COMMERCIAL SHARED SAVINGS PILOT PROGRAM AGREEMENT

BETWEEN

("ACO")

AND

("COMMERCIAL PAYER")

This Commercial Shared Savings Pilot Program Agreement (the "Agreement") is made as of the date it has been signed by ACO and Commercial Payer (collectively "Parties" and each individually a "Party").

WHEREAS, the Green Mountain Care Board ("GMCB") has determined that it is in the State's best interest for commercial health insurers and accountable care organizations to work together to be accountable for the quality and cost of health care in Vermont and to share in the savings generated by that work because it is likely to foster a healthier population, promote healthy lifestyles, create higher quality health care services, foster relationships between health care providers and patients, and generally lower system costs; and

WHEREAS, in an effort to pursue those goals, the Parties, together with the GMCB and in accordance with the authority provided to the GMCB under Act 48 to oversee, implement, regulate and evaluate payment reform pilot programs and models, are establishing a Commercial Population Based Accountable Care Organization Shared Savings Pilot Program; and

WHEREAS, standards for this Commercial Population Based Accountable Care Organization Shared Savings Pilot Program were developed by a multi-stakeholder work group, approved by the Vermont Health Care Innovation Project ("VHCIP") Steering Committee and Core Team and approved by the GMCB; and

WHEREAS, the GMCB requires that accountable care organizations and commercial payers who participate in the Commercial Population Based Accountable Care Organization Shared Savings Pilot Program must enter into a formal written agreement that describes the terms of the Program and the obligations of each party; and

WHEREAS, Commercial Payer and ACO desire to participate in the Commercial Population Based Accountable Care Organization Shared Savings Pilot Program on the terms and conditions hereinafter set forth.

NOW, THEREFORE, the Parties agree as follows:

1. Definitions

As used in this Agreement, the following terms shall have the meaning indicated.

1.1 *ACO* means the party to this Agreement that is a legal entity comprising providers of Health Care Services that agree to work together to be accountable for the quality, cost and overall care of Attributed Lives.

1.2 *ACO Participant* means an individual or group of Health Care Providers that is identified by a TIN that alone or together with one or more other ACO Participant(s) comprise(s) an ACO, provided each such individual or group of Health Care Providers is a participating provider with each Commercial Payer with whom ACO contracts for the Commercial Population Based Accountable Care Organization Shared Savings Pilot Program.

1.3 *Attributed Life/Lives and Commercial Exchange Attributed Life/Lives* mean a commercially insured individual, who has purchased health care insurance that was available through Vermont Health Connect, who is assigned to ACO in accordance with the XSSP Standards and whose cost of care is calculated in the Shared Savings calculation performed under XSSP Standards.

1.4 *Commercial Population Based Accountable Care Organization Shared Savings Pilot Program (XSSP Program)* means the program designed, pursuant to the Green Mountain Care Board's (GMCB) authority under Title 18, Chapter 220 of Vermont Statutes Annotated, within which accountable care organizations have the opportunity to earn Shared Savings from and/or Share Risk with Commercial Payers for actions associated with lowering the cost of care provided to Attributed Lives.

1.5 *Health Care Provider or Provider* means (a) a health care facility, defined as all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, prevention, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered, excluding any facility operated by religious groups relying solely on spiritual means through prayer or healing, but including all institutions included in 18 V.S.A. § 9432 (except health maintenance organizations); and (b) a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care services to an individual during that individual's health care, treatment or confinement.

1.6 *Health Care Services* means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

1.7 *Payer or Commercial Payer* means the party to this Agreement which is a Vermont licensed commercial insurer who offers individual and/or small group products on Vermont Health Connect.

1.8 *Performance Year* means the twelve (12) month period beginning January 1 and ending December 31 of each year during the Agreement's term. The Parties may agree, by mutually accepted amendment to this Agreement, to shorten a Performance Year to less than twelve (12) months and shall provide notification to the GMCB of any such amendment.

1.9 *Quality Measures* means the measures defined by the XSSP Standards, to assess the quality of care furnished by an ACO, such as measures of clinical processes and outcomes or patient and, where practicable, caregiver experience of care and utilization.

