AMENDMENT #1

It is agreed by and between the **State of Vermont, Department of Vermont Health Access** ("State") and **OneCare Vermont Accountable Care Organization, LLC** ("Contractor") that Contract #26179 on the subject of accountability for the cost and quality of health services (the "Agreement") is hereby amended as follows:

1. By deleting Section 6.3 of Attachment A (Scope of Work) and substituting in lieu thereof the following Section 6.3, effective from February 24, 2014 to December 31, 2014:

6.3 Changes to the calculations for determination of Shared Savings will be subject to a determination of materiality threshold. Should the changes exceed this threshold, then the parties will follow the dispute resolution process described in Section 5. The materiality threshold is defined as a change affecting more than 15% of either beneficiaries or expenditures in any of the three eligibility categories for a given benchmark or performance year (ABD Adult/BD Child, General Adult, General Child).

2. By deleting Section III (Medicaid Patient Eligibility Requirements and Patient Attribution) and Section IV (Calculation of Contractor Financial Performance and Shared Savings) of Attachment A, Exhibit 1 (VMSSP Standards) and substituting in lieu thereof the followings Sections III and IV, effective from February 24, 2014 to December 31, 2014:

III. Medicaid Patient Eligibility Requirements and Patient Attribution

A. Eligible Populations

The following population groups are eligible to be considered as attributed lives:

1. Aged, Blind or Disabled (ABD) Adult: Individuals who are 18 years of age or older who are aged, blind or disabled and who are not dually eligible for Medicare; AND Blind or Disabled (BD) Child: Individuals who are under 21 years of age who are aged, blind or disabled and who are not dually eligible for Medicare.
2. General Adult: Parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance; as well as adults with incomes below 133% of the Federal Poverty Level ("FPL") are assigned here. This could also include former Vermont Health Assistance Program, Catamount, Employer-sponsored Insurance Assistance, or previously uninsured individuals.
3. General Child: Children under age 21 who are eligible for cash assistance; as well as children up to age 18 who were previously uninsured, living in families up to 300% FPL, and who are not otherwise classified under BD Child.

B. Excluded Populations

The following populations are excluded from being considered as attributed lives:

1. Individuals who are dually eligible for Medicare and Medicaid;
2. Individuals who have third party liability coverage;
3. Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and
4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

C. Enrollment Requirements

Individuals must be enrolled at least ten non-consecutive months in the calendar year in any aid category across all three population groups. If an individual transitioned from one population group to another within the calendar year (e.g., from General Child to BD Child), then all of the member's months and expenditures are assigned to the population group where the member was enrolled last in the calendar year. Individuals may not be split across the three population groups within a year; however, an individual may appear in multiple population groups across the three baseline years.

D. Attribution Methodology

The State or its designee will conduct attribution monthly. The details of the attribution reports are described in the Data Use Standards, Attachment A, Exhibit 1, Section VIII (B) of this Agreement.

1. Attribution Step 1: Determine all Medicaid beneficiaries who were enrolled for at least 10 months in the study year across any of the three enrollment categories. Assign the beneficiary to the enrollment category where he/she appeared last in the study year.
2. Attribution Step 2: Claims for eligible members are identified for the presence of qualifying CPT Codes (refer to Attachment I) in the calendar year for primary care providers enrolled with Medicaid. The provider specialty must be internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, or naturopathic medicine. In addition to physicians, the primary care provider may be a nurse practitioner, physician assistant, or a provider in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
3. Attribution Step 3: For eligible beneficiaries not attributed in Step 2, assign the beneficiary to his/her primary care provider that he/she selected or was auto-assigned to in the study year. If the beneficiary changed primary care provider selection during the year, then the beneficiary is assigned to the primary care provider which he/she was assigned to last in the year.
4. Attribution is done at the rendering provider level; any ACO Participant that includes at least one ACO Provider/Supplier with Attributed Lives must have an exclusive Participant relationship with one ACO. ACO Participants who do not have lives attributed, can participate in multiple ACOs.

E. Patient Freedom of Choice

Beneficiaries will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. Calculation of Contractor Financial Performance and Shared Savings

A. Summary of Model Specifications

1. Program eligibility requires a minimum number of 5,000 attributed beneficiaries. The maximum savings rate is fifty percent (50%).

2. The Contractors may elect to pursue an optional methodology that increases the maximum savings rate beginning on January 1, 2015. The standards shall remain as set forth in this document for Contractors electing to pursue the alternative methodology. The alternative methodology would increase the maximum sharing rate of 50% for the Contractor by 10% to 60% if the Contractor elects to be accountable for additional non-core service expenditures in the Total Cost of Care (TCOC) as defined by the State. The State will notify the Contractor in writing of which non-core service expenditures will be required no later than October 1, 2014. The Contractor would elect the optional track in writing no later than November 1, 2014.

3. The Contractors will be required to be accountable for additional non-core service expenditures in the Total Cost of Care (TCOC) calculation as defined by the State in 2016. If the Contractor elected to participate in the option described in the paragraph above, the Contractor will continue to receive the additional 10% addition to the maximum sharing rate of 50% (or 60%). The State will notify the Contractor in writing of which non-core service expenditures will be required no later than September 1, 2015.

B. Core Service Expenditures

Core Service expenditures include: inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health clinic, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.

C. Non-Core Service Expenditures

1. Non-Core Service expenditures include: personal care, pharmacy, dental, non- emergency transportation, services administered by the VT Department of Mental Health through Designated Agencies and Specialized Service Agencies, services administered by the VT Division of Alcohol and Drug Abuse Programs, services administered by the VT Department of Disabilities, Aging and Independent Living, services administered by the VT Department for Children and Families and services administered by the Vermont Department of Education.

2. Non-Core Service expenditures also include supplemental, lump sum disproportionate share payments and medical education payments as well as quality incentive payments made outside of the claims system.

D. Calculation of the Expected Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Expected TCOC. In July or August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The State or its designee shall calculate the Expected TCOC using the following steps:

1. Attribute beneficiaries in each of three historic calendar years (the "benchmark years") using the attribution methodology described in Attachment A, Exhibit 1, Section III of this Agreement.
   a. For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years.
   b. For 2015, CYs 2011, 2012, 2013 will be benchmark years.
   c. For 2016, CYs 2012, 2013, 2014 will be benchmark years.

2. Re-price selected services with significant rate changes between the benchmark years and the performance year. The materiality threshold in section 6.3 of Attachment A shall be used to determine what constitutes a significant rate change.
   a. For PY 2014, the base year for re-pricing is rates effective January 1, 2013.
   b. For PY 2015, the base year for re-pricing is rates effective January 1, 2014.
   c. For PY 2016, the base year for re-pricing is rates effective January 1, 2015.

In PY 2014, the selected services identified for re-pricing include inpatient hospital, outpatient

hospital and professional services paid using DVHA's version of the Resource Based Relative Value Scale fee schedule. For all other Core Services, the expenditures captured for the service are the values for actual paid amount on the claim ("original paid"). For each attributed member within a calendar year, sum the values for re-priced services and original paid services.

3. Calculate the Compounded Annual Growth Rate (CAGR)
   a. If determined to be material, adjust expenditures for other changes in utilization. If additional changes in utilization are determined to meet the determination of materiality threshold defined in Attachment A, Section 6.3, adjustments will be applied accordingly.
   b. Calculate an annualized value from the total expenditures captured in Step 2 for each beneficiary so that each beneficiary has a per member per year (PMPY) expenditure value for comparison purposes.
   c. Truncate annualized expenditures at the 99th percentile both within each enrollment category and at total eligible population level (ACO attributed members as well as all non-attributed eligible beneficiaries). In other words, if a particular beneficiary incurred expenditures above the 99th percentile value within the enrollment category, this beneficiary's expenditures are truncated so that their total expenditures in the calculation will equal the value set at the 99th percentile within its enrollment category.
   d. Sum the re-priced, annualized, truncated expenditures within each enrollment category.
   e. Divide the re-priced, annualized, truncated expenditures for the enrollment category by the total annualized member months for the enrollment category to compute the truncated PMPM for each benchmark year.
   f. Use the CMS-HCC (Hierarchical Condition Categories) Community-Based scores to derive risk scores for each enrollment category and at total eligible population level for each year in the three-year benchmark period.
   g. Compute a risk adjustment factor to account for changes in the health status of the attributed population between the earliest and most recent benchmark years. The risk adjustment factor is computed as: [(risk adjustment factor in most recent benchmark year) / (risk adjustment factor in earliest benchmark year)].
   h. Risk-adjust the truncated PMPM in the most recent year of the three-year benchmark period by applying the following formula: [(Truncated PMPM as originally computed in (IV)(D)(3)(e) / (risk adjustment factor computed in (IV)(D)(3)(g)]. This is done at the enrollment category level and at the total eligible population level.
   i. Compute the CAGR for the total eligible population as follows [(Risk-adjusted truncated PMPM for most recent year in the benchmark period) / (Truncated PMPM for earliest year in the benchmark period)^(0.5)]

