1.3.5 Legacy Practice

Legacy practices may be used to conduct attribution only if:

a. Merger, acquisition, or corporate reorganization has resulted in the consolidation or replacement of an NPI that appears on claims for QEMs provided during an Attribution Year; and

b. The NPI will not be used to bill for QEM services provided during the Performance Year.

1.4 Expanded Attribution Cohort

A Member is eligible for Attribution to the Expanded Attribution Cohort in the Performance Year if the Member: i) is not attributed to the Traditional Attribution Cohort through the methodology provided in section 1.3 above, and ii) has no QEM services claims history in the AYs with non-Participating Providers, or iii) fell into one of the exclusion categories below during the AYs.

Members otherwise eligible for attribution to the Expanded Attribution Cohort in the Performance Year will not be attributed if they fall into any of the following exclusion categories:

1.4.1 Member is dually eligible for Medicare;

1.4.2 Member had evidence of third-party liability coverage;

1.4.3 Member has obtained coverage through commercial insurers; or

1.4.4 Member is enrolled in Vermont Medicaid but receives a limited benefits package.

2. Administrative Requirements

2.1 State Registration

Contractor shall maintain its registration as a business in good standing with the Vermont Secretary of State.

2.2 Certification

Contractor agrees to maintain its status as a Vermont certified accountable care organization.

2.3 [intentionally omitted]

2.4 Administrative and Organizational Structure

Contractor shall have in place sufficient administrative and clinical staff and organizational components to comply with all Contract requirements and standards. Contractor shall manage the following major operational areas:

- Administrative and fiscal management
- Member services (but not Medicaid eligibility)
- Provider services (but not DVHA provider enrollment)
- Provider contracting (limited to contractual relationships between Contractor and its provider network)
- Network development and management
- Quality management and improvement

- Care management
- Information systems
- Provider payments
- Performance data reporting and submission of provider payment transactions
- Member and provider grievances, with the exception of fair hearings which are DVHA's responsibility as set forth in Section 4

2.5 Staffing

Contractor shall have in place sufficient administrative, clinical and organizational staffing to comply with all program requirements and standards. Contractor shall maintain a high level of contract performance and data reporting capabilities regardless of staff vacancies or turnover. Contractor shall have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment.

Contractor shall have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (e.g., high school, college degree or graduate degree), professional credentials (e.g., licensure or certifications), work experience, membership in professional or community associations, etc.

2.5.1 Key Staff

Subject to any limitations as a result of the COVID-19 public health emergency and State of Vermont Executive Orders, Contractor shall have an office in the State of Vermont from which, at a minimum, the majority of key staff members physically perform the majority of their daily duties and responsibilities and a major portion of Contractor's operations take place. Contractor shall be responsible for all costs related to securing and maintaining this facility.

Upon DVHA's request, Contractor shall deliver a current staffing plan, including all key staffing positions.

Contractor shall identify and disclose any staff or operational functions located outside the State of Vermont. If any staff or operational functions are located outside the State of Vermont, Contractor shall ensure that these locations do not compromise the delivery of integrated services and the seamless experience for Members and providers.

Contractor shall employ the key staff members listed below. In the event of a vacancy of a key staff member for any reason, Contractor shall notify DVHA in writing within five (5) business days of the vacancy and provide Contractor's plan to fill the vacancy.

The key staff positions include:

- Chief Executive Officer
- Chief Operating Officer
- Chief Medical Officer
- Vice President of Finance
- Director, ACO Payment Reform
- Director, Value Based Care
- Director, Care Coordination
- Director, ACO Program Operations
- Compliance Officer

2.5.2 [intentionally omitted]

2.5.3 Training

On an ongoing basis, Contractor must ensure that each staff person, including Subcontractor staff, has appropriate education and experience to fulfill the requirements of their positions, as well as ongoing training specific to their role in the organization. Contractor must ensure that all staff are trained in the major components of the Vermont Medicaid program, including Program Integrity training required in Section 11.

Contractor shall update its training materials on a regular basis to reflect program changes. Contractor shall maintain documentation to confirm its internal staff training, curricula, schedules and attendance, and shall provide this information to DVHA upon request and during regular on-site visits.

2.5.4 Excluded and Debarred Individuals

In accordance with 42 CFR § 438.610, Contractor must not knowingly have a relationship with the following:

- An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, which relates to debarment and suspension; or

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR § 2.1.01, of a person described above.

For purposes of this prohibition, "relationship" includes directors, officers or partners of Contractor, persons with beneficial ownership of five percent (5%) or more of Contractor's equity, or persons with an employment, consulting or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under the Contract.

If DVHA finds that Contractor is in violation of 42 CFR § 438.610, this shall be grounds for Contract termination.

Contractor shall have policies and procedures in place to routinely monitor staff, subcontractors, and Participating Providers, for individuals debarred or excluded by Federal agencies. Contractor shall monitor external data, such as the U.S. Department of Health and Human Services, Office of Inspector General (OIG) exclusion list, on a monthly basis, for individuals debarred or excluded by Federal agencies. Contractor's discovery of an excluded individual must be immediately referred to DVHA.

Contractor shall be required to disclose to DVHA Program Integrity Unit information required by 42 CFR § 455.106 regarding Contractor's staff and persons with an ownership interest in Contractor that have been convicted of a criminal offense related to that person's involvement in the Medicare or Medicaid program.

2.6 DVHA Meeting Requirements

Contractor shall comply with all reasonable meeting requirements established by DVHA, and is expected to cooperate with DVHA and/or its contractors in preparing for and participating in these meetings. DVHA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

Representatives of DVHA will meet at least annually with Contractor's executive leadership to review Contractor's performance.

2.7 Financial Stability and Accounting

DVHA will monitor Contractor's financial performance to ensure that Contractor is financially capable of performing its obligations under this Agreement. Contractor shall provide DVHA with copies of any filings Contractor is required to make to the Green Mountain Care Board (GMCB) related to Contractor's financial stability, within one business day of making filings with GMCB. Notwithstanding, Contractor is not required to provide any information that would provide an unfair advantage to DVHA in negotiations pertaining to the VMNG Program.

Contractor shall maintain separate accounting records for its Medicaid ACO programs that incorporates performance and financial data of Subcontractors, as appropriate.

Contractor shall notify DVHA of any person or corporation with five percent (5%) or more of ownership or controlling interest in Contractor and shall submit financial statements for these individuals or corporations.

Authorized representatives or agents of State of Vermont and the federal government shall have access to Contractor's accounting records pertaining to Contract and the accounting records of its Subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction.

Copies of any financial and accounting records meeting these criteria shall be made available by Contractor within ten (10) days of receiving a written request from DVHA for specified records. DVHA and other state and federal agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the Contract. Notwithstanding, Contractor is not required to provide any information that would provide an unfair advantage to DVHA in negotiations pertaining to the VMNG Program.

Contractor shall maintain financial records pertaining to the Contract, including all claims records, for the period specified in Attachment C of this Contract. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract.

DVHA will require Contractor to produce the information on Contractor's financial condition at the close of its fiscal year and upon request by the DVHA Commissioner. Any financial statement submitted to DVHA shall be signed under penalty of perjury by Contractor's Chief Financial Officer, Chief Operating Officer or Chief Executive Officer. Information in the financial statement submission shall include, but not be limited to:

- A statement of revenues and expenses; and
- A balance sheet.

Upon request, Contractor shall provide to DVHA confirmation of appropriate insurance coverage for general liability, property, and workers' compensation, in conformance with state and federal regulations and Attachment C to this Agreement.

DVHA may make an examination of the affairs of Contractor as often as it deems prudent. The focus of the examination will be to ensure that Contractor is not subject to adverse actions which in DVHA's determination have the potential to impact Contractor's ability to meet its responsibilities with respect to its use of the payments received from DVHA and Contractor's compliance with the terms and conditions of any financial risk transfer agreement. Responses to DVHA requests shall fully disclose all financial or other information requested. Information designated as confidential may not be disclosed by DVHA without the prior written consent of Contractor except as required by law. If Contractor believes the requested information is confidential and not to be disclosed to third parties, Contractor shall provide a detailed legal analysis to DVHA setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

2.8 Reporting Transactions with parties of interest

Contractor shall disclose to DVHA information on certain types of transactions they have with a "party in interest" defined as:

- Any director, officer, partner or employee responsible for management or administration of Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of Contractor; and, in the case of Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

- Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of Contractor; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the Contractor;

- Any person directly or indirectly controlling, controlled by or under common control of Contractor; and

- Any spouse, child or parent of an individual described above.

Business transactions which shall be disclosed include:

- Any sale, exchange or lease of any property between Contractor and a party in interest;

- Any lending of money or other extension of credit between Contractor and a party in interest; and

- Any furnishing for consideration of goods, services (including management services) or facilities between Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions between Contractor and a party in interest listed above includes:

- The name of the party in interest for each transaction;

- A description of each transaction and the quantity or units involved;

- The accrued dollar value of each transaction during the fiscal year; and

- Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, Contractor may be required to submit a consolidated financial statement for Contractor and the party in interest.

2.9 Subcontracts

Contractor is responsible for the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of Contractor to DVHA to ensure that all activities under the Contract are carried out. Contractor shall oversee Subcontractor activities and submit an annual report on its Subcontractors' compliance, corrective actions, and outcomes of Contractor's monitoring activities. Contractor shall be held accountable for any functions and responsibilities that it delegates.

Contractor shall provide that all Subcontracts indemnify and hold harmless the State of Vermont, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of Contractor and/or the Subcontractors. This indemnification requirement does not extend to the contractual

obligations and agreements between Contractor and health care providers or other ancillary providers that have contracted with Contractor.

The subcontracts shall further provide that the State of Vermont shall not provide such indemnification to the Subcontractor.

Contractor shall monitor the financial stability of Subcontractor(s) whose payments are equal to or greater than five percent (5%) of DVHA's annual Value-Based Care Payments to Contractor.

At least annually, Contractor must obtain the following information from the Subcontractor and use this information to monitor the Subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance. Contractor shall make these documents available to DVHA upon request and DVHA shall have the right to review these documents during Contractor site visits.

Contractor shall comply with 42 CFR § 438.230 and the following subcontracting requirements:

a. Contractor shall obtain the approval from DVHA before subcontracting delegated activities for any portion of the Contract requirements. Contractor shall give DVHA a written request and submit a Subcontractor Compliance Form at least sixty (60) days prior to the intended use of a Subcontractor. DVHA will ensure that the proposed Subcontractor (1) does not appear on the State of Vermont's debarment list, and (2) that the work to be performed by the Subcontractor is appropriate and in accordance with the scope and terms of the agreement.

b. If Contractor makes subsequent changes to the duties included in the Subcontractor contract, it shall notify DVHA sixty (60) days prior to the revised contract effective date and submit an updated Subcontractor Compliance Form for review and approval. DVHA must approve changes in vendors for any previously approved subcontracts.

c. The subcontract shall ensure the Subcontractor is in full compliance with Attachment C regarding fair employment practices and the Americans with Disabilities Act, taxes due the State of Vermont, child support orders (if applicable) and debarment.

d. DVHA will not approve a subcontract involving offshore services.

e. Contractor shall evaluate prospective Subcontractors' abilities to perform delegated activities prior to contracting with the Subcontractor to perform services associated with the Medicaid VMNG Program.

f. Contractor shall have a written agreement with each Subcontractor in place that specifies the Subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement shall be in compliance with the State of Vermont statutes and federal laws and will be subject to the provisions thereof.

g. Contractor shall collect performance data from its Subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews. Contractor shall incorporate all Subcontractors' data into Contractor's performance and financial data for a comprehensive evaluation of Contractor's performance compliance and identify areas for its Subcontractors' improvement when appropriate. Contractor shall take corrective action if deficiencies are identified during the review.

h. All Subcontractors shall fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all Subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that apply to any service or activity delegated under the Subcontract.

i. Contractor shall submit a plan to DVHA on how the Subcontractor will be monitored for debarred employees.

j. Contractor shall fulfill the requirements of 42 CFR § 434.6, which addresses general requirements for all Medicaid contracts and Subcontracts.

Contractor must have policies and procedures addressing auditing and monitoring Subcontractors' data, data submissions and performance. Contractor must integrate Subcontractors' performance data (when applicable) into Contractor's information system to accurately and completely report Contractor performance and confirm contract compliance.

DVHA shall have the right to audit Contractor's Subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions and will assess liquidated damages for non-compliance with reporting requirements and performance standards.

If Contractor uses Subcontractors to provide direct services to Members, the Subcontractors shall meet the same requirements as Contractor, and Contractor shall demonstrate that the Subcontractors are in compliance with these requirements. Contractor shall require Subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the Subcontractors.

2.10 Confidentiality of Member Medical Records and Other Information

Contractor shall ensure that Member medical records as well as any other health and enrollment information that contains individually identifiable health information is used, stored/maintained and disclosed in accordance with the privacy requirements set forth in Attachment E: Business Associate Agreement.

2.11 Response to DVHA Inquiries

DVHA may directly receive inquiries and complaints from external entities, including but not limited to providers, Members, legislators or other constituents which Contractor will be required to research, respond to, and resolve in the timeframe specified by DVHA.

2.12 Dissemination of Information

Upon the request of DVHA, Contractor shall distribute information prepared by DVHA, its designee, or the Federal Government to its Members.

2.13 Maintenance of Records

Contractor shall maintain all financial, quality measurement, and other records that relate to the payments under this Contract for a period of ten (10) years in accordance with DVHA's 1115a waiver document, or for the duration of contested case proceedings, whichever is longer.

2.14 Maintenance of Written Policies and Procedures

Contractor shall develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, State of Vermont Statutes, DVHA Rules applicable to this Contract, the ACO Operations Manual and this Contract. Written guidelines shall be maintained for developing, reviewing and approving all policies and procedures. Contractor shall review all policies and procedures at least annually to ensure they reflect current practice and shall update them as necessary. Reviewed policies shall be signed by appropriate key staff, as listed in section 2.5.1, and dated. All medical and quality management policies shall be reviewed and approved by Contractor's Chief Medical Officer. DVHA has the right to review all Contractor policies and procedures. Should DVHA determine that a policy requires revision, Contractor shall work with DVHA to revise within the timeframes specified by DVHA. If DVHA determines that Contractor lacks a policy or process required to fulfill the terms of the Contract, Contractor must adopt a policy or procedure as directed by DVHA.

2.15 [intentionally omitted]

2.16 DVHA Ongoing Monitoring

DVHA shall conduct ongoing monitoring of Contractor to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of DVHA and may include, but is not limited to, both scheduled and unannounced site visits, review of policies and procedures, and performance reporting.

In support of ongoing monitoring, the following two guidance documents created by DVHA will be effective, and binding on Contractor, upon execution of the Contract:

- The ACO Reporting Manual, dated December 18, 2019, contains a catalog of the reports that will be required to be submitted by Contractor to DVHA and the periodicity schedule of each report submission. For every report, DVHA will provide both a report template and instructions for how to complete each report.

- The ACO Operations Manual, dated December 18, 2019, contains written procedures that will be created for each functional area, as needed, that pertain to the notifications, reporting, or file exchanges between Contractor and DVHA.

Both the ACO Reporting Manual and ACO Operations Manual will be considered "living" documents. DVHA will propose updates, as needed, for Contractor approval. Contractor shall either approve or object to such changes within 30 days of DVHA submitting changes to Contractor or the changes will be deemed approved.

2.17 Material Change

A material change to operations is any change to Contractor's business operation policies that was disclosed to DVHA and relied upon by DVHA, such as an appeals policy, only if that change affects, or can reasonably be expected to materially affect, DVHA's compliance with the federal Medicaid program requirements.

Prior to implementing a material change in operation, Contractor shall submit a notification to DVHA for review and objection or request for modification at least sixty (60) days in advance of the effective date of the change. DVHA may deny such a request if the change materially impacts DVHA's compliance with the federal Medicaid program requirements. The request shall contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. Contractor may be required, at the direction of DVHA, to communicate material changes to Members or providers at least thirty (30) days prior to the effective date of the change.

No change will alter the payment provisions outlined in Attachment B.

2.18 Future Program Guidance

In addition to complying with the ACO Operations Manual and ACO Reporting Manual, Contractor shall operate in compliance with all future program manuals, guidance and policies and procedures, as well as any amendments thereto. Future modifications that have a significant impact on Contractor's responsibilities, as set forth in this Contract, will be made through the Contract amendment process.

3. Covered Services

3.1 Covered Services Included in the ETCOC

The ETCOC for the Traditional and Expanded Attribution Cohorts includes payment for the following categories of Covered Services:

- Inpatient hospital services
- Outpatient hospital services
- Physician services, primary care and specialty
- Nurse practitioner services
- Ambulatory surgical center services
- Federally Qualified Health Center and Rural Health Clinic services
- Home health services
- Hospice services
- Physical, occupational and speech therapy services
- Chiropractor services
- Audiology services
- Podiatrist services
- Optometrist and optician services
- Independent laboratory services
- Mental health and substance abuse services funded by DVHA and not funded by other State of Vermont Departments; *however, H0001 – H2037 are excluded when billed on professional claims*
- Ambulance transport – emergent/non-emergent
- Durable medical equipment, prosthetics and orthotics (except eyewear)
- Medical supplies
- Dialysis facility services
- Preventive services
- Physician administered drug services
- Dental services billed on institutional claims

A detailed listing, by CPT/HCPCS, of Covered Services appears in Attachment A, Exhibit 1. Specific benefits/services and the limitations for these benefits/services are described in Vermont Medicaid Rules and apply to this program. The detailed listing in Attachment A, Exhibit 1 represents national coding conventions at the time of execution of this Contract. Coding conventions are periodically updated. DVHA will update Attachment A, Exhibit 1 on a quarterly basis, as necessary, to align with changes in national coding guidance (including the addition of new codes and the removal of invalid codes), and will include updates as part of the ACO Operations Manual. All new codes will align with the codes used to establish the ETCOC (for example replacement codes), provided however, that in any new codes not used in calculating ETCOC are added to Attachment A, Exhibit 1, the parties agree to meet to discuss, as part of the Year-End Reconciliation, whatever reasonable and appropriate adjustments may be necessary in light of the new codes.

3.2 Services Not Included in the ETCOC

The following services are not Covered Services included in the Contractor's ETCOC:

- Pharmacy
- Nursing facility care
- Psychiatric treatment in a state psychiatric hospital
- Level 1 inpatient psychiatric stays (as defined in the Department of Mental Health's Designated Hospitals Manual and Standards) in any hospital when paid for by DVHA
- Services provided by the Brattleboro Retreat
- Dental services billed on professional claims
- Non-emergency transportation (ambulance transportation is not part of this category)
- Smoking cessation services
- Services provided by Designated Agencies (DAs) and Specialized Service Agencies (SSAs)
- Graduate Medical Education (GME) payments
- Electronic Health Record (EHR) incentive payments

- Disproportionate Share Hospital (DSH) payments

Additionally, the following services for Members are paid for by State of Vermont departments other than DVHA and are not Covered Services included in the Contractor's ETCOC:

- Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by State of Vermont agencies other than DVHA;
- Services administered and paid for by the Vermont Department of Mental Health;
- Services administered and paid for by the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, through a preferred provider network;
- Services administered and paid for by the Vermont Department of Disabilities, Aging and Independent Living;
- Services administered and paid for by the Vermont Agency of Education; and
- Services administered and paid for by the Vermont Department of Health, including smoking cessation services.

3.3 Continuity of Care

Contractor shall implement mechanisms to ensure Participating Providers maintain the continuity of care and coordination of medically necessary health care services for its Attributed Members.

If an Attributed Member in the Traditional Attribution Cohort or Expanded Attribution Cohort becomes ineligible pursuant to section 1.2.2 during an inpatient stay, Contractor will remain financially responsible for the hospital payment until the Member is discharged from the hospital or the Member's eligibility in Medicaid terminates.

3.4 Enhanced Services

Contractor is encouraged to provide programs that enhance the general health and well-being of Members, including programs that address preventive health, risk factors, or personal responsibility.

Enhanced services shall comply with the Member incentives guidelines set forth in Section 8 of this Attachment A and other relevant state and federal regulations regarding inducements. All Enhanced Services offered by Contractor must be approved by DVHA prior to initiating such services.

For purposes of this section, enhanced services under this subsection are any service not included in Sections 3.1 and 3.2.

4. Member Services

4.1 Marketing and Outreach

In accordance with 42 CFR § 438.104, and the requirements outlined in Section 4.5, Contractor may market itself to Members. However, if Contractor chooses to conduct marketing activities, Contractor shall obtain DVHA approval for all marketing and outreach materials at least thirty (30) days prior to distribution.

Contractor may market by mail, mass media advertising (e.g., radio and television) and community-oriented marketing directed at potential members. Contractor shall not design their marketing efforts in such a way that the marketing materials target groups with favorable demographics or healthcare needs.

Any outreach and marketing activities (written and oral) shall be presented and conducted in an easily understood manner and format and at a sixth-grade reading level. Contractor shall not engage in marketing activities that mislead, confuse or defraud Members or DVHA. Statements considered inaccurate, false, or misleading include, but are not limited to, any assertion or written or oral statement that:

- Member or potential member must join the VMNG Program to obtain benefits or to avoid losing benefits;
- Contractor is endorsed by CMS, the federal or state government or a similar entity; or
- Contractor's ACO is the only opportunity to obtain benefits under the State of Vermont's Medicaid program.

4.2 Member Non-Discrimination

Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to attribute to the VMNG Program. Additionally, Contractor shall not discriminate against individuals eligible to attribute on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation and will not use any policy or practice that has the effect of discriminating in such manner.

4.3 Member-Contractor Communications

4.3.1 Member Services Helpline

DVHA shall continue to maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the Vermont Medicaid program as well as basic information about the Contractor's programs. DVHA's member services helpline is intended to be equipped to handle a variety of basic, first-tier Member inquiries, including the ability to address Member questions, concerns, complaints and requests for PCP changes.

Contractor shall be responsible for its own member services helpline to handle second-tier questions from Members (including issues that require specific expertise and authority by Contractor to resolve). Staff assigned to this function must be available to provide "live voice" access to Members during, at a minimum, the hours between 8 a.m. and 5 p.m. Eastern Standard Time, Monday through Friday. Contractor shall provide an after-hours voice message system that informs callers of Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day. During hours of operation, Contractor must be able to receive transfers from DVHA's member services helpline, AHS staff and Members who wish to directly call Contractor.

Contractor's helpline may be closed on all holidays observed by the State of Vermont. Call center closures, limited staffing or early closures shall not burden a Member's access to care.

Contractor's helpline shall offer language translation services for Members whose primary language is not English and shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired Members.

Contractor's Helpline staff shall be trained to ensure that Member questions and concerns are resolved as expeditiously as possible. Contractor shall maintain a system for tracking and reporting the number and type of Members' calls and inquiries it receives during business hours and non-business hours. Contractor shall monitor its member services helpline service and report its telephone service level performance to DVHA in the timeframes and specifications described in the ACO Reporting Manual.

Upon a Member's attribution to the VMNG Program, Contractor shall inform the Member about DVHA's member services helpline as well as Contractor's helpline.

Contractor must meet the following performance standards related to the responsiveness of staffed telephone lines:

- During open hours, seventy-five percent of all incoming calls that opt to talk to a live operator are answered by a live operator within 25 seconds of leaving Contractor's Interactive Voice Response (IVR) system;
  Lost call abandonment rate after the call exits the IVR shall not exceed five percent; and
- 98% of calls are answered by a live agent within four minutes.

4.3.2 Electronic Communications

Contractor shall provide an opportunity for Members to submit questions or concerns electronically, via e-mail and through the Contractor's website without requiring Member login.

Contractor shall respond to questions and concerns submitted by Members electronically within one (1) business day. If Contractor is unable to answer or resolve the Member's question or concern within one business day, Contractor shall notify the Member that additional time will be required and identify when a response will be provided. A final response shall be provided within three (3) business days.

Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. Contractor shall be prepared to provide this information to DVHA upon request.

4.4 Member Information, Outreach and Education

Contractor shall inform Members that information is available upon request in alternative formats and how to obtain them. DVHA defines alternative formats as Braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. To the extent possible, written materials shall not exceed a sixth grade reading level.

Contractor shall inform the Members that, upon the Member's request, Contractor will provide information on the structure and operation of Contractor and, in accordance with 42 CFR § 438.6(h), will provide information on Contractor's provider incentive plans.

Contractor shall be responsible for developing and maintaining Member education programs designed to provide the Members with clear, concise and accurate information about Contractor's program and Contractor's network.

DVHA encourages Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and Member education programs. DVHA encourages Contractor to develop community partnerships with these types of organizations, in particular with community mental health centers, local health offices and prenatal clinics in order to promote health and wellness within its Membership.

Contractor shall have in place policies and procedures to ensure that materials distributed to Members are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the Member. Contractor shall provide information requested by DVHA for use in Member education, upon request.

4.4.1 New Member Materials

Contractor has the option to provide to its Members a welcome packet to introduce them to the VMNG Program. If Contractor chooses this option, the welcome packet is subject to review by DVHA to ensure consistency with other member materials sent out by DVHA. The welcome packet may include, but not limited to, a new member letter, explanation of where to find information about Contractor's provider

network, information about completing a health needs screening, and any unique features of the VMNG Program.

Contractor is required to give DVHA Members the option to opt out of data sharing, that is, for DVHA to send Contractor claims information about the Member. A notice must be sent to Attributed Members by Contractor outlining the procedures that the Member may follow should they wish to change their claims data sharing preferences (either to opt in or opt out of data sharing).

4.4.2 Member Website

Contractor shall provide and maintain a website for Members to access information pertaining to Contractor's services. The website shall be in a DVHA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. Contractor's website information shall be subject to DVHA approval. The website shall be accurate and current, culturally appropriate, and written for understanding at a sixth-grade reading level. Contractor shall inform Members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention by the user to install plug-ins or additional software. Contractor shall allow users print access to the information. Such website information shall include, at minimum, the following:

- A link to DVHA's website so that Members have access to a searchable online directory of participating Medicaid providers and general Medicaid information;
- Contractor's contact information for Member inquiries, grievances and appeals;
- Contractor's Member services phone number, TDD number, hours of operation and after-hours access numbers;
- The Member's rights and responsibilities, as enumerated in 42 CFR § 438.100, which relates to enrollee rights;
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by Contractor;
- Contractor's website privacy statement;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and
- Information related to Contractor's annual quality measurement performance

4.5 Member and Potential Member Communications Review and Approval

Member and potential Member communications developed by Contractor shall be subject to DVHA's approval. Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate DVHA's review and approval of member materials and document its receipt and approval of original and revised documents.

