the Constant Cohort Test, the Contractor will select a continuously enrolled population sample using two years of complete claims data. Using the Symmetry ERG, the Contractor will calculate risk scores for the population for Year One and compare that with the risk scores in Year Two. The ERG scores are based on the mix of diagnosis codes documented on claims. The population risk scores from year one will be the baseline. Using this same cohort population, the Contractor will calculate risk scores for Year Two and compare that score with Year One. The Contractor would consider risk score increases in excess of 1-2% as one indication of improvements in coding impacting risk scores.

The Contractor will conduct a PRG/ERG Risk Score Test that uses both the Symmetry PRG and the ERG over two years to measure the change in coding practices. Based on the expectation that providers are not changing prescribing patterns due to payment methodology changes, the change in the PRG risk score from year one to year two will provide a baseline for observed acuity change in the population. ERG risk scores, on the other hand, will be impacted by changes in medical coding practices. The Contractor will compare the change in ERG scores with the change in PRG risk scores from Year One to Year Two and evaluate whether the ERG scores were impacted by a change in medical coding practices.

The Contractor will also perform an analysis of diagnosis code position frequencies. Using two years of data, the Contractor will calculate the number of claims with one, two, three and four or more diagnosis codes reported on each claim. The Contractor will then compare these Year One frequencies with Year Two frequencies. Similarly, the Contractor will

calculate the number of disease conditions identified for each patient using the chronic/clinical indicators generated by the ERG grouper. Based upon an evaluation of diagnosis codes, the ERG grouper creates 239 variables that identify the acute and chronic/clinical conditions that were reported for on the medical claims for a member. The Contractor will use these variables to identify the number of members with 1,2,3,4 or more chronic/clinical conditions in Year One and Year Two. Increases in the number of diagnoses reported on claims and increases in the number of chronic/ clinical conditions identified for the average member will be indicative of improvements in medical coding.

iv. ACO Medical Record Sampling

The Contractor will draw statistically valid samples from the claims data provided by the payers in each performance year. The Contractor will generate a sample in the size specified by the State that contains only measure-eligible patients and provides all information in a statistically valid sample that can be used by the ACOs to perform the medical records review. These samples will be used by the State for medical record review.

v. Comparison to Reference Totals

The Contractor will compare total expenditures and member months to other existing data sources, such as health plan financial reports, to ensure that the correct subset of data has been included for calculation of ACO savings. The Contractor will verify totals in VHCURES (VHCURES contains a Use Flag field that should assist in identifying the correct subset of data). The Contractor will work with commercial insurers to obtain comparable reference totals and to resolve any identified differences.

b. VHCURES

The Contractor will assess the VHCURES as a source for both ACO financial performance measurement and claims based cost, quality, and utilization measures. The Contractor will assess the timeliness and completeness of VHCURES, beyond an analysis of claims lag or simple frequencies.

4. Calculation of ACO Financial Performance and Calculation of the Distribution of Earned Savings Payments:

The Contractor will calculate finance performance and distribution of earned savings payments for both the Medicaid and Commercial programs. The Contractor will use the State's methodology as identified in the Medicaid Contracts for the Medicaid program (found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/onecare-base-contract-signed.pdf) and as identified in the "Compilation of Pilot Standards" for the Commercial program (Attachment F). The Contractor will perform this process in conformance with the timeline provided in "Timeline for Process of ACO Calculations of Financial Performance and

Payment Distribution" (Attachment H). The Contractor will perform different steps for the Commercial and Medicaid programs. These processes for both programs are described below:

a. Medicaid Program:

The Contractor will follow several steps for this activity. The Contractor will inform the state if any of these steps need to be adjusted:

i. <u>Step 1: Patient Attribution</u>

The Contractor will attribute patients using the State's attribution methodology as found in the Medicaid Contracts for the Medicaid program and will work with the State and Medicaid to identify any steps necessary to complete these tasks in addition to those listed below for attribution:

- Initial attribution will be through claims;
- Subsequently by the member's selected or assigned PCP; and
- The Contractor will utilize a 12-month look-back period to verify that ACO members are appropriately assigned.

The Contractor will perform a final eligibility check that ensures that members may be attributed to only one ACO per month, which eliminates the risk of duplicate records.

ii. <u>Step 2: Aggregate Claims Experience</u>

The Contractor will match eligible ACO members' member identification numbers with the claims data for the measurement period. The Contractor will classify claims into service categories based on the core services for the Medicaid program. The Contractor will exclude claims not within the core services.

iii. <u>Step 3: Validate Data</u>

The Contractor will validate the data. The Contractor will ensure input sources are appropriate, control totals reconcile with summary data, data fields are imported correctly and reasonable values are found within each of the fields. The Contractor will compute the total number of claims and unduplicated recipients for each month of enrollment and for each category of service. The Contractor will determine if the volume of data received is consistent and meets expected benchmarks. The Contractor will identify outlier months within the data that could be erroneous due to potential errors in claims processing or enrollment rosters. The Contractor will discuss data anomalies with the State and payers to ensure issues are addressed as soon as possible.

iv. <u>Step 4: Utilization Adjustments</u>

The Contractor will adjust the completed claims data following the method prescribed by DVHA. The Contractor will also explore other steps to normalize the data prior to modeling. The Contractor will not do any additional normalizing of the data without consultation with Medicaid. After the base data has been adjusted to reflect expected utilization and prices for the Total Cost of Care (TCOC) calculation period, the Contractor will risk adjust the claims experience, apply utilization and unit cost trends, and truncate the data to smooth the impact of outliers such as large claims.

v. Step 5: Apply Risk Adjustment

The Contractor will risk adjust the base data to take into account the acuity of the population, expected changes in utilization and unit cost by applying trend projections, and smooth the data by smoothing outlier claims and members. The Contractor will use diagnosis codes in the CMS' hierarchical condition category found in the most current community version of the software (CMS-HCC) for the Medicaid program. The Contractor will work with the State to ensure the risk adjustment is performed appropriately.

vi. Step 6: Trend Adjusted Experience Forward

For the expected TCOC calculations, the Contractor will apply trend to the base data to bring it to the same period (performance year) as actual costs when calculating shared savings. The Contractor will calculate Cumulative Average Growth Rate (CAGR) at the category of service level for each ACO population.

vii. Step 7: Adjust for Pricing Changes

The Contractor will advise the State as to whether this step should be performed at this stage or a different stage based on review of the data. The Contractor will apply pricing changes to the data to keep it on the same basis as actual data in the performance year. Such pricing changes may include shifts in the Medicaid fee schedule, benefit adjustments, program changes, and other regulatory or economic factors.

viii. Step 8: Truncate Costs at Member Level

Using the State defined methodology, the Contractor will truncate Medicaid expenses at the 99th percentile of annual cost per member. The Contractor will notify the State of any additional outliers and the impact of various smoothing techniques.

ix. Step 9: Summarize TCOC Figures to Determine Savings

The Contractor will provide the expected and actual TCOC figures to the State for review and determination of whether the ACO generated savings. The Contractor will perform this activity twice for each performance year. The first will be an interim analysis in April

prior to complete claims data run-out. The second will be in August after six months of claims run-out.

b. Commercial Program

The Contractor will follow several steps for this activity. The Contractor will inform the state if any of these steps need to be adjusted:

i. Step 1: Patient Attribution

The Contractor will attribute patients using the State's attribution methodology as identified in Attachment F.

The Contractor will engage in the following Commercial program attribution activities:

- Verify that the employer is situated in Vermont or the commercial member is a Vermont resident;
- Ensure that the insurer participating in the ACO is the primary payer for the commercial member;
- Allocate selected primary care providers (PCPs) to members; and
- Use the Blueprint for Health (Blueprint) list of qualifying current procedural terminology (CPT) codes to attribute other members and using the Blueprint attribution methodology to assign those members to the practice in which they have the greatest number of qualifying claims.
- The Contractor will utilize a 24-month look-back period to verify that ACO members are appropriately assigned.

The Contractor will perform a final eligibility check that ensures that members may be attributed to only one ACO per month, which eliminates the risk of duplicate records.

ii. Step 2: Aggregate Claims Experience

The Contractor will match eligible ACO members' member identification numbers with the claims data for the measurement period. The Contractor will classify claims into service categories based on the core services for the Commercial program. The Contractor will exclude claims not within the core services.

iii. Step 3: Validate Data

The Contractor will validate the data. The Contractor will ensure input sources are appropriate, control totals reconcile with summary data, data fields are imported correctly and reasonable values are found within each of the fields. The Contractor will compute the total number of claims and unduplicated recipients for each month of enrollment and for each category of service. The Contractor will determine if the volume of data received is consistent and meets expected benchmarks. The Contractor will

identify outlier months within the data that could be erroneous due to potential errors in claims processing or enrollment rosters. The Contractor will discuss data anomalies with State and payers to ensure issues are addressed as soon as possible.

iv. Step 4: Apply Incurred But Not Reported (IBNR) Factors

The IBNR factor is only applicable for the Commercial Program. The Contractor will develop an ACO-specific IBNR completion factor for categories of service for each participating insurer. The IBNR factor is not applicable for the Medicaid program. The State may ask the Contractor to develop an IBNR factor for the Medicaid program for years two and three of that program. If the State makes this request, the Contractor will develop an ACO-specific IBNR factor for the Medicaid program.

v. Step 5: Utilization Adjustments

The Contractor will adjust the completed claims data for unanticipated events that would impact medical expenses or payer assumptions.

The Contractor will also explore other steps to normalize the data prior to modeling. The Contractor will not do any additional normalizing of the data without consultation with the State. After the base data has been adjusted to reflect expected utilization and prices for the Total Cost of Care (TCOC) calculation period, the Contractor will risk adjust the claims experience, apply utilization and unit cost trends, and truncate the data to smooth the impact of outliers such as large claims.

vi. Step 6: Apply Risk Adjustment

The Contractor will risk adjust the base data to take into account the acuity of the population, expected changes in utilization and unit cost by applying trend projections, and smooth the data by smoothing outlier claims and members. The Contractor will use diagnosis codes in The Center for Consumer Information & Insurance Oversight (CCIIO) risk adjustment methodologies for the Commercial program. The Contractor will work with the State to ensure the risk adjustment is performed appropriately.

vii. Step 7: Trend Adjusted Experience Forward

For the expected TCOC calculations, the Contractor will apply trend to the base data to bring it to the same period (performance year) as actual costs when calculating shared savings. The Contractor will calculate Cumulative Average Growth Rate (CAGR) at the category of service level for each ACO population.

viii. Step 8: Adjust for Pricing Changes

The Contractor will advise the State as to whether this step should be performed at this stage or a different stage based on review of the data. The Contractor will apply pricing changes to the data to keep it on the same basis as actual data in the performance year. Such pricing changes may include shifts in benefit adjustments, program changes, and other regulatory or economic factors.

ix. Step 9: Truncate Costs at Member Level

Using the State defined methodology, the Contractor will truncate commercial expenses through a stop-loss provision by excluding the projected value of allowed claims per claimant in excess of $125,000 per year. The Contractor will notify the State of any additional outliers and the impact of various smoothing techniques.

x. 10: Summarize TCOC Figures to Determine Savings

The Contractor will provide the expected and actual TCOC figures to the State for review and determination of whether the ACO generated savings. The Contractor will perform this activity twice for each performance year. The first will be an interim analysis in April prior to complete claims data run-out. The second will be in August after six months of claims run-out.

5. Calculation of ACO Performance Measures

The Contractor will calculate and provide the State with measures of ACO performance on clinical, claims-based, and survey-based measures. For all measures, the Contractor will document its processes, calculate the measures, and provide reports to the State. If the ACO has generated savings, the Contractor will use the results of this analysis to determine if participating ACOs meet the "Gate" to achieve any shared savings, and the ACOs' positions on the shared savings "Ladder" to determine the amount of shared savings they will receive. The Contractor will utilize the "ACO Shared Savings Methodology Worksheet" (Attachment I) for the Commercial Shared Savings ACO Program. The Contractor will adjust or add measures at the State's request.

a. Clinically-Based Measures in Core Measure Set (Measures #14-#20)

After the Contractor has cleaned and validated the data, the Contractor will perform calculations of the clinically-based performance measures. The State will provide the measure results to the Contractor as numerators and denominators beginning in August 2014. The Contractor will calculate the measures for the first six months of 2014 with these data. The Contractor will prepare a preliminary report for the State in October

2014. The Contractor will follow the data definitions provided by State in the Core Measure Set Narrative Specifications provided as Attachment F to this contract.

b. Claims-Based Measures in Core Measure Set (Measures #1-8; #10-13)

The Contractor will use EBM Connect as the primary analytic software application for 10 of the 12 claims-based measures. For Core Measure 8 (Developmental Screening in the First Three Years of Life), the Contractor will use SAS to produce measure results. For Core Measure 12 (PQI Composite), the Contractor will write logic for the hypertension and heart failure admission rate sub-measures of this measure in SAS and calculate the sub-measures in the external data mart. The Contractor will append the results for Core Measure 8 and the two Core Measure 12 sub-measures with the EBM Connect output file and present them in the report template in a framework that is consistent with the other measures.

c. Survey-Based Measures in Core Measure Set (Measures #21-27)

The Contractor will work with State and its patient experience survey vendor to ensure timely and complete submission of the patient experience survey data needed to calculate these measures, and will conduct basic data validation to ensure accuracy and completeness. The Contractor will perform the necessary composite calculations needed to report these measures, identifying missing data or other issues that might bias or otherwise influence the creation of these index-based or scale indicators.