CAGR Example
VMSSP Contract

TOTAL POPULATION DATA - TRUNCATION:	A (A1 and A3 = B + C + D)	B	C	D	E (E1 and E3 = F + G + H)	F	G	H	I (I1 and I3 = J + K + L)	J	K	L
	2010				**2011**				**2012**			
	TOTAL	**ABD (Adult and Child)**	**Consolidated Adult**	**Consolidated Child**	**TOTAL**	**ABD (Adult and Child)**	**Consolidated Adult**	**Consolidated Child**	**TOTAL**	**ABD (Adult and Child)**	**Consolidated Adult**	**Consolidated Child**
1. Total Truncated Payments (Annualized and Repriced)	$ 177,212,917	$ 54,006,586	$ 76,370,095	$ 46,836,236	$ 185,668,106	$ 54,791,523	$ 80,574,100	$ 50,302,483	$ 191,406,218	$54,508,525	$ 84,386,310	$52,511,383
2. Total Truncated Payments as Percent of Repriced Payments = weighted average of the 3 categories	94%	93%	97%	91%	93%	90%	97%	90%	94%	93%	97%	91%
3. Total Annualized Member Months	874,584	129,144	250,164	495,276	924,408	133,332	274,668	516,408	953,940	137,652	282,636	533,652
4. PMPM = (Row 1/Row 3)	$202.63	$418.19	$305.28	$94.57	$200.85	$410.94	$293.35	$97.41	$200.65	$395.99	$298.57	$98.40

ACO base year baseline PMPM and Total Population CAGR

	A	B	C	D	E = C/D	F = (E/A)^(0.5)
	Truncated PMPM CY 2010	**Truncated PMPM CY 2011**	**Truncated PMPM CY 2012**	**Risk Adj. Factor Applied to CY 2012**	**Risk-Adj. PMPM CY2012**	**CAGR**
***** TOTAL *****	$220.14	$220.43	$218.70			
ABD (Adult and Child)	$483.83	$483.37	$450.36			
Consolidated Adult	$341.94	$336.79	$337.45			
Consolidated Child	$105.84	$108.29	$108.70			
TOTAL POPULATION	$202.63	$200.85	$200.65	1.0076	$199.14	0.9914

Note: revised financial methodology does not calculate CAGR at enrollment category level, but at *total population level*

Calculation of Trended PMPMs

	Truncated PMPM CY 2012	**CAGR**	**Trended Truncated PMPM CY 2014**	**Risk Scores CY 2012**	**Risk Scores CY 2014**	**Risk Adj. Factor to Apply to Trended Truncated PMPM CY 2014**	**Risk Adj Trended Truncated PMPM CY 2014**	**Addition to Trended PMPM***	**FINAL Risk Adjusted Trended Truncated PMPM CY 2014**
***** TOTAL *****	$218.70	0.9914	$214.93	0.4352	0.4311	0.9907	$212.94	1.0300	$219.33
ABD (Adult and Child)	$450.36	0.9914	$442.61	0.5317	0.5308	0.9983	$441.86	1.0300	$455.12
Consolidated Adult	$337.45	0.9914	$331.64	0.5473	0.5378	0.9827	$325.90	1.0300	$335.68
Consolidated Child	$108.70	0.9914	$106.83	0.3757	0.3756	0.9997	$106.80	1.0300	$110.00

4. Determine Expected PMPM

a. Within each enrollment category, trend the truncated PMPM for the most recent year in the benchmark period by two years using the CAGR calculated for total eligible population in (IV)(D)(3)(i). This is the preliminary trended, truncated PMPM for the PY.

b. Use the CMS-HCC (Hierarchical Condition Categories) Community-Based scores to derive risk scores for each enrollment category in the PY.

c. Compute a risk adjustment factor to account for changes in the health status of the attributed population between the most recent benchmark year and the PY. The risk adjustment factor is computed as: [(risk adjustment factor in the PY) / (risk adjustment factor in most recent benchmark year)].

d. Risk-adjust the preliminary trended, truncated PMPM for the PY by applying the following formula: [(Preliminary trended, truncated PMPM as originally computed in (IV)(D)(4)(a) * (risk adjustment factor computed in (IV)(D)(4)(c)]. This is done at the enrollment category level.

e. Adjust for rate changes or other changes deemed material. For PY1, the PMPM calculated in 4d above will be inflated to account for rate increases that went into effect November 1, 2013 which are also in effect in CY 2014 (PY1). PY2 and PY3 adjustments, if necessary, will be made to account for additional rate increases or decreases. The final trended, truncated, risk-adjusted Expected PMPM TCOC for each enrollment category, therefore, is computed as follows: [(Trended, truncated, risk-adjusted PMPM computed in (IV)(D)(4)(d) * (adjustment factor for rate changes)].

E. Retrospective Calculation of the Actual Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Actual TCOC. In July-August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The TCOC will be calculated using Medicaid claims data and enrollment files. TCOC shall be defined to include all paid claims for the Contractor-responsible Core Services as defined in Section IV(B) of this Agreement. Actual TCOC will be calculated by:

1. Run the attribution algorithm as described in Attachment A, Exhibit 1, Section III(A)–(D) of this Agreement using the claims and enrollment data for the performance year (PY).

2. Calculate per member per year expenditures for each attributed beneficiary, imputing an annualized value for those beneficiaries enrolled only 10 or 11 months and not 12 months. The formula for annualizing is the same as that described in Attachment A, Exhibit 1, Section IV(D)(3)(b) of this Agreement.

3. Truncate the annualized expenditures at the 99th percentile for each enrollment category in the same manner as described in Attachment A, Exhibit 1, Section IV(D)(3)(c) of this Agreement.

4. Divide the annualized, truncated expenditures for the enrollment category by the annualized member months for the enrollment category to compute the Actual PMPM TCOC for each enrollment category.

5. Compute weighted Actual and Expected PMPMs as follows:
   a. Compile the actual member months for each enrollment category in the PY.
   b. Multiply the Final trended, truncated, risk-adjusted Expected PMPM TCOC for each enrollment category computed in Section IV(D)(4)(d) by the actual member months for the enrollment category in step 5a above.
   c. The sum of the values in step 5b becomes the Expected total trended dollars used in weighting.
   d. Sum the actual member months in step 5a.
   e. The Weighted Expected PMPM TCOC, therefore, is: [(total trended dollars in step 5c) / (total actual member months in step 5d)].
   f. Multiply the Actual PMPM TCOC for each enrollment category by the actual member months for the enrollment category in step 5a above.
   g. The sum of the values in step 5f becomes the Actual total trended dollars used in weighting.
   h. The Weighted Actual PMPM TCOC, therefore, is: [(total trended dollars in step 5g) / (total actual member months in step 5d)].

F. Aggregate Difference in Expected and Actual Expenditures (Savings Calculation)
Total savings will be calculated by:
[(Weighted Expected PMPM TCOC from (IV)(E)(5)(e) - (Weighted Actual PMPM TCOC from (IV)(E)(5)(h)] * Sum of Actual PY Member Months from (IV)(E)(5)(d)]

G. Total Eligible Savings Amount

1. Based on the calculation in Attachment A, Exhibit 1, Section IV(F) of this Agreement, the State or its designee will determine if the Actual Cost of Care is less than the Expected Cost of Care for the Performance Year.

2. The State will then determine whether or not the savings are greater than or equal to a minimum savings rate (MSR) of 2%.

3. If total savings are greater than or equal to the MSR, then the Contractor will be eligible to share in the savings. If not, the Contractor will not be eligible to share in savings.

4. If the MSR is met, the state will calculate a tiered savings rate based on total savings. If program savings are between 2-5% (Tier 1), the ACO will be eligible for 25% of the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year. If program savings is above 5% (Tier 2), the ACO will be eligible for 50% of the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year. The total eligible amount of shared savings will be calculated by multiplying the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year by the maximum savings rate. For examples:

- If program savings are 4%, and the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year is $100,000, ACO will be eligible for 25% of $100,000, or $25,000 in shared savings.
- If program savings are 5.1% and the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year is $100,000, ACO will be eligible for 50%, or $50,000 in shared savings.

5. The final shared amount is subject to a cap equal to 10% of total actual expenditures in the performance year calculated in Attachment A, Exhibit 1, Section IV(E) of this Agreement.

6. The final sharing rate is equal to the product of the Contractor's quality score and the maximum sharing rate. Computation of the quality score is described in Attachment A, Exhibit 1, Section V of this Agreement.

3. By deleting the final sentence of Attachment B and replacing it with the following sentence, effective February 24, 2014:

The total maximum amount payable under this contract shall not exceed 10% of total actual expenditures in the performance year calculated in Attachment A, Exhibit 1 **Section IV(E)**.

4. By deleting Section 8 of the Personal Services Contract (pp.1-2) (Attachments) and substituting in lieu thereof the following Section 8, effective January 1, 2015:

8. <u>Attachments.</u> This contract consists of (51) pages including the following attachments, which are incorporated herein:

Attachment A - Specifications of Work to be Performed
Attachment B - Payment Provisions
Attachment C - Customary State Contract provisions
Attachment D - Modifications of Insurance
Attachment E – Data Use Agreement
Attachment F - Customary Contract Provisions of the Agency of Human Services
Attachment F - Appendix 1 - Request for Approval to Subcontract
Attachment G - Services Considered in Eligible Individual Attribution

The order of precedence of documents shall be as follows:

1). This document
2). Attachment D
3). Attachment E
4). Attachment C
5). Attachment A
6). Attachment B
7). Attachment F
8). Attachment G

5. By deleting Attachment A (Scope of Work) and substituting in lieu thereof the Attachment A that begins on page 10 of this Amendment #1, effective January 1, 2015.