1.10 *Shared Savings* means the portion of the Payer-specific difference between actual spending and expected spending that ACO is eligible to receive as payment from Payer according to the formulas and procedures set forth in the XSSP Standards. ACO's eligibility for Shared Savings will be determined separately for each Performance Year during this Agreement.

1.11 *Shared Risk* means the portion of the Payer-specific difference between actual spending and expected spending that the ACO shall pay to the Payer for Performance Year 3 according to the formulas and procedures set forth in the XSSP Standards.

1.12 *TIN* means a federal taxpayer identification number or employer identification number as defined by the Internal Revenue Service in 26 C.F.R. 301.6109-1.

1.13 *Vermont Health Connect and Commercial Exchange* mean Vermont's health insurance exchange for individuals, families and small businesses to purchase health insurance.

1.14 *XSSP Standards or ACO XSSP Program Standards* means the set of written standards and guidelines for the Commercial Population Based Accountable Care Organization Shared Savings Pilot Program developed by a multi-stakeholder working group and approved by the GMCB, a copy of which is attached hereto as Exhibit A and incorporated herein by this reference.

2. Eligibility Requirements

2.1 ACO must be a legal entity, recognized and authorized under applicable State or federal law and must meet the requirements set forth in the ACO XSSP Program Standards.

2.2 ACO will, in a manner consistent with the XSSP Standards: (a) promote evidence-based medicine and patient engagement; (b) report on quality and cost metrics to the GMCB; and (c) coordinate care for Attributed Lives.

2.3 An ACO participating in the XSSP Program with one Commercial Payer must have at least five thousand (5,000) Commercial Exchange Attributed Lives. An ACO participating in the XSSP Program with two Commercial Payers must have three thousand (3,000) Commercial Exchange Attributed Lives for each of the two payers, for an aggregate minimum of six thousand (6000) thousand Commercial Exchange Attributed Lives.

2.4 Notwithstanding the provisions of Section 2.3, ACO may enter into this Program Agreement in anticipation of meeting the minimum requirement of Commercial Exchange Attributed Lives during the first Performance Year. In order to establish the number of ACO's Commercial Exchange Attributed Lives, Payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's Commercial Exchange Attributed Lives as of June 30, 2014. Based upon the number ACO's Commercial Exchange Attributed Lives as of June 30, 2014, the Parties may proceed as follows:

2.4.1 If the Commercial Exchange Attributed Lives are below the minimum number required for participation in Section 2.3, the Payer or the ACO may: (1) terminate this Agreement for cause as of June 30, 2014; or (2) the Parties may agree to maintain this Agreement in full force and effect.

2.4.2 If the Commercial Exchange Attributed Lives are above the minimum number required for participation in Section 2.3, the Agreement will continue in effect through the end of the Performance Year, unless terminated pursuant to Section 8.

2.5 Payer is a licensed Vermont insurer offering small group and individual insurance products on Vermont Health Connect.

3. ACO Participation Obligations

3.1 ACO will meet the requirements of each of the XSSP Standards that is applicable to ACO. Should ACO implement a change that causes it to become out of compliance with the applicable XSSP Standards for Financial Stability, Risk Mitigation, Patient Freedom of Choice, Governance, or Data Reporting, ACO shall report that non-compliance to the GMCB as soon as practical, but no more than thirty (30) days from knowledge of non-compliance. The GMCB may, in its program oversight role, take any of the actions set forth in **Exhibit B**, attached hereto and incorporated herein by reference, with regard to the non-compliance.

3.2 ACO will require, through contracts with ACO Participants, that those Providers meet the applicable requirements of the XSSP Standards.

3.3 ACO will submit TINs and National Provider Identification Numbers ("NPIs") for each ACO Participant to the GMCB's third party state analytics contractor, to facilitate the creation of data reports for ACO specific populations by Payers and the third party state analytics contractor.

3.4 ACO is, and will remain during the term of this Agreement, legally entitled to receive and capable of distributing any earned Shared Savings, and, if applicable for Performance Year 3, expects to be capable of repaying any Shared Risk. ACO will distribute Shared Savings to ACO Participants and/or collect Shared Risk in accordance with its contractual obligations.