Contractor shall not refer to or use DVHA or other state agency names or logos in its Member and potential Member communications without prior written approval. Any approval given for the DVHA or other state agency name or logo is specific to the use requested and shall not be interpreted as blanket approval.

4.6 Member-Provider Communications

Contractor shall comply with 42 CFR § 438.102, which relates to member-provider communications.

4.7 Member Rights

Contractor shall ensure that its Participating Providers adhere to the following Member's rights, in cooperation with DVHA:

- The right to receive information in accordance with 42 CFR § 438.10, which relates to informational materials;
- The right to be treated with respect and with due consideration for his or her dignity and privacy;
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
- The right to participate in decisions regarding his or her health care, including the right to refuse treatment;
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and
- The right to be furnished health care services in accordance with 42 CFR § 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

Members shall be free to exercise protected member rights, and Contractor shall ensure that its Participating Providers do not discriminate against a Member that chooses to exercise his or her rights.

4.8 Interpretation Services

In accordance with 42 CFR § 438.10(d)(4), Contractor shall arrange for interpretation services to its Members free of charge for services it provides, including, but not limited to the member services helpline described in Section 4.3.1. Contractor shall notify its Members of the availability of these services and how to obtain them. The requirement to provide interpretation applies to all non-English languages. Interpretation services shall include sign language interpretation services for the deaf.

Additionally, Contractor shall ensure that its Participating Providers arranges for interpretation services to Members seeking healthcare-related services in a provider's service location. This includes ensuring that Participating Providers who have twenty-four (24) hour access to healthcare services in their service locations (e.g. hospital emergency departments) shall provide Members with twenty-four (24) hour oral interpreter services, either through in-person or telephonic interpreters. For example, Contractor shall ensure that Participating Providers provide TDD services for hearing impaired Members, oral interpreters, and sign language interpreters.

For purposes of this section, the terms "Contractor shall arrange for" and "Contractor shall ensure" means that Contractor's network of Participating Providers shall fulfill those requirements.

4.9 Cultural Competency

In accordance with 42 CFR § 438.206, Contractor shall participate in DVHA's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

4.10 Advance Directives

Contractor, through its network of Participating Providers, shall comply with the requirements of 42 CFR § 422.128, which relates to advance directives, for maintaining written policies and procedures for advance directives.

4.11 Member Grievances and Appeals

DVHA shall maintain its own internal grievance and appeals processes. Contractor, however, shall serve as the first line to intake grievances and appeals that are specific to actions taken by Contractor related to its Members. Contractor shall establish written policies and procedures, subject to review and approval by DVHA, governing the resolution of grievances and appeals. For any grievances not resolved by Contractor, Contractor shall offer the Member the opportunity to escalate the grievance to the DVHA grievances and appeals process.

Contractor shall be responsible for addressing the following situations whenever a Member is attributed to the VMNG Program:

- A Member expresses dissatisfaction (a grievance) with the VMNG Program, a VMNG Program policy or a provider affiliated with the VMNG Program; or

- A Member wishes to appeal a decision or action taken by the VMNG Program (in accordance with the definitions provided in 42 CFR § 438.400(b)).

4.11.1 State Fair Hearing Process

In accordance with 42 CFR § 438.408, the State of Vermont maintains a fair hearing process which allows Members the opportunity to appeal Contractor's decisions to the State of Vermont.

If there is a reduction or termination in covered services in amount, duration or scope, then Members must have access to grievances, appeals and a state fair hearing process. In situations where an Attributed Member has exhausted Contractor's grievance and appeals process and is still dissatisfied, the Member may request a DVHA fair hearing within ninety (90) days from the date of Contractor's decision. Although DVHA staff will coordinate the fair hearing process, Contractor shall be responsible for providing all requested information made by DVHA related to the Member appeal in the timeframe requested by the State of Vermont. Contractor shall assist DVHA, as needed and requested by DVHA, in support of the fair hearing process including, but not limited to, attending the fair hearing.

Contractor shall include the DVHA fair hearing process as part of the written internal process for resolution of appeals.

4.11.2 [intentionally omitted]

4.11.3 Member Notice of Grievance, Appeal and Fair Hearing Procedures

Contractor shall follow and communicate, when necessary, information listed in the DVHA General Provider Agreement related to member grievance, appeal and State of Vermont fair hearing procedures and timeframes to providers and Subcontractors at the time they enter a contract with Contractor.

4.11.4 Recordkeeping Requirements of Grievances and Appeals

For purposes of quality review, Contractor shall accurately maintain records for grievances and appeals that contain, at minimum, the following information:

- A general description of the reason for the appeal or grievance;
- The date the appeal or grievance was received;

- The date the appeal or grievance was reviewed;
- The resolution of the appeal or grievance;
- The date of the resolution of the appeal or grievance;
- The dates and details of all correspondence/communication between Contractor and the Member related to the grievance or appeal; and
- The name and UID number of the Member for whom the appeal or grievance was filed.

Contractor shall provide such record(s) of grievances and appeals monthly.

5. Provider Network and Services

Parties agree that while Contractor has a network of Participating Providers to serve Attributed Members, Contractor does not limit Attributed Members to its network of Participating Providers nor to services provided by Participating Providers. Parties further agree that Attributed Members may have care provided by any Medicaid provider in DVHA's network.

5.1 Network Development

Contractor shall develop and maintain a provider network in compliance with the terms of this section and 42 CFR § 438.206.

Contractor shall ensure that all of its Participating Providers can respond to the cultural and linguistic needs of its Attributed Members. The network shall be able to meet the unique needs of its Members, particularly those with special health care needs. Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.
Contractor shall ensure that all of its network providers are enrolled as Medicaid providers and follow all Vermont Medicaid provider enrollment criteria.

Contractor must monitor medical care standards to evaluate access to care and quality of services provided to Members, evaluate providers regarding their practice patterns, and have a mechanism in place to address quality of care concerns.

5.2 Network Composition Requirements

Contractor shall submit network composition reports on a quarterly basis or at any time there is a significant change to the provider network. DVHA shall have the right to expand or revise the network requirements as it deems appropriate.

In accordance with 42 CFR § 438.12, Contractor shall not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. If Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This does not require Contractor to contract with providers beyond the number necessary to serve all of its Members' needs. Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with Contractor's responsibilities.

Contractor shall ensure that its Participating Providers adhere to requirements in the DVHA General Provider Agreement to offer hours of operation to DVHA Members that are no less than the hours of operation offered to commercial members. Contractor shall also make urgent or emergent covered services available 24-hours-a-day, 7-days-a-week, when medically necessary. In meeting these requirements, Contractor shall coordinate with DVHA's Provider and Member Relations unit to monitor the compliance of network providers and take corrective action if there is a failure to comply.

5.3 Provider Contracting

Contractor shall be responsible for ensuring that its Participating Providers are enrolled with Vermont Medicaid. DVHA will continue to enroll and revalidate providers using the Provider Screening and Enrollment requirements in 42 CFR § 455, Subp. E. DVHA's enrollment criteria can be found here: http://www.vtmedicaid.com/#/home

Contractor is responsible for ensuring, that as a condition of participation with Contractor, its Participating Providers have entered into, and shall keep current, a Vermont Medicaid General Provider Agreement.

DVHA shall immediately disenroll any Participating Provider if the provider becomes ineligible to participate in the Medicaid program for any reason. DVHA shall notify Contractor at the time of disenrollment.

DVHA is responsible for determining provider payment suspensions in accordance with 45 CFR 455.23 where there is a credible allegation of fraud against a provider. Upon a partial or full suspension of payment to a Participating Provider, DVHA shall notify Contractor and Contractor shall take all necessary actions to ensure payments are suspended as determined to be appropriate by DVHA.

Contractor shall immediately inform the DVHA PI Unit via a written communication should it disenroll, terminate or deny provider enrollment for "program integrity" reasons (i.e., the detection and investigation of fraud, waste, or abuse). If Contractor terminates a Participating Provider due to fraud, program integrity, or quality reasons, such terminations are considered "for cause" and must be immediately reported to DVHA PI Unit.

Contractor shall report the addition or disenrollment of any Participating Provider at the tax identification number (TIN) level on a monthly basis and indicate each provider's enrollment or termination effective date with Contractor. Refer to Section 10 in this Attachment A for more details on this process.

5.4 Provider Agreements

Contractor must have a process in place to review and authorize all Participating Provider contracts. The Participating Provider contracts must not be in conflict with any aspect of the DVHA General Provider Agreement. DVHA reserves the right to review and approve Contractor network contracts on an annual basis prior to them being sent to Participating Providers.

Participating Provider contracts will contain requirements to maintain active Medicaid participation, to report any events that may impact that participation, and to immediately report any termination from Medicaid. Participating Provider agreements will also require both the Participating Providers and Contractor to comply with all applicable federal, state and local laws and regulations.

Contractor shall include in all its provider agreements provisions to ensure continuation of benefits as required by law. Contractor shall identify and incorporate the applicable terms of this Contract with DVHA into its provider agreements. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the provider agreement, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to Members. The provider agreements shall meet the following requirements:

- Describe the provider claim dispute resolution process;
- Require each provider to maintain a current Vermont Medicaid General Provider Agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board;
- Require providers to adhere to DVHA timely filing requirements for claims submissions;
- Include a termination clause stipulating that Contractor shall terminate its contractual relationship with the provider as soon as Contractor has knowledge that the provider's license or Vermont Medicaid General Provider Agreement has terminated;

- Obligate the terminating provider to submit all claims or encounters for services rendered to Contractor's Members to Fiscal Agent while serving as Contractor's Participating Provider;

- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors; and

- Provide a copy of a Member's medical record at no charge upon request by the Member and facilitate the transfer of the Member's medical record to another provider at the Member's request.

For purposes of this section, Contractor agrees that its network consists of Participating Providers as defined in Section 1.1, which specifies that Participating Providers have a signed agreement with the Contractor meeting the requirements of this Section 5.4.

5.5 [intentionally omitted]

5.6 Medical Records

Contractor's Participating Providers shall permit Contractor and representatives of DVHA to review Members' medical records for the purposes of capturing information for clinical studies, monitoring quality or any other reason. The failure of Contractor and/or its Participating Providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its Participating Providers repaying DVHA or Contractor for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not provided in a timely manner.

5.7 Provider Education and Outreach

Contractor shall provide ongoing education about the VMNG Program as well as Contractor-specific policies and procedures to its provider network. In addition to developing its own provider education and outreach materials, Contractor shall coordinate with DVHA-sponsored provider outreach activities upon request.

Contractor shall educate its contracted providers, including mental health providers, regarding provider requirements and responsibilities, Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud and abuse, pay-for-outcome programs and any other information relevant to improving the services provided to Contractor's members.

5.7.1 Provider Communications Review and Approval

Provider communication materials specific to this Contract, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, shall be subject to DVHA review and approval.

Contractor shall include DVHA's program logo(s) in its provider communication materials upon DVHA's request.

Contractor shall not refer to or use DVHA or other state agency names or logos in its provider communications without prior written approval by DVHA. Any approval given for DVHA or any other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

5.7.2 Provider Policies and Procedures

Contractor will maintain provider policies and procedures specific to Contractor operations and these shall not be in conflict with the information provided in the Vermont General Provider Manual, found at: http://www.vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf of the Vermont Medicaid

General Billing and Forms Manual, found at:
http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf.

Contractor Provider Policies and Procedures shall be available both electronically and in hard copy (upon request) to all Participating Providers, without cost, when they are initially enrolled, when there are any changes in policies and procedures, and upon a provider's request.

5.8 Contractor Outreach with Providers

Contractor shall have in place policies and procedures to maintain frequent communications and provide information to its Participating Provider network. Contractor shall give Participating Providers at least thirty (30) days advance notice of material changes that may affect the Participating Providers' procedures such as changes in Subcontractors or prior authorization policies. Contractor shall post a notice of the changes on its website to inform Participating Providers and make policies available upon request.

In accordance with 42 CFR § 438.102, Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member.

5.8.1 Provider Website

Contractor shall maintain a provider website that contains information about its Medicaid line of business. Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 4.4.2.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. Contractor shall allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- Vermont Medicaid Provider Manual or a link to their website for same and any VMNG Program Provider Policy and Procedure Manual and associated forms;
- Contractor's clinical guidelines;
- Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- Provider payment dispute resolution procedures;
- Appeal procedures;
- Contractor's website privacy statement;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and
- Links to DVHA's website for general Medicaid information.

5.8.2 Provider Services Helpline

In addition to the provider service helpline provided by Fiscal Agent, Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints that are specific to VMNG Program operations. Contractor shall staff the provider services helpline with personnel trained to accurately address provider issues from 8:00 am to 5:00 pm Eastern, Monday through Friday, at minimum. Contractor shall provide a voice message system that informs callers of Contractor's business hours and offers an opportunity to leave a message after business hours.

The Contractor's provider services helpline may be closed on all holidays observed by the State of Vermont government.

Contractor must monitor its provider services helpline and report its telephone service performance to DVHA each month as described in the ACO Reporting Manual, notwithstanding, Contractor may report Member and provider hotline call statistics together.

5.8.3 Fiscal Agent Workshops and Seminars

Fiscal Agent sponsors workshops and seminars for all Vermont Medicaid providers. Contractor shall participate in the workshops and attend the provider seminars. A Contractor representative shall be available to make formal presentations and respond to questions during the scheduled time(s) as requested by DVHA.

5.9 [intentionally omitted]

5.10 Member Payment Liability

Contractor and its Subcontractors shall ensure that Members are not held liable for any of the following:

- Covered services provided to the Member which Contractor is responsible for which Contractor does not pay the provider; or
- Contractor's debts or Subcontractor's debts, in the event of the entity's insolvency.

Contractor shall ensure that its Participating Providers do not balance bill its Members, i.e., charge the member for covered services above the amount paid to the provider by Contractor. If Contractor is aware that any provider is balance billing a Member, Contractor shall instruct the provider to stop billing the Member. Contractor shall also contact the Member to help resolve issues related to the billing.

Vermont Medicaid providers are prohibited from charging a Member, or the family of the Member, for any amount not paid as billed for a covered Medicaid service.

6. [intentionally omitted]

7. Care Management and Care Coordination

Contractor shall develop policies and procedures regarding physical and mental health integration and coordination of care delivery across a care team. Further, Contractor shall monitor and evaluate the effectiveness of its policies and procedures and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes. Contractor shall provide policies and procedures regarding care management to be reviewed by DVHA upon request.

The Vermont Chronic Care Initiative (VCCI) program at DVHA will perform its ordinary member engagement, care coordination and complex care management for Attributed Members in accordance with its usual and customary business practices, which are consistent with Contractor's Care Model, until Attributed Members are affiliated with the appropriate Participating Providers who will assume responsibility for these functions. VCCI will cooperate with Contractor to shift primary responsibility for care coordination of Attributed Members to Participating Providers as soon as responsibly possible for each Attributed Member. Contractor and DVHA, including VCCI, will continue to collaborate as necessary in the best interests of the Attributed Member.

Contractor shall grant VCCI staff access to its care management software platform, Care Navigator, to facilitate transitions in care for Attributed Members as permitted by software licenses and consistent with law.

Expanded Attribution Cohort Members for whom sufficient claims-based data do not exist to conduct data-driven risk stratification will continue to be screened by VCCI in alignment with Care Model and best judgment will be utilized to assign those Members to one of the four care coordination levels.

Contractor shall grant access to Care Navigator to Vermont Agency of Human Services personnel who are designated by an Attributed Member(s) to participate on their care teams, subject to legal, regulatory and contractual limitations and proper documentation of privacy obligations.

At the time that Members are attributed to the VMNG Program, the Members may already be receiving care coordination or complex care management from another entity or entities. In such an event, Contractor will ensure that its Participating Providers, health care providers, and supporting organizations work with the Member and the other care coordination or complex care management entity or entities to determine how the Member should receive care coordination or complex care management services across a team of organizations.

Contractor will provide disease management supports and promote self-management, shared decision-making, lifestyle programming aimed at reducing or eliminating tobacco use and improving nutrition and physical activity, and other beneficial lifestyle changes.

Parties agree that Contractor does not directly deliver health care services or conduct assessments of Members, and that any clinical assessments or screenings conducted directly with Attributed Members will be performed by Contractor's Participating Providers.

7.1 Risk Stratification, Member Screening, and Assessment

7.1.1 Risk Stratification

Within 90 days of the beginning of the PY, Contractor will use the Johns Hopkins Adjusted Clinical Groups (ACG) System to stratify Attributed Members into appropriate care coordination levels based on severity and risk scores. The predictive modeling tool will assign Members to one of four care coordination levels: Low Risk, Medium Risk, High Risk, and Very High Risk. This screening shall identify each Attributed Member's immediate physical and/or mental health care needs, conditions, and ongoing treatment. This screening must identify conditions such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD), Hypertension and Asthma. Additionally, Contractor will identify those Members who are due (or overdue) for their recommended preventive health evaluations.

Contractor shall identify triggers, including those identified by Participating Providers, which would immediately move Members to higher care coordination levels. Contractor shall communicate these triggers to Participating Providers.

Contractor may develop and test other enhanced risk stratification methods, such as those that address needs of specific sub-populations and/or those that incorporate social determinants of health. Upon implementation of additional risk stratification methods for the VMNG Program's Attributed Members, Contractor will notify DVHA of this change.

7.1.1.1 Requirements for Medium Risk Attributed Members

Contractor will ensure that Participating Providers communicate with Medium Risk Attributed Members at minimum two times per performance year. Care coordination services may be provided by non-clinical staff as appropriate with escalation to licensed clinical staff as indicated by educational need, provider request and/or change in clinical status. Medium Risk pregnant women will receive pregnancy care health education materials and other services specific to their pregnancy risk factors.

7.1.1.2 Requirements for High Risk Attributed Members

Contractor will ensure that its Participating Providers communicate with High Risk Attributed Members active in complex care management at minimum four times per performance year. Care coordination services may be provided by non-clinical staff as appropriate with escalation to licensed clinical staff with experience and training in care coordination and/or complex care management as indicated by educational need, provider request and/or change in clinical status. High Risk pregnant women shall receive pregnancy care health education materials and other services specific to their pregnancy risk factors. Contractor shall require Participating Providers to assist High Risk Attributed Members active in complex care management with patient-centered goal setting, identification of barriers and challenges, and prioritization of goals, tasks, and milestones. Contractor shall work with its Participating Providers and High Risk Attributed Members to ensure that a lead care coordinator is selected to facilitate complex care management. Contractor shall ensure that its Participating Providers work with the lead care coordinator, the care team, and the High Risk Attributed Members to develop a comprehensive shared care plan directed at the Member's chronic health condition and psychosocial needs, and to conduct care conferences as appropriate with the Member's care team.

7.1.1.3 Requirements for Very High Risk Attributed Members

Contractor will ensure that its Participating Providers communicate with Very High Risk Attributed Members active in complex care management at minimum monthly during the performance year. For these Very High Risk Attributed Members, Contractor will ensure Participating Providers or their staff performing complex care management identify at least one licensed physician assistant, registered nurse, therapist, social worker, mental health provider, or licensed alcohol and drug counselor (LADC) on the care team who is active in supporting care for the Very High Risk Attributed Member. Complex care management staff must have training, expertise and experience in providing care management and care coordination services for individuals with complex health needs, including individuals with mental health needs. The actively engaged Member-to-staff ratio for complex care management will not exceed 50:1. Contractor's Medical Director or Chief Medical Officer shall be available to consult with individuals on the Member's complex care management team as needed to develop the shared care plans for high risk cases and consult with the DVHA Medical Director as appropriate. Very High Risk pregnant women shall receive pregnancy care health education materials and other services specific to their pregnancy risk factors. Contractor shall work with its Participating Providers and Very High Risk Attributed Members to ensure that a lead care coordinator is selected to facilitate complex care management. Contractor shall ensure that its Participating Providers work with the lead care coordinator, the care team, and the Very High Risk Attributed Members to develop a comprehensive shared care plan directed at the Member's chronic health condition and psychosocial needs, and to conduct care conferences as appropriate with the Member's care team. Contractor shall ensure that its Participating Providers assess Very High Risk Attributed Members for palliative or hospice care needs.

7.1.2 Comprehensive Health Assessment

For Members stratified into the Medium Risk, High Risk, or Very High Risk care coordination levels, Contractor will complete an evidence-based comprehensive health assessment within 180 days of attribution to the VMNG Program, or ensure that its Participating Providers conduct such an assessment. The comprehensive health assessment will be used to develop and implement shared care plans to meet High Risk and Very High Risk Members' needs as well as personal health goals and self-management program recommendations. Contractor and its Participating Providers may utilize different comprehensive health assessments for children, adolescents, and adults.

The completed comprehensive health assessment shall be shared with all members of the individual's care team with appropriate consents and permissions.

7.1.3 [intentionally omitted]

7.1.4 Other Screenings

In addition to the comprehensive health assessment, Contractor shall use other strategies to identify the risk and needs of Attributed Members or shall ensure that its Participating Providers use such strategies. Such strategies may include, but are not limited to screening for substance use disorder, screening for suicide risk, screening for women of child-bearing years, and identifying gaps in care (including those related to social determinants of health such as housing, transportation, and food security). Contractor shall ensure that its Participating Providers review information with Members to identify the Members' strengths, needs and available resources to enable person-centered planning. This will include family and caregiver input, as appropriate.

Contractor shall make any standardized screen or assessment tools in use across its Participating Provider network available for review by DVHA and the Office of the Health Care Advocate upon request.

7.2 [intentionally omitted]

7.3 Shared Care Plan Development

For High Risk and Very High Risk Attributed Members, Contractor shall ensure that its Participating Providers utilize a person-centered shared care plan development process which is evidence-based. Contractors shall initiate mechanisms for Members, their families and/or others chosen by the Member to be actively involved in the development and execution of the shared care plan. Contractor shall review and update the shared care plans with Members on an as-needed basis, no less often than annually as long as the Member is active in complex care management.

7.4 [intentionally omitted]

7.5 Activities related to Quality and Health Management Measurement Improvement

7.5.1 Goals

Contractor shall maintain its population health management analytics and care coordination platform and tools, and provide training and technical assistance to Contractor's Participating Providers to support adoption of tools and use of information to improve care delivery to meet the objectives of the State of Vermont's All-Payer Accountable Care Organization Model.

7.5.2 Deliverables

Contractor shall maintain Contractor's analytics and care coordination platforms as demonstrated through deliverables noted in each performance period below to provide functionality and reporting to meet the needs of Participating Providers, and a changing delivery system.

By December 31, 2021, Contractor shall submit to DVHA for approval and acceptance the following deliverables in accordance with templates and guidance provided by DVHA in the ACO Reporting Manual:

1. Provider Technical Assistance and Training Modules Report: List of training modules in Contractor's eLearn platform and care coordination technical and educational sessions conducted, including learning objectives, agendas where available, numbers of participants, and organizational affiliations to support clinical, financial, operational, and/or quality goals. Additionally, eLearn report will include total number of provisioned users for each participating organization, and number of provisioned users who participated in each training module from January through December of the contract year
2. Quality Measure Scorecard: 2020 Medicaid quality measure scorecard.

7.6 Activities related to Advanced Community Care Coordination (A3C)

Contractor shall implement a financial and clinical model that promotes an integrated team-based system of care coordination consistent with its intellectual properties and health information technology rights. This shall include involvement from local integrated care teams (e.g. Patient-Centered Medical Home and continuum of care providers) that support the physical, mental, and social wellbeing of Attributed Members. One approach to an integrated model of care will be the use of "Advanced Community Care Coordination" (A3C) in ACO participating communities, as specified below.

The populations that are targeted for this project includes High Risk and Very High Risk Attributed Members that are attributed to the VMNG Program as well as other Attributed Members that may benefit from A3C engagement. Care team members shall be authorized by Contractor to retrieve this information from Contractor's care coordination software (Care Navigator), subject to legal, regulatory and contractual limitations and proper documentation of privacy obligations, in order to support them in prioritizing individuals that need outreach.

7.6.1 A3C Goal

Contractor's activities related to A3C are to implement and advance effective team-based care coordination at the local level by strengthening relationships between primary care and the continuum of care providers to support the physical, mental, and social wellbeing of Attributed Members.

7.6.2 Periodic Reporting

Contractor's Care Coordination Dashboard shall include the following monthly reports, as outlined in the ACO Reporting Manual:

7.6.2.1 Care Coordination Status Report: Number and percent of Members by care coordination level and Attribution Cohort, with Status Engaged, with Status in Outreach, Engaged in Community Programs, with Recommended Touches, with a Care Conference, Engaged in Hospice, with Care Team Initiated, with Care Team Created, with Lead Care Coordinator, with Care Plan Initiated, with Care Plan Created, and Care Managed.

7.6.2.2 Care Coordination Progress Report: Number of Members by Attribution Cohort and risk category who are Care Managed, have Shared Care Plan Only, have Lead Care Coordinator Only, have Initial Engagement Activities Only, and are Not Yet Engaged.

7.6.2.3 Care Team Use of Care Navigator Report: Description of and metrics summarizing care team composition and use of Care Navigator. Description of how Contractor is addressing variation in use of Care Navigator between HSAs and Participating Providers.

7.6.3 Deliverables

By July 15, 2021 and December 15, 2021, Contractor shall submit for DVHA's approval the following deliverables, in accordance with templates and guidance provided by DVHA in the ACO Reporting Manual:

7.6.3.1 Care Coordination Implementation Report: A written report summarizing progress made to implement the care coordination and team-based care models in the performance period, referencing key findings from monthly care management reports and describing lessons learned, risks, and mitigation strategies. The report will also describe how Contractor is disseminating information about training opportunities, making progress on implementing the care model with Participating Providers and community partners, developing mechanisms for encouraging and supporting community partners in learning about and implementing the care model, addressing variation in uptake between HSAs and Participating Providers if present (e.g., between HSAs), and encouraging and supporting sharing of successes and challenges in implementation between communities and HSAs. It will include documentation of regular care coordination core team

meetings. This information will be provided on a template and according to guidance provided by DVHA in the 2021 VMNG Reporting Manual.

7.6.3.2 At Risk Subpopulation Progress Report: Care managed values for each selected subpopulation by HSA including the aggregated ACO values.

7.6.3.3 Outreach Progress Report: Values related to minimum outreach expectations met by each HSA including the aggregated ACO values.

By February 28, 2022, Contractor shall submit for DVHA's review the Care Coordination Provider Payment Report including documentation of all complex care coordination payments made to primary care and continuum of care providers, including lead care coordinator and care team PMPM payments and care conference payments, for individual providers and aggregated by tax identification number.