6. By deleting Attachment C (Customary Provisions for Contracts and Grants, revised 11-7-2012) and substituting in lieu thereof the Attachment C that begins on page 29 of this Amendment #1, effective January 1, 2015.

7. By deleting the contact information found in Section 1 of Attachment D (Modifications of Customary Provisions of Attachment C or Attachment F) and substituting in lieu thereof the following contact information, effective January 1, 2015:

Amy Coonradt, MPH
Senior Health Policy Analyst
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
802-585-9063

8. By deleting Attachment G (Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Adjustment) and re-lettering the second Attachment F (Appendix 1 – Request for Approval to Subcontract) as Attachment G, and conforming all internal references to those Attachments, effective January 1, 2015.

9. By deleting the contact information for the second custodian identified in Section 12 of Attachment E (Data Use Agreement) and substituting in lieu thereof the following contact information, effective upon execution of this Amendment #1:

Name of Custodian: Health Catalyst
Contact: Jeff Selander, Chief Financial Officer

Street Address; 3165 Millrock Dr. #400
City, State, Zip: Salt Lake City, UT 84121
Phone: 801-708-6800
Email: jeff.selander@healthcatalyst.com

10. By adding the following sentence to Section 14 of Attachment E (Data Use Agreement), effective upon execution of this Amendment #1:

For purposes of this Agreement, the legal confines of Contractor include the Regional Clinical Performance Committees and attendees at those meetings. The Contractor may further share the above data files with entities with whom it contracts to perform or support ACO Activities if such entities are contractually bound to honor this DUA and ACO Collaborators, and will identify each such ACO Collaborator to DVHA promptly.

11. By deleting Section 15 of Attachment E (Data Use Agreement) and substituting in lieu thereof the following Section 15, effective upon execution of this Amendment #1:

> 15. Users may reuse original or derivative data without prior written authorization from the State for clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation, but shall not disseminate original or derived information from the files provided by the State pursuant to Attachment A, Exhibit 1, Section VIII(B) of the Agreement with or without direct identifiers, to anyone who is not an ACO Participant or an ACO Provider/Supplier an ACO Collaborator, or within the legal confines of Contractor, in an ACO that has entered into a signed agreement with the State. Users may disseminate and link information derived from the files specified in this Data Use Agreement to other sources of individually-identifiable (patient-specific) health information, such as medical records, available to the ACO and its ACO Participants unless expressly prohibited by the Medicaid beneficiary. When using or disclosing protected health information (PHI) or personally identifiable information (PII), obtained under this Data Use Agreement, Users must make reasonable efforts to limit the information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

12. The Parties acknowledge that items 4-11 of Amendment #1 to this Agreement are retroactive to January 1, 2015. As such, DVHA agrees that the ACO is not in breach of any term or obligation of this Agreement as a result of not providing any report, such as the care management standards report established in Attachment A, Exhibit 1, Section VI.D.1, or other information due within calendar year 2015, before this Agreement was finally negotiated.

This Amendment #1 consists of 43 pages. Except as modified by this Amendment #1, all provisions of the Agreement shall remain unchanged and in full force and effect.

STATE OF VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

E-SIGNED by Steven Costantino
on 2016-04-07 11:30:54 GMT

April 07, 2016

STEVEN COSTANTINO, COMMISSIONER — DATE
312 Hurricane Lane, Suite 201
Williston, VT 05495-2087

ONECARE VERMONT ACCOUNTABLE CARE ORG., LLC.

E-SIGNED by Todd Moore
on 2016-04-06 13:42:27 GMT

April 06, 2016

TODD MOORE, CHIEF EXECUTIVE OFFICER — DATE
356 Mountainview Dr.
COLCHESTER, VT 05446

ATTACHMENT A
SCOPE OF WORK

1. Definitions

As used in this Agreement, the following terms shall have the meaning indicated. Further, terms defined in the VMSSP Standards set forth in as Exhibit 1 attached hereto and incorporated herein by reference, shall have the meaning ascribed in the VMSSP Standards.

1.1 *Accountable Care Organization (ACO) or Contractor* means the party to this Agreement that is a legal entity comprised of 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 ACO providers/suppliers that is identified by a Tax Identification Number (TIN), that alone or together with one or more other ACO participants comprises the ACO, and that is included on the list of ACO participants required to be submitted as part of the program.

1.3 *Agency of Human Services* means the Agency defined by 3 V.S.A. § 3001 and created by 3 V.S.A § 3002 as amended.

1.4 *ACO Provider/Supplier* means an individual or entity that is a Medicaid provider or supplier enrolled in Medicaid and bills for services under an ACO Participant Medicaid provider number. For example, a large group practice may qualify as an ACO Participant. A Medicaid enrolled physician billing under the practice Medicaid provider number would be an ACO Provider/Supplier.

1.5 *Attributed Life/Lives* means Beneficiaries who are assigned to an ACO in accordance with the VMSSP Standards (Exhibit 1) and whose cost of care is calculated in the Shared Savings calculation performed under those Standards.

1.6 *Beneficiary* means Medicaid eligible and enrolled persons who meet the criteria of the VMSSP Standards for Attributed Lives (Exhibit 1).

1.7 *Blueprint for Health or Blueprint* means the State of Vermont's program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

1.8 *CMS-HCC (Hierarchical Condition Categories) prospective risk adjustment model* means the community version of the risk-adjustment methodology developed by the Centers for Medicare and Medicaid Services that is most recent at the time of calculation.

1.9 *Current Procedural Terminology (CPT) Codes* means a system of codes developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures.

1.10 *DVHA* means the Department of Vermont Health Access, a Department of the Agency of Human Services and an instrumentality of the State of Vermont. DVHA may be referred to as the "State" in this Agreement.

1.11 *HEDIS* means the Healthcare Effectiveness Data and Information Set.

1.12 *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 provider professional Health Care Services to an individual during that individual's health care treatment or confinement.

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

1.14 *Medicaid* means the Vermont Medicaid program.

1.15 *Minimum Savings Rate* means a percentage of the benchmark that ACO savings must exceed in order to qualify for shared savings.

1.16 *Performance Year* means the twelve 12 month period beginning on January 1 and ending December 31 of each year during the Agreement's term.

1.17 *Primary Care Practice* means individual or group of physicians, nurse practitioners, physician assistants or a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that are 1) enrolled with Medicaid and 2) have at least one provider whose rendering Medicaid provider number is identified with a provider specialty of internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, or naturopathic practitioner.

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

1.19 *Shared Savings* means the portion of the difference between Actual Expenditures that are less than Expected Expenditures in a Performance Year that ACO is eligible to receive as payment according to the formulas and procedures set forth in the VMSSP Standards.

1.20 *Vermont Chronic Care Initiative (VCCI)* means a program for Medicaid beneficiaries managed by DVHA to coordinate the care for beneficiaries presenting complex healthcare needs.

1.21 *Vermont Health Care Innovation Project (VHCIP)* means the collective operational and governance structures with oversight of payment reform activities; co-led by the GMCB and DVHA, and funded by the Center for Medicare and Medicaid Innovation, State Innovation Model grant. The structure includes seven work groups, a Steering Committee and a Core Team. The VHCIP serves to coordinate and make decisions about quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population.

1.22 *VMSSP* means the Vermont Medicaid Shared Savings Program Pilot for Accountable Care Organizations.

1.23 *VMSSP Standards* means the set of written standards and guidelines for the Medicaid Shared Savings Pilot Program for accountable care organizations developed by a multi-stakeholder working group and approved by the GMCB.

2. ACO/Contractor Requirements

2.1 Contractor will meet the requirements of each of the VMSSP Standards that are applicable to ACO/Contractor, attached as Exhibit 1.

2.2 Contractor will require, through Participation Agreements, or other contractual arrangements with ACO Participants, that those providers are enrolled with DVHA.

2.3 Contractor will monitor the quality of care provided to Attributed Lives; promote evidence based medicine and coordinate care for Attributed Lives.

2.4 Contractor will, to the extent permitted by privacy and other laws, receive and synthesize data from the State and other sources via electronic processes and use it to identify opportunities for beneficiary engagement and/or to stratify its population to determine appropriate care models intended to improve outcomes.

2.5 Contractor will designate a representative available to the State to address its concerns and needs and to participate in a reasonable number of regularly scheduled meetings with the State, to occur at least quarterly.

2.6 Contractor will complete the University of California at Berkley "Safety Net Accountable Care Organization (ACO): Readiness Assessment Tool" in the first quarter of each Performance Year.

3. DVHA/State Participation Obligations

3.1 DVHA will meet the requirements of each of the VMSSP Standards, attached as Exhibit 1 and made a part hereof, that is applicable to DVHA.

3.2 DVHA will pay to Contractor any earned Shared Savings due to Contractor in accordance with VMSSP Standards and this Agreement.

4. Program Requirements

4.1 Contractor will provide Beneficiary disclosure and opt-out notices in accordance with the procedures set forth below in order to:
1) ensure that the Beneficiary has been notified that his/her provider is a participant in VMSSP and 2) allow the Beneficiary to opt-out of the sharing of his/her medical claims data between the State and the Contractor. The intention is for each Beneficiary to receive one notice during the course of his/her attribution to the ACO; initial notices will be sent to Beneficiaries at the beginning of this Program, thereafter, notices to newly attributed Beneficiaries will be sent quarterly so long as the State has provided the Contractor with updated Beneficiary lists.