3.5 ACO will participate in work groups related to the XSSP Program as reasonably requested by the GMCB.

3.6 ACO will make its books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations and compliance with the XSSP Standards available for inspection by the GMCB or a designee reasonably acceptable to ACO, at reasonable times and upon reasonable notice. The GMCB will maintain as confidential and not subject to disclosure any information identified as confidential by a Party, to the extent permissible under law, including the Vermont Access to Public Records Act, 1 V.S.A. §§ 315-320. ACO will maintain books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations and compliance with the XSSP for ten (10) years from the termination of this Agreement.

4. Payer Participation Obligations

4.1 Payer will meet the requirements of each of the XSSP Standards that is applicable to Payer.

4.2 Payer will pay to ACO any earned Shared Savings due to ACO or collect Shared Risk due from ACO for Performance Year 3 in accordance with the XSSP Standards.

4.3 Payer will attribute lives to ACO in accordance with the methodology set forth in Section V (or any successor section in an amended or modified XSSP Standards adopted by the Parties as part of this Agreement) of the XSSP Standards and shall provide attribution estimates to ACO as mutually agreed or as set forth in this Agreement.

4.4 Payer will participate in work groups related to XSSP as reasonably requested by the GMCB.

4.5 Should Payer be or become out of compliance with the applicable XSSP Standards, Payer shall report that non-compliance to the GMCB as soon as practical, but no more than thirty (30) days from knowledge of non-compliance. The GMCB may, in its program oversight role, take any of the actions set forth in **Exhibit B** with regard to the non-compliance.

4.6 The Parties recognize that Payers have pre-existing contractual relationships, or provider agreements, with ACO Participants and that those provider agreements are separate and distinct from this Agreement. This Agreement is in addition to those provider agreements and shall not modify them. The Parties also recognize that, despite best efforts to achieve consistency, which they will each exercise, the possibility that conflicts between the provider agreements and ACO Participant agreements may arise in various areas including care management. In such circumstances, the Parties agree to follow the dispute resolution process set forth in Section 9 of this Agreement.

4.7 Payer will make its books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations and compliance with the XSSP Standards available for inspection by the GMCB or a designee reasonably acceptable to Payer, at reasonable times and on reasonable notice. The GMCB will maintain as confidential and not subject to disclosure any information identified as confidential by a Party, to the extent permissible under law, including the Vermont Access to Public Records Act, 1 V.S.A. §§ 315-320. Payer will maintain books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations and compliance with the XSSP Standards for ten (10) years from the termination of this Agreement.

5. Regulatory Oversight

5.1 The Parties recognize that GMCB has oversight authority and responsibilities with respect to payment reform pilot programs and models in the State of Vermont. The Parties acknowledge the GMCB's oversight will be consistent with **Exhibit B** that has been executed by the GMCB and is attached hereto.

6. Program Requirements and Member Protections

6.1 Attributed Lives will be free to use their Providers of choice to the extent permissible pursuant to their health care benefits.

6.2 The calculation of ACO financial performance shall be as set forth in the attached XSSP Standards. Notwithstanding anything to the contrary in the XSSP Standards, the Medical Loss Ratio shall not operate as a limit on Shared Savings unless CMS considers or treats Shared Savings as administrative expenses and Shared Savings are the cause of any penalty for exceeding the Medical Loss Ratio. Additionally, should federal rules and regulations treat ACO Shared Savings payments as administrative costs for Payer, and not as a claims/medical cost, ACO and/or Payer may request that the XSSP Standards be amended to adjust the savings distribution calculation so that Shared Savings in excess of the premium medical expense will not be distributed. The determination of the expected and targeted per member per month ("PMPM") medical expense rates shall be approved by the GMCB, or its designee, in accordance with the XSSP Standards.

7. Data Sharing & Use

7.1 Payer and ACO shall, to the extent permissible by law, exchange data necessary to comply with the XSSP Standards. If required by law, the Parties shall execute Data Use Agreements describing the manner(s) in which Protected Health Information, as defined by HIPAA, will be shared and binding each to comply with applicable laws.