6. <u>Monitoring and Evaluation Measures</u>

The State will provide data to the Contractor for Monitoring and Evaluation measures. These data sources include: VHCURES, the Vermont Department of Education and the Vermont Department of Labor.

The Contractor will use the NQF-endorsed HealthPartners Total Cost of Care Index measures for this analysis. The Contractor will calculate the TCI and RUI measures following the HealthPartners specifications, while maintaining consistency with the ACO financial performance and earned savings payments described above. Contractor will use the following six steps to calculate and report the TCI and RUI measures.

i. <u>Step 1: Data Comparison</u>

The Contractor will ensure the aggregated data from payers is consistent, reasonable and complete; that comparable use of diagnosis coding is used, CPT code frequencies fall within expected ranges, categories of service are consistently represented, and case-mix differences between different payer groups are evaluated.

ii. Step 2: Person Attribution

The Contractor will use the same attribution methodology described above to verify that ACO members are appropriately assigned.

iii. Step 3: Risk Adjustment

The Contractor will use the Symmetry Episode Risk Grouper (ERG) for risk scores and the Total Care Relative Resource Values (TCRRVs) to quantify resource use, if this grouper is comparable to the ACGs used by HealthPartners. The Contractor will independently validate these ERG risk scores using the Symmetry Pharmacy Risk Grouper (PRG) to compute risk scores for each payer using pharmacy data only. The Contractor will use these risk scores to compute the relative ERG and PRG risk score for each payer. If the State requires the contractor to use the ACG risk grouper, the State will pay the licensing fee for this grouper.

iv. Step 4: Apply TCRRV Weights

The Contractor will use TCRRV tables provided by HealthPartners to facilitate comparisons within and across procedures, peer groups, and health care settings, in order to objectively quantify and identify overuse and inefficiency, as well as measure price variations.

v. Step 5: Person-Level Claims Truncation

The Contractor will truncate costs at the person level to remove the effect of outliers. The Contractor and the State will determine the appropriate level for truncating to ensure consistency with financial performance and earned savings payment calculation methodology.

vi. Step 6: Calculate and Stratify TCI and RUI

The Contractor will calculate and stratify the TCI and RUI. The Contractor will recommend variables for stratification and the State will select the variables. The Contractor will compare TCI and RUI scores by Participating ACO, Participating Payer, geography, place of services, and other variables. The Contractor will use interactive reporting tools to allow State and other stakeholders to perform their own analysis on the TCI and RUI measures, as well as the quality, utilization, and other measures in the Monitoring and Evaluation Set.

7. Calculation of the Impact of ACO Quality Performance on the Distribution of Shared Savings

The Contractor will calculate ACO performance relative to the benchmarks. For measures with no national benchmark data, the Contractor will calculate baselines specific to each ACO using data from the base period, and compare ACO performance over time to that baseline. The Contractor will calculate specific ACO point values based on the percentile of the national benchmark or the amount of improvement from the baseline.

The Contractor will compare point values to scoring levels to determine eligibility for payment and levels of payment.

8. Reports

The Contractor will work with the State to develop customized reports to evaluate the performance of the ACOs participating in the Shared Savings Programs. The Contractor will use SAS software and Tableau Desktop / Tableau Reader for these reports. The Contractor will ensure that reports are interactive and flexible, and built using a collaborative design process with State. The Contractor will establish a process for developing ad hoc reports in conjunction with State.

a. Report Generation Process

The Contractor will develop a report generation process that includes frequent review of report design requirements. The process will include the following steps:

i. Collaborative metadata resolution session(s):

The Contractor will clarify the use of terms and labels, etc., and specify/confirm the calculations being used to develop measures included in the reports. The Contractor will schedule and facilitate at least 3 of these sessions. The Contractor will manage the agenda for each session to guarantee that all outstanding topics are resolved. Contractor will develop a compliance checklist to insure that all reports meet standards in place among and between State and other stakeholders.

ii. Collaborative report storyboarding sessions:

The Contractor will schedule and facilitate sessions to include the real-time testing of report formats. For these sessions, the Contractor will develop draft measure results reports to initiate discussion. The Contractor will facilitate discussion of appropriate story telling language for tool tips, and any integrated help messages embedded in the report.

iii. Sharing of draft reports:

The Contractor will share draft report, via a secure protocol, using Tableau Reader or other vehicles that allow efficient collaboration with the State and other stakeholders on report design.

iv. Testing:

The Contractor will develop and manage a testing regime for all report designs that includes compliance and usability checklists. The State and other stakeholders and Contractor will participate in the testing process.

v. Publishing:

The Contractor will publish final report formats for approval by State.

vi. Report release:

The Contractor will consult with the State and other stakeholders to develop a formal approval process that incorporates anticipated and current approval procedures. Contractor will insure final approval of report formats and any derivative materials prior to release. Following approvals, Contractor will work with the State and other stakeholders to release reports as appropriate.

vii. Post-release feedback:

The Contractor will develop and manage a process for considering and communicating feedback after each report is released.

viii. Report editing:

The Contractor will edit reports at the request of State.

b. Delivery, Implementation and Training

The Contractor will provide the following Tableau enabled reports:

- One baseline quality and utilization report
- Twelve quarterly Monitoring and Evaluation utilization measures reports
- Twelve quarterly claims-based payment measures reports
- Three annual quality measures reports
- Three ACO Quality Performance and Distribution of Shared Savings reports
- Collaborative ad hoc reports. To produce the ad hoc reports, Contractor will use the same process described in Section C of this contract. When appropriate, Contractor will engage stakeholders during ad hoc report development.

The Contractor will develop a plan with the State for training in how to use Tableau Reader.

c. Review of Results with Stakeholders

The Contractor will document all steps and calculations used to obtain quality and financial results. The Contractor will clearly and transparently report on the steps performed to obtain those results to the State.

At such times as the State requests, the Contractor will provide a detailed explanation of results at forum(s) attended by stakeholders. Stakeholders include, but are not limited to: ACOs, payers, consumers and clinicians. The Contractor will use multiple methods to both confirm understanding and allow for questions, such as meetings to walk through the documentation detailing the rate calculations which the stakeholders receive prior to the meeting and a question and answer log which is updated frequently and shared with the State and all stakeholders. The Contractor will review stakeholder concerns and issues with the State to ensure that the proposed responses are appropriate.

9. Ad Hoc Tasks

The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a monthly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a monthly basis.

Attachment B
Payment Provisions

1. The maximum amount payable under this contract for services and expenses as outlined in Attachment A shall not exceed $2,200,000. The State does not guarantee the assignment of any minimum number of hours or other work under this contract.

Payments will be made in accordance with the following payment charts:

July 1, 2014 – June 30, 2015		
Contract Section	**Name**	**Fixed Price**
4	ACO Financial Performance	$ 149,820
5, 6	ACO Performance Measures	$ 222,520
7	Impact of ACO Quality Performance	$ 14,320
8	Report Design and Generation	$ 91,540
3b	Assessment VHCURES Database	$ 13,860
4	Assessment ACO Expenditures	$ 12,300
3	Annual Sample Measure-Eligible Patients	$ 12,260
8	Ad-hoc Reports	$ 16,160
1,5,8	VHCIP Work Group	$ 11,480
4,5,6,8,1	Review Results and Reconcile Inconsistencies	$ 14,240
1	Provide Feedback and Advice	$ 39,040
Fixed Price		**$ 597,540**
Travel Costs		**$ 13,177**

July 1, 2015 – June 30, 2016		
Contract Section	**Name**	**Fixed Price**
4	ACO Financial Performance	$ 110,930
5, 6	ACO Performance Measures	$ 218,020
7	Impact of ACO Quality Performance	$ 53,800
8	Report Design and Generation	$ 63,240
3b	Assessment VHCURES Database	$ 6,930
4	Assessment ACO Expenditures	$ 12,300
3	Annual Sample Measure-Eligible Patients	$ 12,260
8	Ad-hoc Reports	$ 16,160
1,5,8	VHCIP Work Group	$ 11,480
4,5,6,8,1	Review Results and Reconcile Inconsistencies	$ 14,240
1	Provide Feedback and Advice	$ 39,040
Fixed Price		**$ 558,400**
Travel Costs		**$ 9,743**

July 1, 2016 – June 30, 2017		
Contract Section	**Name**	**Fixed Price**
4	ACO Financial Performance	$ 110,930

5, 6	ACO Performance Measures	$ 218,020
7	Impact of ACO Quality Performance	$ 49,960
8	Report Design and Generation	$ 61,040
3b	Assessment VHCURES Database	$ -
4	Assessment ACO Expenditures	$ 12,300
3	Annual Sample Measure-Eligible Patients	$ 12,260
8	Ad-hoc Reports	$ 16,160
1,5,8	VHCIP Work Group	$ 11,480
4,5,6,8,1	Review Results and Reconcile Inconsistencies	$ 14,240
1	Provide Feedback and Advice	$ 39,040
Fixed Price		**$ 545,430**
Travel Costs		**$ 12,191**

July 1, 2017 – September 30, 2017		
Contract Section	**Name**	**Fixed Price**
4	ACO Financial Performance	$ 35,740
5, 6	ACO Performance Measures	$ -
7	Impact of ACO Quality Performance	$ 31,000
8	Report Design and Generation	$ 11,435
3b	Assessment VHCURES Database	$ -
4	Assessment ACO Expenditures	$ 12,300
3	Annual Sample Measure-Eligible Patients	$ 5,230
8	Ad-hoc Reports	$ 6,060
1,5,8	VHCIP Work Group	$ 5,740
4,5,6,8,1	Review Results and Reconcile Inconsistencies	$ 7,120
1	Provide Feedback and Advice	$ 19,520
Fixed Price		**$ 134,145**
Travel Costs		**$ 3,861**

Ad hoc tasks will be billed at the following rates:

Section 9 Tasks - Hourly Rates by Labor Category

Labor Category	Hourly Rate*
Vice President	$ 275.00
Managing Consultant	$ 250.00
Senior Consultant	$ 225.00
Consultant	$ 165.00
Research Consultant	$ 140.00
Senior Research Analyst	$ 90.00

CY 2014		Section 4	Sections 5,6	Section 7	Section 8	Section 3b	Section 4	Section 3	Section 8	Sections 1,5,8	Sections 4, 5, 6	Section 1	Travel	TOTAL
Hours														
Steve Johnson		42	40		24	4	12	4		8	16	16		**166**
Linda Shields			88	8						8		16		**120**
Nancy Walczak		16												**16**
Tim Prinz		32	216	40	32					4	16	80		**420**
Scott Smith		118		8	196			32	32	4	16	8		**414**
Dave Schafer			152		40							16		**208**
Sailaja Prakriya		100	88			24	24							**236**
Lia Bunch								24						**24**
Colby Schaeffer		172		8						16	16	24		**236**
Kristal Peyton			348							16				**364**
Matt Trott		92	60		176	32			64					**424**
Michael Holcomb		184	72									32		**288**
Dan Labson		220	138			32	40							**430**
TOTAL		**976**	**1,202**	**64**	**468**	**92**	**76**	**60**	**96**	**56**	**64**	**192**		**3,346**
Labor Dollars	**Rates**													
Vice President	$275.00	$11,550	$11,000		$6,600	$1,100	$3,300	$1,100		$2,200	$4,400	$4,400		**$ 45,650**
Vice President	$275.00		$24,200	$2,200						$2,200		$4,400		**$ 33,000**
Vice President	$275.00	$4,400												**$ 4,400**
Senior Consultant	$225.00	$7,200	$48,600	$9,000	$7,200					$900	$3,600	$18,000		**$ 94,500**
Senior Consultant	$225.00	$26,550		$1,800	$44,100			$7,200	$7,200	$900	$3,600	$1,800		**$ 93,150**
Senior Consultant	$225.00		$34,200		$9,000							$3,600		**$ 46,800**
Senior Consultant	$225.00	$22,500	$19,800			$5,400	$5,400							**$ 53,100**
Consultant	$165.00							$3,960						**$ 3,960**
Consultant	$165.00	$28,380		$1,320						$2,640	$2,640	$3,960		**$ 38,940**
Consultant	$165.00		$57,420							$2,640				**$ 60,060**
Research Consultant	$140.00	$12,880	$8,400		$24,640	$4,480			$8,960					**$ 59,360**
Senior Research Analyst	$90.00	$16,560	$6,480									$2,880		**$ 25,920**
Senior Research Analyst	$90.00	$19,800	$12,420			$2,880	$3,600							**$ 38,700**
TOTAL		**$149,820**	**$222,520**	**$14,320**	**$91,540**	**$13,860**	**$12,300**	**$12,260**	**$16,160**	**$11,480**	**$14,240**	**$39,040**		**$ 597,540**
ODCs														
Long Distance Travel													$ 13,177	**$ 13,177**
TOTAL													$13,177	**$ 13,177**
TOTAL COST/PRICE		**$149,820**	**$222,520**	**$14,320**	**$91,540**	**$13,860**	**$12,300**	**$12,260**	**$16,160**	**$11,480**	**$14,240**	**$39,040**	**$13,177**	**$ 610,717**