8. Quality Management

8.1 Quality Management Definitions

Contractor shall monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to its Attributed Members by all providers, including specialists, in all types of settings, in accordance with the provisions set forth in the Contract. Contractor shall submit quality improvement data in a time and manner as set forth by DVHA including, but not limited to, data that meets HEDIS standards for reporting and measuring outcomes.

Additionally, Contractor must submit information requested by DVHA to complete its annual Quality Strategy Plan. This will include the results of any performance improvement projects or quality improvement projects. For purposes of this Section 8:

- A "quality improvement project" is a planned strategy for program improvement and is incorporated into Contractor's Quality Management and Improvement Program Work Plan.

- A "performance improvement project" shall mean a planned strategy for program improvement which adheres to CMS protocols for performance improvement projects.

8.2 Quality Management and Improvement Program

Contractor's Chief Medical Officer shall be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program shall have objectives that are measurable and supported by consensus among Contractor's medical and quality improvement staff. Through the Quality Management and Improvement Program, Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services that are safe, effective, timely and member centered.

Contractor shall meet the requirements of 42 CFR § 438 subpart E on quality assessment and performance improvement including, but not limited to, the requirements listed below in developing its Quality Management and Improvement Program and the Quality Management and Improvement Program Work Plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to Members with special needs, (ii) completion of performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects; and (iii) production of quality of care reports at least annually or as otherwise required by DVHA.

Contractor's Quality Management and Improvement Program shall:

- Include developing and maintaining an annual Quality Management and Improvement Program Work Plan which sets goals, establishes specific objectives based upon priorities identified, identifies the strategies and activities to undertake, monitors results, and assesses progress toward the goals.

- Have in effect mechanisms to detect both underutilization and overutilization of services and the ability to report these findings to DVHA as required. The activities Contractor takes to address underutilization and overutilization must be documented and outcomes must be reported to DVHA.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.

- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of certain target populations and other quality improvement activities requested by DVHA.

- Use Healthcare Effectiveness Data and Information Set (HEDIS) rate data, Consumer Assessment of Health Plans (CAHPS) survey data, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to Members.

- Collect measurement indicator data related to areas of clinical priority and quality of care.

- Report any national performance measures developed by CMS in the future at the request of DVHA. Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector.

- Report the incentives offered and the results of any physician incentive program, if one has been put in place.

- Report the incentives offered and the results of any Member incentive program, if one has been put in place.

- Participate in other quality improvement activities, including, but not limited to, EQRs, to be determined by DVHA.

For purposes of this section, the Parties agree that the term "participate" means DVHA may request consideration of quality improvement activities and provision of information in support of DVHA's External Quality Review Organization audits in addition to the mandatory efforts required in Sections 8.2, 8.3, 8.4, 8.5, and 8.6 of this Attachment A.

8.3 Quality Improvement Workgroup

Contractor shall establish an internal Quality Improvement Workgroup (QIW) to develop, approve, monitor and evaluate the Quality Management and Improvement Program and Work Plan. The QIW's activities will be overseen by Contractor's Utilization Review Committee (URC) which reports to Contractor's Population Health Strategy Committee (PHSC). Contractor's Chief Medical Officer shall be an active participant in Contractor's URC and PHSC. The URC shall be representative of management staff and Contractor departments representing analytics, clinical, finance, and quality. The DVHA Medical Director or designee shall be invited to participate in the QIW. The PHSC shall represent the geographic diversity of Contractor's network of Participating Providers, include representatives of Contractor's Board of Managers, primary and specialty care providers, continuum of care providers, as well as relevant subject matter experts.

Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, Contractor's Quality Improvement Workgroup and Quality Management and Improvement Program Work Plan. All functional units in Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with Contractor's internal quality management and improvement committee to support Contractor's quality management and improvement goals and objectives.

Contractor shall have appropriate personnel attend and participate in regularly scheduled DVHA quality committee meetings.

8.4 Quality Management and Improvement Program Work Plan Requirements

Contractor's Quality Improvement Workgroup, in collaboration with Contractor's Chief Medical Officer, shall develop an annual Quality Management and Improvement Program Work Plan. The plan shall identify Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals.

Contractor shall submit its Quality Management and Improvement Program Work Plan to DVHA once finalized. Contractor shall provide progress reports to DVHA on no less than a quarterly basis. Contractor must be prepared to periodically, as determined by DVHA, report on its quality management activities to DVHA's Quality Committee.

Contractor shall prepare the annual Quality Management and Improvement Program Work Plan using a standardized format; Contractor shall have discretion in proposing a template for this reporting.

Annually, Contractor will also conduct a comprehensive evaluation of the Quality, Experience, Total Cost of Care and Utilization outcomes to identify accomplishments, opportunities for improvement and to develop interventions to address identified opportunities. The Contractor Utilization Review and Population Health Strategy Committee will review the annual evaluation. The BOM will ultimately approve the evaluation and the results will be made available to DVHA. Contractor will also submit reports to, and work collaboratively with DVHA, when requested to satisfy legislative reporting requirements.

8.5 HEDIS and CAHPS

For the 2021 PY, Contractor is not required to contract with a certified HEDIS Auditor or a certified CAHPS survey vendor to tabulate the results of outcome measures pertaining to the DVHA Members attributed to the VMNG Program. Instead, Contractor will work in close collaboration with DVHA and its contracted HEDIS Auditor and CAHPS survey firm in the sampling of DVHA Members both attributed and not attributed to the VMNG Program.

During the 2021 PY, DVHA and Contractor shall implement a plan for quarterly monitoring of VMNG Program performance on claims-based HEDIS measures that require data that is not shared with Contractor, including claims for diagnoses or procedures related to substance use disorder. To the extent that increased frequency of quality reporting incurs additional costs to DVHA through its HEDIS vendor, Contractor will be financially responsible for these costs.

For the tabulation of HEDIS measures requiring clinical data, Contractor will be responsible at the request of DVHA to conduct chart reviews for a random sample of Attributed Members receiving care from Participating Providers, and to report measure numerator and denominator information to DVHA.

8.6 External Quality Review

Pursuant to federal regulation, DVHA is subject to External Quality Reviews (EQRs). Contractor shall provide all information required for this review in the timeframe and format requested by the EQR organization. Contractor shall cooperate with and participate in all external quality review activities, as requested. Contractor's Quality Management and Improvement Program should incorporate and address findings from these EQRs.

8.7 Incentive Programs

8.7.1 Value-Based Incentive Fund Program

Contractor shall participate in a Value-Based Incentive Fund program that focuses on rewarding Contractor's efforts to improve quality and outcomes for its Attributed Members. The Value-Based Incentive Fund Program is described in Attachment B.

8.7.2 Provider Incentive Programs

In addition to the Value-Based Incentive Fund program in Section 8.7.1, Contractor may establish other incentives for its providers. Contractor will determine its own methodology for incentivizing providers. Contractor will provide DVHA with policies related to provider incentives, and update DVHA if those policies change. Contractor shall comply with federal regulations regarding physician incentive plans as stated in 42 CFR § 538.8(h).

Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Member.

8.7.3 Member Incentive Programs

Contractor may establish Member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non-financial. Contractor will determine its own methodology for providing incentives to Members. Contractor must obtain DVHA approval prior to implementing its member incentive program and before making any changes thereto.

8.8 Member Care & Safety

Contractor has received from DVHA a waiver of prior authorization requirements for services that are (1) included in the ETCOC (see section 3.2) for Attributed Members, (2) provided to Attributed Members and (3) delivered by a provider enrolled with DVHA as a Medicaid provider. Notwithstanding Contractor's waiver of prior authorization under these circumstances, DVHA in the exercise of its responsibility for the care and safety of its entire membership will require prior authorization and clinical review by DVHA for a subset of services that it has identified as having the potential to cause imminent harm if prescribed, fitted, or used incorrectly. For the 2021 Performance Year, a detailed listing by CPT/HCPCS code of services still requiring prior authorization by DVHA appears in Attachment A, Exhibit 1 and these services will require prior authorization review from DVHA notwithstanding DVHA's waiver. As described in Section 3.1 above, Exhibit 1 represents national coding conventions at the time of execution of this Contract and are updated periodically. DVHA will update Attachment A, Exhibit 1 no more frequently than quarterly, as necessary.

8.8.1 Practice Guidelines

Contractor shall utilize practice guidelines that have been established by DVHA. The full list of guidelines is available at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines. Contractor may adopt additional guidelines subject to the review and approval by DVHA.

Pursuant to 42 CFR § 438.210(b), relating to authorization of services, Contractor shall consult with contracting health care professionals in developing practice guidelines. Contractor shall, at a minimum, review and update the guidelines biannually, distribute the guidelines to providers and make the guidelines available to Members upon request.

8.8.2 Member Utilization Oversight

Contractor will maintain policies and practices that support regular and ongoing monitoring of under- and over-utilization, identification of trends, and the identification and implementation of changes in policies, processes, and practices. Contractor will meet with the DVHA Medical Director and/or designees at least biannually to review utilization trends among Attributed Members and non-Attributed Members.

9. Performance Reporting

9.1 ACO Reporting Manual

Contractor shall submit performance data specific to the VMNG Program unless otherwise specified by DVHA. DVHA reserves the right to publish the evaluation of the VMNG Program's performance.

Contractor shall comply with all reporting requirements set forth in this section as well as the ACO Reporting Manual. As referenced in Section 2.16 of this Attachment A, the ACO Reporting Manual will contain a catalog of the reports that will be required to be submitted by Contractor to DVHA and the periodicity schedule of each report submission. For the majority of reports, DVHA will provide both a report template and instructions for how to complete each report. Contractor will have discretion to propose the format for reports for which DVHA does not supply templates. To the extent Contractor elects to fulfill reporting requirements through custom applications within its Work Bench One analytics platform, Parties will mutually agree on the DVHA staff who may access that tool within the Work Bench One application.

Contractor shall submit the requested data completely and accurately within the requested or required timeframes and in the formats identified by DVHA. DVHA reserves the right to require Contractor to work with and submit data to third-party data warehouses or analytic vendors.

Contractor shall have policies, procedures and mechanisms in place to ensure that all performance data submitted to DVHA is materially accurate and materially complete. Contractor shall submit its performance data and reports under the signatures of any key staff identified in Section 2.5.1, certifying Contractor's data is materially accurate and materially complete. The ACO Reporting Manual will include the reporting requirements that are highlighted below.

DVHA reserves the right to audit Contractor's self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions and will assess liquidated damages, as specified, in Attachment B, for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

9.2 CMS Reporting

Contractor shall provide DVHA with data requested by the Centers for Medicare and Medicaid Services (CMS) to meet the reporting obligations described in the CMS Special Terms and Conditions (STCs) for the DVHA's Global Commitment waiver reporting. Contractor shall submit this data in the timeframe specified by DVHA.

9.3 Other Reporting

DVHA shall have the right to require additional reports determined by DVHA be necessary for VMNG Program monitoring.

10. Information Systems

Unless otherwise specified, the provisions of this section apply to Members in the Cohorts.

10.1 Summary of Contractor Information System Responsibilities

Contractor shall have an information system (IS) sufficient to support the VMNG Program requirements, and Contractor shall be prepared to submit all required data and reports accurately and completely in the format specified by DVHA. Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Contract.

In the event the State of Vermont's technical requirements require amendment during the term of the Contract, DVHA will work with Contractor in establishing the new technical requirements. Contractor shall be capable of adapting to any new technical requirements established by the State of Vermont, and the DVHA may require Contractor to agree in writing to the new requirements. Contractor-initiated changes to the requirements shall require DVHA approval. Contractor is required to pay for new technical requirements for its own systems.

Contractor shall develop processes for developing, testing, and promoting system changes and maintenance. Contractor shall notify DVHA prior to the installation or implementation of major software or hardware changes,

upgrades, modifications or replacements that may impact mission critical business processes, such as file exchanges with the Fiscal Agent, service authorization management, provider payment data management, care management files, and any other processing affecting Contractor's capability to interface with DVHA or DVHA's contractors.

Contractor shall have written policies and procedures sufficient to manage the VMNG Program. These policies and procedures will ensure accurate and valid provider payment detail data and will reflect that services delivered to Members and payments made to providers are made in compliance with state and federal regulations and in accordance with this Contract. These policies shall address the submission of provider payment data from any Participating Providers or Subcontractors. DVHA shall monitor Contractor's performance utilizing a random sample audit of all program documentation and payments. DVHA will review Contractor's compliance with its internal policies and procedures to ensure the accuracy and timeliness of the payments to providers and services provided to Members. Contractor is required to comply with the requirements of the review and audit and to provide all requested documentation. DVHA shall require Contractor to submit a corrective action plan and will require non-compliance remedies for Contractor's failure to comply with payment accuracy reporting standards.

Contractor will provide DVHA with a project plan for all system changes or system upgrades associated with this Contract. A project plan will include but is not limited to: project timeline, costs, milestones, deliverables, testing processes and protocols, criteria for a go-no go decision, contingency plan and mitigation strategies. Contractor will provide project plans to DVHA allowing for a thirty (30) day review. Contractor will proceed with the plan only after DVHA's written acceptance and approval of the plan.

Contractor shall have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), which address security and privacy of individually identifiable health information.

Contractor shall attend in person any meetings hosted by DVHA or its Fiscal Agent in relation to the development of and the ongoing remediation of any issues that arise from the data exchange process. Notwithstanding any scheduled meetings where these issues may be addressed, Contractor shall report any problems with data submissions to the designated DVHA Program Manager.

10.2 Security and Privacy Practices

Contractor's IS shall meet the requirements as specified by DVHA. Contractor's electronic mail encryption software for HIPAA security purposes must be compatible with DVHA's and with Fiscal Agent email software.

Contractor's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

Contractor shall make all data available to DVHA and, upon request, to CMS. In accordance with 42 CFR § 438, subpart H, which relates to certifications and program integrity, Contractor shall submit all data, under the signatures of either its Chief Financial Officer or Chief Executive Officer certifying the accuracy, truthfulness and completeness of Contractor's data. Software and services provided to or purchased by DVHA shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d). Any deviation from these architecture requirements shall be approved in writing by DVHA in advance. Contractor shall comply with all DVHA Application Security Policies. Any deviation from DVHA policies shall be approved in writing.

10.3 Disaster Recovery Plan

Information system contingency planning shall be developed in accordance with the requirements of this Section and with 45 CFR § 164.308, which relates to administrative safeguards. Contingency plans shall include: data backup plans, disaster recovery plans and emergency mode of operation plans. Application and Data Criticality

analysis and Testing and Revisions procedures shall also be addressed within Contractor's contingency plan documents. Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. Contractor shall protect against hardware, software and human error. Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. Contractor shall maintain full and complete back-up copies of data and software, and shall back up and store its data in an off-site location.

For purposes of this Attachment A, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. DVHA and Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include, but is not limited to, natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

Contractor shall notify DVHA, at minimum, within four (4) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as those affecting Contractor's capability to interface with DVHA or DVHA's contractors. Depending on the anticipated length of disruption, DVHA, in its discretion, may require Contractor to provide DVHA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster, Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) days. In the event of other disasters or system unavailability caused by the failure of systems and technologies within Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) days.

DVHA may review Contractor's Disaster Recovery Plan for sufficiency at any time upon request.

10.4 Data File Exchanges

This Contractor will be responsible for the receipt and delivery of file exchanges with Fiscal Agent. Contractor must accept and submit data files in electronic format, currently via secure file transfer protocol ("SFTP") or as directed by DVHA. DVHA shall have the right to amend the data transfer process during the Contract term.

Contractor's information systems must utilize DVHA's unique identification number (UID) to properly identify each Member.

The list of data file exchanges is summarized below; however, this list may change in number and/or periodicity at any time during the course of the contract based on the needs of DVHA.

File Name	Inbound to DVHA (or Fiscal Agent)/ Outbound from DVHA (or Fiscal Agent)	Periodicity
Contractor Affiliated Provider File	Inbound	Monthly
DVHA Attributed Member Demographics File	Outbound	Monthly
DVHA Covered Services Claims File	Outbound	Weekly
DVHA FFS Payments File	Outbound	Weekly
DVHA Covered Confidential and Opt Out Claims File	Outbound	Weekly
DVHA FFS Confidential and Opt Out Claims File	Outbound	Weekly

Contractor Non-Claims Payments File	Inbound	Monthly
DVHA Remittance Advice File	Outbound	Monthly
DVHA Attribution PMPM File	Outbound	Monthly
DVHA Pharmacy Claims File	Outbound	Weekly
DVHA Interim Financial Settlement File	Outbound	Quarterly
DVHA Historical Services Claims Files	Outbound	Annual (initial file) and Weekly
DVHA Historical Covered Confidential Claims and Opt Out Claims Files	Outbound	Annual (initial file) and Weekly
DVHA Historical FFS Confidential Claims and Opt Out Claims File	Outbound	Annual (initial file) and Weekly
DVHA Historical Pharmacy Claims Files	Outbound	Annual (initial) and Weekly
DVHA Historical Eligibility File	Outbound	Annual

The organizations involved in file exchange below are noted in parentheses. Specifications for each file type and structure are documented in the "ACO File Format Specifications" document, an updated version of which will be available in first quarter of 2021, and which may be updated as needed throughout the performance period and shall be adhered to unless otherwise mutually agreed upon in writing. Errors or omissions will be corrected by the responsible party within five business days unless otherwise mutually agreed upon timeframes are established and documented in writing.

10.4.1 Contractor Affiliated Provider File

(Contractor to Fiscal Agent) This file contains the current list of TIN level Vermont Medicaid enrolled providers who are affiliated with the Contractor, including a method of identifying changes. Contractor shall submit provider roster updates to Fiscal Agent in an agreed upon format and process. Contractor shall keep provider enrollment and disenrollment information up-to-date.

10.4.2 [intentionally omitted]

10.4.3 DVHA Remittance Advice File

(DVHA or Fiscal Agent to Contractor) This file contains for both Traditional and Expanded Cohorts the total of PMPM payments made by DVHA to the Contractor.

Contractor, being enrolled as a Medicaid provider, receives a remittance advice in the standard available formats for the monthly PMPM payment(s) made to the Contractor. The PMPM lump sum payment is reported as a single line item in the "Financial Items" section of the remittance advice. DVHA Attribution PMPM File will be provided separately and will contain the details of the Members included in the payment.

Contractor shall be responsible for reconciling Value-Based Care Payments against the DVHA Attribution PMPM File and identifying any errors or omissions to the Fiscal Agent within fifteen (15) business days of receipt of the DVHA Attribution PMPM File

10.4.4 DVHA Covered Services Claims File

(DVHA or Fiscal Agent to Contractor) This file contains information related to claims submitted by Participating Providers for VMNG Program -covered services for all Attributed Members to the VMNG Program. The DVHA Covered Claims File contains DVHA's disposition of the claim status which may be paid (or Zero-Paid Claims) or denied (with denial reason).

Fiscal Agent will continue to receive all claims from Vermont Medicaid providers. All claims will continue to be processed through DVHA's edits and audits.

Claims identified as the responsibility of the Contractor will be provided to the Contractor on an agreed upon schedule. The Contractor will then be responsible for any additional review of the claims and payment to Participating Providers for services rendered.

10.4.5 DVHA Pharmacy Claims File

(DVHA or Fiscal Agent to Contractor). This file contains paid pharmacy claims data for all Attributed Members to the Contractor paid by DVHA on a fee-for-service basis.

10.4.6 Contractor Non-Claims Payments File

(Contractor to DVHA or Fiscal Agent) This file contains fixed prospective payments and Comprehensive Payment Reform (CPR) pilot program Payments the Contractor has made to their Participating Providers which were not paid at a claim level.

10.4.7 DVHA FFS Payments File

(DVHA or Fiscal Agent to Contractor) This file contains paid claims data for all Attributed Members to the Contractor paid by DVHA on a fee-for-service basis for both covered and non-covered services: a) for services provided to Attributed Members not included in the Value-Based Care Payments; or b) for VMNG Program-covered and non-covered services provided to Attributed Members by non-participating providers.

10.4.8 [intentionally omitted]

10.4.9 [intentionally omitted]

10.4.10 Contractor Attributed Member Demographics File

(DVHA or Fiscal Agent to Contractor) This file contains summary demographic information on all Attributed Members.

10.4.11 DVHA Covered Confidential and Opt Out Claims File

(DVHA or Fiscal Agent to Contractor) This file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to the VMNG Program Attributed Members. For both Traditional and Expanded Cohorts, the file also contains payment totals, by provider, for Attributed Members who have opted out of data sharing. The file will contain Medicaid ID and Provider ID, a count of claims, a unique member count, a total confidential payment, the amount that would have been paid FFS, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Members' attributed health service area, Attributed Members' MEG, claim type, year and month paid, and Cohort.

10.4.12 DVHA FFS Confidential and Opt Out Claims File

(DVHA or Fiscal Agent to Contractor) This file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to VMNG Program Attributed Members which Fiscal Agent paid fee for service. The file also contains for both Traditional and Expanded Cohorts payment totals, by provider, for Attributed Members who have opted out of data sharing. The file will contain Medicaid ID and Provider ID, a count of claims, a unique member count, a total confidential payment, the amount that was paid FFS, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Member's attributed health service area, Attributed

Members' MEG, claim type, year and month paid, and Cohort.

10.4.13 DVHA Attribution PMPM File

(DVHA or Fiscal Agent to Contractor) In addition to the DVHA Remittance File, a summary file will be generated containing PMPM payment information for each Attributed Member in the Traditional and Expanded Attribution Cohorts. The file will contain all of the Attributed Members for whom a PMPM payment was made along with the PMPM amount, the MEG and Member ID, and all of the Attributed Members for whom a payment was not made including the reason the payment was not made.

10.4.14 DVHA Interim Financial Settlement File

(DVHA or Fiscal Agent to Contractor) This file contains claim level detail information for all claims incurred by Attributed Members (both Zero-Paid Claims and fee for service claims) in each calendar quarter and payment totals by provider for confidential services and services incurred by Attributed Members who have opted out of dating sharing. A quarterly schedule outlining the dates of service and claims paid through dates for each quarterly report will be mutually agreed upon by both Parties prior to submission of the first Interim Financial Settlement File.

10.4.15 DVHA Historical Services Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Services Claims File contains claim level detail information for all claims incurred by Attributed Members for dates of service in the three years prior to the performance year. The weekly Historical Services Claims file contains claim level detail information for all claims incurred by Attributed Members for dates of service in the three years prior to the performance year through the current week's paid date.

10.4.16 DVHA Historical Covered Confidential and Opt Out Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Confidential and Opt Out Claims file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to the VMNG Program Attributed Members in the three years prior to the performance year. The weekly Historical Confidential and Opt Out Claims File contains payment totals, by provider, for confidential services provided to Attributed Members for dates of service in the three years prior to the performance year through the current week's paid date. For both Traditional and Expanded Cohorts, the files also contain payment totals, by provider, for Attributed Members who have opted out of data sharing. The files will contain Medicaid ID and Provider ID, a count of claims, a unique member count, the amount that was zero-paid, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Members' attributed health service area, Attributed Members' MEG, claim type, year and month paid, and Cohort.

10.4.17 DVHA Historical FFS Confidential and Opt Out Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Confidential and Opt Out Claims file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to the VMNG Program Attributed Members in the three years prior to the performance year. The weekly Historical Confidential and Opt Out Claims File contains payment totals, by provider, for confidential services provided to Attributed Members for dates of service in the three years prior to the performance year through the current week's paid date. For both Traditional and Expanded Cohorts, the files also contain payment totals, by provider, for Attributed Members who have opted out of data sharing. The files will contain Medicaid ID and Provider ID, a count of claims, a unique member count, the amount that was paid FFS, the years and months of services, the Performance Year, the Contractor

excluded services flag, Attributed Members' attributed health service area, Attributed Members' MEG, claim type, year and month paid, and Cohort.

10.4.18 DVHA Historical Pharmacy Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Pharmacy Claims File contains paid pharmacy claims data for all Attributed Members for dates of service in the three years prior to the performance year. The weekly Historical Pharmacy Claims File contains paid pharmacy claims data for all Attributed Members for dates of service in the three years prior to the performance year through the current week's paid date.

10.4.19 DVHA Historical Eligibility File

(DVHA or Fiscal Agent to Contractor) The annual Historical Eligibility File contains eligibility information by month for all newly-Attributed Members for the three years prior to the performance year.

10.5 [intentionally omitted]

10.6 Year-End Reconciliation Process

DVHA will complete a Year-End Reconciliation process no later than September 20th of the calendar year following the Performance Year (for example, the reconciliation process for the 2021 Performance Year must be completed no later than 09/20/2022). DVHA will submit the Year-End Reconciliation to Contractor upon completion. The complete Year-End Reconciliation shall be validated by both parties as described in Attachment B, section G, and the Year-End Reconciliation shall be considered final at the time both parties agree in writing that the results are final. This process will be used to reconcile any payments owed from or to Contractor arising out of the PY (refer to the appropriate Attachment B for the PY under reconciliation for application of the Risk Corridor for each party). The files described in Section 10.4 will serve as the primary basis for this reconciliation. However, on an as needed basis, DVHA may request from Contractor additional files to exchange with Fiscal Agent to support this year end reconciliation. Contractor shall provide these files as requested.

DVHA reserves the right for a period of six years following the end of the term or termination of a PY, to reopen a final settlement in order to recalculate amounts owed and make or demand payment of any additional amounts owed to or by the Contractor, if, as a result of later information, it is later determined that the amounts due between the parties was calculated in error due to material errors as referenced in Section C of Attachment B.

DVHA and Contractor agree that this section shall apply to Year-End Reconciliations for Performance Year 2018 onward.

10.7 Health Information Technology and Data Sharing

Contractor shall cooperate and participate in the development and implementation of current and future DVHA- or State of Vermont-sponsored health information technology (HIT) initiatives to the degree they relate directly to VMNG Program.

11. Program Integrity

Contractor shall comply with Program Integrity requirements that are applicable to ACOs in accordance with federal and state law including 42 C.F.R. § 438.608, as more fully set out below.

Contractor will establish a Compliance Program that will fulfill all Program Integrity responsibilities set forth in this Section. The Compliance Program shall include a Compliance Committee comprised primarily of Contractor's Vermont staff and chaired by Contractor's Compliance Officer who is responsible to the Contractor's Board of Members and senior management. The Compliance Committee will be responsible for, *inter alia*, overseeing Contractor's Compliance Program and compliance with this Contract.