7.2 The Parties expressly acknowledge that attribution to an ACO is dependent on enrollment information of members enrolled in Vermont Health Connect Qualified Health Plans and that data exchange may be delayed due to enrollment issues with Vermont Health Connect. The Parties shall work in good faith to exchange data in accordance with Exhibit B and any data exchange guidelines mutually agreed to by the Parties. The Parties acknowledge that any timeline for data exchange requirements may be subject to change due to circumstances related to enrollment data and operational capability.

8. Term & Termination

8.1 This Agreement is for an approximate three year term, the first year of that term beginning January 1, 2014, and running through December 31, 2014; the second year running from January 1, 2015-December 31, 2015 and the third year running from January 1, 2016-December 31, 2016.

8.2 Payer or ACO may terminate this Agreement at the end of any Performance Year hereunder without cause by providing written notice of its intent to terminate at least ninety (90) days prior to the end of the then-current Performance Year.

8.3 Payer or ACO may terminate this Agreement with cause by giving at least sixty (60) days prior written notice in the event that there is a significant or material change to the XSSP Standards.

8.4 Payer or ACO may terminate this Agreement upon a material breach by the other, by providing at least sixty (60) days prior written notice to the Party alleged to be in breach

identifying, with specificity, such breach, but only in the event that the alleged breaching Party fails to cure same within the sixty (60) day notice period.

8.5 Payer or ACO may terminate this Agreement, with cause, during the first Performance Year only and no later than forty-five (45) days after receiving information that ACO's Commercial Exchange Attributed Lives are less than the minimums required in Section 2.3. Such termination will be effective as of June 30, 2014.

8.6 In the event this Agreement is terminated, ACO's continued right to Shared Savings will terminate as of the last effective day of the Agreement, but ACO's right to Shared Savings for any full Performance Year for which this Agreement was in effect shall not be impaired by termination. If the Agreement is terminated with an effective date of termination during a Performance Year for any reason other than ACO's material breach and if ACO has met the minimum Quality Measure scores and minimum number of Attributed Lives for the time during which it participated, then ACO shall be entitled to Shared Savings earned in the Performance Year of termination which shall be calculated and paid according to the following guidelines:

8.6.1 When termination occurs at any time during a Performance Year, ACO shall be entitled to a proportion of Shared Savings commensurate with the number of full months for which the Agreement was in effect, according to the formula: [Number of Months in Effect/12] * [Total Annual Savings of ACO in Performance Year], in addition to any unpaid Shared Savings from the prior Performance Year.

8.6.2 Calculations and payments under this section will be made according to the same schedule and requirements for Shared Savings calculated under this Agreement generally. This means that calculations are made retrospectively at the end of the Performance Year in which termination occurred.

8.6.3 For termination effective prior to the last day a month, no credit will be given for any partial month; rather the numerator, Number of Months in Effect in paragraph 8.6.1 will be the number of months in which the Agreement was in effect from the first day of the month through the last day of the month.

8.7 In the event this Agreement is terminated during a Performance Year in which Payer might earn Shared Risk, Payer's continued right to Shared Risk will terminate as of the last effective date of the Agreement. If the Agreement is terminated during a period when Payer might earn Shared Risk for any reason other than Payer's material breach and if Payer has met the obligations established to receive Shared Risk, then Payer shall be entitled to a pro rata share of any Shared Risk earned in the Performance Year of termination, calculated by the same methodology set forth in Section 8.6 related to pro rata Shared Savings.

8.8 Notwithstanding anything to the contrary herein, should this Agreement be terminated, the Parties' obligations to continue participation in the XSSP Program to the extent required to determine and pay Shared Savings earned to ACO or Shared Risk owed to Payer as applicable shall continue until all distributions for the Performance Year in which termination occurred have been finally made.

9. Progressive Dispute Resolution

9.1 Disputes between the ACO and Payer related to or arising out of the terms of this Agreement shall be submitted to the dispute resolution process described herein before any Party pursues a remedy from a third party; provided that nothing shall limit a Party from seeking a restraining order or injunction or seeking similar relief as required for the Party to comply with its legal obligations.

9.1.1 The issue in dispute will be referred in writing to the appropriate department directors for each Party. Such directors shall gather the information they need to evaluate the issue in dispute and will have fourteen (14) days from the date the issue is referred to them in writing to resolve the dispute.