4.1.1 Contractor is responsible for notification to Beneficiaries that will provide the Beneficiary with: (1) notice of his/her Health Care Provider's participation in the VMSSP: (2) appropriate disclosure of the use of his/her claims data; and (3) the ability to opt-out of sharing his/her claims data if desired. The notification should be sent to initially Attributed Lives in the first quarter of 2014 if beneficiary lists have been provided to Contractor. Notifications to subsequently Attributed Lives should be sent quarterly or as new beneficiary lists become available.

4.1.2 Contractor must provide Beneficiaries with the written notification described in Section 4.1.1 by mail and/or in person prior to, during or following the Beneficiary's visit to a participating Primary Care Practice, so long as Contractor has received notice of the assignment via a Beneficiary list. Contractor may use electronic communication if a Beneficiary agrees to this method of communication. The language used in the notification must reflect the appropriate literacy level and/or a diversity of languages represented within the Medicaid population. The form of notification will be approved by the State and the notification process will include:

a. Contractor will track and report to the State on the notification and method of notification;
b. Contractor will identify to DVHA any Beneficiaries who seek to opt-out of sharing their claims data by providing DVHA with a list of such Beneficiaries on a monthly basis by uploading the list in a form specified by DVHA, to a secured site identified by DVHA; and
c. DVHA will record these Beneficiaries and exclude them from the claims data extracts described in this Attachment A, Exhibit 1, Section VIII, Data Use.

4.2 Contractor will, no later than 60 days after the beginning of Performance Years 2 and 3, and at such time as mutually agreed for Performance Year 1, update the ACO Participant (Participant name and Tax Identification Number (TIN) information) and ACO Provider/Supplier (Provider/Supplier name and Medicaid ID) reporting spreadsheets to submit them to the State. The Parties expect that administrative rules surrounding this process will be enacted, but until such time as they are, agree to follow the protocol set forth herein.

4.2.1 This submission must include any new forms of ACO Participant agreements and identify any material changes to previously submitted forms of ACO Participant agreements. Submissions must be received by the State no later than April 10 of a given Performance Year. Contractor shall submit any subsequent amendments to the content of the reporting spreadsheets no later than 15 business days after the beginning of each calendar month.

4.2.2 The Contractor must submit any material changes to the form of the ACO Participant Agreements to the State for evaluation by State only to ensure that the Agreements have the required regulatory elements: (a) a requirement that ACO Participants comply with the requirements of the VMSSP; (b) a description of the ACO Participant's rights and obligations in and representation by the ACO, including how the opportunity to share in savings or other financial arrangements will encourage ACO Participants to adhere to the quality assurance and improvement program and evidence-based clinical guidelines and should include language giving ACO the authority to terminate an ACO Participant for its non-compliance with the requirements of the VMSSP; and (c) a statement that Beneficiaries are free to use their providers of choice, consistent with their benefits.

5. Dispute Resolution

5.1 Progressive Dispute Resolution. Disputes between the ACO and DVHA 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.

a. The issue in dispute will be referred to The ACO Program Director for DVHA, and the individual referred to in Paragraph 2.5 of Attachment A of this Agreement for the Contractor, or their respective designees. Each representative shall consult with the managerial or directorial staff who are routinely tasked with oversight of work concerning the subject matter of the issue in dispute. The Parties 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 resolve the dispute.

b. If the program directors, or individuals referred to in Section 5.1.a, have not resolved the issue in dispute within fourteen (14) days, the issue will be referred to the Commissioner of the Department of Vermont Health Access, or his/her designee, for the State, and to the Chief Executive Officer of the ACO, or his/her designee, for the ACO. The parties 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 resolve the dispute.

If the issue in dispute is not resolved by the Senior Leaders, or the individuals referred to in Section 5.1.b, within thirty days from the date the issue is referred, ACO or Payer may bring an action in any court with jurisdiction.

6. Changes During the Agreement Term

6.1 This Agreement, including Exhibits, and attachments, may only be amended or modified in writing as mutually agreed to by the Parties.

6.2 The Parties intend, at a minimum, to amend this Agreement for Performance Years 2 and 3 to maintain its consistency with any changes to relevant standards adopted by the Vermont Health Care Innovation Project (VHCIP). Any such amendments must be mutually agreed to by the Parties in writing.

6.3 Changes to the calculations for determination of Shared Savings will be subject to a determination of materiality threshold. Should the changes exceed this threshold, then the parties will follow the dispute resolution process described in Section 5. The materiality threshold is defined as a change affecting more than 15% of either beneficiaries or expenditures in any of the three eligibility categories for a given benchmark or performance year (ABD Adult/BD Child, General Adult, General Child).

6.3.1 The State will issue written guidance concerning whether changes in provider coding patterns have had a material impact on medical spending. The Parties agree that if the State determines that there has been an impact, they will refer to VHCIP for advice as to how such impact should be addressed in this Agreement. The Parties agree that their intent, if confronted with such a situation, is to amend, in writing, this Agreement in a mutually agreeable manner consistent with the advice received from VHCIP, if that is reasonably possible.

6.3.2 At the request of the Contractor, the State will reconsider Expected Spending if unanticipated events, such as macro-economic or environmental events, occur that would reasonably be expected to have significant, unanticipated impact upon medical expenses. The State will make reasonable adjustment(s) to Expected Spending if such is the case. Whether an adjustment is reasonable shall be a matter for the sole discretion of the State, however a disagreement about such an adjustment will constitute a basis for termination of this Agreement by ACO with the right to receive Shared Savings through the Performance Year of Termination as described by Section 7.

7. Effect of Termination

The provisions of this Paragraph 7, shall apply notwithstanding anything to the contrary in this Agreement, and with the specific intent to supersede the Personal Services Contract pages of this Agreement and all other provisions of all other Attachments**,**

7.1 In the event of termination of this Agreement for any reason, after the first Performance Year, ACO shall be entitled to, and DVHA shall pay, all Shared Savings earned for any Performance Year prior to termination, regardless of whether they have been paid as of the date of termination.

7.2 If the Agreement is terminated by the State for any reason other than Contractor's material breach and if Contractor has met the minimum Quality Measure scores for the time during which it participated and all other requirements for participation during that time period,

including but not limited to number of Attributed Lives, Contractor shall be entitled to and DVHA shall pay all Shared Savings calculated in accordance with the following guidelines:

7.2.1 When termination occurs at any time during a Performance Year, Contractor shall be entitled to a proportion of shared savings commensurate with the number of full months for which the program was active, according to the formula: [Number of Active Months/12] * [Total Annual Savings of ACO in Performance Year], in addition to any unpaid Shared Saving from the prior Performance Year.

7.2.2 Calculations and payments under this section will be made according to the same schedule and requirements as for Shared Savings calculated under this Agreement generally. This means that calculations are made retrospectively at the end of the Performance Year and are subject to all the requirements of the Performance Year in which the termination occurred. In order to realize the payment of Shared Savings under this provision, Contractor must report (if applicable) any performance data, and must meet quality thresholds established for that Performance Year for the period of time before termination.

7.2.3 For termination effective in the middle of a month (i.e. between the first and last days of a month), no credit will be given for any partial month; rather the numerator, Number of Active Months in 7.2.1, will be the number of months where the contract was in force from the first day of the month through the last day of that month.

7.3 Should the Contractor terminate without cause before July 1 of a Performance Year, Contractor will forfeit any Shared Savings accrued during that Performance Year.

7.4 Termination by either party will be communicated through certified first class mail, with return receipt requested, to:

7.4.1 The Commissioner of DVHA, if the Agreement is terminated by the Contractor, or;

7.4.2 The Chief Executive Officer of the Contractor, if the Agreement is terminated by the State.

7.5 Termination notices that do not specify an effective date, will be effective twenty (20) days from the date of the notice, unless otherwise mutually agreed by the Parties.

7.6 Notwithstanding Sections 7.1 and 7.2, in the event that this Agreement is terminated by the State due wholly to failure of federal financial participation funds to match state share of Shared Savings, the matter will be referred to the process described in Sections 4A and 4B of Attachment C, and Sections 7A and 7B of the Personal Services Contract, as described in Attachment D.

Exhibit 1
Medicaid Shared Savings ACO Program Standards (VMSSP Standards)

I. Financial Stability

A. The parties intend to protect the Contractor 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 Contractor 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). To that end, the Contractor will not be responsible financially if Actual TCOC exceeds Expected TCOC under this Agreement (i.e., no downside risk).

B. If requested by the State, the Contractor will furnish financial reports regarding risk performance, with report formats defined by the State.

C. In order to continue to be eligible to participate in the Medicaid Shared Savings Program, the Contractor shall maintain responsibility for a minimum number of attributed lives, as defined in Section 1.5 of Attachment A, and Sections III and IV(A) of Attachment A, Exhibit 1 of this Agreement.

D. A Risk Mitigation plan is not required**.**

II. Contractor Governance

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

B. The Contractor must identify its board members, define their roles and describe the responsibilities of the board in writing to the State.