Contractor will provide training to Contractor's staff, including those who are responsible for staffing the toll-free Member services and provider relations phone line, Contractor's senior management, and the Contractor's Compliance Officer for the detection of fraud, waste, and abuse and how to report such instances or suspicions to the appropriate personnel. Contractor shall provide DVHA training schedules, content, and participation lists within 10 days of completion of each training conducted under this Contract. Trainings shall, at a minimum, be conducted annually and include:

- Federal and State standards and requirements under this Contract;
- Identifying, reporting, and appropriately handling for-cause provider terminations; and
- Information about the rights of employees to be protected against retaliation for reporting compliance concerns.

Contractor's Compliance Officer and Compliance Committee shall ensure that compliance policies, including the Compliance Plan, are up to date, appropriate annual training and education occurs, provisions are in place to detect fraud, waste and abuse, and for the development of corrective action initiatives. Contractor shall provide reports on Contractor's compliance activities to its Board of Managers. All of the aforementioned activities shall comply with the applicable requirements outlined in 42 C.F.R. § 438.608(a)(1)(i) – (vii).

Contractor reports provided as required by this Contract and the ACO Reporting Manual may be shared with DVHA PI Unit.

11.1 Code of Conduct

Contractor will establish a code of conduct for all employees and Board of Members that requires compliance with all applicable state and federal laws, regulations, and standards. The code of conduct will include information about the standards of conduct, policies, and procedures as well as a prohibition against retaliation for reporting compliance concerns. The code of conduct will describe lines of communication between Contractor representatives and the Compliance Officer and encourage the reporting of concerns. The code of conduct will also include disciplinary guidelines for enforcement of these standards within the first quarter of 2021.

A copy of Contractor's code of conduct shall be submitted to DVHA by January 31, 2021. If the code of conduct is updated during the Performance Year, it shall be submitted to DVHA within 10 days of the revision becoming final.

11.2 Compliance Plan

Contractor must have a Compliance Plan that describes in detail the manner in which it will detect fraud, waste, and abuse in accordance with federal and state law and regulation, including 42 CFR § 438.608. Contractor shall submit the Compliance Plan which reflects the requirements of this Contract to DVHA's Program Manager and DVHA PI Unit no later than 30 days after the effective date of this Contract and no later than ten business days after any relevant revisions are made. The table provided in Exhibit 3 shall be completed and attached as a cover sheet to the Compliance Plan upon submission. Upon receipt, if DVHA PI Unit determines it necessary, a meeting will be scheduled to discuss the Compliance Plan and any necessary changes.

Only those provisions of Contractor's Compliance Plan that relate to this Contract and its requirements will be provided to DVHA. Any provisions of Contractor's Compliance Plan that do not relate to this Contract, and are, therefore, not provided to DVHA, shall only be documented in separate sections within Contractor's Compliance Plan or in a separate Compliance Plan for DVHA.

The Compliance Plan shall provide for cooperation with the DVHA PI Unit's fraud, waste and abuse efforts, including DVHA PI Unit initiated audits of Participating Providers.

The Compliance Plan shall include specific and detailed internal procedures for Contractor to efficiently detect, report, and, where appropriate, investigate, fraud, waste, and abuse, including:

- The designation of a Compliance Officer and a Compliance Committee. A detailed list of the type and frequency of training and education that will be provided.

- An organizational chart of Contractor's organization and communication plan highlighting lines of communication between the Compliance Officer and the organization's employees as well as DVHA PI Unit.

- Detailed descriptions of the processes for internal monitoring and auditing.

- Description of the specific controls in place for prevention, detection, and reporting of potential or suspected fraud, waste, and abuse, including, but not limited to:

    - Process for the confidential reporting of Compliance Plan violations to the Compliance Officer or designated person.

    - Adherence to ACO related regulations and applicable waivers granted under the Affordable Care Act, Stark Law, Anti-kickback statute, civil money penalty law (CMP), Gainsharing CMP, and incentives.

    - Ensuring that the identities of individuals reporting violations of Contractor are protected and that there is no retaliation against such persons.

- Provisions enabling the efficient identification, investigation, and resolution of fraud, waste and abuse issues of vendors, subcontractors and Contractor itself based on the information available to Contractor.

- Provisions for the prompt referral of any identified, suspected, or alleged instances of fraud, waste, or abuse to DVHA PI Unit.

- Provisions for development of, and adherence to, corrective action plans and initiatives.

Contractor shall conduct risk assessments of its Compliance Program, including its program for detecting and preventing fraud, waste and abuse, and requirements of its contracts with subcontractors and Participating Providers on a semi-annual basis, with the first due to DVHA PI Unit by March 31, 2021 and the second due to DVHA PI Unit by September 31, 2021. The risk assessment shall also be updated after Program Integrity related actions are taken. The risk assessments will identify and prioritize the top three areas of risk as same may occur within this value based payment arrangement including, but not limited to, risk in the following categories: (1) calculation of the ETCOC; (2) distribution of the Fixed Prospective Payment (FPP) and (3) payments from the Value Based Incentive Fund. The risk assessments will provide an action plan to mitigate those risks.

Discovery of any other Program Integrity related actions will be communicated to DVHA PI unit within 30 days and notice of such actions shall outline action plans to mitigate such risk.

11.3 Ongoing Monitoring of Contractor's Provider Network

Contractor shall promptly refer incidents of any suspected or confirmed fraud, waste and abuse to the DVHA PI Unit.

Contractor will work cooperatively, and maintain communication, with the DVHA PI Unit to develop and implement any necessary corrective action plans required in the event of Contractor's fraud, waste or abuse. Contractor shall further require their Participating Providers or subcontractors to comply with corrective action plans as a result of fraud, waste, and abuse activities identified by either Contractor or the DVHA PI Unit.

Contractor shall cooperate with all appropriate state and federal agencies, including the Medicaid Fraud and Residential Abuse Unit (MFRAU) and the DVHA PI Unit, in their investigations of fraud, waste, and abuse.

Contractor's Compliance Officer shall attend and participate in DVHA-provided trainings to Participating Providers on detecting fraud, waste, and abuse.

By January 31, 2021, May 31, 2021, and September 31, 2020, and more frequently if reasonably directed by the DVHA PI Unit, Contractor shall submit a detailed report to DVHA which outlines Contractor's compliance and program integrity-related activities as well as identifies Contractor's progress in meeting program integrity-related goals and objectives.

Contractor agrees that the DVHA PI Unit is responsible for overseeing the integrity of all Medicaid payment, including the underutilization of services or the over reporting of services such as split billing, unbundling of services or other billing methods that would cause the VMNG Program's Expected Total Cost of Care to increase artificially in future years.

Contractor agrees that the DVHA PI Unit may conduct oversight reviews of Contractor's Compliance Program or other program integrity-related activities to determine the Contractor's compliance with this Contract. Such audit activities will be conducted, to the extent feasible, with minimal disruption to Contractor's activities, and may include conducting interviews of relevant staff, reviewing all documentation, and any performance metrics. The DVHA PI Unit may issue a corrective action plan or performance improvement plan and outline timelines for improvement measures and Contractor shall cooperate in promptly implementing such plan.

12. Special Data Sharing Provisions

Contractor is a business associate of covered entities providing care under Medicaid and is authorized to request and receive protected health information (PHI) and to act as custodian of such PHI on its covered entities' behalf.

As permitted by law, Contractor may request and receive Medicaid data from DVHA on behalf of another covered entity for treatment, payment, or health care operations purposes. Contractor will comply with the safeguarding requirements for Medicaid data found in 33 V.S.A. § 1902a and the privacy and security requirements for PHI under HIPAA with respect to all data received from DVHA on behalf of another covered entity and all data received or created on behalf of DVHA pursuant to this Contract.

Contractor will act as a business associate of DVHA and will comply with the terms of Attachment E: Business Associate Agreement in all instances in which PHI is provided by DVHA to Contractor in its capacity as a business associate, including the two (2) "Special Data Sharing" instances detailed in Sections 12.1 and 12.2.

Contractor will not use or disclose the PHI received or created pursuant to the terms of 12.1 or 12.2 for any purpose other than the purpose stated in that section or as provided in Attachment E.

12.1 Medicare ACO-Attributed Individual Identification Assistance

Contractor will assist DVHA in the creation of a list of individuals that are both:
(1) enrolled in the Vermont Medicaid Program and any Medicare plan ("Dually-Eligible Individuals"); and

(2) attributed to Contractor's Vermont Modified Next Generation ACO Program.

DVHA will provide Contractor with a list of Dually Eligible Individuals which Contractor will use to create a list of Dually-Eligible Individuals that are attributed to the Vermont Modified Next Generation ACO Program ("Dually-Eligible Attributed Member List").

Once the Dually Eligible Attributed Member List is created, it will be maintained and used by Contractor according to the privacy provisions of its Business Associate Agreements with other covered entities. Contractor will return or destroy all other PHI created or received under this section 12.1 in accordance with the applicable Business Associate Agreement within thirty (30) days after each list is generated.

12.2 Data sharing for activities relating to actuarial analyses and financial modeling

Contractor agrees to assist DVHA in the review of the actuarial analysis and financial modeling related to the VMNG Program by other DVHA contractors. This review may require access to PHI that is outside the scope of data available to Contractor as a Business Associate of Covered Entities currently participating in the VMNG Program.

To achieve this purpose, Contractor shall be provided the claims data set underlying any actuarial analysis or financial model for which DVHA requests review, including claims data relating to providers who are not currently participating in Contractor's network. Contractor, acting as a Business Associate of DVHA, and its actuarial subcontractor shall use this data set for the sole purpose of evaluating and validating DVHA's actuarial findings and reporting its conclusions and recommendations to DVHA. Claim-level detail in the dataset provided to Contractor will not include any confidential claims (data that falls under 42 CFR Part 2). Refer to Sections 10.4.11-10.4.12 for further description of confidential data exchange.

Contractor will return or destroy all PHI received under this Section 12.2 in accordance with the Business Associate Agreement.

EXHIBIT 1

TO

ATTACHMENT A

Included and Excluded Service Codes

{PROVIDED SEPARATELY}

EXHIBIT 2

TO

ATTACHMENT A

Attribution Technical Specifications

Table 1. Qualifying Evaluation & Management (QEM) Services

Code	Description
Office or Other Outpatient Services	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
99241	Consultation: Office and Outpatient, 15 minutes
99242	Consultation: Office and Outpatient, 30 minutes
99243	Consultation: Office and Outpatient, 40 minutes
99244	Consultation: Office and Outpatient, 60 minutes
99245	Consultation: Office and Outpatient, 80 minutes
Nursing Facility Care	
99304	Initial Nursing Facility Care, brief
99305	Initial Nursing Facility Care, moderate
99306	Initial Nursing Facility Care, comprehensive
99307	Subsequent Nursing Facility Care, brief
99308	Subsequent Nursing Facility Care, limited
99309	Subsequent Nursing Facility Care, comprehensive
99310	Subsequent Nursing Facility Care, extensive
99315	Nursing Facility Discharge Services, brief
99316	Nursing Facility Discharge Services, comprehensive
99318	Other Nursing Facility Services
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief

99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Preventative Care/Wellness Visits	
G0438	Annual wellness visit
G0439	Annual wellness visit
99381	Preventive Medicine Visits - Initial, age younger than 1 year
99382	Preventive Medicine Visits – Initial, age 1 through 4 years
99383	Preventive Medicine Visits – Initial, age 5 through 11 years
99384	Preventive Medicine Visits – Initial, age 12 through 17 years
99385	Preventive Medicine Visits – Initial, age 18 through 39 years
99386	Preventive Medicine Visits – Initial, age 40 through 64 years
99387	Preventive Medicine Visits – Initial, age 65 years and older
99391	Preventive Medicine Visits – Periodic, age younger than 1 year
99392	Preventive Medicine Visits – Periodic, age 1 through 4 years
99393	Preventive Medicine Visits – Periodic, age 5 through 11 years
99394	Preventive Medicine Visits – Periodic, age 12 through 17 years
99395	Preventive Medicine Visits – Periodic, age 18 through 39 years
99396	Preventive Medicine Visits – Periodic, age 40 through 64 years
99397	Preventive Medicine Visits – Periodic, age 65 years and older
99401	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 15 minutes
99402	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 30 minutes
99403	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 45 minutes
99404	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 60 minutes
99406	Counseling Services: Smoking and Tobacco Cessation, 3 to 10 minutes
99407	Counseling Services: Smoking and Tobacco Cessation, greater than 10 minutes
99408	Counseling Services: Alcohol and/or substance abuse, 3 to 10 minutes
99409	Counseling Services: Alcohol and/or substance abuse, greater than 10 minutes
99411	Counseling Services: Preventive medicine in group setting, 30 minutes
99412	Counseling Services: Preventive medicine in group setting, 60 minutes
99420	Health Risk Assessment – Admin and interpretation of health risk assessment

99429	Health Risk Assessment – Unlisted preventive medicine service
Child and Maternal Health	
99460	Evaluation and Management Svcs. for Age 28 Days or less, initial hosp. or birthing center
99461	Evaluation and Management Svcs. for Age 28 Days or less, initial care
99462	Evaluation and Management Svcs. for Age 28 Days or less, subsequent hosp. care
99463	Evaluation and Management Svcs. for Age 28 Days or less, admitted and disch. same day
99464	Attendance at Delivery
99465	Newborn Resuscitation
FQHC/RHC Encounter	
T1015	Clinic visit/ encounter, all-inclusive (includes revenue codes 521, 522, 525)
Other	
99354	Prolonged Services Direct Contact, first hour
99355	Prolonged Services Direct Contact, each additional 30 minutes
99358	Prolonged Services Indirect Contact, first hour
99359	Prolonged Services Indirect Contact, each additional 30 minutes
99490	Comprehensive Care Plan Establishment/Implementation/Revision/Monitoring
99495	Communication (14 Days of Discharge)
99496	Communication (7 Days of Discharge)

Table 2. Specialty and Category of Service codes used for attribution based on primary care practitioners

Specialty Code	**Specialty**
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
S15	Certified Family Practitioner
S16	Certified Pediatric Practitioner
S17	Other Certified Nurse Practitioner
S36	Naturopathic Physician with Childbirth Endorsement
S37	Naturopathic Physician w/o Childbirth Endorsement
Category of Service Code	**Specialty**
1201	Rural Health Clinic (RHC)
1401	Federally Qualified Health Center (FQHC)

Table 3. Funding sources excluded from expenditure calculations

Funding Source	**Description**
B	DAIL – DS Services
C	GENERAL ASSISTANCE - STATE FUND (DCF)
E	HIV DRUG - DOH
G	DMH
H	DOE
I	DCF
J	VDH
K	ADAP
L	DAIL
R	VHAP - OADAP SERVICES (VDH)
S	DMH - CRT CASE RATE
Z	LADIES FIRST (VDH)

OneCare Compliance Plan Checklist

Contractor's Compliance Plan, as detailed in Attachment A, Section 11 of this Contract, shall provide the specific manner in which Contractor will detect fraud, waste, and abuse, including cooperation with and referral to DVHA's PI Unit.

Contractor is required, in accordance with Attachment A, Section 11.2, to submit its Compliance Plan to DVHA no later than 30 days after the effective date of the Contract and no later than ten days after any revisions to the Compliance Plan are made. The below table must be completed and attached as a cover sheet with the submission of Contractor's Compliance Plan.

Program Integrity Responsibility Requirement		Location in Compliance Plan (section and page number)
Designation of a Compliance Officer and a Compliance Committee		
A detailed list of type and frequency of training and education that will be provided to Contractor's staff to detect fraud, waste, and abuse		
An organizational chart of Contractor's organization		
A communication plan highlighting lines of communication between:	1. Compliance Officer and the organizations employees	
	2. Contractor and the DVHA PI Unit	
Detailed descriptions of processes for internal monitoring and auditing		
Description of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse		
Provisions enable efficient identification, investigation, and resolution of fraud, waste, and abuse issues of vendors, subcontractors, and Contractor		
Provisions for prompt referral of any identified, suspected, or alleged instances of fraud, waste, or abuse to the DVHA PI Unit		
Provisions for development of, and adherence to, corrective action plans and initiatives		

ATTACHMENT B
PAYMENT PROVISIONS

SECTIONS

A. Definitions: Refer to Attachment A, Section 1 for defined terms used in this attachment.

B. Methodology for ETCOC

DVHA's actuary shall develop, with validation by Contractor or its designee, actuarially certified rates set in this Contract. The ETCOC shall be calculated separately for the Traditional Attribution Cohort and Expanded Attribution Cohort based upon the following methodology:

i. Determine Attributed Members and allocate each Attributed Member to a MEG.

ii. Identify all Base Year claims for Attributed Members using four months of runout.

iii. Calculate the baseline expenditure on a PMPM basis for each of the MEGs.

iv. For each MEG, trend the Base Year claims forward to the 2021 program year by applying a trend factor, agreed to by the Parties, that combines the impact of utilization changes, rate changes, truncation adjustment, and population changes to determine the pre-adjusted ETCOC PMPM for each MEG. The trend factor for each MEG will be adjusted for mutually agreed upon, material external changes in underlying reimbursements or policies that are not expected to continue into the Performance Year. The trend factor shall be developed independent of any assumptions about Contractor activity or efficiency during the Performance Year.

v. Apply a VMNG Program efficiency factor equaling a 0.2% reduction applied to the pre-adjusted ETCOC PMPM for each MEG.

C. General Payment Provisions

The maximum dollar amount payable under this Contract is not intended as any form of a guaranteed amount. Contractor will be paid for products or services actually performed as specified in Attachment A up to the maximum allowable amount specified in this Contract.

The expenditures incurred by an Attribution-eligible Member, for purposes of financial calculations for any Performance Year or Base Year, is the sum of all Medicaid payments on claims for Covered Services, subject to the inclusions and exclusions for the ETCOC set forth in sections 3.1 and 3.2. Refer to Exhibit 1 to Attachment A (Included Service Codes) for a detailed listing of the codes that represent the services included in the financial calculations.

The expenditures used in financial calculations represent the total amount paid to providers for Covered Services, as listed in Attachment A, section 3.1, that are incurred during the Base Year or Performance Year and paid within four months of the close of the Base Year or Performance Year. The financial calculations shall include an estimated completion factor. As such, claims for dates of service within the Performance Year that are submitted for payment more than four months after the end of the Performance Year will not be used in financial calculations, but will be processed in the same manner as any claims submitted for payment during or within four months of the close of the Performance Year.

This is a risk sharing arrangement wherein DVHA holds Contractor accountable to an ETCOC measured against the actual expenditures by DVHA to providers for delivering that care. Within the Risk Corridors as defined in section F below, if the ATCOC is greater than the ETCOC, Contractor shall pay DVHA the difference between the ATCOC and ETCOC and if the ATCOC is less than the ETCOC, DVHA shall pay Contractor the difference between the ATCOC and ETCOC.

The Parties acknowledge that this financial agreement is based on calculations that rely on underlying data from DVHA, which has been assumed to be valid and accurate. To the extent that it is discovered that there is a material error(s) in the underlying data or calculation thereon, for example, if Members are categorized incorrectly in MEGs, DVHA and Contractor will work together to remedy the material error(s) and re-negotiate these payment terms with corrected data.

The Parties shall meet to discuss the specific payment provision calculations for the next Performance Year at least 90 days before the start of a Performance Year. If the payment provisions are not acceptable to Contractor or DVHA, either may terminate this Contract for the upcoming Performance Year at any time before December 31st of the year before the Performance Year begins.

As part of this Contract, DVHA will pay to Contractor for Eligible Members in the Traditional Attribution Cohort and the Expanded Attribution Cohort a Value-Based Care Payment. The Value-Based Care Payment is paid monthly and includes the following components:

a. A Fixed Prospective Payment to be used for reimbursement of services to meet the healthcare needs of Attributed Members; and
b. For the Traditional Attribution Cohort, an Administrative Fee of $6.50 per Eligible Member per month. Contractor must use at least half of the Administrative Fee to fund its ACO Programs and initiatives to Participating Providers. Any unspent funds shall be returned to DVHA.
c. For the Expanded Attribution Cohort, an Administrative Fee of $5.00 per Eligible Member per month. Contractor must use at least half of the Administrative Fee to fund its ACO Programs and initiatives to Participating Providers. Any unspent funds shall be returned to DVHA.

D. Payment for ETCOC Services

1. DVHA agrees to pay Contractor prospectively on a monthly basis a Value-Based Care Payment based on an estimated cost of Covered Services that would be billed by a defined list of Participating Providers for each Eligible Member that is attributed to Contractor in the Traditional Attribution Cohort and Expanded Attribution Cohort plus the administrative fee. Parties agree that DVHA will provide Contractor thirty (30) days or until January 31, 2020, whichever is sooner, to conduct an actuarial review of the benchmarks in Exhibit 1 to Attachment B. Upon Contractor's completion of the actuarial review, Parties will meet to finalize the benchmark and derivative payments and calculations, which may include adjustment to Exhibit 1 to Attachment B for material changes of 1% or more for any PMPM rate. If, after good faith negotiations, Parties are not able to reach agreement on the adjustments, Contractor may terminate this Contract.

The monthly Value-Based Care Payment is calculated by multiplying the PMPM amount in Exhibit 1 to Attachment B by the number of Eligible Members in the corresponding MEG. The sum of these MEG-specific calculations will total the Value-Based Care Payment

If it is determined that a Value-Based Care Payment was paid with respect to any Eligible Member(s) who were or should have been ineligible in any given month, the Value-Based Care Payment(s) will be recouped in the Year-End Reconciliation for the Performance Year. In the event of the death of an Eligible Member Contractor shall receive

100% of the usual Value Based Care Payment for the month in which the Eligible Member died.

2. DVHA shall directly reimburse providers not participating in the Fixed Prospective Payment model for covered services provided to Eligible Members in the Cohorts according to DVHA's current, approved fee-for-service fee schedules. The Fee-For-Service Payments and the underlying methodology will not be affected by the Agreement. The Parties agree that, pending negotiations in section D.1 above, Exhibit 1 to Attachment B contains the estimated value of potential fee-for-service payments in the ETCOC.

3. In exchange for the payment described in Sections 1 above, Contractor agrees to pay for healthcare services in a manner that aligns with the goals stated in this Contract and in general alignment with the Medicaid covered services described in Section 3 of Attachment A of this Contract subject to the limitations noted in this Contract.

E. (Intentionally omitted)

F. Risk Corridor

1. The Parties agree that the ETCOC serves as the benchmark upon which the Risk Corridor is based.

2. Additionally, the Parties agree to a Risk Corridor arrangement as follows:

    a. For the Traditional Attribution Cohort, the Risk Corridor will be 2% and applied as follows:
        - If, at the time of Year-End Reconciliation, the ATCOC is between 100% and 102% of the ETCOC amount, Contractor agrees it is liable for the costs between 100% and 102%. To the extent those costs are borne by DVHA during the year, Contractor shall be liable to DVHA. If the ATCOC is greater than 102% of the ETCOC amount, Contractor is liable for costs between 100% and 102%, and DVHA is liable for any costs exceeding 102%.
        - Conversely, if the ATCOC is between 98% and 100% of the ETCOC, Contractor will be entitled to receive from DVHA payment of the full amount of the ETCOC. If the ATCOC is lower than 98% of the ETCOC, Contractor will be entitled to receive payment of the full value of the ETCOC less the difference between the ATCOC and 98% of the ETCOC.

    b. For the Expanded Attribution Cohort, the Risk Corridor will be 1% upside and 1% downside and applied as follows:
        - If, at the time of final reconciliation, the ATCOC is between 100% and 101% of the ETCOC amount, Contractor agrees it is liable for the costs between 100% and 101%. To the extent those costs are borne by DVHA during the year, Contractor shall be liable to DVHA. If the ATCOC is greater than 101% of the ETCOC amount, Contractor is liable for costs between 100% and 101%, and DVHA is liable for any costs exceeding 101%.
        - Conversely, if the ATCOC is between 99% and 100% of the ETCOC, Contractor will be entitled to receive from DVHA payment of the full amount of the ETCOC. If the ATCOC is lower than 99% of the ETCOC, Contractor will be entitled to receive payment of the full value of the ETCOC less the difference between the ATCOC and 99% of the ETCOC.

3. Prior to the Year-End Reconciliation, the downside risk for the Traditional Attribution Cohort and Expanded Attribution Cohort shall be reduced by the proportion of Performance Year 2021 months within the federally-declared Public Health Emergency. The result shall be a proportional reduction in any financial liability Contractor may bear for an ATCOC greater than 100% of the ETCOC for both the Traditional Attribution Cohort and the Expanded Attribution Cohort.

4. If during the Contract, DVHA or Contractor determines that the Fee-for-Service Payments are 10% or more above the allocation of Fee-for-Service Payments (Exhibit 1 to Attachment B) multiplied by the number of member months or if the ATCOC is projecting to exceed 102% of the benchmark for the Traditional Attribution Cohort or 101% for the Expanded Attribution Cohort, then the parties shall meet to discuss

utilization or costs and potential remedies. Evaluations will occur no less frequently than quarterly within 60 days of the end of the quarter.

5. Parties agree to monitor changes in healthcare demand/delivery during the Performance Year with specific regard to impacts that may be resulting from the COVID-19 pandemic. If COVID-19 related shifts are noted that were not captured in part or in full during the process to set the ETCOC, Parties shall meet to discuss these shifts and potential remedies.

G. Reconciliation

1. Year-End Reconciliation Process: The Parties agree that year-end reconciliation, as defined in Attachment A, Section 1.1, will be conducted separately for the Traditional and Expanded Attribution Cohorts and in accordance with Section 10.6 of Attachment A of this Contract using all reports in Section 10.4 through and including 10.4.9.

2. Before calculating any differences between the ETCOC and ATCOC, DVHA will retrospectively review attribution and Member eligibility for the Performance Year. DVHA will communicate proposed changes to Contractor and Contractor will have the opportunity to review and validate the proposed changes to the extent possible. In the event there are valid changes, DVHA will calculate any corresponding financial reconciliation of the ETCOC and Value-Based Care Payment and present this reconciliation to Contractor. Contractor will have the opportunity to review the reconciliation for accuracy. After validation, the dollar amount of the reconciliation will be factored into the calculation to determine the final program settlement amount.

3. Prior to calculating any differences between the ETCOC and ATCOC, DVHA will remove from the calculation of the ATCOC the cost of Covered Services, determined by combining the fee-for-service payments and amounts that would have been paid to providers on Zero-Paid Claims, in excess of $200,000 for any individual ABD Member and $100,000 for any individual Members under all other MEG assignments.