9.1.2 If the department directors have not resolved the issue in dispute within fourteen (14) days from the date the issue is referred to them in writing, the issue will be referred in writing to the appropriate senior leaders of ACO and Payer and the Parties will be jointly responsible to contemporaneously send a notice describing the dispute to the GMCB. Such senior leaders shall gather the information they need to evaluate the issue in dispute and will have thirty (30) days from the date the issue is referred to them in writing to resolve the dispute.

9.1.3 If the issue in dispute is not resolved by the senior leaders within thirty (30) days from the date the issue is referred to them in writing, ACO or Payer may bring an action in any court with jurisdiction.

10. General Provisions

10.1 Confidentiality. The Parties all acknowledge that they may disclose confidential and proprietary information in the course of performance of this Agreement. All information so disclosed by one Party to the other Party which is not otherwise publically available shall be deemed confidential and shall not be disclosed by the receiving Party to any third party without the prior written consent of the Party who disclosed the information to the receiving Party. Upon termination of this Agreement for any reason, any Party in possession of another's confidential information shall return all electronic and printed materials containing confidential or proprietary information that it is not required to retain pursuant to this Agreement or law or certify that those materials have been destroyed. The obligations of this Section 10.1 shall survive termination of the Agreement for any reason.

10.2 Compliance with Laws. The Parties to this Agreement shall comply with and abide by all applicable federal, state and local laws, rules and regulations (including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its promulgating regulations federal and state antitrust laws and regulations, federal and state anti-kickback laws and regulations, and federal and state self-referral laws and regulations.

10.3 Warranty of Authority. Each Party hereby represents and warrants that it is duly organized and in good standing in its state of organization and has the right, power and authority to enter into, execute and perform this Agreement and its obligations hereunder.

10.4 Authority to Bind. The execution and delivery of this Agreement and the performance of the actions contemplated hereby are duly authorized and approved by all

necessary corporate actions of each Party, respectively, and the persons signing this Agreement on behalf of each Party has the necessary authority to bind such Party to the terms of this Agreement. The execution and performance of this Agreement and any agreements contemplated hereby will not constitute a breach or violation of (i) each Party's respective organizational documents; or (ii) any mortgage, deed, arrangement or other instrument to which a Party is respectively subject or bound.

10.5 Notices. All notices as may be required under the terms and conditions of this Agreement shall be made in writing and shall be sent by certified mail, return receipt requested or receipted overnight carrier or receipted courier service and shall be sent to the Parties at the addresses set forth below or to such other address that a Party may hereafter designate in a notice pursuant to this Section 10.5.

10.6 Entire Document. This Agreement, including Exhibits and attachments, as well as any documents incorporated by reference herein, constitute the entire agreement among the Parties with regard to the subject matter hereof and supersedes any oral or written understandings or agreements prior to the execution of this Agreement.

10.7 Amendments. This Agreement, including Exhibits, may be only amended or modified in writing as mutually agreed by the Parties.

10.8 Independent Contractor. None of the provisions of this of this Agreement create a relationship other than that of independent entities contracting solely for the purposes of effecting the provisions of this Agreement. Except as explicitly provided otherwise in this Agreement, no Party, shall be construed to be the agent, partner, employee, or representative of any of the other Parties.

10.9 No Third-Party Beneficiaries. Except as specifically provided herein by express language, no person or entity shall have any rights, claims, benefits, or powers under this Agreement, and this Agreement shall not be construed or interpreted to confer any rights, claims, benefits or powers upon any third party.

10.10 Section Headings. All Section headings contained herein are for convenience or reference only and are not intended to limit, define or extend the scope of any provisions of this Agreement.

10.11 Severability. In the event any part of this Agreement shall be determined to be invalid, illegal or unenforceable under any federal or state law or regulation, or declared null and void by any court of competent jurisdiction, then such part shall be reformed, if possible, to conform with the law and, in any event, the remaining parts of this Agreement shall be fully effective and operative so far as reasonably possible to carry out the contractual purposes and terms set forth herein.

10.12 Waiver of Breach. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation of this Agreement.

10.13 Consent for Publicity. Any use of another Party's name, logo, trademark or service mark, or the name, logo, trademark or service mark of any affiliate of Payer, by the other Party without prior written approval from the other Party is strictly prohibited.