CY 2015		Section 4	Sections 5,6	Section 7	Section 8	Section 3b	Section 4	Section 3	Section 8	Sectio ns 1,5,8	Sections 4, 5, 6	Section 1	Travel	TOTAL
Hours														
Steve Johnson		22	40	20	24	2	12	4		8	16	16		**164**
Linda Shields			88							8		16		**112**
Nancy Walczak		12		12										**24**
Tim Prinz		32	216	48	32					4	16	80		**428**
Scott Smith		88		52	136			32	32	4	16	8		**368**
Dave Schafer			144		24							16		**184**
Sailaja Prakriya		44	80			12	24							**160**
Lia Bunch								24						**24**
Colby Schaeffer		168		84						16	16	24		**308**
Kristal Peyton			348							16				**364**
Matt Trott		120	60		96	16			64					**356**
Michael Holcomb		124	72	96								32		**324**
Dan Labson		100	128			16	40							**284**
TOTAL		**710**	**1,176**	**312**	**312**	**46**	**76**	**60**	**96**	**56**	**64**	**192**		**3,100**
Labor Dollars	**Rates**													
Vice President	$275.00	$6,050	$11,000	$5,500	$6,600	$550	$3,300	$1,100		$2,200	$4,400	$4,400		**$ 45,100**
Vice President	$275.00		$24,200							$2,200		$4,400		**$ 30,800**
Vice President	$275.00	$3,300		$3,300										**$ 6,600**
Senior Consultant	$225.00	$7,200	$48,600	$10,800	$7,200					$900	$3,600	$18,000		**$ 96,300**
Senior Consultant	$225.00	$19,800		$11,700	$30,600			$7,200	$7,200	$900	$3,600	$1,800		**$ 82,800**
Senior Consultant	$225.00		$32,400		$5,400							$3,600		**$ 41,400**
Senior Consultant	$225.00	$9,900	$18,000			$2,700	$5,400							**$ 36,000**
Consultant	$165.00							$3,960						**$ 3,960**
Consultant	$165.00	$27,720		$13,860						$2,640	$2,640	$3,960		**$ 50,820**
Consultant	$165.00		$57,420							$2,640				**$ 60,060**
Research Consultant	$140.00	$16,800	$8,400		$13,440	$2,240			$8,960					**$ 49,840**
Senior Research Analyst	$90.00	$11,160	$6,480	$8,640								$2,880		**$ 29,160**
Senior Research Analyst	$90.00	$9,000	$11,520			$1,440	$3,600							**$ 25,560**
TOTAL		**$110,930**	**$218,020**	**$53,800**	**$63,240**	**$6,930**	**$12,300**	**$12,260**	**$16,160**	**$11,480**	**$14,240**	**$39,040**		**$ 558,400**
ODCs														
Long Distance Travel													$ 9,743	**$ 9,743**
TOTAL													$9,743	**$ 9,743**
TOTAL COST/PRICE		**$110,930**	**$218,020**	**$53,800**	**$63,240**	**$6,930**	**$12,300**	**$12,260**	**$16,160**	**$11,480**	**$14,240**	**$39,040**	**$9,743**	**$ 568,143**

CY 2016		Section 4	Sections 5,6	Section 7	Section 8	Section 3b	Section 4	Section 3	Section 8	Sectio ns 1,5,8	Sections 4, 5, 6	Section 1	Travel	TOTAL
Hours														
Steve Johnson		22	40	20	16		12	4		8	16	16		**154**
Linda Shields			88							8		16		**112**
Nancy Walczak		12		12										**24**
Tim Prinz		32	216	40	32					4	16	80		**420**
Scott Smith		88		52	136			32	32	4	16	8		**368**
Dave Schafer			144		24							16		**184**
Sailaja Prakriya		44	80				24							**148**
Lia Bunch								24						**24**
Colby Schaeffer		168		76						16	16	24		**300**
Kristal Peyton			348							16				**364**
Matt Trott		120	60		96				64					**340**
Michael Holcomb		124	72	88								32		**316**
Dan Labson		100	128				40							**268**
TOTAL		**710**	**1,176**	**288**	**304**		**76**	**60**	**96**	**56**	**64**	**192**		**3,022**
Labor Dollars	**Rates**													
Vice President	$275.00	$6,050	$11,000	$5,500	$4,400		$3,300	$1,100		$2,200	$4,400	$4,400		**$ 42,350**
Vice President	$275.00		$24,200							$2,200		$4,400		**$ 30,800**
Vice President	$275.00	$3,300		$3,300										**$ 6,600**
Senior Consultant	$225.00	$7,200	$48,600	$9,000	$7,200					$900	$3,600	$18,000		**$ 94,500**
Senior Consultant	$225.00	$19,800		$11,700	$30,600			$7,200	$7,200	$900	$3,600	$1,800		**$ 82,800**
Senior Consultant	$225.00		$32,400		$5,400							$3,600		**$ 41,400**
Senior Consultant	$225.00	$9,900	$18,000				$5,400							**$ 33,300**
Consultant	$165.00							$3,960						**$ 3,960**
Consultant	$165.00	$27,720		$12,540						$2,640	$2,640	$3,960		**$ 49,500**
Consultant	$165.00		$57,420							$2,640				**$ 60,060**
Research Consultant	$140.00	$16,800	$8,400		$13,440				$8,960					**$ 47,600**
Senior Research Analyst	$90.00	$11,160	$6,480	$7,920								$2,880		**$ 28,440**
Senior Research Analyst	$90.00	$9,000	$11,520				$3,600							**$ 24,120**
TOTAL		**$110,930**	**$218,020**	**$49,960**	**$61,040**		**$12,300**	**$12,260**	**$16,160**	**$11,480**	**$14,240**	**$39,040**		**$ 545,430**
ODCs														
Long Distance Travel													$ 12,191	**$ 12,191**
TOTAL													$12,191	**$ 12,191**
TOTAL COST/PRICE		**$110,930**	**$218,020**	**$49,960**	**$61,040**		**$12,300**	**$12,260**	**$16,160**	**$11,480**	**$14,240**	**$39,040**	**$12,191**	**$ 557,621**

CY 2017		Section 4	Sections 5,6	Section 7	Section 8	Section 3b	Section 4	Section 3	Section 8	Sectio ns 1,5,8	Sections 4, 5, 6	Section 1	Travel	TOTAL
Hours														
Steve Johnson		8		10	4		12	2		4	8	8		**56**
Linda Shields										4		8		**12**
Nancy Walczak		4		10										**14**
Tim Prinz		12		20	8					2	8	40		**90**
Scott Smith		20		28	19			12	12	2	8	4		**105**
Dave Schafer					4							8		**12**
Sailaja Prakriya		22					24							**46**
Lia Bunch								12						**12**
Colby Schaeffer		42		52						8	8	12		**122**
Kristal Peyton										8				**8**
Matt Trott		44			24				24					**92**
Michael Holcomb		30		68								16		**114**
Dan Labson		50					40							**90**
	TOTAL	**232**		**188**	**59**		**76**	**26**	**36**	**28**	**32**	**96**		**773**
Labor Dollars	**Rates**													
Vice President	$275.00	$2,200		$2,750	$1,100		$3,300	$550		$1,100	$2,200	$2,200		**$ 15,400**
Vice President	$275.00									$1,100		$2,200		**$ 3,300**
Vice President	$275.00	$1,100		$2,750										**$ 3,850**
Senior Consultant	$225.00	$2,700		$4,500	$1,800					$450	$1,800	$9,000		**$ 20,250**
Senior Consultant	$225.00	$4,500		$6,300	$4,275			$2,700	$2,700	$450	$1,800	$900		**$ 23,625**
Senior Consultant	$225.00				$900							$1,800		**$ 2,700**
Senior Consultant	$225.00	$4,950					$5,400							**$ 10,350**
Consultant	$165.00							$1,980						**$ 1,980**
Consultant	$165.00	$6,930		$8,580						$1,320	$1,320	$1,980		**$ 20,130**
Consultant	$165.00									$1,320				**$ 1,320**
Research Consultant	$140.00	$6,160			$3,360				$3,360					**$ 12,880**
Senior Research Analyst	$90.00	$2,700		$6,120								$1,440		**$ 10,260**
Senior Research Analyst	$90.00	$4,500					$3,600							**$ 8,100**
	TOTAL	**$35,740**		**$31,000**	**$11,435**		**$12,300**	**$5,230**	**$6,060**	**$5,740**	**$7,120**	**$19,520**		**$ 134,145**
ODCs														
Long Distance Travel													$ 3,861	**$ 3,861**
	TOTAL												$3,861	**$ 3,861**

TOTAL COST/PRICE	$35,740	$31,000	$11,435	$12,300	$5,230	$6,060	$5,740	$7,120	$19,520	$3,861	$ 138,006

2. Payments for subcontractors will only be made upon approval (see Attachment C, #15).

3. The State shall reimburse the Contractor for travel expenses utilizing the most current General Services Administration Per Diem Study for lodging, meals and incidentals. Expenses will not be reimbursed without prior written approval from the State. Contractor must submit receipts to the state for all expenses.

4. This contract is 100% funded through a federal grant opportunity. There is a 10% limit on indirect expenses according to the federal grant requirements.

 Source of Funds: 100% Federal
 CDFA Title: State Innovation Models: Funding for Model Design or Model Testing Assistance
 CDFA Number: 93.624
 Award Number: JGJCMS331181-01-00, 1GICMS331181:0202
 Award Year: FFY2013, FFY2014
 Federal Granting Agency: HHS, CMS/CMS Innovation Center

5. Contractor shall submit an invoice on a monthly basis to the State for services provided and expenses incurred during the previous month. Invoice must include unique invoice number, dates of service, itemized hours being invoiced, a list of allowable expenses incurred and the address for remittance of payment. A billing for mileage shall include the points of origin and destination and the number of miles traveled. Only actual charges will be paid.

6. Services performed between July 1, 2014 and the start of this contract that are in conformity with Attachment A can be billed under this contract.

7. Upon full payment by the State, all products of the Contractor's work, including outlines, reports, charts, sketches, drawings, art work, plans, photographs, specifications, estimates, computer programs, or similar documents, become the sole property of the State of Vermont and may not be copyrighted or resold by Contractor."

Invoices shall be submitted to:

Janet Richard
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

ATTACHMENT C: STANDARD STATE PROVISIONS
FOR CONTRACTS AND GRANTS

1. **Entire Agreement:** This Agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

2. **Applicable Law:** This Agreement will be governed by the laws of the State of Vermont.

3. **Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement.

4. **Appropriations:** If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority. In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, and in the event federal funds become unavailable or reduced, the State may suspend or cancel this Grant immediately, and the State shall have no obligation to pay Subrecipient from State revenues.

5. **No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. **Independence, Liability:** The Party will act in an independent capacity and not as officers or employees of the State.

   The Party shall defend the State and its officers and employees against all claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit.

   After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party.

   The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party.

7. **Insurance**: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverages are in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the state through the term of the Agreement. No warranty is made that the coverages and limits listed

herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.

General Liability and Property Damage: With respect to all operations performed under the contract, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

Premises - Operations

Products and Completed Operations

Personal Injury Liability

Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

$1,000,000 Per Occurrence

$1,000,000 General Aggregate

$1,000,000 Products/Completed Operations Aggregate

$ 50,000 Fire/ Legal/Liability

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than: $1,000,000 combined single limit.

Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

8. **Reliance by the State on Representations:** All payments by the State under this Agreement will be made in reliance upon the accuracy of all prior representations by the Party, including but not limited to bills, invoices, progress reports and other proofs of work.

9. **Requirement to Have a Single Audit:** In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a Single Audit is required for the prior fiscal year. If a Single Audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required.

   For fiscal years ending before December 25, 2015, a Single Audit is required if the subrecipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. For fiscal years ending on or after December 25, 2015, a Single Audit is required if the subrecipient expends $750,000 or more in federal assistance during its fiscal year and must be conducted in accordance with 2 CFR Chapter I, Chapter II, Part 200, Subpart F. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a Single Audit is required.

10. **Records Available for Audit:** The Party will maintain all books, documents, payroll papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the Agreement

and for three years thereafter for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this Agreement.