4. Prior to calculating any differences between the ETCOC and ATCOC, DVHA will remove from the calculation of the ATCOC any COVID-19-related episodes of care. Episodes will include one month post hospital discharge, as triggered by an inpatient stay with diagnosis code U07.1 (COVID-19) through the duration of the COVID-19 Public Health Emergency. DVHA will also ensure that the calculation of the ATCOC does not include the cost of administering the COVID-19 vaccine or the cost of the COVID-19 vaccine by excluding the following codes: 91300 (SARSCOV2 VAC 30MCG/0.3ML IM), 91301 (SARSCOV2 VAC 100MCG/0.5ML IM), 0001A (ADM SARSCOV2 30MCG/0.3ML 1st), 0002A (ADM SARSCOV2 30MCG/0.3ML 2nd), 0011A (ADM SARSCOV2 100MCG/0.5ML1st), and 0012A (ADM SARSCOV2 100MCG/0.5ML2nd).

5. The aggregate difference between the ETCOC and ATCOC will be determined by subtracting the ATCOC from the ETCOC. By way of example, the calculations will be applied in the following order.

Year-End Reconciliation Calculations

DVHA Value-Based Care Payment to Contractor	(A)	*(B) + (C)*
Fixed Prospective Payment	(B)	
Administrative Fee (includes Population Health Program Funds)	(C)	
Population Health Program Funds	(D)	
Total Contractor Payments to Participating Providers	(E)	*(B) + (D)*

Total Expected Zero-paid Claims	(F)	*(B)*
Total Actual Zero-paid Claims	(G)	

Zero-paid Claims Over (Under) Spend	(H)	*(G) – (F)*

Total Expected FFS	(I)	
Actual FFS - In Network	(J)	
Actual FFS - Out of Network	(K)	
Total Actual FFS	(L)	*(J) + (K)*
FFS Over (Under) Spend	(M)	*(L) – (I)*

ETCOC	(N)	*(F) + (I)*
ATCOC	(O)	*(F) + (L)*
Total Cost of Care Over (Under) Spend	(P)	*(O) – (N)*

Year-End Reconciliation of Value-Based Care Payment (if necessary)	(Q)	

Contractor Financial Liability before Risk Corridor	(R)	*(P) + (Q)*

Contractor Financial Liability after Risk Corridor	(S)	
Year-End Reconciliation of Unearned Value-Based Incentive Fund Payment	(T)	
Year-End Reconciliation of Undistributed Population Health Program Funds	(U)	*(C) – (D)*

Final Cash Settlement	**(V)**	***(S) + (T) + (U)***

H. Hold Harmless

Fee-for-service rate increases or reductions for any covered services in this Contract will result in two impacts on this Contract. First, the Fixed Prospective Payment totals will be adjusted accordingly as part of the annual financial reconciliation. Second, the ETCOC will need to be increased or decreased. Under these circumstances DVHA will hold Contractor harmless for any material fee-for-service reimbursement changes implemented during the Performance Year, as follows:

- The ETCOC will be increased to fully mitigate the impact to Contractor of any fee for service reimbursement increases implemented by DVHA.
- The ETCOC will be decreased to fully mitigate the impact to Contractor of any fee for service reimbursement decreases implemented by DVHA.

I. Dispute Resolution Process

1. The Parties agree that to resolve disputes regarding Attachment B using the following dispute resolution process prior to pursing a remedy from a third party:

   a. The issue in dispute will be referred to the DVHA Program Manager, and the individual referred to in Section 7 on page 2 of Attachment A of this Contract for 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) business days from the date the issue is referred to resolve the dispute.

   b. If the individuals referred to in the preceding paragraph have not resolved the issue in dispute within fourteen (14) business days, the issue will be referred to the Commissioner of DVHA, or his or her designee, and to the Chief Executive Officer of Contractor, or his or her designee. The Parties shall

gather the information they need to evaluate the issue in dispute and will have thirty (30) business days from the date the issue is referred to resolve the dispute.

c. If the issue is not resolved by the management in subsection (b), within thirty (30) business days from referral, DVHA or Contractor may bring an action for relief in the Washington Civil Division of the Vermont Superior Court.

J. Value-Based Incentive Fund Program and Year-End Quality Adjustment

Contractor is required to fund a Value-Based Incentive Fund equivalent to an agreed-upon percentage of the ETCOC. The fund shall be used to reward Participating Providers for high-quality care delivery. The annual quality score will be used to determine how much of the fund is distributed to Participating Providers, how much is retained by Contractor for future investment in quality improvement activities, and how much is paid to DVHA. In addition, a calculation will be performed at the end of the Performance Year as part of the Year-End Reconciliation process described in section G, whereby the annual quality score will be used to determine what amount the Contractor shall additionally reinvest in quality improvement activities.

1. Program Establishment and Eligibility

   DVHA has established the following framework through which Contractor shall allocate a portion of the ETCOC to a Value-Based Incentive Fund that can be used for: value-based payments to Participating Providers, reinvestment into VMNG Program wide quality improvement initiatives, or a combination of the two. Contractor's ability to use these funds is subject to Contractor's complete and timely satisfaction of its obligations under the Contract. This includes, but is not limited to, timely submission of Contractor's HEDIS data for the measurement year as well as timely submission of reports identified by DVHA in the ACO Reporting Manual.

   Contractor may be required to pay up to $250,000.00 should the DVHA Commissioner find that Contractor is in violation of a Corrective Action Plan, subject to Contractor's appeal rights under this Contract and the Vermont Administrative Procedures Act.

   DVHA may, at its option, reinstate Contractor's eligibility for participation in the Value-Based Incentive Fund once Contractor has properly corrected all prior instances of non-compliance of its obligations under the Contract, and DVHA has satisfactory assurances of acceptable future performance.

2. Value-Based Incentive Fund Potential

   During the 2021 measurement year, the Contractor will fund one percent of the Traditional Attribution Cohort's ETCOC for the Value-Based Incentive Fund. Contractor has discretion as to when Value-Based Incentive Fund distributions are made to Participating Providers.

   Contractor agrees to produce a report showing distribution of the Value-Based Incentive Fund no later than October 31st of the Calendar Year following the Performance Year.

3. Performance Measures, Incentive Payment Structure, and Year-End Quality Adjustment

   The performance measures, targets and incentive payment opportunities for Performance Year 2021 are set forth in the tables below. Performance measures and targets may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. The performance measures and targets applicable during subsequent years of the Contract shall be established annually by DVHA and reflected in an amendment to the Contract.

   Contractor performance on payment measures will be the basis for the calculation of the Year-End Quality Adjustment amount and the amount of the Value-Based Incentive Fund that is distributed to Participating Providers. Payment measure results will be scored according to the methodology outlined in subsections a. through f., below. Reporting measures are those that Contractor is required to report; however, Contractor

performance on Reporting measures will not impact the distribution of the Value-Based Incentive Fund or the calculation of the Year-End Quality Adjustment amount. Reporting measures will not be scored. All performance measures for the Expanded Attribution Cohort will be reporting measures, as set forth below.

Contractor results and performance shall be calculated based on care delivered during Performance Year 2021 Contractor shall submit information to DVHA, in the format and detail specified by DVHA, with respect to each performance measure set forth below. Any payment measure results received after the required submission date will not be included in the scoring methodology used to determine Contractor's eligibility for an incentive payment.

Measure	Measure Use – Traditional Attribution Cohort	Measure Use – Expanded Attribution Cohort	Data Source	National or Multi-State Medicaid Benchmarks Available for 2021 Contract Year
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Abuse or Dependence	Payment	Reporting	Claims	Yes
30 Day Follow-Up after Discharge from the ED for Mental Health	Payment	Reporting	Claims	Yes
Adolescent Well Care Visits	Payment	Reporting	Claims	Yes
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Payment	Reporting	Claims	No
Developmental Screening in the First 3 Years of Life	Payment	Reporting	Claims	Yes
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	Payment	N/A	Clinical	Yes
Hypertension: Controlling High Blood Pressure	Payment	N/A	Clinical	Yes
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	Payment	Reporting	Claims	Yes
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Payment	Reporting	Claims	Yes
Screening for Clinical Depression and Follow-Up Plan	Payment	N/A	Clinical	No
Follow-Up after Hospitalization for Mental Illness (7 Day Rate)	Reporting	Reporting	Claims	Yes
Tobacco Use Assessment and Tobacco Cessation Intervention	Reporting	N/A	Clinical	No
Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey Composite Measures collected by DVHA[§]	Reporting	N/A	Survey	No

[§] DVHA's certified CAHPS vendor will calculate VMNG Program specific performance on behalf of Contractor.

a. Each payment measure will carry equal weight in the scoring methodology; Reporting measures will not be scored.
b. Contractor's quality performance in each Performance Year will be compared to national Medicaid percentile benchmarks that are the most currently available to DVHA (or multi-state benchmarks, if no national benchmarks are available), and each measure will be scored individually. DVHA will inform Contractor of the versions of benchmarks to be utilized within a reasonable timeframe to permit OneCare to effectively measure.
c. If a measure no longer meets best clinical practice due to change in clinical evidence or guidelines, or identification of potential harm to patients, the measure will revert to pay for reporting for the current

Performance Year, awarded two points, and will be modified or removed from future performance years as mutually determined by DVHA and Contractor.

d. Contractor may earn up to 2 points per measure for attainment relative to national benchmarks (or multi-state benchmarks if no national benchmarks are available). Contractor may earn points for statistically significant improvement between the current Performance Year and the prior Performance Year. Statistical significance will be defined by a p-value of 0.1 using a one-way ANOVA. Points are determined by Contractor's net improvement in measures and is calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. One bonus point will be awarded for each significantly improved quality measure and one bonus point subtracted for each measure with a statistically significant decline in quality performance. However, any quality measure with a statistically significant decline that remains within the highest benchmark quartile will be exempted from the calculation of Contractor's net bonus quality improvement score. The total number of bonus points cannot exceed eight and will not be less than zero.
e. The total possible points will be calculated as the number of payment measures multiplied by a maximum of 2 points per payment measure; Contractor may not earn more than the total possible points for attainment and improvement combined.
f. 2021 performance will be compared to national benchmarks that are the most currently available to DVHA ; if national benchmarks are unavailable, 2021 performance will be compared to prior year VMNG Program -specific performance. DVHA will inform Contractor of the versions of benchmarks to be utilized within a reasonable timeframe to permit OneCare to effectively measure. Statistical significance will be defined by a p-value of 0.1 using a one-way ANOVA. 2 points will be awarded for significant improvement, 1 point will be awarded for no change and 0 points will be awarded for significant decline. In the event the 2021 performance is statistically no different than zero, the measure will only be eligible for a maximum of 1 point as the improvement from 2020 that would be needed to attain 2 points will not be possible. This may impact the total possible points available.
g. DVHA will make its best efforts to distribute a report identifying Contractor's performance during Calendar Year 2021 and the amount of incentive payments, if any, earned for each measure identified in this section 3 by August 1, 2022.

	2021
% of ETCOC for Traditional Attribution Cohort Allocated to Value-Based Incentive Fund	1.0%
Maximum of Year-End Quality Adjustment as % of ETCOC	1.0%
Total Possible Points	Up to 20
Points Awarded for Reporting	0
Improvement Points Available	Yes

National (or Multi-State) Benchmark	**2021 Points Awarded**
90th+ percentile*	2
75th+ percentile	1.75
50th+ percentile	1
25th+ percentile	0.25
<25th percentile	0

*In the event 90th percentile benchmarks are not available for any measure, two points shall be awarded for achieving the 75th percentile on such measures.

h. Contractor shall distribute Value-Based Incentive Funds to Participating Providers using a methodology (and quality measures appropriate for provider comparison) of their choosing. Contractor shall annually provide a distribution plan to DVHA prior to the distribution of funds. DVHA shall have 30 days to review and object to the distribution plan. If DVHA fails to object within 30 days, the distribution plan shall be deemed approved.
i. Fifty (50) percent of Value-Based Incentive Funds not distributed to Participating Providers based on

quality performance shall be reinvested into ongoing quality improvement initiatives using an approach proposed by Contractor and approved by DVHA; the remaining fifty (50) percent shall be paid to DVHA. Contractor shall annually provide a proposed approach for the distribution of both Value-Based Incentive Funds for quality improvement and the Year-End Quality Adjustment amount to DVHA for approval within 90 days after the completion of the Year-End Reconciliation process. Such approval by DVHA shall be granted or denied within thirty (30) days of Contractor's submission to the contract monitor. Failure to response within thirty (30) days will constitute approval. Contractor shall supply an annual report detailing the planned distribution of funds for quality improvement initiatives by December 31st.

j. The proportion of the Value Based Incentive Fund available for allocation to network providers shall be determined by the overall quality score; half of the remainder shall be reinvested and the other half of the remainder shall be paid to DVHA, per the formulae below.
    a. Proportion of Value-Based Incentive Fund available for distribution to Participating Providers = (1/[total possible points])*[points earned]
    b. Proportion of Value-Based Incentive Fund available for reinvestment in quality improvement initiatives by Contractor = (1//[total possible points])*([total possible points]-[points earned])/2
    c. Proportion of Value-Based Incentive Fund Payable to DVHA = (1//[total # possible points])*([total possible points]-[points earned])/2
k. The Year-End Quality Adjustment shall be determined by the overall quality score per the formula below.
    a. Year-End Quality Adjustment to be reinvested in quality improvement initiatives by Contractor = ETCOC – (ETCOC*(1-(.01/[total possible points])*([total possible points] – [points earned])))

EXHIBIT 1

TO

ATTACHMENT B

Expected Total Cost of Care (ETCOC) and Value-Based Care Payment

Table 1. Traditional Attribution Cohort

	A=B+C	B	C	D	E = C + D
MEG	**ETCOC**	**Allocation for FFS**	**Allocation for FPP**	**Admin**	**Monthly Value-Based Care Payment to Contractor**
ABD	$565.09	$277.69	$287.40	$6.50	$293.90
New Adult	$325.97	$133.06	$192.91	$6.50	$199.41
Non-ABD Adult	$427.43	$136.99	$290.44	$6.50	$296.94
Consolidated Child	$113.10	$62.70	$50.40	$6.50	$56.90

Table 2. Expanded Attribution Cohort

		A=B+C	B	C	D	E = C + D
MEG	**Sub-Group**	**ETCOC**	**Allocation for FFS**	**Allocation for FPP**	**Admin**	**Monthly Value-Based Care Payment to Contractor**
ABD	No QEMs in AYs	$402.74	$170.84	$231.90	$5.00	$236.90
	No Claims in AYs	$261.87	$111.09	$150.78	$5.00	$155.78
	New Member & TPL in AYs	$518.27	$219.85	$298.42	$5.00	$303.42
New Adult	No QEMs in AYs	$232.64	$105.04	$127.60	$5.00	$132.60
	No Claims in AYs	$151.27	$68.30	$82.97	$5.00	$87.97
	New Member & TPL in AYs	$299.38	$135.17	$164.21	$5.00	$169.21
Non-ABD Adult	No QEMs in AYs	$305.24	$126.52	$178.72	$5.00	$183.72
	No Claims in AYs	$198.47	$82.27	$116.20	$5.00	$121.20
	New Member & TPL in AYs	$392.80	$162.82	$229.98	$5.00	$234.98
Consolidated Child	No QEMs in AYs	$80.97	$40.44	$40.53	$5.00	$45.53
	No Claims in AYs	$52.23	$26.08	$26.15	$5.00	$31.15
	New Member & TPL in AYs	$104.20	$52.04	$52.16	$5.00	$57.16

ATTACHMENT C: STANDARD STATE PROVISIONS FOR CONTRACTS AND GRANTS
REVISED DECEMBER 15, 2017

1. Definitions: For purposes of this Attachment, "Party" shall mean Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement. "Agreement" shall mean the specific contract or grant to which this form is attached.

2. 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.

3. Governing Law, Jurisdiction and Venue; No Waiver of Jury Trial: This Agreement will be governed by the laws of the State of Vermont. Any action or proceeding brought by either the State or the Party in connection with this Agreement shall be brought and enforced in the Superior Court of the State of Vermont, Civil Division, Washington Unit. The Party irrevocably submits to the jurisdiction of this court for any action or proceeding regarding this Agreement. The Party agrees that it must first exhaust any applicable administrative remedies with respect to any cause of action that it may have against the State with regard to its performance under this Agreement. Party agrees that the State shall not be required to submit to binding arbitration or waive its right to a jury trial.

4. Sovereign Immunity: The State reserves all immunities, defenses, rights or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution. No waiver of the State's immunities, defenses, rights or actions shall be implied or otherwise deemed to exist by reason of the State's entry into this Agreement.

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: The Party will act in an independent capacity and not as officers or employees of the State.

7. Defense and Indemnity: The Party shall defend the State and its officers and employees against all third party claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party in connection with the performance of this Agreement. 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. The State retains the right to participate at its own expense in the defense of any claim. The State shall have the right to approve all proposed settlements of such claims or suits.

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 in connection with the performance of this Agreement.

The Party shall indemnify the State and its officers and employees if the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party or an agent of the Party in connection with the performance of this Agreement.

Notwithstanding any contrary language anywhere, in no event shall the terms of this Agreement or any document furnished by the Party in connection with its performance under this Agreement obligate the State to (1) defend or indemnify the Party or any third party, or (2) otherwise be liable for the expenses or reimbursement, including attorneys' fees, collection costs or other costs of the Party or any third party.

8. 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 this 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. Vermont will accept an out-of-state employer's workers' compensation coverage while operating in Vermont provided that the insurance carrier is licensed to write insurance in Vermont and an amendatory endorsement is added to the policy adding Vermont for coverage purposes. Otherwise, the party shall secure a Vermont workers' compensation policy, if necessary to comply with Vermont law.

General Liability and Property Damage: With respect to all operations performed under this Agreement, 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 Each Occurrence

$2,000,000 General Aggregate

$1,000,000 Products/Completed Operations Aggregate

$1,000,000 Personal & Advertising Injury

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 $500,000 combined single limit. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, limits of coverage shall not be less than $1,000,000 combined single limit.

Additional Insured. The General Liability and Property Damage coverages required for performance of this Agreement shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, then the required Automotive Liability coverage shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

Notice of Cancellation or Change. There shall be no cancellation, change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) without thirty (30) days written prior written notice to the State.

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

10. False Claims Act: The Party acknowledges that it is subject to the Vermont False Claims Act as set forth in 32 V.S.A. § 630 *et seq.* If the Party violates the Vermont False Claims Act it shall be liable to the State for civil penalties, treble damages and the costs of the investigation and prosecution of such violation, including attorney's fees, except as the same may be reduced by a court of competent jurisdiction. The Party's liability to the State under the False Claims Act shall not be limited notwithstanding any agreement of the State to otherwise limit Party's liability.

11. Whistleblower Protections: The Party shall not discriminate or retaliate against one of its employees or agents for disclosing information concerning a violation of law, fraud, waste, abuse of authority or acts threatening health or safety, including but not limited to allegations concerning the False Claims Act. Further, the Party shall not require such employees or agents to forego monetary awards as a result of such disclosures, nor should they be required to report misconduct to the Party or its agents prior to reporting to any governmental entity and/or the public.

12. Location of State Data: No State data received, obtained, or generated by the Party in connection with performance under this Agreement shall be processed, transmitted, stored, or transferred by any means outside the continental United States, except with the express written permission of the State.

13. 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.

14. Fair Employment Practices and Americans with Disabilities Act: Party agrees to comply with the requirement of 21 V.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.

15. 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.

16. 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 this 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.

17. Taxation of Purchases: All State purchases must be invoiced tax free. An exemption certificate will be furnished upon request with respect to otherwise taxable items.

18. Child Support: (Only applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date this 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.

19. 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 shall be responsible and liable to the State for all acts or omissions of Subcontractors and any other person performing work under this Agreement pursuant to an agreement with Party or any Subcontractor.

In the case this Agreement is a contract with a total cost in excess of $250,000, the Party shall provide to the State a list of all proposed Subcontractors and Subcontractors' Subcontractors, together with the identity of those Subcontractors' workers compensation insurance providers, and additional required or requested information, as applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54).

Party shall include the following provisions of this Attachment C in all subcontracts for work performed solely for the State of Vermont and Subcontracts for work performed in the State of Vermont: Section 10 ("False Claims Act"); Section 11 ("Whistleblower Protections"); Section 12 ("Location of State Data"); Section 14 ("Fair Employment Practices and Americans with Disabilities Act"); Section 16 ("Taxes Due the State"); Section 18 ("Child Support"); Section 20 ("No Gifts

or Gratuities"); Section 22 ("Certification Regarding Debarment"); Section 30 ("State Facilities"); and Section 32.A ("Certification Regarding Use of State Funds").

20. No Gifts or Gratuities: Party shall not give title or possession of anything 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.

21. Copies: Party shall use reasonable best efforts to ensure that all written reports prepared under this Agreement are printed using both sides of the paper.

22. 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

23. Conflict of Interest: Party shall fully disclose, in writing, any conflicts of interest or potential conflicts of interest.

24. Confidentiality: Party acknowledges and agrees that this Agreement and any and all information obtained by the State from the Party in connection with this Agreement are subject to the State of Vermont Access to Public Records Act, 1 V.S.A. § 315 et seq.

25. Force Majeure: Neither the State nor the Party shall be liable to the other for any failure or delay of performance of any obligations under this Agreement to the extent such failure or delay shall have been wholly or principally caused by acts or events beyond its reasonable control rendering performance illegal or impossible (excluding strikes or lock-outs) ("Force Majeure"). Where Force Majeure is asserted, the nonperforming party must prove that it made all reasonable efforts to remove, eliminate or minimize such cause of delay or damages, diligently pursued performance of its obligations under this Agreement, substantially fulfilled all non-excused obligations, and timely notified the other party of the likelihood or actual occurrence of an event described in this paragraph.

26. Marketing: Party shall not refer to the State in any publicity materials, information pamphlets, press releases, research reports, advertising, sales promotions, trade shows, or marketing materials or similar communications to third parties except with the prior written consent of the State.

27. Termination:

- **A. Non-Appropriation:** 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.
- **B. Termination for Cause:** Either party may terminate this Agreement if a party materially breaches its obligations under this Agreement, and such breach is not cured within thirty (30) days after delivery of the non-breaching party's notice or such longer time as the non-breaching party may specify in the notice.
- **C. Termination Assistance:** Upon nearing the end of the final term or termination of this Agreement, without respect to cause, the Party shall take all reasonable and prudent measures to facilitate any transition required by the State. All State property, tangible and intangible, shall be returned to the State upon demand at no additional cost to the State in a format acceptable to the State.

28. Continuity of Performance: In the event of a dispute between the Party and the State, each party will continue to perform its obligations under this Agreement during the resolution of the dispute until this Agreement is terminated in accordance with its terms.

29. No Implied Waiver of Remedies: Either party's delay or failure to exercise any right, power or remedy under this Agreement shall not impair any such right, power or remedy, or be construed as a waiver of any such right, power or remedy.

All waivers must be in writing.

30. State Facilities: If the State makes space available to the Party in any State facility during the term of this Agreement for purposes of the Party's performance under this Agreement, the Party shall only use the space in accordance with all policies and procedures governing access to and use of State facilities which shall be made available upon request. State facilities will be made available to Party on an "AS IS, WHERE IS" basis, with no warranties whatsoever.

31. Requirements Pertaining Only to Federal Grants and Subrecipient Agreements: If this Agreement is a grant that is funded in whole or in part by Federal funds:

A. Requirement to Have a Single Audit: 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.

B. Internal Controls: 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).

C. Mandatory Disclosures: In accordance with 2 CFR 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.

32. Requirements Pertaining Only to State-Funded Grants:

A. Certification Regarding Use of State Funds: If 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.

B. Good Standing Certification (Act 154 of 2016): If this Agreement is a State-funded grant, Party hereby represents: (i) that it has signed and provided to the State the form prescribed by the Secretary of Administration for purposes of certifying that it is in good standing (as provided in Section 13(a)(2) of Act 154) with the Agency of Natural Resources and the Agency of Agriculture, Food and Markets, or otherwise explaining the circumstances surrounding the inability to so certify, and (ii) that it will comply with the requirements stated therein.

(End of Standard Provisions)

ATTACHMENT D
MODIFICATION OF CUSTOMARY PROVISIONS
OF
ATTACHMENT C OR ATTACHMENT F (Restated)

1. **The insurance requirements contained in Attachment C, Section 8 are amended to add:**
   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 *$2,000,000* per occurrence, and *$6,000,000* aggregate.

2. **Requirements of other Sections in Attachment C are hereby modified:**
   Sections 17, 18, and 27 B. are hereby deleted.

   The terms "Subcontract" and "Subcontractor" shall have the same meaning as defined in Attachment A to this Contract.

3. **Requirements of Sections in Attachment F are hereby modified:**
   a. Contractor agrees to the provisions of 45 CFR § 95.617 governing intellectual property ownership. Without restating the regulation, DVHA has all rights in software or modifications associated for any software designed developed or installed with federal financial participation as works for hire. However, it has no rights in proprietary software or its modification.

   b. The terms "Subcontract" and "Subcontractor" shall have the same meaning as defined in Attachment A to this Contract.

4. **Additional Modifications**
   a. Contractor shall comply with all provisions of the Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Vermont Medicare ACO Initiative within the Vermont All Payer Model dated December 20, 2018(the "Federal Waiver").

      Nothing in this Contract shall limit the State of Vermont's right to establish Vermont specific conditions related to fraud and abuse for participation in this ACO Program that differ from, or are in addition to, the conditions set forth by CMS in the Federal Waiver. Vermont shall provide Contractor with written notice of any Vermont specific conditions related to the fraud and abuse waivers in writing 90 days prior to their effect.

      The State of Vermont does not intend to prohibit conduct that would be permissible under the Federal Waiver and agrees that conduct and arrangments that are permissible under the Federal Waiver are not inconsistent with State law. The State agrees that it does not view the applicable State fraud and abuse laws as restricting conduct that is permitted under federal law, and, to the extent Contractor and its network act consistently with the Federal Waiver, Contractor has not violated State law in so doing. Robust Program Integrity functions have been agreed to by Contractor in Section 11 of Attachment A. Moreover, the Parties agree that DVHA will continue to perform its Program Integrity functions of Contractor providers as provided by law. Nothing in this Contract shall preclude the State of Vermont from enforcing fraud and abuse laws for behavior that is inconsistent with, or outside the scope of, the Federal Waiver.

5. **Reasons for Modifications:**
   Modifications under section one are to comply with the terms of the contract, those under section 2 are not necessary because Contractor is a Corporate entity, those under section 3 are required for conformity with Federal law.