10.14 Not a Provider Contract. This Agreement shall not constitute a provider contract within the meaning of the term as used by the Vermont Department of Financial Regulation or the GMCB.

10.15 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Any signature delivered by facsimile machine or by .pdf, .tif, .gif, .peg or other similar attachment shall be treated in all manners and respects as an original executed counterpart and shall be considered to have the same binding legal effect as if it were the original signed version

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the Effective Date indicated above.

ACO

By: _____
Name
Title
Address

Effective Date: _____

PAYER,

By: _____
Name
Title
Address

Effective Date: _____

EXHIBIT A

XSSP Standards Approved by GMCB

This document contains ACO Commercial Shared Savings Pilot Program Standards reviewed and approved by the Green Mountain Care Board, December 5, 2013

ACO pilot standards are organized in the following 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

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. Payers 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.

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 Three 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 ACO will furnish financial reports regarding risk performance to the VHCIP Payment Models Work Group or its successor [1] and to the GMCB on a semi-annual basis by June 30th and December 31st in accordance with report formats defined by the GMCB.

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

1. For Performance Years 2 and 3, and subject to approval by the Green Mountain Care Board, ACOs are required to demonstrate that actual or projected

[1] All future references to the VHCIP Payment Models Work Group should be understand to mean that work group or its successor,

enrollment meets or exceeds a minimum of 60,000 annually attributed member months in aggregate. For Performance Year 1, and subject to the approval of the Green Mountain Care Board, ACOs must demonstrate that enrollment meets 5000 attributed lives for ACOs participating with one insurer and 3000 attributed lives for each insurer (total of 6000) for ACOs participating with two insurers.

2. In Performance Years 2 and 3, a participating insurer may 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.

E. 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 should be able 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, 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

Subject to the provisions in this Agreement relating to Performance Year 1, an ACO must have at least 5,000 commercial Exchange lives attributed to one participating insurer or at least 3,000 commercial Exchange pilot lives attributed to each of two participating insurers, for a total of 6000 lives, in order to participate in the pilot.

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[2] 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

[2] 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.

practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

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

CPT-4 Code Description Summary
newborn infant: 99460-99463 • 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. The VHCIP Payment Models Work Group will reconsider whether OB/Gyns should be added to the attributing clinician list during Year 1.

10. In order to allow for orderly attribution of lives to a single ACO, and subject to the Green Mountain Care Board's approval of this provision, primary care providers, or providers on whom attribution is based, may not be ACO Participants in more than one ACO.

VI. Calculation of ACO Financial Performance and Distribution of Reconciliation 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[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.

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 [4].

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."

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 targeted 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

[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.

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."

Actions Initiated After the Performance Year Ends

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 a common methodology across commercial insurers;
- 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. [5]

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.

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[6] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

[5] A reciprocal approach shall apply to ACO excess spending in Year3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.

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

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
Core-6	Avoidance of Antibiotic Treatment for Adults	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30

	With Acute Bronchitis NQF #0058, NCQA HEDIS AAB		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%

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.

Step 6: Process for Review and Modification of the Measures ***(still under development)***

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 (*still under development*)

1. **Payer Provision of Data to ACOs and ACO Provision of Data to Payers**

EXHIBIT B

GREEN MOUNTAIN CARE BOARD
REGULATORY OVERSIGHT ROLE

GMCB acknowledges, by affixing its signature to this Exhibit, that the following accurately describes the GMCB's regulatory oversight role with respect to the Parties' performance of this Agreement.

1. General XSSP Standards Compliance Oversight.

(a) Generally. GMCB will oversee compliance by ACO and Payer with XSSP Standards. It is the intention of the GMCB that neither the ACO nor the Commercial Payer be deprived of the benefits of this Agreement as a result of insignificant, insubstantial or immaterial noncompliance with the XSSP Standards.

(b) Audits. GMCB, to the extent permitted by law, shall have access to Commercial Payer's and ACO's books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations, and compliance with the XSSP Standards available for inspection by the GMCB or a designee reasonably acceptable to Commercial Payer and ACO, at reasonable times and on reasonable notice. The GMCB will maintain as confidential and not subject to disclosure any information identified as confidential by a Party to the extent permissible under the law, including the Vermont Access to Public Records Act, 1 V.S.A. §§ 315-320. Payer and ACO will maintain books, records, contracts and other information related to Quality Performance Measures, Shared Savings distributions, Shared Risk obligations and compliance with the XSSP for ten (10) years from the termination of this Agreement.