11. **Fair Employment Practices and Americans with Disabilities Act**: Party agrees to comply with the requirement of Title 21V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement. Party further agrees to include this provision in all subcontracts.

12. **Set Off**: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

13. **Taxes Due to the State**:

    a. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

    b. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

    c. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

    d. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

14. **Child Support**: (Applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she:

    a. is not under any obligation to pay child support; or
    b. is under such an obligation and is in good standing with respect to that obligation; or
    c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

    Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

15. **Sub-Agreements**: Party shall not assign, subcontract or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party also agrees to include in all subcontract or subgrant agreements a tax certification in accordance with paragraph 13 above.

16. **No Gifts or Gratuities**: Party shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

17. **Copies**: All written reports prepared under this Agreement will be printed using both sides of the paper.

18. **Certification Regarding Debarment:** Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

    Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing/debarment

19. **Certification Regarding Use of State Funds:** In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

(End of Standard Provisions)

Attachment D
Other Contract Provisions

1. Confidentiality. Contractor agrees to keep information related to the State and all agencies and companies related to this contract confidential and agrees not to use any information obtained in relation to the services performed under this contract for any purpose other than as authorized by the State. Contractor agrees not to publish, reproduce, or otherwise divulge such information in whole or in part, in any manner or form or authorize or permit others to do so. Contractor will take reasonable measures as are necessary to restrict access to confidential information in the Contractor's possession to those employees who must have the information to perform their job. Contractor agrees to immediately notify, in writing, the State's authorized representative in the event Contractor determines or has reason to suspect a breach of this requirement.

2. Obligations Regarding Protected Information. Contractor shall assure compliance by the State and Contractor of any and all obligations the State or Contractor may have under HIPAA and any other applicable state or federal law regarding protected health, personal, or otherwise confidential information.

3. Security. Contractor shall maintain security and confidentiality policies and procedures consistent with industry standards with regard to the information obtained from regulated entities. Contractor shall have recovery procedures in place to handle replacement of data in the event of a disaster.

4. Conflicts of Interest. If the State determines that a conflict of interest, as defined by the State, exists between a regulated entity and a member or members of the Contractor's staff, the Contractor shall substitute similarly qualified individuals for the conflicted members. If the State determines that a conflict of interest, as determined by the State, exists between Contractor and a regulated entity, the State may immediately remove that assignment from the Contractor, or may invoke its right to terminate this contract pursuant to paragraph 7 on page 1 of this contract. The State reserves the right to make the ultimate determination as to whether a conflict of interest exists.

5. Protection of Personal Information. Contractor agrees to establish and maintain policies and procedures designed to ensure compliance with 9 V.S.A. Chapter 62 (Protection of Personal Information) with respect to data collected in connection with Contractor's activities pursuant to the Contract.

6. Prior Approval of Workers. The state shall have the right to approve any personnel the Contractor proposes to assign to work requested by the State prior to the commencement of such work. If the proposed personnel of the Contractor are not acceptable to the State, the State may choose to withdraw the assignment of such work from the Contractor, and Contractor will assign personnel acceptable to the State.

7. Intellectual Property/Work Product Ownership. All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement—including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio), pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement, or are a result of the services required under this grant—shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion, unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30 days notice by the State. With respect to software computer programs and/or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Contractor, shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

   The Contractor shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State. If the Contractor is operating a system or application on behalf of the State of Vermont, then the Contractor shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Contractor's materials.

8. Professional Liability Insurance Obligation. With respect to all operations performed under the contract, the Party shall carry professional liability insurance.

   The policy limits shall not be less than:

   $2,000,000 Per Occurrence
   $5,000,000 Aggregate

   Party shall provide a certificate of insurance to show that the above coverage and minimum limits are in effect before commencing work on this contract and shall ensure that it maintains a current such certificate of insurance on file with the State throughout the term of this contract.

9. Requirement to have a single audit. Attachment C, Section 9 does not apply to the Contractor as a for-profit subrecipient hereunder. The Contractor shall comply with all applicable federal procurement laws and regulations, as well as the provisions of this agreement and shall adhere to the Audit and Records requirements defined in FAR 52.215-2 (incorporated herein by reference) throughout the performance period of this contract.

Attachment E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between **the State of Vermont Green Mountain Care Board** ("Covered Entity") and **The Lewin Group, Inc.** ("Business Associate") as of **July 1, 2014** ("Effective Date"). This Agreement supplements and is made a part of the Contract to which it is an attachment.

Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including the Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 ("Privacy Rule") and the Security Standards at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by subtitle D of the Health Information Technology for Economic and Clinical Health Act.

The parties agree as follows:

1. <u>Definitions</u>. All capitalized terms in this Agreement have the meanings identified in this Agreement, 45 CFR Part 160, or 45 CFR Part 164.

The term "Services" includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR 160.103 under the definition of Business Associate.

The term "Individual" includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

The term "Breach" means the acquisition, access, use or disclosure of protected health information (PHI) in a manner not permitted under the HIPAA Privacy Rule, 45 CFR part 164, subpart E, which compromises the security or privacy of the PHI. "Compromises the security or privacy of the PHI" means poses a significant risk of financial, reputational or other harm to the individual.

2. <u>Permitted and Required Uses/Disclosures of PHI</u>.

2.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying contract with Covered Entity. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

2.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with

such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents (including subcontractors) in accordance with Sections 8 and 16 or (b) as otherwise permitted by Section 3.

3. **Business Activities**. Business Associate may use PHI received in its capacity as a "Business Associate" to Covered Entity if necessary for Business Associate's proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as "Business Associate" to Covered Entity for Business Associate's proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if (a) Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person and (b) the person notifies Business Associate, within three business days (who in turn will notify Covered Entity within three business days after receiving notice of a Breach as specified in Section 5.1), in writing of any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in this Section must be of the minimum amount of PHI necessary to accomplish such purposes.

4. **Safeguards**. Business Associate shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

5. **Documenting and Reporting Breaches**.

5.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI as soon as it (or any of its employees or agents) become aware of any such Breach, and in no case later than three (3) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

5.2 Business Associate shall provide Covered Entity with the names of the individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR §164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it.

5.3 When Business Associate determines that an impermissible acquisition, use or disclosure

of PHI by a member of its workforce does not pose a significant risk of harm to the affected individuals, it shall document its assessment of risk. Such assessment shall include: 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low risk of harm. When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity.

6. **Mitigation and Corrective Action.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity.

7. **Providing Notice of Breaches.**

7.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate's employees or agents was responsible constitutes a Breach as defined in 45 CFR §164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individuals whose PHI was the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

7.2 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

7.3 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or
obtain additional information, as set forth in 45 CFR §164.404(c).

7.4 Business Associate shall notify individuals of Breaches as specified in 45 CFR §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR §164.406.

8. **Agreements by Third Parties**. Business Associate shall ensure that any agent (including a subcontractor) to whom it provides PHI received from Covered Entity or created or received

by Business Associate on behalf of Covered Entity agrees in a written agreement to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. For example, the written contract must include those restrictions and conditions set forth in Section 14. Business Associate must enter into the written agreement before any use or disclosure of PHI by such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of PHI to any agent without the prior written consent of Covered Entity.

9. **Access to PHI**. Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

10. **Amendment of PHI**. Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

11. **Accounting of Disclosures**. Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

12. **Books and Records**. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity upon Covered Entity's request in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

13. **Termination.**

13.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 17.7.

13.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate this Contract without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate this Contract without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under this Contract, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

14. Return/Destruction of PHI.

14.1 Business Associate in connection with the expiration or termination of this Contract shall return or destroy all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this Contract that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

14.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI.

15. Penalties and Training. Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in training regarding the use, confidentiality, and security of PHI.

16. Security Rule Obligations. The following provisions of this Section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

16.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

16.2 Business Associate shall ensure that any agent (including a subcontractor) to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any agent without the prior written consent of Covered Entity.

16.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an agent, including a subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident, and in no case later than three (3) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

16.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

17. <u>Miscellaneous</u>.

17.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the Contract, the terms of this Agreement shall govern with respect to its subject matter. Otherwise the terms of the Contract continue in effect.

17.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

17.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

17.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule) in construing the meaning and

effect of this Agreement.

17.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

17.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity under this Contract even if some of that information relates to specific services for which Business Associate may not be a "Business Associate" of Covered Entity under the Privacy Rule.

17.7 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 11 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

VT Analytics Contract
Attachment F

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
May 15, 2014

ACO pilot standards are organized in the following four categories:

- Standards related to the ACO's structure:
    - Financial Stability
    - Risk Mitigation
    - Patient Freedom of Choice
    - ACO Governance

- Standards related to the ACO's payment methodology:
    - Patient Attribution Methodology
    - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
    - Care Management
    - Payment Alignment
    - Data Use Standards

- Process for review and modification of measures.

The objectives and details of each draft standard follow.

I. Financial Stability

Objective: Protect ACOs from the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the ACO can focus on management of "performance risk" (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition).

A. Standards related to the effects of provider coding patterns on medical spending and risk scores

1. The GMCB's Analytics Contractor will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.

The Payers and ACOs shall participate in a GMCB-facilitated process to review and consider the financial impact of any identified changes in ACO provider coding patterns.

B. Standards related to downside risk limitation

1. The Board has established that for the purposes of the pilot program, the ACO will assume the following downside risk in each pilot program year:
   - Year 1: no downside risk
   - Year 2: no downside risk
   - Year 3: downside risk not less than 3% and up to 5%

2. ACOs are required to submit a Risk Mitigation Plan to the state that demonstrates that the ACO has the ability to assume not less than 3% and up to 5% downside risk in Year 3 and receive state approval. Such a plan may, but need not, include the following elements: recoupment from payments to participating providers, stop loss protection, reinsurance, a provider payment withhold provision, and reserves (e.g., irrevocable letter of credit, escrow account, surety bond).

3. The Risk Mitigation Plan must include a downside risk distribution model that does not disproportionately punish any particular organization within the ACO and maintains network adequacy in the event of a contract year in which the ACO has experienced poor financial performance.

C. Standards related to financial oversight.

1. The payer will furnish financial reports regarding each ACO's risk performance for each six-month performance period to the GMCB and DVHA in accordance with report formats and timelines defined by the GMCB, through a collaborative process with ACOs and payers.

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. For Year 1 of the ACO pilot, an ACO participating with one commercial payer must have at least five thousand (5,000) commercial attributed lives as of June 30, 2014. For Year 1 of the ACO pilot, an ACO participating with two commercial payers must have three thousand (3,000) commercial attributed lives for each of the two payers, for an aggregate minimum of six thousand (6,000) commercial attributed lives, as of June 30, 2014.

   In order to establish the number of an ACO's commercial attributed lives, the payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's commercial attributed lives as of June 30, 2014. Based upon the number of an ACO's commercial attributed lives as of June 30, 2014, the ACO and payer may proceed as follows: if the commercial attributed lives are below the minimum number required for participation, the payer or the ACO may:
   a. terminate their agreement for cause as of June 30, 2014; or
   b. agree to maintain their agreement in full force and effect.

2. In Performance Years 2 and 3, a participating insurer may elect to not participate with an ACO, if: (1) that ACO is participating with one commercial insurer and that ACO's projected or actual attributed member months with that insurer fall below 60,000 annually; or (2) that ACO is participating with two commercial insurers and that ACO's projected or annual attributed member months with that insurer fall below 36,000 annually.

If an ACO falls below the attribution threshold required for participation in the pilot in Years 2 and 3, it may request that the relevant payers participate in a GMCB-facilitated process to determine whether one or more of the payers would find it acceptable to waive the enrollment threshold and either a) establish a contract with the ACO in the absence of meeting this requirement, or b) permit an already-contracted ACO eligibility to share in any generated savings. While the GMCB will facilitate this process, the decision regarding whether to waive the enrollment threshold and contract with the ACO, or to permit a contracted ACO to share in any savings, remains with the payer.

F. The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.

II. Risk Mitigation

The ACOs must provide the GMCB with a detailed plan to mitigate the impact of the maximum potential loss on the ACO and its provider network in Year 3 of the commercial ACO pilot. Such a plan must establish a method for repaying losses to the insurers participating in the pilot. The method may include recoupment from payments to its participating providers, stop loss reinsurance, surety bonds, escrow accounts, a line of credit, or some other payment mechanism such as a withhold of a portion of any previous shared savings achieved. The ACO must provide documentation of its ability to repay such losses 90 days prior to the start of Year 3.

Any requirements for risk mitigation, as noted above, will be the responsibility of the ACO itself, and not of the participating providers. The burden of holding participating providers financially accountable shall rest with the ACO, and the ACO must to exhibit their ability to manage the risk as noted above.

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, and holding ACO management accountable for the ACO's activities.

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;
    c. making meeting minutes available to the ACO's provider network upon request, and
    d. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

    b. is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

    A "participant" does not need to have lives attributed to the ACO to be considered a participant. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

    The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board, with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution Methodology

Patients will be attributed to an ACO as follows:

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
   - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members to select a primary care provider, attribute those members to that provider.