C. The Contractor's governing body must have a transparent governing process which includes the following:

1. Publishing the names and contact information for the governing body members, for example, on a website;
2. 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 the Contractor's activities;
3. Making meeting minutes available to the Contractor's provider network upon request, and
4. Posting summaries of Contractor activities provided to the Contractor's consumer advisory board on the ACO's website.

D. The Contractor's governing body members shall have a fiduciary duty to the ACO and act consistently with that duty.

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

1. Has a signed Participant Agreement;
2. Has programs designed to improve quality, patient experience, and manage costs; and
3. Is eligible to receive shared savings distributions based on the distribution rules of the Contractor or participate in alternative financial incentive programs as agreed to by the Contractor and its participants.
4. A "participant" does not need to have lives attributed to the Contractor to be considered a participant.
5. Of the 75% participant membership required on governing bodies:
    a. At least one seat must be held by a participant representative of the mental health and substance abuse community of providers; and
    b. At least one seat must be held by a participant representative of the post-acute care (such as home health or skilled nursing facilities) or long term care services and supports community of providers.
    c. Institutional and home-based long-term care providers, sub-specialty providers, mental health providers and substance abuse treatment providers are strongly encouraged to participate on ACO clinical advisory boards. This shall not be construed to create a right to participate or to be represented.
    d. It is also strongly encouraged that ACO participant membership serving all ages of Medicaid beneficiaries (pediatric and geriatric) be represented in governance and in clinical advisory roles. This shall not be construed to create a right to participate or to be represented.

F. The Contractor's governing body must include at least one consumer member who is a Medicaid beneficiary. Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The Contractor's governing board shall consult with advocacy groups and organizational staff in the recruitment process for the consumer member. The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

G. The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each

meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

III. Medicaid Patient Eligibility Requirements and Patient Attribution

A. Eligible Populations
The following population groups are eligible to be considered as attributed lives:

1. Aged, Blind or Disabled (ABD) Adult: Individuals who are 18 years of age or older who are aged, blind or disabled and who are not dually eligible for Medicare; AND Blind or Disabled (BD) Child: Individuals who are under 21 years of age who are aged, blind or disabled and who are not dually eligible for Medicare.
2. General Adult: Parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance; as well as adults with incomes below 133% of the Federal Poverty Level ("FPL") are assigned here. This could also include former Vermont Health Assistance Program, Catamount, Employer-sponsored Insurance Assistance, or previously uninsured individuals.
3. General Child: Children under age 21 who are eligible for cash assistance; as well as children up to age 18 who were previously uninsured, living in families up to 300% FPL, and who are not otherwise classified under BD Child.

B. Excluded Populations
The following populations are excluded from being considered as attributed lives:

1. Individuals who are dually eligible for Medicare and Medicaid;
2. Individuals who have third party liability coverage;
3. Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and
4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

C. Enrollment Requirements
Individuals must be enrolled at least ten non-consecutive months in the calendar year in any aid category across all three population groups. If an individual transitioned from one population group to another within the calendar year (e.g., from General Child to BD Child), then all of the member's months and expenditures are assigned to the population group where the member was enrolled last in the calendar year. Individuals may not be split across the three population groups within a year; however, an individual may appear in multiple population groups across the three baseline years.

D. Attribution Methodology
The State or its designee will conduct attribution monthly. The details of the attribution reports are described in the Data Use Standards, Attachment A, Exhibit 1, Section VIII (B) of this Agreement.

1. Attribution Step 1: Determine all Medicaid beneficiaries who were enrolled for at least 10 months in the study year across any of the three enrollment categories. Assign the beneficiary to the enrollment category where he/she appeared last in the study year.

2. Attribution Step 2: Claims for eligible members are identified for the presence of qualifying CPT Codes (refer to Attachment H) in the calendar year for primary care providers (identified by Medicaid provider number) combined with billing practices (identified by TIN) enrolled with Medicaid. The primary care provider specialty must be internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, or naturopathic medicine. The primary care provider must be a physician, nurse practitioner, physician assistant, or a provider in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

3. Attribution Step 3: For eligible beneficiaries not attributed in Step 2, assign the beneficiary to his/her primary care provider that he/she selected or was auto-assigned to in the study year. If the beneficiary changed primary care provider selection during the year, then the beneficiary is assigned to the primary care provider which he/she was assigned to last in the year.

4. Attribution is done at a combination of the rendering provider and billing practice TIN levels; any ACO Participant that includes at least one ACO Provider/Supplier with Attributed Lives must have an exclusive Participant relationship with one ACO. ACO Participants who do not have lives attributed can participate in multiple ACOs.

E. Patient Freedom of Choice

Beneficiaries will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. Calculation of Contractor Financial Performance and Shared Savings

A. Summary of Model Specifications

1. Program eligibility requires a minimum number of 5,000 attributed beneficiaries. The maximum savings rate is fifty percent (50%).

B. Core Service Expenditures

Core Service expenditures include: inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health clinic, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.

C. Non-Core Service Expenditures

1. Non-Core Service expenditures include: personal care, pharmacy, dental, non- emergency transportation, services administered by the VT Department of Mental Health through Designated Agencies and Specialized Service Agencies, services administered by the VT Division of Alcohol and Drug Abuse Programs, services administered by the VT Department of Disabilities, Aging and Independent Living, services administered by the VT Department for Children and Families and

services administered by the Vermont Department of Education.

2. Non-Core Service expenditures also include supplemental, lump sum disproportionate share payments and medical education payments as well as quality incentive payments made outside of the claims system.

D. Calculation of the Expected Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Expected TCOC. In July or August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The State or its designee shall calculate the Expected TCOC using the following steps:

1. Attribute beneficiaries in each of three historic calendar years (the "benchmark years") using the attribution methodology described in Attachment A, Exhibit 1, Section III of this Agreement.
   a. For 2014, calendar years (CYs) 2010, 2011 and 2012 will be benchmark years.
   b. For 2015, CYs 2011, 2012, 2013 will be benchmark years.
   c. For 2016, CYs 2012, 2013, 2014 will be benchmark years.

2. Re-price selected services with significant rate changes between the benchmark years and the performance year. The materiality threshold in section 6.3 of Attachment A shall be used to determine what constitutes a significant rate change.
   a. For PY 2014, the base year for re-pricing is rates effective January 1, 2013.
   b. For PY 2015, the base year for re-pricing is rates effective January 1, 2014.
   c. For PY 2016, the base year for re-pricing is rates effective January 1, 2015.

In PY 2014, the selected services identified for re-pricing include inpatient hospital, outpatient hospital and professional services paid using DVHA's version of the Resource Based Relative Value Scale fee schedule. For all other Core Services, the expenditures captured for the service are the values for actual paid amount on the claim ("original paid"). For each attributed member within a calendar year, sum the values for re-priced services and original paid services.

3. Calculate the Compounded Annual Growth Rate (CAGR)
   a. If determined to be material, adjust expenditures for other changes in utilization. If additional changes in utilization are determined to meet the determination of materiality threshold defined in Attachment A, Section 6.3, adjustments will be applied accordingly.
   b. Calculate an annualized value from the total expenditures captured in Step 2 for each beneficiary so that each beneficiary has a per member per year (PMPY) expenditure value for comparison purposes.
   c. Truncate annualized expenditures at the 99th percentile both within each enrollment category and at total eligible population level (ACO attributed members as well as all non-attributed eligible beneficiaries). In other words, if a particular beneficiary incurred expenditures above the 99th percentile value within the enrollment category, this beneficiary's expenditures are truncated so that their total expenditures in the calculation will equal the value set at the 99th percentile within its enrollment category.
   d. Sum the re-priced, annualized, truncated expenditures within each enrollment category.
   e. Divide the re-priced, annualized, truncated expenditures for the enrollment category by the total annualized member months for the enrollment category to compute the truncated PMPM for each benchmark year.

f. Use the CMS-HCC (Hierarchical Condition Categories) Community-Based scores to derive risk scores for each enrollment category and at total eligible population level for each year in the three-year benchmark period.

g. Compute a risk adjustment factor to account for changes in the health status of the attributed population between the earliest and most recent benchmark years. The risk adjustment factor is computed as: [(risk adjustment factor in most recent benchmark year) / (risk adjustment factor in earliest benchmark year)].

h. Risk-adjust the truncated PMPM in the most recent year of the three-year benchmark period by applying the following formula: [(Truncated PMPM as originally computed in (IV)(D)(3)(e) / (risk adjustment factor computed in (IV)(D)(3)(g)]. This is done at the enrollment category level and at the total eligible population level.

i. Compute the CAGR for the total eligible population as follows [(Risk-adjusted truncated PMPM for most recent year in the benchmark period) / (Truncated PMPM for earliest year in the benchmark period)^(0.5)] A more detailed example of the CAGR calculation is outlined on the next page.