ATTACHMENT E
BUSINESS ASSOCIATE AGREEMENT

SOV CONTRACTOR: ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION

SOV CONTRACT NO. 32318 **CONTRACT EFFECTIVE DATE:** JANUARY 1, 2017

This Business Associate Agreement ("Agreement"), effective April 1, 2020 ("Effective Date"), is entered into by and between the State of Vermont Agency of Human Services, operating by and through its Department of Vermont Health Access ("Covered Entity") and Party identified in this Agreement as Contractor or Grantee above **("**Business Associate"). This Agreement supplements and is made a part of the contract ("Contract") to which it is attached.

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

The parties agree as follows:

1. Definitions. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations. Terms defined in this Agreement are italicized. Unless otherwise specified, when used in this Agreement, defined terms used in the singular shall be understood if appropriate in their context to include the plural when applicable.

"*Agent*" means an Individual acting within the scope of the agency of the *Business Associate*, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c) and includes Workforce members and *Subcontractors*.

"*Breach*" means the acquisition, Access, Use or Disclosure of *Protected Health Information* (*PHI*) which compromises the Security or privacy of the *PHI*, except as excluded in the definition of *Breach* in 45 CFR § 164.402.

"*Business Associate*" shall have the meaning given for "Business Associate" in 45 CFR § 160.103 and means Contractor or Grantee and includes its Workforce, *Agents* and *Subcontractors*.

"*Electronic PHI*" shall mean *PHI* created, received, maintained or transmitted electronically in accordance with 45 CFR § 160.103.

"*Individual*" includes a Person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"*Protected Health Information*" ("*PHI*") shall have the meaning given in 45 CFR § 160.103, limited to the *PHI* created or received by *Business Associate* from or on behalf of Covered Entity.

"*Required by Law*" means a mandate contained in law that compels an entity to make a use or disclosure of *PHI* and that is enforceable in a court of law and shall have the meaning given in 45 CFR § 164.103.

"*Report*" means submissions required by this Agreement as provided in section 2.3.

"*Security Incident*" means the attempted or successful unauthorized Access, Use, Disclosure, modification, or destruction of Information or interference with system operations in an Information System relating to *PHI* in accordance with 45 CFR § 164.304.

"*Services*" includes all work performed by the *Business Associate* for or on behalf of Covered Entity that requires the Use and/or Disclosure of *PHI* to perform a *Business Associate* function described in 45 CFR § 160.103.

"*Subcontractor*" means a Person to whom *Business Associate* delegates a function, activity, or service, other than in the

capacity of a member of the workforce of such *Business Associate*.

"*Successful Security Incident*" shall mean a *Security Incident* that results in the unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

"*Unsuccessful Security Incident*" shall mean a *Security Incident* such as routine occurrences that do not result in unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System, such as: (i) unsuccessful attempts to penetrate computer networks or services maintained by *Business Associate*; and (ii) immaterial incidents such as pings and other broadcast attacks on *Business Associate's* firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above with respect to *Business Associate's* Information System.

"*Targeted Unsuccessful Security Incident*" means an *Unsuccessful Security Incident* that appears to be an attempt to obtain unauthorized Access, Use, Disclosure, modification or destruction of the Covered Entity's *Electronic PHI*.

2. Contact Information for Privacy and Security Officers and Reports.

2.1 *Business Associate* shall provide, within ten (10) days of the execution of this Agreement, written notice to the Contract or Grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer of the *Business Associate*. This information must be updated by *Business Associate* any time these contacts change.

2.2 Covered Entity's HIPAA Privacy Officer and HIPAA Security Officer contact information is posted at: https://humanservices.vermont.gov/rules-policies/health-insurance-portability-and-accountability-act-hipaa

2.3 *Business Associate* shall submit all *Reports* required by this Agreement to the following email address: AHS.PrivacyAndSecurity@vermont.gov

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Subject to the terms in this Agreement, *Business Associate* may Use or Disclose *PHI* to perform *Services*, as specified in the Contract or Grant. Such Uses and Disclosures are limited to the minimum necessary to provide the *Services*. *Business Associate* shall not Use or Disclose *PHI* in any manner that would constitute a violation of the Privacy Rule if Used or Disclosed by Covered Entity in that manner. *Business Associate* may not Use or Disclose *PHI* other than as permitted or required by this Agreement or as *Required by Law* and only in compliance with applicable laws and regulations.

3.2 *Business Associate* may make *PHI* available to its Workforce, *Agent* and *Subcontractor* who need Access to perform *Services* as permitted by this Agreement, provided that *Business Associate* makes them aware of the Use and Disclosure restrictions in this Agreement and binds them to comply with such restrictions.

3.3 *Business Associate* shall be directly liable under HIPAA for impermissible Uses and Disclosures of *PHI*.

4. Business Activities. *Business Associate* may Use *PHI* if necessary for *Business Associate's* proper management and administration or to carry out its legal responsibilities. *Business Associate* may Disclose *PHI* for *Business Associate's* proper management and administration or to carry out its legal responsibilities if a Disclosure is *Required by Law* or if *Business Associate* obtains reasonable written assurances via a written agreement from the Person to whom the information is to be Disclosed that such *PHI* shall remain confidential and be Used or further Disclosed only as *Required by Law* or for the purpose for which it was Disclosed to the Person, and the Agreement requires the Person to notify *Business Associate*, within five (5) business days, in writing of any *Breach* of Unsecured *PHI* of which it is aware. Such Uses and Disclosures of *PHI* must be of the minimum amount necessary to accomplish such purposes.

5. Electronic PHI Security Rule Obligations.

5.1 With respect to *Electronic PHI*, *Business Associate* shall:

a) Implement and use Administrative, Physical, and Technical Safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312;

b) Identify in writing upon request from Covered Entity all the safeguards that it uses to protect such Electronic PHI;

c) Prior to any Use or Disclosure of *Electronic PHI* by an *Agent* or *Subcontractor*, ensure that any *Agent* or

Subcontractor to whom it provides *Electronic PHI* agrees in writing to implement and use Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of Electronic PHI. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the Use or Disclosure of *Electronic PHI*, and be provided to Covered Entity upon request;

d) Report in writing to Covered Entity any *Successful Security Incident* or *Targeted Security Incident* as soon as it becomes aware of such incident and in no event later than five (5) business days after such awareness. Such report shall be timely made notwithstanding the fact that little information may be known at the time of the report and need only include such information then available;

e) Following such report, provide Covered Entity with the information necessary for Covered Entity to investigate any such incident; and

f) Continue to provide to Covered Entity information concerning the incident as it becomes available to it.

5.2 Reporting *Unsuccessful Security Incidents. Business Associate* shall provide Covered Entity upon written request a *Report* that: (a) identifies the categories of Unsuccessful Security Incidents; (b) indicates whether *Business Associate* believes its current defensive security measures are adequate to address all Unsuccessful Security Incidents, given the scope and nature of such attempts; and (c) if the security measures are not adequate, the measures *Business Associate* will implement to address the security inadequacies.

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

6. <u>Reporting and Documenting Breaches</u>.

6.1 *Business Associate* shall *Report* to Covered Entity any *Breach* of Unsecured *PHI* as soon as it, or any Person to whom *PHI* is disclosed under this Agreement, becomes aware of any such *Breach*, and in no event later than five (5) business days after such awareness, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Such *Report* shall be timely made notwithstanding the fact that little information may be known at the time of the *Report* and need only include such information then available.

6.2 Following the *Report* described in 6.1, *Business Associate* shall conduct a risk assessment and provide it to Covered Entity with a summary of the event. *Business Associate* shall provide Covered Entity with the names of any *Individual* whose Unsecured *PHI* has been, or is reasonably believed to have been, the subject of the *Breach* and any other available information that is required to be given to the affected *Individual*, as set forth in 45 CFR § 164.404(c). Upon request by Covered Entity, *Business Associate* shall provide information necessary for Covered Entity to investigate the impermissible Use or Disclosure. *Business Associate* shall continue to provide to Covered Entity information concerning the *Breach* as it becomes available.

6.3 When *Business Associate* determines that an impermissible acquisition, Access, Use or Disclosure of *PHI* for which it is responsible is not a *Breach*, and therefore does not necessitate notice to the impacted *Individual*, it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). *Business Associate* shall make its risk assessment available to Covered Entity upon request. It shall include 1) the name of the person making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the *PHI* had been compromised.

7. <u>Mitigation and Corrective Action.</u> *Business Associate* shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible Use or Disclosure of *PHI*, even if the impermissible Use or Disclosure does not constitute a *Breach*. *Business Associate* shall draft and carry out a plan of corrective action to address any incident of impermissible Use or Disclosure of *PHI*. *Business Associate* shall make its mitigation and corrective action plans available to Covered Entity upon request.

8. <u>Providing Notice of Breaches</u>.

8.1 If Covered Entity determines that a *Breach* of *PHI* for which *Business Associate* was responsible, and if requested by Covered Entity, *Business Associate* shall provide notice to the *Individual* whose *PHI* has been the subject of the *Breach*. When so requested, *Business Associate* shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. *Business Associate* shall be responsible for the cost of notice and related remedies.

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

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

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

9. Agreements with Subcontractors. *Business Associate* shall enter into a Business Associate Agreement with any *Subcontractor* to whom it provides *PHI* to require compliance with HIPAA and to ensure *Business Associate* and *Subcontractor* comply with the terms and conditions of this Agreement. *Business Associate* must enter into such written agreement before any Use by or Disclosure of *PHI* to such *Subcontractor*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the Use or Disclosure of *PHI*. *Business Associate* shall provide a copy of the written agreement it enters into with a *Subcontractor* to Covered Entity upon request. *Business Associate* may not make any Disclosure of *PHI* to any *Subcontractor* without prior written consent of Covered Entity.

10. Access to PHI. *Business Associate* shall provide access to *PHI* in a Designated Record Set to Covered Entity or as directed by Covered Entity to an *Individual* to meet the requirements under 45 CFR § 164.524. *Business Associate* shall provide such access in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for Access to *PHI* that *Business Associate* directly receives from an *Individual*.

11. Amendment of PHI. *Business Associate* shall make any amendments to *PHI* in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an *Individual*. *Business Associate* shall make such amendments in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for amendment to *PHI* that *Business Associate* directly receives from an *Individual*.

12. Accounting of Disclosures. *Business Associate* shall document Disclosures of *PHI* and all information related to such Disclosures as would be required for Covered Entity to respond to a request by an *Individual* for an accounting of disclosures of *PHI* in accordance with 45 CFR § 164.528. *Business Associate* shall provide such information to Covered Entity or as directed by Covered Entity to an *Individual*, to permit Covered Entity to respond to an accounting request. *Business Associate* shall provide such information in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any accounting request that *Business Associate* directly receives from an *Individual*.

13. Books and Records. Subject to the attorney-client and other applicable legal privileges, *Business Associate* shall make its internal practices, books, and records (including policies and procedures and *PHI*) relating to the Use and Disclosure of *PHI* available to the Secretary of Health and Human Services (HHS) in the time and manner designated by the Secretary. *Business Associate* shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether *Business Associate* is in compliance with this Agreement.

14. Termination.

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all the *PHI* is destroyed or returned to Covered Entity subject to Section 18.8.

14.2 If *Business Associate* fails to comply with any material term of this Agreement, Covered Entity may provide an opportunity for *Business Associate* to cure. If *Business Associate* does not cure within the time specified by Covered Entity or if Covered Entity believes that cure is not reasonably possible, Covered Entity may immediately terminate the Contract or Grant without incurring liability or penalty for such termination. If neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary of HHS. Covered Entity has the right

to seek to cure such failure by *Business Associate*. Regardless of whether Covered Entity cures, it retains any right or remedy available at law, in equity, or under the Contract or Grant and *Business Associate* retains its responsibility for such failure.

15. Return/Destruction of PHI.

15.1 *Business Associate* in connection with the expiration or termination of the Contract or Grant shall return or destroy, at the discretion of the Covered Entity, *PHI* that *Business Associate* still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. *Business Associate* shall not retain any copies of *PHI*. *Business Associate* shall certify in writing and report to Covered Entity (1) when all *PHI* has been returned or destroyed and (2) that *Business Associate* does not continue to maintain any *PHI*. *Business Associate* is to provide this certification during this thirty (30) day period.

15.2 *Business Associate* shall report to Covered Entity any conditions that *Business Associate* believes make the return or destruction of *PHI* infeasible. *Business Associate* shall extend the protections of this Agreement to such *PHI* and limit further Uses and Disclosures to those purposes that make the return or destruction infeasible for so long as *Business Associate* maintains such *PHI*.

16. Penalties. *Business Associate* understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of *PHI* and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations.

17. Training. *Business Associate* understands its obligation to comply with the law and shall provide appropriate training and education to ensure compliance with this Agreement. If requested by Covered Entity, *Business Associate* shall participate in Covered Entity's training regarding the Use, Confidentiality, and Security of *PHI*; however, participation in such training shall not supplant nor relieve *Business Associate* of its obligations under this Agreement to independently assure compliance with the law and this Agreement.

18. Miscellaneous.

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

18.2 Each party shall cooperate with the other party to amend this Agreement from time to time as is necessary for such party to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA. This Agreement may not be amended, except by a writing signed by all parties hereto.

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

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule, Security Rule, and HITECH) in construing the meaning and effect of this Agreement.

18.5 *Business Associate* shall not have or claim any ownership of *PHI*.

18.6 *Business Associate* shall abide by the terms and conditions of this Agreement with respect to all *PHI* even if some of that information relates to specific services for which *Business Associate* may not be a "*Business Associate*" of Covered Entity under the Privacy Rule.

18.7 *Business Associate* is prohibited from directly or indirectly receiving any remuneration in exchange for an *Individual's PHI*. *Business Associate* will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing *PHI* may not be sold without Covered Entity's or the affected Individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for *Business Associate* to return or destroy *PHI* as provided in Section 14.2 and (b) the obligation of *Business Associate* to provide an accounting of disclosures as set forth in Section 12 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

ATTACHMENT F
AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT/GRANT PROVISIONS

1. **Definitions:** For purposes of this Attachment F, the term "Agreement" shall mean the form of the contract or grant, with all of its parts, into which this Attachment F is incorporated. The meaning of the term "Party" when used in this Attachment F shall mean any named party to this Agreement *other than* the State of Vermont, the Agency of Human Services (AHS) and any of the departments, boards, offices and business units named in this Agreement. As such, the term "Party" shall mean, when used in this Attachment F, Contractor or Grantee with whom the State of Vermont is executing this Agreement. If Party, when permitted to do so under this Agreement, seeks by way of any Subcontract, sub-grant or other form of provider agreement to employ any other person or entity to perform any of the obligations of Party under this Agreement, Party shall be obligated to ensure that all terms of this Attachment F are followed. As such, the term "Party" as used herein shall also be construed as applicable to, and describing the obligations of, any Subcontractor, sub-recipient or sub-grantee of this Agreement. Any such use or construction of the term "Party" shall not, however, give any Subcontractor, sub-recipient or sub-grantee any substantive right in this Agreement without an express written agreement to that effect by the State of Vermont.

2. **Agency of Human Services**: The Agency of Human Services is responsible for overseeing all contracts and grants entered by any of its departments, boards, offices and business units, however denominated. The Agency of Human Services, through the business office of the Office of the Secretary, and through its Field Services Directors, will share with any named AHS-associated party to this Agreement oversight, monitoring and enforcement responsibilities. Party agrees to cooperate with both the named AHS-associated party to this contract and with the Agency of Human Services itself with respect to the resolution of any issues relating to the performance and interpretation of this Agreement, payment matters and legal compliance.

3. **Medicaid Program Parties** (*applicable to any Party providing services and supports paid for under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver*):

   Inspection and Retention of Records: In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u).

   Subcontracting for Medicaid Services: Notwithstanding any permitted subcontracting of services to be performed under this Agreement, Party shall remain responsible for ensuring that this Agreement is fully performed according to its terms, that Subcontractor remains in compliance with the terms hereof, and that Subcontractor complies with all state and federal laws and regulations relating to the Medicaid program in Vermont. Subcontracts, and any service provider agreements entered into by Party in connection with the performance of this Agreement, must clearly specify in writing the responsibilities of the Subcontractor or other service provider and Party must retain the authority to revoke its Subcontract or service provider agreement or to impose other sanctions if the performance of the Subcontractor or service provider is inadequate or if its performance deviates from any requirement of this Agreement. Party shall make available on request all contracts, Subcontracts and service provider agreements between the Party, Subcontractors and other service providers to the Agency of Human Services and any of its departments as well as to the Center for Medicare and Medicaid Services.

   Medicaid Notification of Termination Requirements: Party shall follow the Department of Vermont Health Access Managed-Care-Organization enrollee-notification requirements, to include the requirement that Party provide timely notice of any termination of its practice.

Encounter Data: Party shall provide encounter data to the Agency of Human Services and/or its departments and ensure further that the data and services provided can be linked to and supported by enrollee eligibility files maintained by the State.

Federal Medicaid System Security Requirements Compliance: Party shall provide a security plan, risk assessment, and security controls review document within three months of the start date of this Agreement (and update it annually thereafter) in order to support audit compliance with 45 CFR 95.621 subpart F, *ADP System Security Requirements and Review Process*.

4. **Workplace Violence Prevention and Crisis Response** (*applicable to any Party and any Subcontractors and sub-grantees whose employees or other service providers deliver social or mental health services directly to individual recipients of such services*):

Party shall establish a written workplace violence prevention and crisis response policy meeting the requirements of Act 109 (2016), 33 VSA §8201(b), for the benefit of employees delivering direct social or mental health services. Party shall, in preparing its policy, consult with the guidelines promulgated by the U.S. Occupational Safety and Health Administration for *Preventing Workplace Violence for Healthcare and Social Services Workers*, as those guidelines may from time to time be amended.

Party, through its violence protection and crisis response committee, shall evaluate the efficacy of its policy, and update the policy as appropriate, at least annually. The policy and any written evaluations thereof shall be provided to employees delivering direct social or mental health services.

Party will ensure that any Subcontractor and sub-grantee who hires employees (or contracts with service providers) who deliver social or mental health services directly to individual recipients of such services, complies with all requirements of this Section.

5. **Non-Discrimination**:

Party shall not discriminate, and will prohibit its employees, agents, Subcontractors, sub-grantees and other service providers from discrimination, on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, and on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. Party shall not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity as provided by Title 9 V.S.A. Chapter 139.

No person shall on the grounds of religion or on the grounds of sex (including, on the grounds that a woman is pregnant), be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by State of Vermont and/or federal funds.

Party further shall comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, requiring that contractors and Subcontractors receiving federal funds assure that persons with limited English proficiency can meaningfully access services. To the extent Party provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services, such individuals cannot be required to pay for such services.

6. **Employees and Independent Contractors**:

Party agrees that it shall comply with the laws of the State of Vermont with respect to the appropriate classification of its workers and service providers as "employees" and "independent contractors" for all purposes, to include for purposes related to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party agrees to ensure that all of its Subcontractors or sub-grantees also remain in legal compliance as to the appropriate classification of "workers" and "independent contractors" relating to unemployment compensation

insurance and workers compensation coverage, and proper payment and reporting of wages. Party will on request provide to the Agency of Human Services information pertaining to the classification of its employees to include the basis for the classification. Failure to comply with these obligations may result in termination of this Agreement.

7. **Data Protection and Privacy:**

Protected Health Information: Party shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this Agreement. Party shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

Substance Abuse Treatment Information: Substance abuse treatment information shall be maintained in compliance with 42 C.F.R. Part 2 if the Party or Subcontractor(s) are Part 2 covered programs, or if substance abuse treatment information is received from a Part 2 covered program by the Party or Subcontractor(s).

Protection of Personal Information: Party agrees to comply with all applicable state and federal statutes to assure protection and security of personal information, or of any personally identifiable information (PII), including the Security Breach Notice Act, 9 V.S.A. § 2435, the Social Security Number Protection Act, 9 V.S.A. § 2440, the Document Safe Destruction Act, 9 V.S.A. § 2445 and 45 CFR 155.260. As used here, PII shall include any information, in any medium, including electronic, which can be used to distinguish or trace an individual's identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with any other personal or identifiable information that is linked or linkable to a specific person, such as date and place or birth, mother's maiden name, etc.

Other Confidential Consumer Information: Party agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to and uses of personal information relating to any beneficiary or recipient of goods, services or other forms of support. Party further agrees to comply with any applicable Vermont State Statute and other regulations respecting the right to individual privacy. Party shall ensure that all of its employees, Subcontractors and other service providers performing services under this agreement understand and preserve the sensitive, confidential and non-public nature of information to which they may have access.

Data Breaches: Party shall report to AHS, though its Chief Information Officer (CIO), any impermissible use or disclosure that compromises the security, confidentiality or privacy of any form of protected personal information identified above within 24 hours of the discovery of the breach. Party shall in addition comply with any other data breach notification requirements required under federal or state law.

8. **Abuse and Neglect of Children and Vulnerable Adults:**

Abuse Registry. Party agrees not to employ any individual, to use any volunteer or other service provider, or to otherwise provide reimbursement to any individual who in the performance of services connected with this agreement provides care, custody, treatment, transportation, or supervision to children or to vulnerable adults if there has been a substantiation of abuse or neglect or exploitation involving that individual. Party is responsible for confirming as to each individual having such contact with children or vulnerable adults the non-existence of a substantiated allegation of abuse, neglect or exploitation by verifying that fact though (a) as to vulnerable adults, the Adult Abuse Registry maintained by the Department of Disabilities, Aging and Independent Living and (b) as to children, the Central Child Protection Registry (unless the Party holds a valid child care license or registration from the Division of Child Development, Department for Children and Families). See 33 V.S.A. §4919(a)(3) and 33 V.S.A. §6911(c)(3).

Reporting of Abuse, Neglect, or Exploitation. Consistent with provisions of 33 V.S.A. §4913(a) and §6903, Party and any of its agents or employees who, in the performance of services connected with this agreement, (a) is a caregiver or has any other contact with clients and (b) has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall: as to children, make a report containing the information required by 33 V.S.A. §4914 to the Commissioner of the Department for Children and Families within 24 hours; or, as to a vulnerable adult, make a report containing the information required by 33 V.S.A. §6904 to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. Party will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

9. **Information Technology Systems**:

Computing and Communication: Party shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Party as part of this agreement. Options include, but are not limited to:

1. Party's provision of certified computing equipment, peripherals and mobile devices, on a separate Party's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.

2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

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

Party shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State of Vermont.

If Party is operating a system or application on behalf of the State of Vermont, Party shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Party's materials.

Party acknowledges and agrees that should this agreement be in support of the State's implementation of the Patient Protection and Affordable Care Act of 2010, Party is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Such agreement will be subject to, and incorporates here by reference, 45 CFR 74.36, 45 CFR 92.34 and 45 CFR 95.617 governing rights to intangible property.

Security and Data Transfers: Party shall comply with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Party of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Party to implement any required.

Party will ensure the physical and data security associated with computer equipment, including desktops, notebooks, and other portable devices, used in connection with this Agreement. Party will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. Party will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, Party shall securely delete data (including archival backups) from Party's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

Party, in the event of a data breach, shall comply with the terms of Section 7 above.

10. **Other Provisions**:

Environmental Tobacco Smoke. Public Law 103-227 (also known as the Pro-Children Act of 1994) and Vermont's Act 135 (2014) (An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands) restrict the use of tobacco products in certain settings. Party shall ensure that no person is permitted: (i) to use tobacco products or tobacco substitutes as defined in 7 V.S.A. § 1001 on the premises, both indoor and outdoor, of any licensed child care center or afterschool program at any time; (ii) to use tobacco products or tobacco substitutes on the premises, both indoor and in any outdoor area designated for child care, health or day care services, kindergarten, pre-kindergarten, elementary, or secondary education or library services; and (iii) to use tobacco products or tobacco substitutes on the premises of a licensed or registered family child care home while children are present and in care. Party will refrain from promoting the use of tobacco products for all clients and from making tobacco products available to minors.

Failure to comply with the provisions of the federal law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The federal Pro-Children Act of 1994, however, does not apply to portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

2-1-1 Database: If Party provides health or human services within Vermont, or if Party provides such services near the Vermont border readily accessible to residents of Vermont, Party shall adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211 (Vermont 211), and will provide to Vermont 211 relevant descriptive information regarding its agency, programs and/or contact information as well as accurate and up to date information to its database as requested. The "Inclusion/Exclusion" policy can be found at www.vermont211.org.

Voter Registration: When designated by the Secretary of State, Party agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

Drug Free Workplace Act: Party will assure a drug-free workplace in accordance with 45 CFR Part 76.