4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[1] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

[1] Should the Blueprint for Health change the qualifying CPT codes to be other than those listed in this table, the VHCIP Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463

CPT-4 Code Description Summary
• Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least monthly.

9. Using a GMCB-facilitated process, the participating ACOs and payers will reconsider during Year 1 whether obstetricians and gynecologists should be added to the attributing clinician list.

10. A qualified primary care practitioner to whom lives have been attributed by a payer may only participate as a primary care practitioner in one ACO. If a qualified primary care practitioner works under multiple tax ID numbers, the practitioner may not use a specific tax ID number with more than one ACO.

VI. Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

(See attached spreadsheet.)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.

Years 1 and 2: The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[2], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2.

The ACO-responsible services used to define expected spending shall include all covered services except for:

1. services that are carved out of the contract by self-insured employer customers
   - prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion, and
2. dental benefits[3].

Year 3: The Year 3 expected spending shall be calculated using an alternative methodology to be developed through the Payment Models Work Group and recommended to the GMCB Board for approval. The employed trend rate will be made available to the insurers prior to the deadline for GMCB rate submission in order to facilitate the calculation of premium rates for the Exchange. It is the shared intent of the pilot participants and the GMCB that the methodology shall not reduce expected spending based on any savings achieved by the pilot ACO(s) in the first two years.

The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."

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[2] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.

[3] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the <u>targeted</u> PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.

Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

As noted above, the Year 3 targeted spending shall be calculated using an alternative methodology to be developed by the VHCIP Payment Models Work Group and approved by the GMCB.

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

<u>Actions Initiated After the Performance Year Ends</u>

Step 3: Determine actual spending and whether the ACO has generated savings.

No later than eight months (i.e., two months following the six-month claim lag period) following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using the risk adjustment model utilized by Center for Consumer Information and Insurance Oversight (CCIIO) for the federal exchange. The GMCB may consider alternatives for future years;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000, and

- conversion from allowed to paid claims value.

For Years 1 and 2, insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold. The GMCB and participating pilot insurers and ACOs will reassess this practice during Years 1 and 2 for Year 3.

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

In Years 1 and 2 of the pilot:

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

In Year 3 of the pilot:
The formula for distribution of insurer-specific savings will be the same as in Years 1 and 2, except that the ACO will be responsible for a percentage of the insurer-specific excess spending up to a cap equal to an amount no less than 3% and up to 5% of the ACO's insurer-specific expected spending.

All participating ACOs shall assume the same level of downside risk in Year 3, as approved by the VHCIP Payment Models Work Group and the GMCB.

The calculation of the ACO's liability will be as follows:

- If the ACO's total actual spending is greater than the total expected spending (called "excess spending"), then the ACO will assume responsibility for insurer-specific actual medical expense spending that exceeds the insurer-specific expected spending in a way that is reciprocal to the approach to distribution of savings.
- If the insurer-specific excess spending is less than the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 25% of the insurer-specific excess spending.
- If the ACO's excess spending exceeds the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 60% of the insurer-specific excess spending over the difference, up to a cap equal to an amount no greater than 5% of the ACO's insurer-specific expected spending.

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap. [4]

Step 4: Assess ACO quality performance to inform savings distribution.

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

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[4] A reciprocal approach shall apply to ACO excess spending in Year 3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.

Methodology for distribution of shared savings: For year one of the commercial pilot, compare the ACO's performance on the payment measures (see Table 1 below) to the PPO HEDIS national percentile benchmark[5] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

Table 1. Core Measures for Payment in Year One of the Commercial Pilot

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 Nat. 50th: .78 Nat. 25th: .83 *Please note, in interpreting this measure, a lower rate is better.
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 89.74 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET CMMI	Claims	Nat. 90th: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09

[5] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The Ladder: In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

Table 2. Distribution of Shared Savings in Year One of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Please note that the following provision is contained within the ACO-payer program agreements but is not yet under consideration for standards incorporation by the SIM Steering Committee, SIM Core Team, and GMCB:

Eligibility for shared savings based on performance improvement.

Should the ACO, in Years 2 or 3, fail to meet the minimum quality score, it may still be eligible to receive hared savings if the GMCB determines, after providing notice to and accepting written input from the insurer and ACO (and input from ACO participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior pilot years. The GMCB will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the GMCB.

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month claim lag period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

VII. Care Management Standards (*still under development*)

Objective: Effective care management programs close to, if not at, the site of care for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. Any standards will be developed by the VHCIP Care Models Work Group. For Year 1 of the pilot emphasis will be placed upon member communication and care transitions.

VIII. Payment Alignment

Objective: Improve the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
   a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
   b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO Data Use Standards

ACOs and payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" document in the format defined through a collaborative process led by the GMCB.

IV. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to

national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national x^{th} percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work

Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications** for **the next pilot year by no later than** October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a

change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

VT Analytics Contract
Attachment G
Contractor Timeline and Process for Reporting Payment, Reporting and Monitoring & Evaluation Measures
Revised May 20, 2014

Date	Deliverable	Details
30 days following the contract start date	Exchange premium and enrollment by product	Thirty days after the analytics contractor contract start date, the analytics contractor will provide the GMCB with a report of Exchange premium and enrollment by product, and of expected and targeted commercial PMPM spending for each ACO.
October 15, 2014	Baseline quality and utilization report	After receiving the numerators and denominators for M&E measures #10-23 and the claims files for the Claims-based quality measures required for Year One (core measures #1-13) **for the time period covering January 1, 2013 through December 31, 2013** from the payers on August 1, 2014, the GMCB analytics contractor will compile a report to include quality and utilization information for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO. The analytics contractor will provide the GMCB with all reports and provide each ACO and payer with its respective quality and utilization reports no later than 75 days after receiving the claims files.
November 7, 2014	Quarter 1 and 2 2014 Monitoring and Evaluation utilization measures report	After receiving the numerators and denominators for M&E measures #12-23 **for the time period covering January 1, 2014 through June 30, 2014** from the payers on October 7, 2014 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than one month following the receipt of the numerators and denominators.
November 22, 2014	Six-month 2014 claims-based measures report (Repeat for years 2015 and 2016)	After receiving the claims files for the Claims-based quality measures required for Year One (core measures #1-13) **for the time period covering January 1, 2014 through June 30, 2014** from the payers on October 7, 2014 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile a report to include quality information for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO. The analytics contractor will provide the GMCB with all reports and provide each ACO and payer with its respective quality reports no later than 45 days after receiving the claims files.

Date	Deliverable	Details
January 21, 2015	Quarter 3 2014 Monitoring and Evaluation utilization measures report (Repeat for years 2015 and 2016)	After receiving the numerators and denominators for M&E measures #12-23 **for the time period covering January 1, 2014 through September 30, 2014** from the payers on January 7, 2015, (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than two weeks following the receipt of the numerators and denominators.
February 22, 2015	Nine-month 2014 claims-based measures report (Repeat for years 2015 and 2016)	After receiving the claims files for the Claims-based quality measures required for Year One (core measures #1-13**) for the time period covering January 1, 2014 through September 30, 2014** from the payers on January 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile a report to include quality information for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO. The analytics contractor will provide the GMCB with all reports and provide each ACO and payer with its respective quality reports no later than 45 days after receiving the claims files.
August 29, 2015	Final Monitoring and Evaluation measures report (Repeat for years 2015 and 2016)	After receiving the numerators and denominators from the payers for M&E measures #1-6 and #10-23, from the appropriate state agencies for M&E measures #8 and 9, and the Vermont Assembly of Home Health and Hospice Agencies for M&E measure #7 **for the time period covering January 1, 2014 through December 31, 2014** on July 15, 2015 (to account for a 180-day claims lag and two weeks to process the data), the GMCB analytics contractor will compile the rates for all of the Monitoring and Evaluation measures for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB. This report, due no later than 45 days after receiving the numerators and denominators, will summarize all of the M&E measures for the entire performance year.
July 21, 2015	Quarter 1 2015 Monitoring and Evaluation utilization measures report (Repeat for year 2016)	After receiving the numerators and denominators for M&E measures #12-23 **for the time period covering January 1, 2015 through March 31, 2015** from the payers on July 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than two weeks following the receipt of the numerators and denominators.

Date	Deliverable	Details
August 31, 2015	Final (18-month) 2014 quality measures report used to inform savings distribution (Repeat for performance years 2015 and 2016)	After receiving on July 15, 2015: • the final claims files for the claims-based quality measures required for Year One (core measures #1-13) **for the time period covering January 1, 2014 through December 31, 2014** from the payers; • the numerators and denominators for the clinical data-based reporting measures (core measures #14-20) **for the time period covering January 1, 2014 through December 31, 2014** from the ACOs, and • the patient experience measures (core measures #21-29) **for the time period covering January 1, 2014 through December 31, 2014** from the state's survey contractor, the GMCB analytics contractor will conduct a final assessment of each ACO's Year 1 performance on both the payment and reporting measures. (The analytics contractor will also assess the implications of ACO quality performance on distribution of any earned savings. See Attachment H.) The GMCB analytics contractor will compile the final quality measures report data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO and submit the report to the GMCB no later than 45 days following the receipt of the final claims files.
October 21, 2015	Quarter 2 2015 Monitoring and Evaluation utilization measures report (Repeat for year 2016)	After receiving the numerators and denominators for M&E measures #12-23 **for the time period January 1, 2015 to June 30, 2015** from the payers on October 7, 2015 (to account for a 90-day claims lag and one week to process the data), the GMCB analytics contractor will compile the utilization data for the Medicaid population and by individual commercial payer and combined commercial populations for each ACO into an ACO monitoring and evaluation report to be submitted to the GMCB no later than two weeks following the receipt of the numerators and denominators.

VT Analytics Contract

Attachment H

Timeline and Process for Calculation of Commercial ACO Financial Performance and Payment

Revised April 30, 2014

Date	Action	Responsible Party	Details
July 31, 2014	Determine the expected PMPM medical expense for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending" for Year 1	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "insurer-specific expected spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of expected spending.
July 31, 2014	Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO for Year 1	GMCB analytics contractor	Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population.
August 15, 2014	The GMCB approves the target rate for Year 1	GMCB	The GMCB will review the targeted spending calculations and notify the relevant payers and providers of the approved rate.

Date	Action	Responsible Party	Details
August 31, 2014	Determine the <u>expected</u> PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO for Year 1	GMCB analytics contractor	The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[1], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2. 1. The ACO-responsible services used to define expected spending shall include all covered services except for: a. services that are carved out of the contract by self-insured employer customers b. prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following SIM Payment Models Work Group discussion, and c. dental benefits[2].
November 30, 2014	Determine the <u>expected</u> PMPM medical expense for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending" for Year 2	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "insurer-specific expected spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of expected spending.

[1] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.
[2] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

Date	Action	Responsible Party	Details
November 30, 2014	Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO for Year 2	GMCB analytics contractor	Years 1 and 2: The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[3], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2. 1. The ACO-responsible services used to define expected spending shall include all covered services except for: a. services that are carved out of the contract by self-insured employer customers b. prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following SIM Payment Models Work Group discussion, and c. dental benefits[4].
November 30, 2014	Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO for Year 2	GMCB analytics contractor	Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population.
December 15, 2014	The GMCB approves the target rate for Year 2	GMCB	The GMCB will review the targeted spending calculations and notify the relevant payers and providers of the approved rate.

[3] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.

[4] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

Date	Action	Responsible Party	Details
April 30, 2015	Calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending	GMCB analytics contractor	The GMCB's analytics contractor will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad and inform the insurers and ACOs of the results, providing supporting documentation when doing so.
May 15, 2015	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.	Insurer	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible. The insurers must notify the GMCB that they have offered the ACOs this opportunity.
August 31, 2015	Determine actual spending and whether the ACO has generated savings for Year 1.	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "actual medical expense spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of actual medical expense spending.

Date	Action	Responsible Party	Details
August 31, 2015	Compare the actual spending for each ACO to its expected spending.	GMCB analytics contractor	The GMCB's analytics contractor will a conduct the aggregate assessment: a. If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer. b. If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers. c. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer. Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level. Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step In Years 1 and 2 of the pilot: a. If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings. b. If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending). c. An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

Date	Action	Responsible Party	Details
August 31, 2015	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2015	Notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of this aggregate and insurer specific assessments after the completion of the GMCB's analytics contractor's analysis.
September 15, 2015	Savings distributed to contracted ACOs for Year 1	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.
November 30, 2015	Determine the expected PMPM medical expense for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending" for Year 3	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "insurer-specific expected spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of expected spending.