CAGR Example
VMSSP Contract

TOTAL POPULATION DATA - TRUNCATION:	A (A1 and A3 = B + C + D)	B	C	D	E (E1 and E3 = F + G + H)	F	G	H	I (I1 and I3 = J + K + L)	J	K	L
	2010				**2011**				**2012**			
	TOTAL	**ABD (Adult and Child)**	**Consolidated Adult**	**Consolidated Child**	**TOTAL**	**ABD (Adult and Child)**	**Consolidated Adult**	**Consolidated Child**	**TOTAL**	**ABD (Adult and Child)**	**Consolidated Adult**	**Consolidated Child**
1. Total Truncated Payments (Annualized and Repriced)	$ 177,212,917	$ 54,006,586	$ 76,370,095	$ 46,836,236	$ 185,668,106	$ 54,791,523	$ 80,574,100	$ 50,302,483	$ 191,406,218	$54,508,525	$ 84,386,310	$52,511,383
2. Total Truncated Payments as Percent of Repriced Payments = weighted average of the 3 categories	94%	93%	97%	91%	93%	90%	97%	90%	94%	93%	97%	91%
3. Total Annualized Member Months	874,584	129,144	250,164	495,276	924,408	133,332	274,668	516,408	953,940	137,652	282,636	533,652
4. PMPM = (Row 1/Row 3)	$202.63	$418.19	$305.28	$94.57	$200.85	$410.94	$293.35	$97.41	$200.65	$395.99	$298.57	$98.40

ACO base year baseline PMPM and Total Population CAGR

	A	B	C	D	E = C/D	F = (E/A)^(0.5)
	Truncated PMPM CY 2010	**Truncated PMPM CY 2011**	**Truncated PMPM CY 2012**	**Risk Adj. Factor Applied to CY 2012**	**Risk-Adj. PMPM CY2012**	**CAGR**
***** TOTAL *****	$220.14	$220.43	$218.70			
ABD (Adult and Child)	$483.83	$483.37	$450.36			
Consolidated Adult	$341.94	$336.79	$337.45			
Consolidated Child	$105.84	$108.29	$108.70			
TOTAL POPULATION	$202.63	$200.85	$200.65	1.0076	$199.14	0.9914

Note: revised financial methodology does not calculate CAGR at enrollment category level, but at *total population level*

Calculation of Trended PMPMs

	Truncated PMPM CY 2012	**CAGR**	**Trended Truncated PMPM CY 2014**	**Risk Scores CY 2012**	**Risk Scores CY 2014**	**Risk Adj. Factor to Apply to Trended Truncated PMPM CY 2014**	**Risk Adj Trended Truncated PMPM CY 2014**	**Addition to Trended PMPM***	**FINAL Risk Adjusted Trended Truncated PMPM CY 2014**
***** TOTAL *****	$218.70	0.9914	$214.93	0.4352	0.4311	0.9907	$212.94	1.0300	$219.33
ABD (Adult and Child)	$450.36	0.9914	$442.61	0.5317	0.5308	0.9983	$441.86	1.0300	$455.12
Consolidated Adult	$337.45	0.9914	$331.64	0.5473	0.5378	0.9827	$325.90	1.0300	$335.68
Consolidated Child	$108.70	0.9914	$106.83	0.3757	0.3756	0.9997	$106.80	1.0300	$110.00

4. Determine Expected PMPM

a. Within each enrollment category, trend the truncated PMPM for the most recent year in the benchmark period by two years using the CAGR calculated for total eligible population in (IV)(D)(3)(i). This is the preliminary trended, truncated PMPM for the PY.

b. Use the CMS-HCC (Hierarchical Condition Categories) Community-Based scores to derive risk scores for each enrollment category in the PY.

c. Compute a risk adjustment factor to account for changes in the health status of the attributed population between the most recent benchmark year and the PY. The risk adjustment factor is computed as: [(risk adjustment factor in the PY) / (risk adjustment factor in most recent benchmark year)].

d. Risk-adjust the preliminary trended, truncated PMPM for the PY by applying the following formula: [(Preliminary trended, truncated PMPM as originally computed in (IV)(D)(4)(a) * (risk adjustment factor computed in (IV)(D)(4)(c)]. This is done at the enrollment category level.

e. Adjust for rate changes or other changes deemed material. For PY1, the PMPM calculated in 4d above will be inflated to account for rate increases that went into effect November 1, 2013 which are also in effect in CY 2014 (PY1). PY2 and PY3 adjustments, if necessary, will be made to account for additional rate increases or decreases. The final trended, truncated, risk-adjusted Expected PMPM TCOC for each enrollment category, therefore, is computed as follows: [(Trended, truncated, risk-adjusted PMPM computed in (IV)(D)(4)(d) * (adjustment factor for rate changes)].

E. Retrospective Calculation of the Actual Total Cost of Care (TCOC)

In April following the end of a performance year (PY), the State or its designee will calculate an interim Actual TCOC. In July-August, the State or its designee will calculate the final Actual TCOC for use in the calculation of savings. The TCOC will be calculated using Medicaid claims data and enrollment files. TCOC shall be defined to include all paid claims for the Contractor-responsible Core Services as defined in Section IV(B) of this Agreement. Actual TCOC will be calculated by:

1. Run the attribution algorithm as described in Attachment A, Exhibit 1, Section III(A)–(D) of this Agreement using the claims and enrollment data for the performance year (PY).

2. Calculate per member per year expenditures for each attributed beneficiary, imputing an annualized value for those beneficiaries enrolled only 10 or 11 months and not 12 months. The formula for annualizing is the same as that described in Attachment A, Exhibit 1, Section IV(D)(3)(b) of this Agreement.

3. Truncate the annualized expenditures at the 99th percentile for each enrollment category in the same manner as described in Attachment A, Exhibit 1, Section IV(D)(3)(c) of this Agreement.

4. Divide the annualized, truncated expenditures for the enrollment category by the annualized member months for the enrollment category to compute the Actual PMPM TCOC for each enrollment category.

5. Compute weighted Actual and Expected PMPMs as follows:
   a. Compile the actual member months for each enrollment category in the PY.
   b. Multiply the Final trended, truncated, risk-adjusted Expected PMPM TCOC for each enrollment category computed in Section IV(D)(4)(d) by the actual member months for the enrollment category in step 5a above.
   c. The sum of the values in step 5b becomes the Expected total trended dollars used in weighting.
   d. Sum the actual member months in step 5a.
   e. The Weighted Expected PMPM TCOC, therefore, is: [(total trended dollars in step 5c) / (total actual member months in step 5d)].
   f. Multiply the Actual PMPM TCOC for each enrollment category by the actual member months for the enrollment category in step 5a above.
   g. The sum of the values in step 5f becomes the Actual total trended dollars used in weighting.
   h. The Weighted Actual PMPM TCOC, therefore, is: [(total trended dollars in step 5g) / (total actual member months in step 5d)].

F. Aggregate Difference in Expected and Actual Expenditures (Savings Calculation)
Total savings will be calculated by:
[(Weighted Expected PMPM TCOC from (IV)(E)(5)(e) - (Weighted Actual PMPM TCOC from (IV)(E)(5)(h)] * Sum of Actual PY Member Months from (IV)(E)(5)(d)

G. Total Eligible Savings Amount

1. Based on the calculation in Attachment A, Exhibit 1, Section IV(F) of this Agreement, the State or its designee will determine if the Actual Cost of Care is less than the Expected Cost of Care for the Performance Year.

2. The State will then determine whether or not the savings are greater than or equal to a minimum savings rate (MSR) of 2%.

3. If total savings are greater than or equal to the MSR, then the Contractor will be eligible to share in the savings. If not, the Contractor will not be eligible to share in savings.

4. If the MSR is met, the state will calculate a tiered savings rate based on total savings. If program savings are between 2-5% (Tier 1), the ACO will be eligible for 25% of the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year. If program savings is above 5% (Tier 2), the ACO will be eligible for 50% of the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year. The total eligible amount of shared savings will be calculated by multiplying the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year by the maximum savings rate. For examples:

- If program savings are 4%, and the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year is $100,000, ACO will be eligible for 25% of $100,000, or $25,000 in shared savings.
- If program savings are 5.1% and the difference between Expected Cost of Care and the Actual Cost of Care of the Performance Year is $100,000, ACO will be eligible for 50%, or $50,000 in shared savings.

5. The final shared amount is subject to a cap equal to 10% of total actual expenditures in the performance year calculated in Attachment A, Exhibit 1, Section IV(E) of this Agreement.

6. The final sharing rate is equal to the product of the Contractor's quality score and the maximum sharing rate. Computation of the quality score is described in Attachment A, Exhibit 1, Section V of this Agreement.

7. Effective January 1, 2015, in the event that the State determines that the Contractor's shared savings has been affected by up-coding, meaning coding that does not meet regulatory standards and as to which disciplinary action against the provider has been pursued, or inaccurate performance data, DVHA may reduce the ACO's savings in accordance with Exhibit 1, Section IX, subsection II (VMSSP Program Integrity Requirements). The State shall apply the adjustment when calculating shared savings for the final performance year (Calendar Year 2016).

V. Performance Measurement and Shared Savings

To be eligible for savings, the Contractor must first meet the quality performance threshold. The State or its designee will calculate the threshold and quality score and in so doing will sample only Beneficiaries meeting the continuous enrollment and attribution requirements listed in the specifications for each quality measure.

The calculations are described below.

A. Assignment of Scores to Core Payment Measures

1. Table 1 below summarizes the Core payment measures and benchmarks used in the calculation. Points are assigned using the following methodology:

a. One point is assigned to the national Medicaid HEDIS 25th percentile for each measure.
b. Two points are assigned to the national Medicaid HEDIS 50th percentile for each measure.
c. Three points are assigned to the national Medicaid HEDIS 75th percentile for each measure.