Lobbying: No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

AHS ATT. F 5/16/2018

EXHIBIT C

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement					***Not part of OCV Financial Statement - Illustrative for Comparison											
Income Statement	**2016**		**2017**		**2018**			**2019**	**2020 Budget Round 2**	**2018B - 2018P $ Change**	**2018B - 2018P % Change**	**2018B - 2019B $ Change**	**2018B - 2019B % Change**	**2018P - 2019B $ Change**	**2018P - 2019B % Change**
	Budget	**Actual**	**Budget**	**Actual**	**Budget Submitted**	**Budget Approved**	**Projected**	**Budget Submitted**							
Revenues															
Program Target Revenue															
Medicare Modified Next Gen - Basic***	$ -	$ -			$ 347,240,276	$ 347,240,276	$ 366,931,119	$ 460,866,439	$ 526,275,110	$ 19,690,843	5.7%	$ 113,626,163	32.7%	$ 93,935,320	25.6%
Medicare Modified Next Gen - Added	-	-			7,762,500	7,762,500	7,776,760	6,445,980	8,401,660	14,260	0.2%	(1,316,520)	-17.0%	(1,330,780)	-17.1%
Medicaid Next Generation Year 2***	-	-			118,833,295	118,833,295	117,484,110	193,327,432	248,513,292	(1,349,185)	-1.1%	74,494,137	62.7%	75,843,322	64.6%
Medicaid Expanded									57,569,236						
BCBSVT - QHP Program***	-	-			133,395,719	133,395,719	100,385,204	124,784,779	100,320,855	(33,010,515)	-24.7%	(8,610,940)	-6.5%	24,399,574	24.3%
MVP QHP									46,728,978						
BCBSVT Primary									225,249,708						
Self-Funded Programs	-	-			-	-	42,711,613	65,289,304	-	42,711,613	#DIV/0!	65,289,304	#DIV/0!	22,577,692	52.9%
Other - (Enter Account Here)	-	-			-	-			-						
Total	-	-	-	-	607,231,790	607,231,790	635,288,806	850,713,934	1,213,058,838	28,057,016	4.6%	243,482,144	40.1%	215,425,128	33.9%
Payer Program Support Revenue															
VHCIP	-	2,091,144	1,200,000	1,500,000	-	-				-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
VMNG PMPM General Revenue	-	-	2,184,000	2,077,783	3,134,352	3,134,352	3,087,729	5,045,917	7,187,634	(46,623)	-1.5%	1,911,565	61.0%	1,958,188	63.4%
VMNG PHM Program Pilot - Complex CC	-	-	1,300,000	1,307,983	2,980,045	2,980,045	2,945,961	5,579,347	-	(34,084)	-1.1%	2,599,302	87.2%	2,633,386	89.4%
Commercial - QHP Program Reform Pilot Support	-	-	-	-	1,000,000	1,000,000	745,326	851,213	1,127,695	(254,674)	-25.5%	(148,787)	-14.9%	105,886	14.2%
Commercial - Self-Funded Programs Revenue	-	-	-	-	-	-		1,361,275	3,161,780	-	#DIV/0!	1,361,275	#DIV/0!	1,361,275	#DIV/0!
Primary Prevention Revenue	-	-	-	-	1,500,000	1,500,000		1,000,000	-	(1,500,000)	-100.0%	(500,000)	-33.3%	1,000,000	#DIV/0!
OUD Investment Revenue	-	-	-	-	-	-		1,200,000	-	-	#DIV/0!	1,200,000	#DIV/0!	1,200,000	#DIV/0!
UVMMC Self-Funded Pilot Revenue	-	-	-	-	1,075,896	1,075,896	759,139	-	-	(316,757)	-29.4%	(1,075,896)	-100.0%	(759,139)	-100.0%
CMMI Revenue			2,000,000	1,999,548	-	-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Value Based Incentive Fund			-	412,070	-	-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other - (Enter Account Here)	-	-	-	-	-	-		-	-						
Other - (Enter Account Here)	-	-	-	-	-	-		-	-						
Total	-	2,091,144	6,684,000	7,297,384	9,690,293	9,690,293	7,538,156	15,037,751	11,477,109	(2,152,137)	-22.2%	5,347,458	55.2%	7,499,595	99.5%
State HIT Support															
Informatics Infrastructure Support	-	-	1,500,000	1,500,000	3,500,000	3,500,000	3,500,000	4,250,000	2,800,000	(0)	0.0%	750,000	21.4%	750,000	21.4%
Other - (Enter Account Here)	-	-	-	-	-	-		-	-	-					
Other - (Enter Account Here)	-	-	-	-	-	-		-	-	-					
Total	-	-	1,500,000	1,500,000	3,500,000	3,500,000	3,500,000	4,250,000	2,800,000	(0)	0.0%	750,000	21.4%	750,000	21.4%
Grant Revenue															
Robert Wood Johnson	-	-	124,443	-	51,851	51,851	51,851	-	75,000	-	0.0%	(51,851)	-100.0%	(51,851)	-100.0%
Other - (Enter Account Here)	-	-	-	-	-	-		-	-						
Other - (Enter Account Here)	-	-	-	-	-	-		-	-						
Total	-	-	124,443	-	51,851	51,851	51,851	-	75,000	-	0.0%	(51,851)	-100.0%	(51,851)	-100.0%
MSO Revenues															
Adirondack ACO Revenues	-	-	216,000	216,000	216,000	216,000	216,000	-	94,500	-	0.0%	(216,000)	-100.0%	(216,000)	-100.0%
CAC Revenues	-	-	104,000	-	104,000	104,000	139,289	-	146,253	35,289	33.9%	(104,000)	-100.0%	(139,289)	-100.0%
Other - (Enter Account Here)	-	-	-	-	-	-		-	-						
Other - (Enter Account Here)	-	-	-	-	-	-		-	-						
Total	-	-	320,000	216,000	320,000	320,000	355,289	-	240,753	35,289	11.0%	(320,000)	-100.0%	(355,289)	-100.0%
Other Revenue															
Member Contributions	-	5,192,955	-	-	-	-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Hospital Participation Fee	-	2,000,000	4,318,597	2,459,389	18,459,071	18,459,071	17,399,336	28,617,281	18,225,772	(1,059,735)	-5.7%	10,158,210	55.0%	11,217,945	64.5%
Bad Debt	-	-	-	-	-	-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Due to DVHA from Hospitals	-	-	-	1,397,134	-	-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other Revenue	-	-	-	600	-	-		-	1,513,321	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
UVMMC Funding	-	-	-	-	-	-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
DHH Funding	-	-	-	-		-		-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Delivery System Reform Funding	-	-	-	-	-	-		-	3,900,000						
Fixed Payment Allocation for Care Coordination	-	-	-	-	-	-		-	4,300,000						
Total	-	7,192,955	-	1,397,734	18,459,071	18,459,071	17,399,336	28,617,281	27,939,093	(1,059,735)	-5.7%	10,158,210	55.0%	11,217,945	64.5%
Total Revenues	-	9,284,099	8,628,443	10,411,118	639,253,005	639,253,005	664,133,437	898,618,967	1,255,590,792	24,880,432	3.9%	259,365,962	40.6%	234,485,529	35.3%

Income Statement	2016 Budget	2016 Actual	2017 Budget	2017 Actual	2018 Budget Submitted	2018 Budget Approved	2018 Projected	2019 Budget Submitted	2020 Budget Round 2	2018B - 2018P $ Change	2018B - 2018P % Change	2018B - 2019B $ Change	2018B - 2019B % Change	2018P - 2019B $ Change	2018P - 2019B % Change
Expenses															
Health Services Spending		-													
Payer-Paid FFS***		-			228,417,540	228,417,540	401,383,842	517,906,948	811,574,481	172,966,302	75.7%	289,489,408	126.7%	116,523,106	29.0%
OneCare Hospital Payments***		-			371,051,749	371,051,749	213,615,912	313,676,394	393,082,697	(157,435,837)	-42.4%	(57,375,355)	-15.5%	100,060,482	46.8%
Expected Spending Under (Over) Claims Target****		-			-	-	12,512,293	11,073,117	-	12,512,293	#DIV/0!	11,073,117	#DIV/0!	(1,439,175)	-11.5%
Other - (Enter Account Here)		-			-	-		-	-						
Total	-	-	-	-	599,469,289	599,469,289	627,512,046	842,656,459	1,204,657,178	28,042,757	4.7%	243,187,170	40.6%	215,144,413	34.3%
Operational Expenses															
Salaries and Benefits	6,051,827	5,299,659	5,839,224	4,922,769	6,583,992	6,583,992	6,985,570	8,868,076	8,352,999	401,578	6.1%	2,284,084	34.7%	1,882,506	26.9%
Contracted Services	845,002	722,060	2,953,115	2,568,450	817,507	817,507	629,078	2,163,124	1,521,813	(188,429)	-23.0%	1,345,617	164.6%	1,534,046	243.9%
Software	-	-	-	-	-	-	-	3,163,190	3,631,889	-	#DIV/0!	3,163,190	#DIV/0!	3,163,190	#DIV/0!
Insurance	-	-	-	-	-	-	-	84,531	118,859	-	#DIV/0!	84,531	#DIV/0!	84,531	#DIV/0!
Supplies	-	-	-	-	-	-	-	152,414	195,330	-	#DIV/0!	152,414	#DIV/0!	152,414	#DIV/0!
Travel			-	-	-	-	-	138,245	66,750	-	#DIV/0!	138,245	#DIV/0!	138,245	#DIV/0!
Occupancy			-	-	-	-	-	393,439	431,389	-	#DIV/0!	393,439	#DIV/0!	393,439	#DIV/0!
Other Expenses			-	-	-	-	-	184,337	597,452	-	#DIV/0!	184,337	#DIV/0!	184,337	#DIV/0!
Purchased Services	-	-	978,250	847,440	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
General Office Expenses (Rent, Office Supplies, IT, Mainter	2,726,528	3,262,381	784,451	692,279	3,591,161	3,591,161	3,122,418	-	-	(468,743)	-13.1%	(3,591,161)	-100.0%	(3,122,418)	-100.0%
Reinsurance / Risk Protection	-	-	-	-	1,500,000	1,500,000	660,000	767,833	-	(840,000)	-56.0%	(732,167)	-48.8%	107,833	16.3%
Total	9,623,357	9,284,100	10,555,040	9,030,938	12,492,660	12,492,660	11,397,065	15,915,189	14,916,480	(1,095,595)	-8.8%	3,422,529	27.4%	4,518,124	39.6%
PHM/Payment Reform Programs															
Basic OCV PMPM	-	-	1,092,000	1,038,892	4,781,010	4,781,010	4,063,692	5,935,530	8,420,662	(717,318)	-15.0%	1,154,520	24.1%	1,871,838	46.1%
Complex Care Coordination Program	-	-	1,300,000	977,616	7,064,722	7,064,722	5,748,492	9,181,362	9,672,306	(1,316,230)	-18.6%	2,116,640	30.0%	3,432,871	59.7%
Value-Based Incentive Fund	-	-	-	412,070	4,305,223	4,305,223	4,250,704	7,537,231	5,640,553	(54,519)	-1.3%	3,232,008	75.1%	3,286,527	77.3%
Comprehensive Payment Reform Program	-	-	-	-	1,800,000	1,800,000	711,493	2,250,000	1,178,196	(1,088,507)	-60.5%	450,000	25.0%	1,538,507	216.2%
Primary Prevention	300,000	-	-	-	1,577,600	1,577,600	469,429	910,720	540,000	(1,108,171)	-70.2%	(666,880)	-42.3%	441,291	94.0%
Specialist Program Pilot	-	-	-	-	-	-	-	2,000,000	754,800	-	#DIV/0!	2,000,000	#DIV/0!	2,000,000	#DIV/0!
Innovation Fund	-	-	-	-	-	-	-	1,000,000	725,521	-	#DIV/0!	1,000,000	#DIV/0!	1,000,000	#DIV/0!
RCRs	-	-	-	-	-	-	-	375,000	-	-	#DIV/0!	375,000	#DIV/0!	375,000	#DIV/0!
PCMH Legacy Payments	-	-	-	-	1,973,649	1,973,649	1,830,264	1,830,264	1,993,092	(143,385)	-7.3%	(143,385)	-7.3%	-	0.0%
CHT Block Payment	-	-	-	-	2,518,898	2,518,898	2,245,853	2,411,679	2,440,322	(273,045)	-10.8%	(107,219)	-4.3%	165,827	7.4%
SASH	-	-	-	13,857	3,269,954	3,269,954	3,704,400	3,815,532	3,968,246	434,446	13.3%	545,578	16.7%	111,132	3.0%
Due to DVHA from OCV	-	-	-	1,397,134	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Primary Care Case Management	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other Reform Initiatives	-	-	-	-	-	-	-	-	683,437						
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-						
Total	300,000	-	2,392,000	3,839,569	27,291,056	27,291,056	23,024,326	37,247,319	36,017,134	(4,266,730)	-15.6%	9,956,263	36.5%	14,222,993	61.8%
Total Expenses	9,923,357	9,284,100	12,947,040	12,870,507	639,253,005	639,253,005	661,933,437	895,818,967	1,255,590,792	22,680,432	3.5%	256,565,962	40.1%	233,885,529	35.3%
Net Income	**$ (9,923,357.00)**	**$ (1)**	**$ (4,318,597.00)**	**$ (2,459,389.00)**	**$ -**	**$ -**	**$ 2,200,000**	**$ 2,800,000**	**$ -**	**$ 2,200,000**	**#DIV/0!**	**$ 2,800,000**	**#DIV/0!**	**$ 600,000**	**27.3%**
Other Reportables						0.7%									
FTEs		40.30		42.75	49.50	49 50	46.05	62.63	67.25	-3.45	-7.0%	13.13	26.5%	16 58	36.0%
Monitoring Items*															
Administrative (Operating) Expense Ratio+					1.95%	1 95%	1.72%	1.77%							
PHM/Payment Reform (less MC SASH & Bpt)/Revenues					3.1%	3.1%	2.3%	4.14%							
Operating Margin					0.0%	0.0%	0.3%	0.3%							
Total Margin					0.0%	0.0%	0.3%	0.3%							

*Will self-calculate with conditional formatting

**** Does not factor in risk corridor limits or upside/downside arrangement adjustments; Excludes Medicare advanced shared savings

+Administrative Expense Ratio is calculated as Total Operating Expenses (row 84) divided by Total Revenues (row 62)

Observations:

Questions:

EXHIBIT D

Part 6. ACO Financial Plan - Appendix 6.2: Income Statement										***Not part of OCV Financial Statement - Illustrative for Comparison							
									(288,361.00)								
Income Statement	**2016**		**2017**		**2018**		**2019**		**2020 ~**			**2021**					
	Budget	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Actual ^**	**Budget Submitted**	**Budget Approved**	**Projected**	**Budget Submitted**	**2020B - 2020P $ Change**	**2020B - 2020P % Change**	**2020B - 2021B $ Change**	**2020B - 2021B % Change**	**2020P - 2021B $ Change**	**2020P - 2021B % Change**
Revenues																		
Program Target Revenue																		
Medicare - Claims	$ -	$ -	$ -	$ -	$ 347,240,276	$ 377,155,427	$ 460,866,439	$ 481,955,464	$ 526,275,110	$ 526,275,110	$ 526,275,110	$ 645,122,160	$ -	0.0%	$ 118,847,051	22.6%	$ 118,847,051	22.6%
Medicare - Shared Savings Carryforward	$ -	$ -	$ -	$ -	$ 7,762,500	$ 7,776,760	$ 6,445,980	$ 13,854,249	$ 8,401,660	$ 8,401,660	$ 8,401,660	$ 8,401,660	$ -	0.0%	$ -	0.0%	$ -	0.0%
Medicaid	$ -	$ -	$ -	$ -	$ 118,833,295	$ 117,249,629	$ 193,327,432	$ 199,215,952	$ 306,082,527	$ 306,082,527	$ 306,082,527	$ 322,522,714	$ -	0.0%	$ 16,440,187	5.4%	$ 16,440,187	5.4%
Commercial - QHP ^^^	$ -	$ -	$ -	$ -	$ 133,395,719	$ 103,251,399	$ 124,784,779	$ 104,830,235	$ 147,049,832	$ 147,049,832	$ 147,253,404	$ 184,821,171	$ 203,572	0.1%	$ 37,771,338	25.7%	$ 37,567,766	25.5%
Commercial - Self-Funded	$ -	$ -	$ -	$ -	$ -	$ -	$ 65,289,304	$ 48,307,035	$ 225,249,708	$ 225,249,708	$ 154,404,896	$ 259,869,615	$ (70,844,813)	-31.5%	$ 34,619,906	15.4%	$ 105,464,719	68.3%
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -						
Total	$ -	$ -	$ -	$ -	$ 607,231,790	$ 605,433,215	$ 850,713,934	$ 848,162,935	$ 1,213,058,838	$ 1,213,058,838	$ 1,142,417,597	$ 1,420,737,319	$ (70,641,241)	-5.8%	$ 207,678,482	17.1%	$ 278,319,722	24.4%
Payer Program Support Revenue																		
VHCIP	$ -	$ 2,091,144	$ 1,200,000	$ 1,500,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
VMNG PMPM General Revenue	$ -	$ -	$ 2,184,000	$ 2,077,783	$ 3,134,352	$ 3,084,621	$ 5,045,917	$ 5,395,629	$ 7,187,634	$ 7,187,634	$ 7,187,634	$ 7,451,403	$ -	0.0%	$ 263,769	3.7%	$ 263,769	3.7%
VMNG PHM Program Pilot - Complex CC	$ -	$ -	$ 1,300,000	$ 1,307,983	$ 2,980,045	$ 2,901,190	$ 5,579,347	$ 5,500,000	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Commercial - QHP Program Reform Pilot Support	$ -	$ -	$ -	$ -	$ 1,000,000	$ 743,600	$ 851,213	$ 702,465	$ 1,127,695	$ 1,127,695	$ 1,129,467	$ 1,177,310	$ 1,773	0.2%	$ 49,615	4.4%	$ 47,843	4.2%
Commercial - Self-Funded Programs Revenue	$ -	$ -	$ -	$ -	$ -	$ 750,972	$ 1,361,275	$ 1,243,648	$ 3,161,780	$ 3,161,780	$ 3,445,325	$ 3,445,325	$ 283,546	9.0%	$ 283,546	9.0%	$ -	0.0%
Primary Prevention Revenue	$ -	$ -	$ -	$ -	$ 1,500,000	$ -	$ 1,000,000	$ 1,100,000	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
OUD Investment Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,200,000	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
UVMMC Self-Funded Pilot Revenue	$ -	$ -	$ -	$ -	$ 1,075,896	$ -	$ -	$ 372,457	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
CMMI Revenue	$ -	$ -	$ 2,000,000	$ 1,999,548	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Value Based Incentive Fund	$ -	$ -	$ -	$ 412,070	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
BCBSVT Primary Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ -	$ 2,091,144	$ 6,684,000	$ 7,297,384	$ 9,690,293	$ 7,480,382	$ 15,037,751	$ 14,314,198	$ 11,477,109	$ 11,477,109	$ 11,762,427	$ 12,074,039	$ 285,318	2.5%	$ 596,930	5.2%	$ 311,612	2.6%
State Support																		
Informatics Infrastructure Support	$ -	$ -	$ 1,500,000	$ 1,500,000	$ 3,500,000	$ 3,500,000	$ 4,250,000	$ 4,250,000	$ 2,800,000	$ 2,800,000	$ 2,800,000	$ -	$ -	0.0%	$ (2,800,000)	-100.0%	$ (2,800,000)	-100.0%
Delivery System Reform	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,900,000	$ 3,900,000	$ 3,900,000	$ 3,900,000	$ -	0.0%	$ -	0.0%	$ -	0.0%
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ -	$ -	$ 1,500,000	$ 1,500,000	$ 3,500,000	$ 3,500,000	$ 4,250,000	$ 4,250,000	$ 6,700,000	$ 6,700,000	$ 6,700,000	$ 3,900,000	$ -	0.0%	$ (2,800,000)	-41.8%	$ (2,800,000)	-41.8%
Grant Revenue																		
Robert Wood Johnson	$ -	$ -	$ 124,443	$ -	$ 51,851	$ -	$ -	$ 29,242	$ 75,000	$ 75,000	$ 75,000	$ 75,000	$ -	0.0%	$ -	0.0%	$ -	0.0%
Vermont Department of Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 40,000		#DIV/0!	$ 40,000	#DIV/0!	$ 40,000	#DIV/0!
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ -	$ -	$ 124,443	$ -	$ 51,851	$ -	$ -	$ 29,242	$ 75,000	$ 75,000	$ 75,000	$ 115,000	$ -	0.0%	$ 40,000	53.3%	$ 40,000	53.3%
MSO Revenues																		
Adirondack ACO Revenues	$ -	$ -	$ 216,000	$ 216,000	$ 216,000	$ 216,000	$ -	$ 216,000	$ 94,500	$ 94,500	$ 94,500	$ -	$ -	0.0%	$ (94,500)	-100.0%	$ (94,500)	-100.0%
CAC Revenues	$ -	$ -	$ 104,000	$ -	$ 104,000	$ -	$ -	$ 139,289	$ 146,253	$ 146,253	$ 146,253	$ 149,178	$ -	0.0%	$ 2,925	2.0%	$ 2,925	2.0%
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ -	$ -	$ 320,000	$ 216,000	$ 320,000	$ 216,000	$ -	$ 355,289	$ 240,753	$ 240,753	$ 240,753	$ 149,178	$ -	0.0%	$ (91,575)	-38.0%	$ (91,575)	-38.0%
Other Revenue																		
Member Contributions	$ 5,833,357	$ 5,192,956	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Hospital Dues	$ 2,000,000	$ 2,000,000	$ 4,318,597	$ 2,459,389	$ 18,459,071	$ 17,399,336	$ 28,617,281	$ 25,428,461	$ 18,225,772	$ 18,225,772	$ 17,629,773	$ 14,935,770	$ (595,998)	-3.3%	$ (3,290,002)	-18.1%	$ (2,694,004)	-15.3%
Blueprint Self-Management Contract	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 861,000	$ -	#DIV/0!	$ 861,000	#DIV/0!	$ 861,000	#DIV/0!
Deferred Dues	$ -	$ -	$ -	$ 1,397,134	$ -	$ -	$ -	$ -	$ 1,480,321	$ 1,480,321	$ 1,480,321	$ 2,400,036	$ -	0.0%	$ 919,715	62.1%	$ 919,715	62.1%
Deferred VBIF	$ -	$ -	$ -	$ 600	$ -	$ 282,516	$ -	$ 27,000	$ 33,000	$ 33,000	$ 33,000	$ 74,000	$ -	0.0%	$ 41,000	124.2%	$ 41,000	124.2%
UVMMC Funding	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 306,142	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Grant Revenue	$ 2,090,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ -	#DIV/0!	$ -	#DIV/0!
Settlement Income - Payers	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,059,786	$ -	$ -	$ -	$ -			$ -	#DIV/0!	$ -	#DIV/0!
Settlement Income - Network	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,269,273	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Fixed Payment Allocation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,300,000	$ 4,300,000	$ 4,300,000	$ 3,780,835						
Total	$ 9,923,357	$ 7,192,956	$ 4,318,597	$ 3,857,123	$ 18,459,071	$ 17,681,853	$ 28,617,281	$ 44,090,662	$ 24,039,093	$ 24,039,093	$ 23,443,095	$ 22,051,641	$ (595,998)	-2.5%	$ (1,987,452)	-8.3%	$ (1,391,454)	-5.9%

Income Statement	2016		2017		2018		2019		2020 ~			2021	2020B - 2020P		2020B - 2021B		2020P - 2021B	
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual ^	Budget Submitted	Budget Approved	Projected	Budget Submitted	$ Change	% Change	$ Change	% Change	$ Change	% Change
Total Revenues	$ 9,923,357	$ 9,284,100	$ 12,947,040	$ 12,870,507	$ 639,253,005	$ 634,311,450	$ 898,618,967	$ 911,202,326	$ 1,255,590,792	$ 1,255,590,792	$ 1,184,638,872	$ 1,459,027,177	$ (70,951,921)	-5.7%	$ 203,436,385	16.2%	$ 274,388,306	23.2%
Expenses																		
Payer-Paid FFS***	$ -	$ -	$ -	$ -	$ 228,417,540	$ 360,265,990	$ 517,906,948	$ 523,316,746	$ 811,574,481	$ 811,574,481	$ 740,933,240	$ 937,916,841	$ (70,641,241)	-8.7%	$ 126,342,361	15.6%	$ 196,983,601	26.6%
Fixed Prospective Payments	$ -	$ -	$ -	$ -	$ 371,051,749	$ 237,390,466	$ 313,676,394	$ 325,923,374	$ 393,082,697	$ 393,082,697	$ 393,082,697	$ 474,418,818	$ -	0 0%	$ 81,336,121	20.7%	$ 81,336,121	20.7%
Expected Spending Under (Over) Claims Target****	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,073,117	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Settlement Expense - Payers	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,972,874	$ -	$ -	$ -	$ -		#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Settlement Expense - Network	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,623,203	$ -	$ -	$ -	$ -		#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ -	$ -	$ -	$ -	$ 599,469,289	$ 597,656,455	$ 842,656,459	$ 859,836,197	$ 1,204,657,178	$ 1,204,657,178	$ 1,134,015,937	$ 1,412,335,659	$ (70,641,241)	-5 9%	$ 207,678,482	17.2%	$ 278,319,722	24.5%
Operational Expenses																		
Salaries and Benefits	$ 6,051,827	$ 5,299,659	$ 5,839,224	$ 4,922,769	$ 6,583,992	$ 6,600,698	$ 8,868,076	$ 8,232,650	$ 8,352,999	$ 8,352,999	$ 8,341,011	$ 9,823,181	$ (11,988)	-0.1%	$ 1,470,182	17.6%	$ 1,482,170	17.8%
Contracted Services	$ 845,002	$ 722,060	$ 2,953,115	$ 2,568,450	$ 817,507	$ 1,304,899	$ 2,163,124	$ 2,227,949	$ 1,521,813	$ 1,521,813	$ 1,230,312	$ 938,250	$ (291,501)	-19 2%	$ (583,563)	-38.3%	$ (292,062)	-23.7%
Software	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,163,190	$ 2,600,557	$ 3,631,889	$ 3,631,889	$ 3,501,974	$ 3,578,979	$ (129,915)	-3.6%	$ (52,910)	-1.5%	$ 77,005	2.2%
Insurance/Risk Protection	$ -	$ -	$ -	$ -	$ 1,500,000	$ 785,018	$ 84,531	$ 89,667	$ 118,859	$ 118,859	$ 118,859	$ 122,425	$ -	0 0%	$ 3,566	3.0%	$ 3,566	3.0%
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ 152,414	$ 315,750	$ 195,330	$ 195,330	$ 120,312	$ 329,209	$ (75,018)	-38.4%	$ 133,879	68.5%	$ 208,897	173.6%
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ 138,245	$ 148,467	$ 89,250	$ 89,250	$ 47,240	$ 63,250	$ (42,010)	-47.1%	$ (26,000)	-29.1%	$ 16,010	33.9%
Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ 393,439	$ 362,957	$ 431,389	$ 431,389	$ 450,065	$ 542,661	$ 18,676	4 3%	$ 111,272	25.8%	$ 92,596	20.6%
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ 184,337	$ 472,446	$ 574,952	$ 574,952	$ 584,803	$ 734,593	$ 9,851	1.7%	$ 159,641	27.8%	$ 149,790	25.6%
Meetings	$ -	$ -	$ 978,250	$ 847,440	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Professional Development	$ 2,726,528	$ 3,262,381	$ 784,451	$ 692,279	$ 3,591,161	$ 2,976,510	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Reinsurance / Risk Protection	$ -	$ -	$ -	$ -	$ -	$ -	$ 767,833	$ 916,050	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ 9,623,357	$ 9,284,100	$ 10,555,040	$ 9,030,938	$ 12,492,660	$ 11,667,125	$ 15,915,189	$ 15,366,493	$ 14,916,480	$ 14,916,480	$ 14,394,576	$ 16,132,547	$ (521,904)	-3 5%	$ 1,216,067	8.2%	$ 1,737,971	12.1%
PHM/Payment Reform Programs																		
Basic OCV PMPM	$ -	$ -	$ 1,092,000	$ 1,038,892	$ 4,781,010	$ 4,040,439	$ 5,935,530	$ 6,581,843	$ 8,420,662	$ 8,420,662	$ 8,778,018	$ 9,694,801	$ 357,356	4 2%	$ 1,274,139	15.1%	$ 916,783	10.4%
Complex Care Coordination Program	$ -	$ -	$ 1,300,000	$ 977,616	$ 7,064,722	$ 5,618,420	$ 9,181,362	$ 9,186,729	$ 9,672,306	$ 9,672,306	$ 9,672,510	$ 7,275,652	$ 204	0 0%	$ (2,396,654)	-24.8%	$ (2,396,858)	-24.8%
Value-Based Incentive Fund - Total	$ -	$ -	$ -	$ 412,070	$ 4,305,223	$ 4,243,973	$ 7,537,231	$ 6,224,607	$ 5,640,553	$ 5,640,553	$ 5,566,458	$ 2,000,000	$ (74,094)	-1 3%	$ (3,640,553)	-64.5%	$ (3,566,458)	-64.1%
Comprehensive Payment Reform Program	$ -	$ -	$ -	$ -	$ 1,800,000	$ 715,806	$ 2,250,000	$ 1,338,005	$ 1,192,196	$ 1,192,196	$ 1,192,196	$ 1,200,000	$ -	0 0%	$ 7,804	0.7%	$ 7,804	0.7%
Primary Prevention	$ 300,000	$ -	$ -	$ -	$ 1,577,600	$ 620,381	$ 910,720	$ 727,627	$ 540,000	$ 540,000	$ 540,000	$ 950,000	$ -	0 0%	$ 410,000	75.9%	$ 410,000	75.9%
Specialist Program	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,000,000	$ 139,240	$ 754,800	$ 754,800	$ 754,800	$ 65,777	$ -	0 0%	$ (689,023)	-91.3%	$ (689,023)	-91.3%
Innovation Fund	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,000,000	$ 351,818	$ 725,521	$ 725,521	$ 725,521	$ 239,320	$ -	0 0%	$ (486,201)	-67.0%	$ (486,201)	-67.0%
RCRs	$ -	$ -	$ -	$ -	$ -	$ -	$ 375,000	$ 325,000	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
VBIF Quality Initiatives	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,000	$ 33,000	$ 33,000	$ 33,000	$ 74,000	$ -	0 0%	$ 41,000	124.2%	$ 41,000	124.2%
PCMH Payments	$ -	$ -	$ -	$ -	$ 1,973,649	$ 1,830,264	$ 1,830,264	$ 1,865,619	$ 1,993,092	$ 1,993,092	$ 1,993,092	$ 1,993,092	$ -	0 0%	$ -	0.0%	$ -	0.0%
Community Health Team Payments	$ -	$ -	$ -	$ -	$ 2,518,898	$ 2,245,852	$ 2,411,679	$ 2,321,670	$ 2,440,322	$ 2,440,322	$ 2,440,322	$ 2,440,322	$ -	0 0%	$ -	0.0%	$ -	0.0%
SASH	$ -	$ -	$ -	$ 13,857	$ 3,269,954	$ 3,704,400	$ 3,815,532	$ 3,834,054	$ 3,968,246	$ 3,968,246	$ 3,968,246	$ 3,968,246	$ -	0 0%	$ -	0.0%	$ -	0.0%
Primary Care Engagement Investment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 636,436	$ 636,436	$ 564,194	$ 657,760	$ (72,242)	-11.4%	$ 21,324	3.4%	$ 93,566	16.6%
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Other - (Enter Account Here)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!	$ -	#DIV/0!	$ -	#DIV/0!
Total	$ 300,000	$ -	$ 2,392,000	$ 2,442,435	$ 27,291,056	$ 23,019,535	$ 37,247,319	$ 32,923,212	$ 36,017,134	$ 36,017,134	$ 36,228,358	$ 30,558,970	$ 211,224	0.6%	$ (5,458,164)	-15.2%	$ (5,669,388)	-15.6%
Total Expenses	$ 9,923,357	$ 9,284,100	$ 12,947,040	$ 11,473,373	$ 639,253,005	$ 632,343,115	$ 895,818,967	$ 908,125,901	$ 1,255,590,792	$ 1,255,590,792	$ 1,184,638,872	$ 1,459,027,177	$ (70,951,921)	-5.7%	$ 203,436,385	16.2%	$ 274,388,306	23.2%
Net Income	**$ -**	**$ -**	**$ -**	**$ 1,397,134**	**$ -**	**$ 1,968,335**	**$ 2,800,000**	**$ 3,076,425**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**#DIV/0!**	**$ -**	**#DIV/0!**	**$ -**	**#DIV/0!**
Other Reportables																		
FTEs - Prorated for Time of Hire ^^^^	40.30		44.00		49.50	51.00	59 03	59.03	59.03	64.65	5.62	0 0%	5.62	9.5%	5.62	9.5%		
FTEs - Based on Positions							67 25	67.25	67.25	64.65								
Monitoring Items*																		
Administrative (Operating) Expense Ratio+							1.19%	1.19%	1.22%	1.11%								
PHM/Payment Reform (less MC SASH & Bpt)/Revenues							2.5%	2.5%	2.7%	2.1%								
Operating Margin							0.0%	0.0%	0.0%	0.0%								
Total Margin							0.0%	0.0%	0.0%	0.0%								