Date	Action	Responsible Party	Details
November 30, 2015	Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO for Year 3	GMCB analytics contractor	The Year 3 expected spending shall be calculated using an alternative methodology to be developed through the Payment Models Work Group and recommended to the GMCB Board for approval
November 30, 2015	Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO for Year 3	GMCB analytics contractor	Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population.
December 15, 2015	The GMCB approves the target rate for Year 3	GMCB	The GMCB will review the targeted spending calculations and notify the relevant payers and providers of the approved rate.
April 30, 2016	Calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending	GMCB analytics contractor	The GMCB's analytics contractor will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad and inform the insurers and ACOs of the results, providing supporting documentation when doing so.
May 15, 2016	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.	Insurer	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible. The insurers must notify the GMCB that they have offered the ACOs this opportunity.

Date	Action	Responsible Party	Details
August 31, 2016	Determine actual spending and whether the ACO has generated savings for Year 2	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "actual medical expense spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of actual medical expense spending.
August 31, 2016	Compare the actual spending for each ACO to its expected spending for Year 2.	GMCB analytics contractor	The GMCB's analytics contractor will a conduct the aggregate assessment: a. If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer. b. If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers. c. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer. Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level. Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step In Years 1 and 2 of the pilot: a. If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-

			specific targeted spending, the ACO will share 25% of the insurer-specific savings. b. If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending). c. An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.
Date	**Action**	**Responsible Party**	**Details**
August 31, 2016	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2016	Notify each ACO and insurer dyad of results of this aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments after the completion of the GMCB's analytics contractor's analysis.
September 15, 2016	Savings distributed to contracted ACOs for Year 2	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

Date	Action	Responsible Party	Details
April 30, 2017	Calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending	GMCB analytics contractor	The GMCB's analytics contractor will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad and inform the insurers and ACOs of the results, providing supporting documentation when doing so.
May 15, 2017	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.	Insurer	If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible. The insurers must notify the GMCB that they have offered the ACOs this opportunity.
August 31, 2017	Determine actual spending and whether the ACO has generated savings for Year 3	GMCB analytics contractor	The GMCB's analytics contractor must provide the amount of "actual medical expense spending" for each ACO agreement to the relevant ACO, payer and the GMCB. The analytics contractor must provide documentation demonstrating the calculations used to arrive at the amount of actual medical expense spending.
August 31, 2017	Compare the actual spending for each ACO to its expected spending.	GMCB analytics contractor	The GMCB's analytics contractor will a conduct the aggregate assessment: a. If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer. b. If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers. c. If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

Date	Action	Responsible Party	Details
August 31, 2017	Assess ACO quality performance to inform savings distribution	GMCB analytics contractor	The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.
August 31, 2017	Notify each ACO and insurer dyad of results of the aggregate and insurer specific assessments and any adjustments for quality.	GMCB	The GMCB will notify each ACO and insurer dyad of results of this aggregate assessment after the completion of the GMCB's analytics contractor's analysis.
September 15, 2017	Savings distributed to contracted ACOs for Year 3	Insurers	The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

Vermont ACO Pilot Calculation of Commercial ACO Savings - Year 1 Calculation of Adjusted Expected Medical Expense

Carrier 1

Initial Assumptions — Allowed Basis

	Full PMPM Exchange Premium	Dental Premium Component	Full PMPM Exchange Premium Less Dental	Medical Expense Components PMPM (Paid Basis)	Assumed Paid to Allowed Ratios	Medical Expense Component (Allowed Basis)	Retail Rx Allowed Expense	Initial Expected Allowed Medical Expense (adjusted for excluded Rx services PMPM, without adjusting for risk)	Adjustment for Projected High-cost Outlier Expense	Expected Allowed Medical Expense (after truncation of outlier claims expense)	Anticipated Member Months for ACO	Weighted Average Allowed Expected Medical Expense PMPM
Platinum	$ 805.89	$ 40.29	$ 765.60	$ 685.01	0.91	752.75	$ 90.33	$ 662.42	$ 46.37	$ 616.05	30,780	
Gold	$ 672.02	$ 33.60	$ 638.42	$ 571.22	0.79	723.06	$ 86.77	$ 636.29	$ 44.54	$ 591.75	64,980	
Silver	$ 538.15	$ 26.91	$ 511.24	$ 457.43	0.68	672.69	$ 80.72	$ 591.97	$ 41.44	$ 550.53	150,480	
Bronze	$ 404.28	$ 20.21	$ 384.07	$ 343.64	0.58	592.48	$ 71.10	$ 521.38	$ 36.50	$ 484.89	95,760	
Total											342,000	$ 545.88

Paid Basis

	Expected Medical Claim Paid to Allowed Ratio Assumed in Pricing (AV)	Expected Paid Medical Expense PMPM (After Truncation of Outlier Claims and Network Adjustment)	Weighted Average Expected Paid Medical Expense PMPM
Platinum	0.90	$ 554.45	
Gold	0.80	$ 473.40	
Silver	0.70	$ 385.37	
Bronze	0.60	$ 290.93	
Total			$ 390.87

Preliminary Adjustment for Actual Initial Enrollment (to be performed in January each year)

	Initial Enrollment by Plan (Expressed as Member Months, Assuming 12 Months Per Enrollee)	Weighted Average Initial Expected Allowed Medical Expense PMPM	Weighted Average Initial Expected Paid Medical Expense PMPM
Platinum	31,088		
Gold	66,929		
Silver	148,975		
Bronze	102,463		
Total	349,455	$ 545.01	$ 389.58

Adjustments After Considering Year 1 Actual Experience on a Paid Basis (to be performed after the end of each year)

	Risk Score of Population Reflected in Rates	Risk Score of Actual Enrollees	Risk Adjustment Factor	Risk-adjusted Expected Medical Expense	Actual Member Months for ACO	Weighted Average Risk-adjusted Expected Paid Medical Expense PMPM
Platinum	1.10	1.05	0.95	$ 529.25	28,800	
Gold	1.07	1.03	0.96	$ 455.70	61,200	
Silver	1.00	1.00	1.00	$ 385.37	180,000	
Bronze	0.95	0.81	0.85	$ 248.06	90,000	
Total	1.01				360,000	$ 374.51

Carrier 2

Initial Assumptions — Allowed Basis

	Full PMPM Exchange Premium	Dental Premium Component	Full PMPM Exchange Premium Less Dental	Medical and RX Expense Components PMPM (Paid Basis)	Assumed Paid to Allowed Ratios	Medical Expense Component (Allowed Basis)	Retail Rx Allowed Expense	Initial Expected Allowed Medical Expense (adjusted for excluded Rx services PMPM, without adjusting for risk)	Adjustment for Projected High-cost Outlier Expense	Expected Allowed Medical Expense (after truncation of outlier claims expense)	Anticipated Member Months for ACO	Weighted Average Allowed Expected Medical Expense PMPM
Platinum	$ 872.82	$ 43.64	$ 829.18	$ 741.90	0.90	824.33	$ 98.92	$ 725.41	$ 50.78	$ 674.63	11,400	
Gold	$ 738.96	$ 36.95	$ 702.01	$ 628.12	0.80	785.15	$ 94.22	$ 690.93	$ 48.36	$ 642.56	21,660	
Silver	$ 605.09	$ 30.25	$ 574.84	$ 514.33	0.70	734.75	$ 88.17	$ 646.58	$ 45.26	$ 601.32	37,620	
Bronze	$ 471.22	$ 23.56	$ 447.66	$ 400.54	0.60	667.56	$ 80.11	$ 587.45	$ 41.12	$ 546.33	43,320	
Total											114,000	$ 595.59

Paid Basis

	Expected Medical Claim Paid to Allowed Ratio Assumed in Pricing (AV)	Expected Paid Medical Expense PMPM (After Truncation of Outlier Claims and Network Adjustment)	Weighted Average Expected Paid Medical Expense PMPM
Platinum	0.90	$ 607.17	
Gold	0.80	$ 514.05	
Silver	0.70	$ 420.92	
Bronze	0.60	$ 327.80	
Total			$ 421.86

Preliminary Adjustment for Actual Initial Enrollment (to be performed in January each year)

	Initial Enrollment by Plan (Expressed as Member Months, Assuming 12 Months Per Enrollee)	Weighted Average Initial Expected Allowed Medical Expense PMPM	Weighted Average Initial Expected Paid Medical Expense PMPM
Platinum	11,514		
Gold	22,310		
Silver	37,244		
Bronze	46,352		
Total	117,420	$ 594.64	$ 420.12

Adjustments After Considering Year 1 Actual Experience on a Paid Basis (to be performed after the end of each year)

	Risk Score of Population Reflected in Rates	Risk Score of Actual Enrollees	Risk Adjustment Factor	Risk-adjusted Expected Medical Expense	Actual Member Months for ACO	Weighted Average Risk-adjusted Expected Paid Medical Expense PMPM
Platinum	1.08	1.02	0.94	$ 573.44	12,000	
Gold	1.05	0.98	0.93	$ 479.78	25,200	
Silver	0.99	0.94	0.95	$ 399.67	37,200	
Bronze	0.94	0.96	1.02	$ 334.77	45,600	
Total	0.99				120,000	$ 409.21

Carriers 1 and 2 Combined

Weighted Average Allowed Expected Medical Expense PMPM	Weighted average Expected Paid Medical Expense PMPM	Weighted Average Initial Expected Allowed Medical Expense PMPM	Weighted Average Initial Expected Paid Medical Expense PMPM
$ 558.31	$ 398.62	557.49	397.26

Carriers 1 and 2 Combined

Allowed Basis Weighted average risk-adjusted Expected Medical Expense PMPM
$ 383.18

Summary Member Counts:

	Anticipated Members	Actual Members
Carrier 1	28,500	30,000.00
Carrier 2	114,000	10,000.00
ACO Tot.	142,500	40,000

Vermont ACO Pilot Calculation of Commercial ACO Savings Achievement and Distribution - Year 1

Calculation for Year 1 Assuming ACO Savings

Steps A-C are completed at the aggregate ACO level

Step	Description	Medical Spend PMPM		Other Factors	Notes
A	Expected Spending for Year 1	$	383.18		For Year 1 this is the portion of commercial insurer Exchange premium for medical expenses translated to paid dollars, adjusted for excluded services and high-cost outliers, risk-adjusted based on actual enrollment and then weighted by ACO attributed lives in each insurer's Exchange products.
B	Actual Spending for Year 1	$	353.61		Insurers will calculate PMPM spending and the GMCB will calculate a weighted average based on the ACO's enrollment in Exchange-based products.
C	Aggregate Shared Savings (PMPM)	$	29.57		Total ACO Expected Savings minus Actual Savings. If the ACO has generated savings (i.e., actual PMPM spending is less than expected PMPM spending), move to Step D. If the ACO has not generated savings, no further actions should be taken.

Steps D-N are completed at the insurer-specific level

Step	Description	Medical Spend PMPM		Notes
D	Calculating Insurer-Specific Risk-Adjusted Expected Spending on a **Paid Basis** for Year 1			This is Step A repeated, but performed this time at the individual insurer level.
	Insurer 1	$	374.51	
	Insurer 2	$	409.21	
E	Relevant CMS Minimum Savings Rate		-2.2%	The selected CMS Minimum Savings Rate (MSR) in this example is for an ACO with 40,000 attributed commercial patients. The MSR would be higher for smaller attributed patient counts, and as low as 2.0% for larger attributed patient counts.
F	Calculating Insurer-Specific Targeted Spending			Insurer-specific Targeted Spending is calculated as Year 1 insurer-specific Expected Spending * Minimum Savings Rate.
	Insurer 1	$	366.27	
	Insurer 2	$	400.21	
G	Insurer-Specific Actual Spending			Insurers will calculate actual PMPM spending.
	Insurer 1	$	328.92	(In this spreadsheet this is pulled from step R, please make any changes there)
	Insurer 2	$	427.70	

Step	Item		Value	Description
H	Actual Insurer-Specific Spending Compared With Insurer-Specific *Expected* Spending			Savings calculated as insurer-specific Expected Spending minus insurer-specific Actual Spending
	Insurer 1	$	45.59	
	Insurer 2	$	(18.49)	If a positive number, savings have been achieved relative to Expected Spending. If a negative number, there is no ACO eligibility for shared savings relative to Expected Spending.
I	Actual Insurer-Specific Spending Compared With Insurer-Specific *Targeted* Spending			Savings calculated as insurer-specific Actual Spending - insurer-specific Targeted Spending
	Insurer 1	$	37.35	
	Insurer 2	$	(27.50)	If a positive number, savings have been achieved relative to Targeted Spending. If a negative number, there is no ACO eligibility for shared savings relative to Targeted Spending.
J	Comparison of Actual Insurer-Specific Spending Compared with Insurer-Specific Target and Insurer-Specific Expected			
			60%	Rate used if insurer-specific Actual Spending is below insurer-specific Targeted Spending.
J-1	Insurer 1		$22.41	
	Insurer 2		$0.00	If insurer-specific Actual Spending is less than insurer-specific Targeted Spending, the ACO is eligible for 60% of the savings when subtracting insurer-specific Actual Spending from insurer-specific Targeted Spending.
J-2	Insurer 1		$2.06	
	Insurer 2		$0.00	If insurer-specific Actual Spending is less than insurer-specific Expected Spending, the ACO is eligible for 25% of the savings when subtracting insurer-specific Targeted Spending from insurer-specific Expected Spending.
J-3	Shared Savings Total Before Savings Cap Test			
	Insurer 1		$24.47	
	Insurer 2		$0.00	Total eligible shared savings before savings cap test: Step J-1 + Step J-2.
K	Calculate Insurer Specific Savings Distribution Cap			An insurer's allocation of eligible savings to an ACO will be capped at 10% of the ACO's insurer-specific Expected Spending.
	Insurer 1		$37.45	
	Insurer 2		$40.92	