2. For measures where national Medicaid HEDIS benchmarks do not exist (Core-1, Core-8, and Core-12 in Table 1), points are assigned using the following methodology: The State or its designee will calculate an ACO-specific 2014 performance and assign 0, 2, or 3 points based on statistically significant decline, no statistically significant change, or statistically significant improvement, respectively, in the 2015 performance year.. For each of the ten Core Payment measures, a maximum of 3 points will be awarded, for a maximum of 30 possible points in total.

3. In addition to earning points for attainment of quality relative to national benchmarks, ACOs can earn one additional point for every measure that is compared to a national benchmark (Core-2 – Core-7, Core-17) for which they achieved statistically significant improvement relative to the prior program year. Improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks (Core-1 , Core-8, Core-12). An ACO may earn up to 7 improvement points, but no ACO may earn more than the maximum 30 possible points.

B. Requirements for Reporting Measures

Table 2 below summarizes the Core reporting measures. These measures will not be used in the calculation but submission of these measures by the Contractor to the State is required; however, failure to report will not jeopardize Shared Savings or funding. The State also requires the reports to include an analysis of barriers, costs incurred related to reporting and a plan to mitigate those barriers where possible. Guidelines for the content and format of this analysis and plan will be provided by the State.

Table 1. Core Measures for Payment

#	Measure	Data Source	National HEDIS Benchmarks (CY 2012)
Core-1	All-Cause Readmissions	Claims	National Benchmark Unavailable
Core-2	Adolescent Well-Care Visits	Claims	Nat. 75th: 57.07 Nat. 50th: 47.24 Nat. 25th: 41.72
Core-9	Hypertension (HTN): Controlling High Blood Pressure	Clinical	Nat. 75th: 62.91 Nat. 50th: 56.11 Nat. 25th: 50.00
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-Day	Claims	Nat. 75th: 54.64 Nat. 50th: 43.95 Nat. 25th: 30.91
Core-5	Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (composite)	Claims	Nat. 75th: 29.64 Nat. 50th: 24.75 Nat. 25th: 20.59
Core-6	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	Claims	Nat. 75th: 28.07 Nat. 50th: 22.14 Nat. 25th: 17.93
Core-7	Chlamydia Screening in Women	Claims	Nat. 75th: 63.72 Nat. 50th: 57.15 Nat. 25th: 50.97
Core-8	Developmental Screening in the First 3 Years of Life (composite)	Claims	National Benchmark Unavailable
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	Claims	National Benchmark Unavailable
Core-17	Diabetes Care: HbA1c Poor Control (>9.0%)	Clinical	Nat. 75th: 36.53 Nat. 50th: 44.89 Nat. 25th: 53.77

Table 2. Core Measures for Reporting

#	Measure	Data Source
Core-10	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	Claims
Core-13	Appropriate Testing for Children with Pharyngitis	Claims

Core-53	Diabetes Composite (D2) (All-or-Nothing Scoring): Hemoglobin A1c Poor Control (>9%), Eye Exam <140/90, Tobacco Non-Use, Aspirin Use	Clinical
Core-14	Childhood Immunization Status	Clinical
Core-15	Pediatric Weight Assessment and Counseling	Clinical
Core-18	Colorectal Cancer Screening	Clinical
Core-19	Screening for Clinical Depression and Follow-Up Plan	Clinical
Core-20	Adult BMI Screening and Follow-Up	Clinical
Core-30	Cervical Cancer Screening	Clinical
Core-36	Tobacco Use Assessment and Tobacco Cessation Intervention	Clinical
Core-21	Access to Care Composite	Survey
Core-22	Communication Composite	Survey
Core-23	Shared Decision-Making Composite	Survey
Core-24	Self-Management Support Composite	Survey
Core-25	Comprehensiveness Composite	Survey
Core-26	Office Staff Composite	Survey
Core-27	Information Composite	Survey
Core-28	Coordination of Care Composite	Survey
Core-29	Specialist Care Composite	Survey
Core-51	Provider Knowledge of DLTSS Services and Help from Case Manager/Service Coordinator	Survey

C. Calculation of Performance

The State or its designee will calculate the performance of the Contractor for the measures and assign points as described in Attachment A, Exhibit 1, Section V(A) of this Agreement. The State or its designee will also calculate the total number of points possible for the measures described in Attachment A, Exhibit 1, Section V(A) of this Agreement**.**

D. Threshold Calculation

The Contractor must earn at least 16 out of 30 points in order to meet the minimum threshold for performance ("the gate"). If the Contractor is not able to meet the overall quality gate, then it will not be eligible for any

shared savings.

E. Calculation of the Quality Score

If the Contractor meets the performance threshold ("the gate"), it may retain at least 75% of the savings for which it is eligible. The amount of eligible savings will vary based on the Contractor's quality score ("the ladder"). The quality score will be equal to the Contractor's actual performance as determined in Table 3 based on calculations described in Attachment A, Exhibit 1 Section V of this Agreement.

Table 3. Quality Score "Gate and Ladder"

Points Earned (out of 30 possible points)	Quality Score
16-17	75%
18	80%
19-20	85%
21	90%
22-23	95%
>24	100%

F. Final Calculation of Shared Savings Payments
The total eligible savings amount calculated in Attachment A, Exhibit 1, Section IV(G)(5) will be multiplied by quality score determined in Attachment A, Exhibit 1, Section V(E) of this Agreement**.** This represents the Contractor's share in the savings to be paid via the terms listed in Attachment B, Payment Provisions.

VI. Care Management Standards

A. The Contractor will maintain regular contact with Vermont Chronic Care Initiative (VCCI) to ensure that efforts around care management are well coordinated through regular and ad-hoc in-person and telephonic meetings; at minimum, the Contractor agrees to a meeting monthly but as frequently as both parties agree is needed.

B. The Contractor will maintain as needed contact with other Vermont Agency of Human Services (AHS) departments engaged in care management or care coordination activities particularly as it relates to federal mandates (e.g., Early Periodic Screening, Diagnosis, and Treatment) and vulnerable populations (e.g., Disabilities, Traumatic Brain Injury, Integrated Family Services). Examples of this contact will include but not be limited to: meetings (in- person and telephonic), educational outreach, partnering, launching or rolling out new or existing initiatives, and direct care coordination.

C. The Contractor's Care Management programs will be consistent with and be guided by the eleven (11) principles outlined in the Care Management Standards approved by the SIM Care Models/Care Management work group, set forth below in paragraphs 1-2.

1. Care Management Definition:

Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

2. Care Management Standards:

a. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

b. Guidelines, Decision Aids, and Self-Management (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports its participating providers in the consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

c. Population Health Management (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#7: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#8: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
- Recognizing disability and long terms services and supports providers as partners in serving people with high or complex needs.

#9: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs.

d. Data Collection, Integration and Use (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G)

#10: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) provides people access to their own health care information as required by law.

#11: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

e. As long as ACO's Clinical Model or Care Model is consistent with the Care Management Standards in the above sections, any AHS or DVHA employee and/or contractors who provide care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS or DVHA programs or procedures and with DVHA's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. DVHA and AHS acknowledge that this cooperation is critical to the ACO's ability to successfully meet the quality, patient experience and financial performance thresholds under this Agreement. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS or DVHA programs or procedures that cannot be resolved; the parties may invoke the Dispute Resolution Process set forth in Section 5 of Attachment A.

D. Evaluation Mechanism:

DVHA, with consultation from AHS, may evaluate the consistency of Contractor's Care Management programs with the SIM Care Models/Care Management "best practice" Standards as follows:

1. For Care Management Standards 1-3:

Contractor shall submit to DVHA in writing no later than September 30, 2015; and thereafter, no more frequently than annually, as part of its materials to accompany ACO Transformation Meetings as organized by the GMCB in subsequent years; a written report including the following information:

a. A description of Contractor's organizational structure that provides a forum for provider and beneficiary collaboration in Contractor activities that support the Three Part Aim. The description shall also include examples of challenges and successes (as related to standard #1).
b. A description of the Contractor's efforts to support primary care practices' capacity to meet person-centered requirements related to care management (as related to standard #2).
c. A description of the communications with Contractor's Consumer Advisory Board (as related to standard #3).

2. For Care Management Standards 4-11:

Contractor shall participate in periodic strategic dialogue with DVHA representatives through the mechanism of the ACO Transformation Meetings as organized by the GMCB. Contractor shall be prepared to respond to questions addressed at elements of the Care Management Standards, particularly standards #4-11. Written materials, discussion and the meeting minutes/reports will be used to assist DVHA in understanding the Contractor's care management strategies and model.

E. Should DVHA determine that Contractor's Care Management programs are inconsistent with the Care Management Standards, DVHA will submit its determination and the detailed reasons for same to Contractor. Contractor will have thirty (30) days to respond to the written determination and either agree to change its Care Management programs or dispute DVHA's conclusions with detailed reasons. Should the Parties disagree, the dispute will be submitted to the contractual Dispute Resolution Process.

VII. Payment Alignment

The parties share the objective of improving 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.