(c) Noncompliance. In the event that ACO or Commercial Payer reports noncompliance to the GMCB, GMCB may provide the Parties with notice of noncompliance and the opportunity to object or cure.

(i) If the relevant Party objects to notice of noncompliance, it shall provide written notice of the objection to the GMCB and the other Party to this Agreement within ten (10) business days of receipt of the notice, with a reasonably specific description of its objection(s), and may additionally choose to present the objection at a meeting of the GMCB. The GMCB will review the objection and, after a hearing and the development of a factual hearing record sufficient to serve as the basis for judicial review if a hearing is requested, issue a written decision to the Parties as to whether it finds the Party to be in compliance with XSSP Standards, with a detailed description of the reason(s) for that decision.

of receipt of the notice of noncompliance of the GMCB's decision finding the Party noncompliant, provide the GMCB and the other Party with a written proposed corrective action plan. The GMCB will review and approve or modify the plan of correction within thirty (30) days of receipt and notify the Parties of its decision. If the plan of correction is modified the Party may object as set forth above in subsection (i). After resolution of any objection, the Party will implement the plan of correction and the GMCB may reasonably monitor the implementation of that plan of correction.

(iii) To the extent the Parties are engaged in dispute resolution or have declared material breach as provided for in the Agreement, the GMCB will act in conformance with the time frames set forth in the Agreement.

2. Commercial Payer Oversight.

(a) Attributed Lives. GMCB may verify attribution and Commercial Payer's calculations of attribution and may require from Commercial Payer only such information necessary and permitted by law to achieve this purpose.

(b) Workgroup Participation. GMCB may require Commercial Payer to participate in work groups related to XSSP Standards.

3. ACO Oversight.

(a) Performance Against Core Measures for Payment. GMCB shall evaluate the ACO's performance against the Core Measures for Payment set forth in the XSSP Standards.

(b) Approval of Risk Mitigation Plan. GMCB shall review and approve ACO's Risk Mitigation Plan, as required in the XSSP Standards, and shall establish and evaluate financial reports regarding risk performance from ACO to evaluate its ability to bear downside risk in Performance Year 3 of this Agreement. If the GMCB reasonably determines that ACO is substantially unable to bear 3% - 5% financial risk in Performance Year 3, it may, after a hearing and the development of a factual hearing record sufficient to serve as the basis for judicial review, disqualify ACO from participation in the XSSP Program for Performance Year 3.

(c) Should ACO, in Performance Years 2 or 3, fail to meet the minimum quality scores, it may still be eligible to receive Shared Savings if the GMCB determines, after providing notice to and accepting written input from Commercial Payer and ACO (and input from ACO Participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior Performance Years. The Board 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 Board.

(d) Workgroup Participation. GMCB may require ACO to participate in a reasonable number of work groups related to XSSP.

4. Reports.

quarterly reports that include: (i) performance on the measures in the Monitoring and Evaluation Measures Set in the XSSP Standards to be established as well as other performance metrics; and (ii) findings from quarterly cost and utilization evaluations for ACO.

(b) Risk Performance Reports. GMCB shall review and approve of ACO Risk Mitigation Plans in accordance with Section 3(b) above and establish and evaluate financial reports regarding risk performance from the ACO.

5. Compliance with Privacy and Security Laws

The GMCB acknowledges that Commercial Payers and ACO are subject to regulatory and contractual obligations to comply with the Health Information Portability and Accountability Act ("HIPAA") which restrict their ability to disclose protected health information (PHI). GMCB acknowledges that it and any third-party it might engage to perform work on its behalf may only receive PHI or other data as permitted by law.

The GMCB hereby acknowledges that this Exhibit B is a fair and accurate representation of the GMCB's regulatory oversight role for compliance with the XSSP Standards.

GREEN MOUNTAIN CARE BOARD

By: _____

Printed Name: _____

Title:_____

Date Signed: _____