L	Total Potential Shared Savings Before Quality Evaluation			
	Insurer 1		$24.47	
	Insurer 2		$0.00	
M	Actual Member Months Per Insurer			The number of member months is reported by the insurers and are required for the quality point evaluation.
	Insurer 1		360,000	
	Insurer 2		120,000	
	Total		480,000	
N	Shared Savings earned by ACO by Insurer Before Quality Gate			(Sum of insurer-specific savings for the ACO) * (total member months for insurer)
	Insurer 1	$	8,809,935	
	Insurer 2	$	-	
	Total	$	8,809,935	

O	Cap Test to Ensure that No Insurer Pays Out More than the Aggregate Savings			
	Aggregate Savings PMPM	$	29.57	This is from Step C above
	Total Aggregate Savings	$	14,194,274	Aggregate Savings PMPM * Total Member Month
	Total Insurer Potential Payout	$	8,809,935	Tests if individual insurer's combined savings are greater than the aggregate savings. If the insurer's savings are greater than the aggregate savings, the combined individual-level insurer savings are capped at the aggregate savings.
P	Proportional Reduction (if necessary)			If the total potential combined insurer-level savings are greater than the aggregate savings, the insurer-specific shared savings are capped at the total aggregate savings and proportionately allocated by each insurers percent of shared savings
	Total Insurer Potential Payout	Not Necessary		
	Insurer 1	$	-	
	Insurer 2	$	-	
	Total	$	-	

Q	Evaluate Quality Points and Distribute Shared Savings	*This model assumes the quality point evaluation has been completed.*
	ACOs Must Obtain at Least 55% of Quality Points to Retain Shared Savings. Shared Savings Are Distributed as Shown Below	

% of Eligible Points	% of Earned Savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

% of Eligible Points	Distributed Savings Scenario 60%		
<55%	$0.00		The ACO does not receive any shared savings for failure to meet the "quality gate."
55%	$6,607,451	$13.77	
60%	$7,047,948	$14.68	
65%	$7,488,445	$15.60	
70%	$7,928,941	$16.52	
75%	$8,369,438	$17.44	
80%	$8,809,935	$18.35	ACO earns all of the shared savings for which it is eligible.

For Reference : Insurer-Specific Reconciliation With Aggregate - Make any changes to actual spending here in the cells highlighted in green at the insurer-specific level and aggregate data will automatically upda

R	Expected PMPM on a Paid Basis	Actual PMPM	Total Expected	Total Actual
Insurer 1	$ 374.51	$ 328.92	$ 134,822,990	$ 118,409,536
Insurer 2	$ 409.21	$ 427.70	$ 49,104,968	$ 51,324,147
Total			$ 183,927,958	$ 169,733,683
Total PMPM			$ 383.18	$ 353.61

te.

Expected - Actual		PMPM	
$	16,413,453	$	45.59
$	(2,219,179)	$	(18.49)
$	14,194,274	$	29.57

Vermont ACO Pilot Calculation of Commercial ACO Savings Achievement and Distribution - Year 2

Calculation for Year 2: Two Scenarios, One Assuming ACO Savings, One Assuming ACO Excess Spending

Steps A-C are completed at the aggregate ACO level

Step	Description	Scenario Assuming Overall Savings Medical Spend PMPM	Scenario Assuming Overall Excess Spending Medical Spend PMPM	Notes
A	Expected Spending for Year 2	$ 409.58	$ 409.58	For Year 2 this is the portion of commercial insurer Exchange premium for medical expenses translated to paid dollars, adjusted for excluded services and high-cost outliers, risk-adjusted based on actual enrollment, and then weighted by ACO attributed lives in each insurer's Exchange products.
B	Actual Spending for Year 2	$ 409.33	$ 420.77	Insurers will calculate PMPM spending and the GMCB will calculate a weighted average based on the ACO's enrollment in Exchange-based products.
C	Expected Spending - Actual Spending	$ 0.25	$ (11.18)	This is the aggregate savings or excess spending for the ACO.

Steps D-N are completed at the insurer-specific level

Step	Description	Scenario Assuming Overall Savings Medical Spend PMPM	Scenario Assuming Overall Excess Spending Medical Spend PMPM	Notes
D	Calculating Insurer-Specific Expected Spending for Year 2			This is Step A repeated, but performed this time at the individual insurer level.
	Insurer 1	$ 397.09	$ 397.09	
	Insurer 2	$ 447.06	$ 447.06	
E	Relevant CMS Minimum Savings Rate	-2.2%	-2.2%	The selected CMS Minimum Savings Rate (MSR) in this example is for an ACO with 40,000 attributed commercial patients. The MSR would be higher for smaller attributed patient counts, and as low as 2.0% for larger attributed patient counts.
F	Calculating Insurer-Specific Targeted Spending			
	Insurer 1	$ 388.35	$ 388.35	Insurer-specific Targeted Spending is calculated as Year 2 insurer-specific Expected Spending * Minimum Savings Rate
	Insurer 2	$ 437.22	$ 437.22	
G	Insurer-Specific Actual Spending			Insurers will calculate PMPM spending and the GMCB will calculate a weighted average based on the ACO's enrollment in Exchange-based products.
	Insurer 1	$ 402.09	$ 410.00	
	Insurer 2	$ 431.06	$ 453.06	

Step	Description	Scenario 1	Scenario 2	Notes
H	Actual Insurer-Specific Spending Compared With Insurer-Specific *Expected* Spending			Savings (above the target) are calculated as insurer-specific Actual Spending minus insurer-specific Expected Spending
	Insurer 1	$ (5.00)	$ (12.91)	
	Insurer 2	$ 16.00	$ (6.00)	Since the second scenario generates Excess Spending, and has insurer-specific Excess Spending, after this step move to Step R.
I	Actual Insurer-Specific Spending Compared With Insurer-Specific *Targeted* Spending			Savings below the target are calculated as insurer-specific Targeted Spending minus insurer-specific Actual Spending In the scenario assuming Excess Spending we are only concerned when insurer-specific Actual Spending is greater then insurer-specific Expected Spending
	Insurer 1	$ (13.74)	NA	
	Insurer 2	$ 6.16	NA	
J	Comparison of Actual Insurer-Specific Spending Compared with Insurer-Specific Target and Insurer-Specific Expected	60%	NA	Rate used if insurer-specific Actual Spending is below insurer-specific Targeted Spending.
J-1	Insurer 1	$0.00	NA	If insurer-specific Actual Spending is less than insurer-specific Targeted Spending, the ACO is eligible for 60% of the savings when subtracting insurer-specific Actual Spending from insurer-specific Targeted Spending.
	Insurer 2	$3.70	NA	
J-2	Insurer 1	$0.00	NA	If insurer-specific Actual Spending is less than insurer-specific Expected Spending, the ACO is eligible for 25% of the savings when subtracting insurer-specific Targeted Spending from insurer-specific Expected Spending.
	Insurer 2	$2.46	NA	
J-3	Shared Savings Total Before Savings Cap Evaluation			
	Insurer 1	$0.00	NA	Total eligible shared savings before savings cap test: Step J-1 + Step J-2.
	Insurer 2	$6.16	NA	
K	Calculate Savings Distribution Cap			An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific Expected Spending.
	Insurer 1	$39.71	NA	
	Insurer 2	$44.71	NA	
L	Total Amount of Shared Savings Before Quality Evaluation			
	Insurer 1	$0.00	NA	
	Insurer 2	$6.16	NA	

M	Actual Member Months Per Insurer			The number of member months is reported by the insurers and are required for the quality point evaluation.
	Insurer 1		360,000	This scenario assumes the same number of member months as Year 1 for the sake of simplification.
	Insurer 2		120,000	
	Total		480,000	
N	Shared Savings earned by ACO by Insurer Before Quality Gate			(Sum of insurer-specific savings for the ACO) * (total member months for insurer)
	Insurer 1		$0	
	Insurer 2		$738,917	
	Total Shared Savings due to ACO	$	738,917	

O	Cap Test To Ensure that No Insurer Pays Out More Than the Aggregate Savings			
	Aggregate Savings PMPM	$	0.25	This is from Step C above.
	Total Aggregate Savings	$	120,000	Aggregate Savings PMPM * Total Member Months
	Total Insurer Potential Payout	$	120,000	Tests if individual insurer's combined savings are greater than the aggregate savings. If the insurer's savings are greater than the aggregate savings, the combined individual-level insurer savings are capped at the aggregate savings.
P	Proportional Reduction (if necessary)			If the total potential combined insurer-level savings are greater than the aggregate savings, the insurer-specific shared savings are proportionately reduced from each insurer's shared savings.
	Total Insurer Potential Payout	$	120,000	
	Insurer 1	$	-	
	Insurer 2	$	120,000	
	Total	$	120,000	

Q Evaluate Quality Points and Distribute Shared Savings

This model assumes the quality point evaluation has been completed.

ACOs Must Obtain at Least 55% of Quality Points to Retain Shared Savings. Shared Savings Are Distributed as Shown Below

% of Eligible Points	% of Earned Savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Percent of Eligible Points		Total Amount of Shared Savings Distributed to ACO Based on Points Earned		
Rate used if insurer-specific Actual Spending is below insurer-specific Targeted Spending		60%		
	<55%	$0.00		ACO does not get any shared savings for failure to meet the "quality gate."
	55%	$90,000	$0.19	
	60%	$96,000	$0.20	
	65%	$102,000	$0.21	
	70%	$108,000	$0.23	
	75%	$114,000	$0.24	
	80%	$120,000	$0.25	ACO earns all of the shared savings for which it is eligible.

ACO Downside Risk Calculation

				The ACO is responsible for 60% of the excess spending between actual and risk target.
R	Calculate ACO Risk Potential Liability			The ACO is responsible for 25% of the excess spending between the expected spending and the risk target. The risk target is calculated as the expected spending * 1+MSR (with the MSR switched from negative to positive for the purposes of this calculation).
R - 1	Calculate the targeted spending for the purpose of ACO risk			
	Insurer 1	$	405.83	
	Insurer 2	$	456.90	
R - 2	Calculate ACO Insurer-Specific Downside Risk (PMPM) Before 1% Cap			
	Insurer 1	NA	($7.75)	
	Insurer 2	NA	($3.60)	
S	Calculate ACO Risk Cap 1% of ACO's Insurer-Specific Expected Spending			
	Insurer 1	NA	($3.97)	
	Insurer 2	NA	($4.47)	
T	Calculate ACO Insurer-Specific Downside Risk (PMPM)			
	Insurer 1	NA	($3.97)	
	Insurer 2	NA	($3.60)	
U	Calculate ACO Insurer-Specific Downside Risk (Total Dollars)			
	Insurer 1	$	(1,429,524)	
	Insurer 2	$	(432,000)	
	Total ACO Risk	$	(1,861,524)	
	ACO Total Downside Risk PMPM	$	(3.88)	

V	Ensure that the ACO is not Liable for More Than the Insurer-Specific Loss			
	Total Aggregate Excess Spending	$	(5,367,600)	
	Total ACO Potential Repayment	$	(1,861,524)	
W	Proportional Reduction (if necessary)			If the total potential combined insurer-level Excess Spending is greater than the aggregate Excess Spending, the insurer-specific Excess Spending is proportionately reduced from each insurer's Excess Spending.
	Amount of Over Payment	Not Necessary		
	Insurer 1	$	-	
	Insurer 2	$	-	
	Total	$	-	
	Total ACO Potential Payout			
	Insurer 1	$	(1,429,524)	
	Insurer 2	$	(432,000)	
	Total ACO Potential Payout	$	(1,861,524)	

For Reference : Insurer-Specific Reconciliation With Aggregate - Make any changes to actual spending here in the cells highlighted in green at the insurer-specific level and aggregate data will automatically update.