A. The performance incentives that are incorporated into the payment arrangements between the State and the Contractor should be appropriately reflected in those that the Contractor utilizes with participating providers. Annually, no later than the third quarter of each program year, the Contractor will share with the State their written plans for:

1. Aligning provider payment and compensation with Contractor performance incentives for cost and quality; and

2. Distributing any earned shared savings.

3. Specific to affiliated providers or incentive pool forms of compensation, the Contractor will provide detailed and specific plans for funding and distribution under these programs.

B. The State will support the Contractor by collaborating to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

VIII. Data Use

A. Program Reporting Requirements- Contractor to the State
The following tables summarize reporting requirements:

Report	***Details***	***Start Date***	***Frequency***	***Responsible Party***	***Receiving Party***	***Format***
Monthly provider changes within PCP practices for attribution. Other additions to participant, provider/supplier lists.	Additions and terminations by site, including site-specific information of providers practicing at multiple sites	As mutually agreeable to the parties	Monthly	ACO	DVHA	Specified by State
Clinical data-based measures required for Year One Contractor may elect between the Sample method and the Electronic data method	Sample method: Contractors, the State or its designee will generate sample. Contractor will generate numerators and denominators and report to the State or its designee using report template. OR Electronic data method: The Contractor generates numerators and denominators for all practices with EHR capability to report one or more rates, and reports percentage of attributed lives represented by the practices reporting each measure.	Sample method: The State or its designee provide sample to Contractor by January 2015. Sample and electronic data methods: The Contractor report to the State or its designee by April 2015.	Annual	Contractor	Contractor and the State	VHCIP Specified Format

B. Reports from the State to the Contractor
The following tables summarize reporting requirements:

Report	***Details***	***Start Date***	***Frequency***	***Responsible Party***	***Receiving Party***	***Format***
Patient attribution report - enrollment	Data file with list of patients that are attributed to a particular Contractor, with identification of Primary Care Physician	January 2014	Monthly	The State or its designee	Contractor	State specified, includes HCC Scores
Patient attribution report - claims extract	Initial file to contain 12 months of incurred claims, including pharmacy, for attributed enrollees. Every month thereafter a file contained claims paid in the past month for currently attributed enrollees, and for the past 12 months for new enrollees	March 2014	Monthly	The State or its designee	Contractor	VHCURES Format
If requested, Stratification of patients by risk score with supplemental information	The State's software	April 2014	Quarterly	The State or its designee	Contractor	Format used by the State
If requested, Patient gaps in care	The State's gaps in care reports	Existing payer schedules	Existing payer schedules	The State or its designee	Contractor	Format used by the State

IX. Program Integrity

I. Program Monitoring

A. General Methods Used to Monitor ACOs Participating in VMSSP

In addition to the existing structure and experience of DVHA in monitoring organizational, provider, and supplier behavior with respect to Medicaid program integrity requirements, quality measurement, avoidance of particular types of beneficiaries, overutilization, and claims submissions; the following methods can be used to monitor ACO performance:

- Analysis of specific financial and quality data, as well as aggregated annual and quarterly reports.
- Site visits.
- Collection, assessment and follow up investigation of beneficiary and provider complaints.
- Audits (including, for example, analysis of claims, chart review, beneficiary surveys, coding audits).

B. Monitoring Compliance

If at any time throughout the contract period, DVHA, through its routine monitoring and evaluation of the program, determines that the ACO, its participants, its ACO Providers/Suppliers or other individuals or entities that the ACO contracts with to fulfill its obligations under this agreement, has failed to comply with any of the requirements of this Agreement, DVHA retains the right to impose one or more of the following actions, including termination of the ACO from the program.

- Provide a warning notice to the ACO describing the issue of concern.
- Request a Corrective Action Plan (CAP) from the ACO.
- Place the ACO on a special monitoring plan.
- Terminate the Agreement in the event of a material failure, including the failure of the ACO to submit or implement a CAP.

DVHA shall provide a fourteen (14) calendar day prior notice to the ACO that it intends to terminate the Agreement.

The parties agree that the Dispute Resolution process in Section 5 of the contract may be invoked by the parties to resolve any actions DVHA may take with regard to subsection B.

II. VMSSP Program Integrity Requirements

The parties agree to two VMSSP Program Integrity Requirements.

1. The parties agree that the claims filing by ACO Participants and Suppliers may affect the shared savings contracted between the parties. More particularly, upcoding by ACO Participants and or Suppliers or in accurate performance data may garner larger shared savings than warranted. Upcoding, as used in this paragraph, denotes a practice of a health care provider to bill for a higher

reimbursement code than the medical record supports, in contravention to regulatory standards and as to which disciplinary action against the provider has been pursued.

Based upon this potential concern, the ACO agrees that should DVHA find either issue is present in data used to provide shared savings it shall have the ability to reduce shared savings. Such reduction is noted in Attachment A, Exhibit 1, Section IV(G)(7) above.

2. The parties agree that it is important that data generated by ACO administrative officials to DVHA is accurate, materially correct, and complete. While DVHA does not require ACO officials to warranty information provided to DVHA to calculate shared savings, the ACO does agree to verify such data is complete, accurate and materially correct prior to its submission to DVHA.

A. Conflict of Interest Policy

The ACO governing body must have a conflicts of interest policy that applies to members of the governing body. DVHA further recommends that the ACO coordinate its compliance programs with those of its participating provider groups.

B. Prohibition on Avoiding At-Risk Beneficiaries and Cost-Shifting

ACOs, ACO participants, ACO providers/suppliers, and other individuals or entities that the ACO contracts with to fulfill its obligations under this agreement are prohibited from:

(1) Avoiding at-risk beneficiaries; whether via the utilization of preferential referral agreements with their providers, or by other means.

(2) Requiring that beneficiaries be referred only to ACO participants or ACO providers/suppliers within the ACO network.

C. Audits and Record Retention

(1) The ACO agrees that authorized representatives of DVHA, MFRAU, and the Secretary shall have the right to make physical inspection of the ACO's place of business and to examine records relating to ACO activities under this Agreement and to audit the ACO's financial records as provided by 42 C.F.R § 431.107. If the ACO fails to submit copies of records, or provide appropriate access to records, to DVHA or its agent within reasonable specified timeframes, DVHA may provide for a sanction in paragraph I.(B.). The records described in the first sentence of this paragraph include, but are not limited to, those records that relate to the following activities:

(a) The ACO's compliance with the Medicaid Shared Savings Program.
(b) The reported quality measures and determination of the amount due from DVHA under the agreement.
(c) If as a result of any inspection, evaluation, or audit, it is determined that the amount of shared savings due to the ACO has been calculated in error, DVHA reserves the right to reopen the initial determination and issue a revised initial determination.

(2) Maintenance of records. The maintenance of records pertains to all records collected by the ACO to report to DVHA under this agreement, any records used by the ACO to generate reports or data to DVHA, any data used by the ACO to receive payments from DVHA under this agreement and any notes regarding the data. The ACO agrees, and must require its participants, providers/suppliers, and other individuals or entities that the ACO contracts with, to:

(a) Maintain such books, contracts, records, documents, and other evidence for a period of 6 years from the final date of the agreement, unless:

(i) The ACO agrees that the six (6) year time requirement to maintain records will be extended in the case an audit or litigation regarding this contract work occurs prior to the end of the six (6) year period. The extended period will end at the conclusion of the audit or conclusion of the litigation.

(3) In the event an audit occurs and the ACO asserts that such records are confidential under state or federal law, it shall mark such records "Confidential" at the time of submission. The parties acknowledge that certain records might be subject to an exemption under either federal or state law. The parties also agree that DVHA has the obligation under both federal and state law to interpret potential exclusions regarding disclosure.

D. Beneficiary Inducements

ACOs, ACO Participants, ACO Providers/S-suppliers, and other individuals or entities that the ACO contracts with to fulfill its obligations under this agreement, are prohibited from providing gifts or other remuneration to Medicaid beneficiaries as inducements for receiving items or services from or remaining in, an ACO or with ACO Providers/Suppliers in a particular ACO or receiving items or services from ACO Participants or ACO Providers/ Suppliers except where there is a a reasonable connection between the inducement and the medical care of the beneficiary and the inducement advances a clinical goal for the beneficiary.

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.

*Professional Liability***:** Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of ***$1,000,000*** per occurrence, and ***$3,000,000*** aggregate.

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 shall maintain all records pertaining to performance under this agreement. "Records" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired by the Party in the performance of this agreement. Records produced or acquired in a machine readable electronic format shall be maintained in that format. The records described shall be made available at reasonable times during the period of the Agreement and for three years thereafter or for any period required by law 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.

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.

20. **Internal Controls:** In the case that this Agreement is an award that is funded in whole or in part by Federal funds, in accordance with 2 CFR Part II, §200.303, the Party must establish and maintain effective internal control over the Federal award to provide reasonable assurance that the Party is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States and the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

21. **Mandatory Disclosures:** In the case that this Agreement is an award funded in whole or in part by Federal funds, in accordance with 2CFR Part II, §200.113, Party must disclose, in a timely manner, in writing to the State, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures may result in the imposition of sanctions which may include disallowance of costs incurred, withholding of payments, termination of the Agreement, suspension/debarment, etc.

22. Conflict of Interest: Party must disclose in writing any potential conflict of interest in accordance with Uniform Guidance §200.112, Bulletin 5 Section X and Bulletin 3.5 Section IV.B.

(AHS - State of Vermont – Attachment C - 9-1-2015_rev)