X	Scenario 1: Shared Savings	Expected PMPM on a Paid Basis	Actual PMPM	Total Expected	Total Actual	Expected - Actual	PMPM
	Insurer 1	$ 397.09	$ 402.09	$ 142,952,400	$ 144,752,400	$ (1,800,000)	$ (5.00)
	Insurer 2	$ 447.06	$ 431.06	$ 53,647,200	$ 51,727,200	$ 1,920,000	$ 16.00
	Total			$ 196,599,600	$ 196,479,600	$ 120,000	$ 0.25
	Total PMPM			$ 409.58	$ 409.33		$ 0.25

Scenario 2: Excess Spending	Expected PMPM on a Paid Basis	Actual PMPM	Total Expected	Total Actual	Expected - Actual	PMPM
Insurer 1	$ 397.09	$ 410.00	$ 142,952,400	$ 147,600,000	$ (4,647,600)	$ (12.91)
Insurer 2	$ 447.06	$ 453.06	$ 53,647,200	$ 54,367,200	$ (720,000)	$ (6.00)
Total			$ 196,599,600	$ 201,967,200	$ (5,367,600)	$ (11.18)
Total PMPM			$ 409.58	$ 420.77		$ (11.18)

Vermont ACO Pilot Calculation of Commercial ACO Savings Achievement and Distribution - Year 3

Calculation for Year 3: Two Scenarios, One Assuming ACO Savings, One Assuming ACO Excess Spending

Steps A-C are completed at the aggregate ACO level

Step	Description	Scenario Assuming Overall Savings Medical Spend PMPM	Scenario Assuming Overall Excess Spending Medical Spend PMPM	Notes
A	Expected Spending for Year 3	$ 411.69	$ 411.69	For Year 3 this will be calculated using an alterntative methodology to be defined by the GMCB with pilot participant input.
B	Actual Spending for Year 3	$ 394.80	$ 412.07	Insurers will calculate PMPM spending and the GMCB will calculate a weighted average based on the ACO's enrollment in Exchange-based products.
C	Expected Spending - Actual Spending	$ 16.89	$ (0.38)	This is the aggregate savings or excess spending for the ACO.

Steps D-N are completed at the insurer-specific level

Step	Description	Scenario Assuming Overall Savings Medical Spend PMPM	Scenario Assuming Overall Excess Spending Medical Spend PMPM	Notes
D	Calculating Insurer-Specific Expected Spending for Year 3			This is Step A repeated, but performed this time at the individual insurer level.
	Insurer 1	$ 393.78	$ 393.78	
	Insurer 2	$ 465.43	$ 465.43	
E	Relevant CMS Minimum Savings Rate	-2.2%	-2.2%	The selected CMS Minimum Savings Rate (MSR) in this example is for an ACO with 40,000 attributed commercial patients. The MSR would be higher for smaller attributed patient counts, and as low as 2.0% for larger attributed patient counts.
F	Calculating Insurer-Specific Targeted Spending			
	Insurer 1	$ 385.11	$ 385.11	Insurer-specific Targeted Spending is calculated as Year 3 insurer-specific Expected Spending * Minimum Savings Rate
	Insurer 2	$ 455.19	$ 455.19	
G	Insurer-Specific Actual Spending			

Step	Description	Scenario 1	Scenario 2	Notes
				Insurers will calculate PMPM spending and the GMCB will calculate a weighted average based on the ACO's enrollment in Exchange-based products.
	Insurer 1	$ 375.00	$ 392.76	
	Insurer 2	$ 454.18	$ 470.00	
H	Actual Insurer-Specific Spending Compared With Insurer-Specific *Expected* Spending			Savings (above the target) are calculated as insurer-specific Actual Spending minus insurer-specific Expected Spending
	Insurer 1	$ 18.78	$ 1.02	
	Insurer 2	$ 11.25	$ (4.57)	Since the second scenario generates Excess Spending, and has insurer-specific Excess Spending, after this step move to Step R.
I	Actual Insurer-Specific Spending Compared With Insurer-Specific *Targeted* Spending			Savings below the target are calculated as insurer-specific Targeted Spending minus insurer-specific Actual Spending In the scenario assuming Excess Spending we are only concerned when insurer-specific Actual Spending is greater then insurer-specific Expected Spending
	Insurer 1	$ 10.11	NA	
	Insurer 2	$ 1.01	NA	
J	Comparison of Actual Insurer-Specific Spending Compared with Insurer-Specific Target and Insurer-Specific Expected			
		60%	NA	Rate used if insurer-specific Actual Spending is below insurer-specific Targeted Spending.
				If insurer-specific Actual Spending is less than insurer-specific Targeted Spending, the ACO is eligible for 60% of the savings when subtracting insurer-specific Actual Spending from insurer-specific Targeted Spending.
J-1	Insurer 1	$6.07	NA	
	Insurer 2	$0.60	NA	
				If insurer-specific Actual Spending is less than insurer-specific Expected Spending, the ACO is eligible for 25% of the savings when subtracting insurer-specific Targeted Spending from insurer-specific Expected Spending.
J-2	Insurer 1	$2.17	NA	
	Insurer 2	$2.56	NA	
J-3	Shared Savings Total Before Savings Cap Evaluation			
	Insurer 1	$8.23	NA	Total eligible shared savings before savings cap test: Step J-1 + Step J-2.
	Insurer 2	$3.16	NA	
K	Calculate Savings Distribution Cap			An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific Expected Spending.
	Insurer 1	$39.38	NA	
	Insurer 2	$46.54	NA	

L	Total Amount of Shared Savings Before Quality Evaluation			
	Insurer 1	$8.23	NA	
	Insurer 2	$3.16	NA	

M	Actual Member Months Per Insurer		The number of member months is reported by the insurers and are required for the quality point evaluation.
	Insurer 1	360,000	This scenario assumes the same number of member months as Year 1 for the sake of simplification.
	Insurer 2	120,000	
	Total	480,000	
N	Shared Savings earned by ACO by Insurer Before Quality Gate		(Sum of insurer-specific savings for the ACO) * (total member months for insurer)
	Insurer 1	$2,964,316	
	Insurer 2	$379,684	
	Total Shared Savings due to ACO	$ 3,344,001	

O	Cap Test To Ensure that No Insurer Pays Out More Than the Aggregate Savings		
	Aggregate Savings PMPM	$ 16.89	This is from Step C above.
	Total Aggregate Savings	$ 8,109,342	Aggregate Savings PMPM * Total Member Months
	Total Insurer Potential Payout	$ 3,344,001	Tests if individual insurer's combined savings are greater than the aggregate savings. If the insurer's savings are greater than the aggregate savings, the combined individual-level insurer savings are capped at the aggregate savings.
P	Proportional Reduction (if necessary)		If the total potential combined insurer-level savings are greater than the aggregate savings, the insurer-specific shared savings are proportionately reduced from each insurer's shared savings.
	Total Insurer Potential Payout	Not Necessary	
	Insurer 1	$ -	
	Insurer 2	$ -	
	Total	$ -	

Q Evaluate Quality Points and Distribute Shared Savings

This model assumes the quality point evaluation has been completed.

ACOs Must Obtain at Least 55% of Quality Points to Retain Shared Savings. Shared Savings Are Distributed as Shown Below

% of Eligible Points	% of Earned Savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Percent of Eligible Points	Total Amount of Shared Savings Distributed to ACO Based on Points Earned
Rate used if insurer-specific Actual Spending is below insurer-specific Targeted Spending	60%

<55%	$0.00			ACO does not get any shared savings for failure to meet quality gate.
55%	$2,508,001	$5.23		
60%	$2,675,201	$5.57		
65%	$2,842,401	$5.92		
70%	$3,009,601	$6.27		
75%	$3,176,801	$6.62		
80%	$3,344,001	$6.97		ACO earns all of the shared savings for which it is eligible.

ACO Downside Risk Calculation

R	Calculate ACO Risk Potential Liability				The ACO is responsible for 60% of the excess spending between actual and risk target.
					The ACO is responsible for 25% of the excess spending between the expected spending and the risk target. The risk target is calculated as the expected spending * 1+MSR (with the MSR switched from negative to positive for the purposes of this calculation).
R - 1	Calculate the Targeted Spending for the Purpose of ACO Risk Assessment				
	Insurer 1		$	402.44	
	Insurer 2		$	475.67	
R - 2	Calculate ACO Insurer-Specific Downside Risk (PMPM) Before 5% Cap				
	Insurer 1	NA		$0.00	
	Insurer 2	NA		($2.74)	
S	Calculate ACO Risk Cap 5% of ACO's Insurer-Specific Expected Spending				
	Insurer 1	NA		($19.69)	
	Insurer 2	NA		($23.27)	
T	Calculate ACO Insurer-Specific Downside Risk (PMPM)				
	Insurer 1	NA		$0.00	
	Insurer 2	NA		($2.74)	
U	Calculate ACO Insurer-Specific Downside Risk (Total Dollars)				
	Insurer 1		$	-	
	Insurer 2		$	(329,290)	
	Total ACO Risk		$	(329,290)	
	ACO Total Downside Risk PMPM		$	(0.69)	

V	Ensure that the ACO is not Liable for More Than the Insurer-Specific Loss			
	Total Aggregate Excess Spending	$	(181,744)	
	Total ACO Potential Repayment	$	(181,744)	
W	Proportional Reduction (if necessary)			If the total potential combined insurer-level Excess Spending is greater than the aggregate Excess Spending, the insurer-specific Excess Spending is proportionately reduced from each insurer's Excess Spending.
	Amount of Over Payment	$	(181,744)	
	Insurer 1	$	-	
	Insurer 2	$	(181,744)	

PMPM
$ 18.78
$ 11.25
$ 16.89
$ 16.89
$ 1.02
$ (4.57)
$ (0.38)
$ (0.38)

STATE OF VERMONT CONTRACT SUMMARY AND CERTIFICATION - Form AA-14

PERFORMANCE MEASURES ☐ CHECK IF ARRA FUNDED CONTRACT ☐ CHECK IF IRENE FUNDED CONTRACT ☐

I. CONTRACT INFORMATION

Contract# 00000000000000000000027060
Amendment # N/A

Agency/Departme Agency of Administration, Department of Buildings and General Services
Business Unit: Vendor No:
Contractor: THE LEWIN GROUP
Address: 3130 FAIRVIEW PARK DRIVE, SUITE 500, FALLS CHURCH, VA 22042

Starting Date: 7/1/2014 Ending Date: 9/30/2017
Summary of contract or amendment: DATA ANALYTIC SERVICES

II. FINANCIAL INFORMATION

Maximum $ payable under contract: $2,200,000.00 Maximum units under contract: If Renewal:
This Amendment-$ Change: Cum. Amendments- $ Change: $0.00 Cum % Change: 0%
Unit change: Prior $ max: Prior units:
Rate: Prior Rate:
Source of Funds: General Fund: Federal: Other Fund:
Appropriation(s) Dept Id #: 1100891201

III. SUITABILITY OF PERSONAL SERVICES CONTRACT

☒ Yes ☐ No Does this contractor meet all three parts of the "ABC" definition of independent contractor? (See Bulletin 3.5) If not, please indicate why this work is being arranged through a contract.
☐ Yes ☒ No Is agency liable for income tax withholding or FICA?
☐ Yes ☒ No Should contractor be paid on the state payroll?

IV. PUBLIC COMPETITION

The agency has taken reasonable steps to control the price of the contract and to allow qualified businesses to compete for the work authorized by this contract. The agency has done this through:

☒ Standard bid or RFP ☐ Simplified bid ☐ Sole Sourced ☐ Qualification Based Selection

V. TYPE OF CONTRACT

☒ Personal Service ☐ Construction ☐ Architectural / Engineering ☐ Commodity ☐ Privatization**
**Requires DHR review

VI. CONFLICT OF

I certify that no person able to control or influence award of this contract had a pecuniary interest in its award or performance, either personally or through a member of his or her household, family, or business.

☐ Yes ☒ No Is there an "appearance" of a conflict of interest so that a reasonable person may conclude that this contractor was selected for improper reasons? (If yes, explain)

VII. PRIOR APPROVALS REQUIRED OR REQUESTED

☒ Yes ☐ No Contract must be approved by the Attorney General under 3 VSA §311(a)(10) (over $10,000).
☐ Yes ☒ No I request the Attorney General to review this contract as to form.
☐ Yes ☐ No Already performed by in-house AAG, or counsel? ________ (Initial)
☐ Yes ☒ No Contract must be approved by the CIO/Commissioner of DII; for IT hardware, software or IT related personal services over $15,000
☐ Yes ☒ No Contract must be approved by the CMO; for Marketing services over $15,000
☒ Yes ☐ No This contract must be approved by the Secretary of Administration.
☐ Yes ☒ No DHR

VIII. AGENCY HEAD CERTIFICATION

I have made reasonable inquiry as to the accuracy of the above information.

E-SIGNED by Michael J. Obuchowski
on 2014-07-02 15:58:01 GMT

Date | Agency or Department Head | Date | Approval by Agency Secretary (if required)

E-SIGNED by Jacob Humbert
on 2014-07-07 14:25:35 GMT

Date | Approval by Attorney General | Date | **Reviewed By Comm. DHR or DHR AAG

E-SIGNED by Michael Clasen
on 2014-07-07 18:35:25 GMT

Date | CIO (initial) | Date | CMO (initial) | Date | Approval by Secretary of Administration

Revised July 1, 2006

E-SIGNED by DAVID BEATTY
on 2014-07-07 18:33:38 GMT