*Will self-calculate with conditional formatting

**** Does not factor in risk corridor limits or upside/downside arrangement adjustments; Excludes Medicare shared savings carryover

+Administrative Expense Ratio is calculated as Total Operating Expenses (row 84) divided by Total Revenues (row 62)

^ Pre-Audit Estimates

EXHIBIT E

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

FY20 ACCOUNTABLE CARE ORGANIZATION BUDGET ORDER

In re:	OneCare Vermont Accountable Care Organization, LLC Fiscal Year 2020	)))) Docket No. 19-001-A

INTRODUCTION

The Green Mountain Care Board (GMCB or Board) is charged with reviewing, modifying, and approving the budgets of accountable care organizations (ACOs). 18 V.S.A. § 9382(b). Fiscal Year 2020 (FY20) is the third year that ACO budgets are subject to Board review. Below, we describe the relevant legal framework, outline the criteria that the Board considered during its review, and present specific Findings and Conclusions in support of our Order establishing an FY20 budget for OneCare Vermont Accountable Care Organization, LLC (OneCare).

LEGAL FRAMEWORK

In its review of an ACO's budget, the Board must consider statutory factors that generally fall into the following categories:

- Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;
- The ACO's efforts to strengthen and provide resources to primary care, invest in social determinants of health, address the impact of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health;
- Health resource allocation priorities;
- Transparency of the ACO's costs;
- Effects of Medicaid reimbursement on other payers;
- Solvency and ability to assume financial risk;
- Administrative costs;
- The character, competence, fiscal responsibility and soundness of the ACO and its leaders; and
- The Office of the Health Care Advocate's (HCA) feedback and public comment.

See 18 V.S.A. § 9382(b)(1). In addition to these statutory criteria, the Board will consider the requirements of the Vermont All-Payer Accountable Care Organization Model Agreement (APM Agreement) between the State of Vermont and the Centers for Medicare & Medicaid Services

(CMS), any benchmarks established in the Board's ACO budget guidance, and the elements of the ACO's payer programs. GMCB Rule 5.000, § 5.405(b).

The APM Agreement provides for Medicare's participation in a statewide health care payment and delivery system reform effort referred to as the "All-Payer ACO Model" (hereafter "the Model"). The Model relies on private-sector health care providers voluntarily working together, as part of an ACO, to reduce health care spending and improve health care quality and outcomes for Vermonters. Relevant requirements of the APM Agreement include:

- **Total Cost of Care (TCOC) Growth Targets.** The State is responsible for limiting per person spending growth over the five performance years of the agreement.
    - The target for Medicare TCOC per Beneficiary Growth is a compounding rate that is at least 0.2% below projected national Medicare growth.
    - The target for All-Payer TCOC per Beneficiary Growth is a compounding rate of 3.5% or less over the five performance years of the APM Agreement.
- **Statewide Health Outcomes and Quality of Care Targets.** The State is responsible for meeting a series of targets tied to three overarching population health goals:
    - Improving access to primary care;
    - Reducing deaths due to suicide and drug overdose; and
    - Reducing the prevalence and morbidity of chronic disease.
- **Scale Targets.** Over the five performance years of the agreement, the State is responsible for steadily increasing the percentages of Vermont Medicare Beneficiaries and Vermont All-Payer Scale Target Beneficiaries that are aligned to a Scale Target ACO Initiative.
    - By the end of the 2020, the third performance year of the APM Agreement, the State is expected to have 58% of All-Payer Scale Target Beneficiaries and 79% Vermont Medicare Beneficiaries aligned to a qualifying initiative.
- **Alignment.** Scale Target ACO Initiatives offered by payers must reasonably align with the Medicare program, referred to as the Vermont Medicare ACO Initiative.

APM Agreement, §§ 6-9, Appendix 1.

FY20 REVIEW PROCESS

An ACO bears the burden of justifying its budget proposal. GMCB Rule 5.000, § 5.405(a). The Board issued FY20 budget guidance on July 1, 2019. 2020 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: OneCare Vermont, ACO, LLC. The FY20 budget guidance provided OneCare with a detailed framework for its FY20 budget submission. OneCare submitted its proposed FY20 budget on October 1, 2019 and presented it at a public meeting on October 30, 2019. OneCare Vermont 2020 Fiscal Year Budget Submission (Budget Submission); OneCare PowerPoint (Oct. 30, 2019). At the Board's November 20, 2019 meeting, Board staff and payer representatives presented data regarding OneCare's 2018 performance under the Vermont Medicaid Next Generation Program, the Vermont Modified Next Generation ACO Initiative, and the Blue Cross and Blue Shield of Vermont Next Generation Qualified Health Plan (QHP) Program. 2018 ACO Quality and Financial Results by Payer (Nov. 20, 2019). At a public meeting on December 11, 2019, Board staff presented data regarding OneCare's proposed FY20 budget. GMCB PowerPoint (Dec. 11,

2019). Board staff made recommendations regarding the approval of OneCare's FY20 budget on December 18, 2019. GMCB PowerPoint (Dec. 18, 2019). Throughout the budget review process, OneCare responded to questions from the Board, Board staff, and the Office of the Health Care Advocate (HCA). The Board accepted public comments on OneCare's proposed budget from October 3 through December 18, 2019. On December 18, 2019, the Board voted to establish OneCare's budget on terms and subject to conditions described below. Minutes, Green Mountain Care Board Meeting (Dec. 18, 2019). The written materials from this process are posted on the Board's website[1] and video recordings of the meetings are available from ORCA Media.[2]

FINDINGS

Changes in Leadership and Management

1. OneCare is a "manager-managed" limited liability company organized under Vermont law in 2012 by the University of Vermont Medical Center (UVMMC), a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health (DH-H), a New Hampshire nonprofit corporation. Sixth Amended and Restated Operating Agreement of OneCare Vermont Accountable Care Organization, LLC (Operating Agreement), 1; 11 V.S.A. § 4054.

2. OneCare is governed by a Board of Managers that is comprised largely of representatives of participating health care providers, as required by the Board's rules and federal requirements for participation in Medicare ACO programs. Operating Agreement, 7-8; Certification Eligibility Verification Form for OneCare Vermont Accountable Care Organization, LLC (Sept. 3, 2019) (Verification Form), OneCare Vermont Board of Managers Effective as of September 2019; GMCB Rule 5.202(b); 42 C.F.R. § 425.106(c)(3). In 2019, OneCare expanded the number of Managers on its Board of Managers from 19 to 21, six of which are appointed by the Members, UVMMC and DH-H. Budget Submission, 7; *see also* Operating Agreement, 7-9.

3. FY19 saw several changes to OneCare's executive team. Early in the year, CEO Todd Moore left the organization for a job opportunity out of state. He was replaced on an interim basis by Kevin Stone, the Chair of OneCare's Board of Managers. Following an extensive national search, Victoria Loner was chosen to serve as OneCare's new CEO, effective August 1, 2019. Budget Submission, 8. Ms. Loner previously worked as OneCare's Vice President/Chief Operating Officer. *Id.*; Verification Form, OneCare Leadership Team. The vacancy created by Ms. Loner's appointment as OneCare's CEO was filled by Sara Barry, formerly OneCare's Senior Director of Value Based Care. Budget Submission, 8; OneCare Vermont, Leadership, https://www.onecarevt.org/leadership/. OneCare's Vice President of Finance and Strategy, whose time was split between OneCare and the Adirondacks ACO, also left OneCare in FY19 to dedicate fulltime efforts to the Adirondacks ACO. The vacancy created by her departure will be filled as a Chief Financial Officer, with fulltime efforts dedicated to OneCare. Budget Submission, 8.

[1] Written budget materials are available at https://gmcboard.vermont.gov/content/2020-aco-oversight. Board presentations are available at https://gmcboard.vermont.gov/board/meetings.
[2] https://www.orcamedia net/series/green-mountain-care-board.

FY20 Payer Programs/ACO Initiatives

4. OneCare expects to contract with Medicare, Medicaid, Blue Cross and Blue Shield of Vermont (BCBSVT), and MVP Health Plan, Inc. (MVP) in FY20. OneCare PowerPoint (Oct. 30, 2019), 13. 2020 will be OneCare's third consecutive year participating in a Medicare program based on the Medicare Next Generation ACO Model[3] and its fourth consecutive year participating in the Vermont Medicaid Next Generation Program. GMCB PowerPoint (Dec. 11, 2019), 34.

5. OneCare's negotiations with the Department of Vermont Health Access (DVHA) regarding the specifics of the 2020 Medicaid program are ongoing. In 2019, OneCare and DVHA piloted a geographic attribution concept in the St. Johnsbury Health Service Area (HSA) and are discussing a potential statewide expansion of this approach for 2020. Budget Submission, 13-14. Due to the timing of these discussions, OneCare's FY20 budget does not include additional Medicaid beneficiaries who may be attributed under an expanded geographic attribution approach or their expected cost of care. *Id.* at 22. OneCare hopes to be able to expand the geographic attribution approach to other payer programs in future years of the APM. *Id.* at 15.

6. 2020 will be OneCare's third consecutive year participating in the BCBSVT Next Generation QHP Program. GMCB PowerPoint (Dec. 11, 2019), 34. OneCare and BCBSVT will be piloting a fixed payment model for this program that will likely start in the second quarter of FY20. OneCare PowerPoint (Oct. 30, 2019), 13.

7. While negotiations are still ongoing, OneCare anticipates contracting with BCBSVT in 2020 for its Administrative Services Only (ASO) and large group business. Budget Submission, 15. OneCare is also negotiating with MVP for its qualified health plan (QHP) business. Budget Submission, 6, 15. Because negotiations are ongoing, the details of these programs are uncertain.

FY18 Performance

8. The 2018 Medicare program included a +/- 5% risk corridor and 80% risk sharing, meaning that within five percentage points of the target, OneCare would earn 80% of any savings and would be responsible for 80% of any losses. OneCare's 2018 performance in the Medicare program was within the risk corridor. Excluding money that was paid to OneCare in advance of program settlement and that the Board required OneCare to use to fund Blueprint for Health programs,[4] spending for OneCare's attributed population was approximately 2.8% below the target and OneCare earned approximately $5.6 million in shared savings. Medicare 2018 Settlement, https://gmcboard.vermont.gov/aco-certification-and-budget-review; GMCB PowerPoint (Nov. 20, 2019), 13.

[3] In 2018, performance year 1 of the APM, OneCare participated in a modified version of Medicare's Next Generation ACO Model. Beginning in 2019, OneCare began participating in the Vermont Medicare ACO Initiative, which is based largely on the Next Generation ACO Model, but which can be tailored to support alignment with other payer's ACO programs. APM Agreement, § 1.dd.

[4] Approximately $7.7 million was included in OneCare's 2018 benchmark and distributed to OneCare in advance of settlement. OneCare used this money to fund Blueprint for Health programs, including Supports and Services at Home (SASH). GMCB PowerPoint (Nov. 20, 2019), 13.

9. 2018 was the first year that OneCare participated in a Medicare program based on the Medicare Next Generation ACO Model. As is common in the first year of a Medicare program, 2018 was a reporting-only year in terms of quality measurement. GMCB PowerPoint (Nov. 20, 2019), 16. Because OneCare satisfied its reporting obligations, it earned a quality score of 100%. Had its results been scored, OneCare would have earned a score of 82.4% because it received 32.95 out of a possible 40 points. GMCB PowerPoint (Nov. 20, 2019), 16.

10. The 2018 Medicaid program included a +/- 3% risk corridor with 100% risk sharing, meaning that within three percentage points of the target, OneCare would earn 100% of any savings and would be responsible for 100% of any losses. OneCare's performance in the 2018 Medicaid program was $1,540,534 or 1.3% above the target and within the risk corridor. Thus, OneCare was required to pay DVHA $1,540,534 in losses. GMCB PowerPoint (Nov. 20, 2019), 8; Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 7, https://dvha.vermont.gov/administration/1final-vmng-2018-report-09-20-19.pdf.

11. OneCare's losses under the 2018 Medicaid program were driven by higher than projected fee-for-service spending—payments that DVHA made on OneCare's behalf for services delivered to attributed Medicaid beneficiaries. However, zero-paid "shadow" fee-for-service claims were $7,663,309 less than projected (i.e., less than the fixed prospective payments from DVHA). The savings realized on the fixed prospective payment portion of the Medicaid target is not reflected in the program's shared savings/loss calculation. Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 7-8.

12. OneCare's performance in the 2017 Medicaid program was also within the +/- 3% risk corridor, and resulted in savings of approximately $2.7 million DVHA has described this as an encouraging signal about the potential for an ACO to moderate healthcare expenditures relative to a prospectively agreed upon price. *See* Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 7; 2017 Vermont Medicaid Next Generation Pilot Program 2017 Performance (Sept. 20, 2018), https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-2017-Report-FINAL-09-20-18.pdf.

13. OneCare earned 17 out of 20 possible points on the ten payment measures that were included in the 2018 Medicaid program. OneCare's overall quality score was therefore 85%. Vermont Medicaid Next Generation Pilot Program 2018 Performance (Sept. 20, 2019), 9. In describing OneCare's 2018 performance, DVHA noted that OneCare exceeded the national 75th percentile on measures relating to developmental screening in the first three-years of life and 30-day follow-up rates after discharge from Emergency Departments for mental health, alcohol, and other drug abuse or dependence. GMCB PowerPoint (Nov. 20, 2019), 28. DVHA also described progress on the expansion of OneCare's care coordination model. *Id.* at 30.

14. The 2018 BCBSVT QHP program included a +/- 6% risk corridor with 50% risk sharing, meaning that within six percentage points of the target, OneCare would earn 50% of any savings and would be responsible for 50% of any losses. OneCare's performance in 2018 was 1.3% above the target and it was required to pay BCBSVT $645,574 in losses. GMCB PowerPoint (Nov. 20, 2019), 39.

15. OneCare earned a quality score of 86% in the 2018 BCBSVT QHP program. OneCare PowerPoint (Oct. 30, 2019), 9. In describing the 2018 results, BCBSVT noted that it had seen early indicators of positive impact based on utilization and quality metrics. GMCB PowerPoint (Nov. 20, 2019), 40.

16. While OneCare lost money in the 2018 BCBSVT QHP program, the money it was required to pay under the program reduced BCBSVT's 2020 QHP rates by 0.2%. Decision and Order, *In re Blue Cross and Blue Shield of Vermont 2020 Individual and Small Group Rate Filing*, Docket No. GMCB-006-19rr, Findings, ¶ 51.

FY20 Provider Network

17. OneCare has a broad provider network for FY20 that includes all but one of Vermont's 14 community hospitals, as well as Dartmouth Hitchcock Medical Center (DHMC), which is located just across the border in New Hampshire. OneCare's FY20 network will also include federally qualified health centers (FQHCs), skilled nursing facilities (SNFs), home health agencies, designated agencies (DAs), area agencies on aging, independent primary care and specialist practices, and an ambulatory surgical center. Budget Submission, Part 1, Attachments A & B, 11.

18. Hospital participation in payer programs is expected to expand slightly in FY20 compared to FY19. Copley hospital, which is located in the Morrisville HSA and did not participate in OneCare in FY19, is expected to participate with OneCare in the Medicaid program in FY20. North Country Hospital, which participated only in the Medicaid program in FY19, is expected to expand its participation in FY20 to the BCBSVT QHP program as well. Springfield Hospital, which filed for Chapter 11 bankruptcy on June 26, 2019, will continue to participate in the Medicaid and BCBSVT QHP programs but will no longer participate in the Medicare program in FY20 due to the amount of risk involved. Budget Submission, 30; TR (Oct. 30, 2019) at 111.

19. OneCare added FQHCs, primary care practices, and specialty practices to its FY20 network. Budget Submission, 5, Appendix 2.1. While OneCare lost several independent practices from the network, analysis of OneCare's budget submission shows that more independent practices, including primary care, specialists, and physical therapists, were added to the network than dropped out. GMCB PowerPoint (Dec. 11, 2019), 45.

Population Health Management and Payment Reform Spending

20. OneCare's Clinical Consultants collaborate with the Blueprint for Health (the Blueprint) on quality and population health initiatives. OneCare and Blueprint leaders co-plan and facilitate monthly meetings of Blueprint Project Managers and Quality Improvement Facilitators, Community Health Team (CHT) Leads, Agency of Human Services Field Directors, and Vermont Department of Health District Directors. At these meetings, participants discuss quality gaps, identify root causes, consider possible strategies for collaboration, and plan future work. OneCare's Clinical Consultants and Blueprint staff also meet with HSA community collaboratives, comprised of a broader range of stakeholders and providers, to provide technical

assistance and support each community in meeting the objectives it has identified to achieve the ACO and community quality goals. Budget Submission, 39.

21. OneCare's FY20 budget reflects continued investment in the Blueprint's Patient-Centered Medical Home (PCMH), CHT, and Support and Services at Home (SASH) programs. As the Blueprint noted in its 2018 Annual Report, ACOs that include primary care providers working in Patient-Centered Medical Home settings have been found to achieve higher savings and better-quality care. Annual Report on The Vermont Blueprint for Health (Jan. 31, 2019), 8 (citing Patient-Centered Primary Care Collaborative, *Advanced Primary Care: A Key Contributor to Successful ACOs* (August 2018)).

22. OneCare plans to continue its Basic OneCare PMPM payments in FY20—$3.25 per member per month (PMPM) payments to attributing primary care practices for each attributed patient when the practice attests to having achieved a set of criteria to facilitate primary care transformation. OneCare's criteria include population health monitoring activities, utilization of data to identify strengths and opportunities, as well as implementation of quality improvement initiatives to strengthen person-centered care and outcomes. Budget Submission, 42.

23. OneCare's FY20 budget reflects the continuation of the Comprehensive Payment Reform (CPR) Program, which is designed to transition independent primary care practices from fee-for-service reimbursement to a PMPM payment model and facilitate innovation within practices. *See* Verification Form, 13; Budget Submission, 42. OneCare continues to evolve the program with input from independent primary care practices. 2018 Comprehensive CPR Pilot Final Report (Oct. 31, 2019), 1. For FY20, OneCare plans to introduce new accountability to the program through a variable component of the PMPM payment that will be tied to care coordination engagement and achievement of care delivery transformation targets. Budget Submission, 7.

24. OneCare's FY20 budget also reflects the continuation of the value-based incentive fund (VBIF), which is designed to incentivize high quality care and reward the quality achievements of OneCare's network. Funds will be disbursed to network providers based on quality scores and in accordance with OneCare's VBIF distribution policy, which was modified for FY20 to strengthen practice-level quality incentives. Under the modified policy, 70% of the VBIF funds will still be available to attributing primary care providers based on attribution. However, of the 70% that is allocated to primary care providers, 10% will now be reserved for practices that exceed the network average on primary care engagement by payer. Furthermore, 10% of the VBIF will be allocated to quality improvement initiative(s) approved by the Board of Managers. VBIF Variable Memo Q3 (Oct. 31, 2019).[5]

25. OneCare will be continuing its complex care coordination program in FY20. This program provides funding for primary care practices, home health agencies, areas agencies on aging, and DAs to engage patients in need of additional supports and services and to coordinate the provision of these supports and services across organizational boundaries in order to enhance patients' experiences with care and reduce costs. *See* Budget Submission, 42; Verification Form, 9. Under the program, lead care coordinators and care team members are responsible for

[5] The amount of VBIF available for reinvestment in FY19 and FY20 based on FY18 performance is $167,505. Budget Submission, 43.

outreach to patients, participation in care conferences, and addressing patient goals while working to improve the physical and mental health of individuals. Verification Form, 10.

26. In its budget hearing, OneCare noted that it has seen a marked increase in the number of patients whose care is being managed through the care coordination program, from 504 in 2018 to 3,044 as of October 25, 2019. OneCare PowerPoint (Oct. 30, 2019), 34. OneCare also noted that it has seen a 33% reduction in emergency department (ED) utilization among care managed Medicare patients and a 13% reduction in ED utilization among care managed Medicaid patients. OneCare PowerPoint (Oct. 30, 2019), 36.

27. OneCare led an extensive process in FY19 to evolve its complex care coordination payment model away from a capacity-building program to one that pays for effective engagement in care coordination programming. Budget Submission, 44. Part of this evolution is a significant enhancement in the PMPM payments that are provided to the lead care coordinator and care team members for patients under active care management. Budget Submission, 7; OneCare PowerPoint (Oct. 30, 2019), 38.

28. In 2019, OneCare funded Regional Clinical Representatives (RCRs) to facilitate information sharing and communication between itself and the HSAs. Budget Submission, Appendix 4.2; OneCare Responses to Questions on FY20 Budget Submission (Oct. 25, 2019), 9. For FY20, RCRs will continue to function in this way, however, the funding will now come directly from participating hospitals. OneCare Responses to Questions on FY20 Budget Submission (Oct. 25, 2019), 9.

29. OneCare's budget reflects continued funding for the evidence-based Developmental Understanding and Legal Collaborations for Everyone (DULCE) program. GMCB PowerPoint (Dec. 11, 2019), 62. This program seeks to ensure that newborns and their families receive quality medical care as well as the social services and community support they need during the first six months of the newborn's life. Families participating in the program receive comprehensive social determinants of health screening with a unique emphasis on the legal needs that might cause family stress or uncertainty. Verification Form, 15.

30. OneCare's FY20 budget reflects continued support for and expansion of RiseVT, which is part of OneCare's primary prevention strategy to keep people well and to prevent disease before it occurs. Under this program, program managers work with local partners to identify opportunities to enhance the overall wellness of towns by offering health programs, working to improve local systems such as walkability and school wellness policies, and making grants to aligned community programs. Budget Submission, 7. In 2020, RiseVT anticipates expanding to seven additional cities/towns and will implement a campaign to reduce the consumption of sugar-sweetened beverages by people 18 to 35 years old. *Id.* at 44.

31. In FY19, OneCare allocated more than $1 million from its innovation fund to support nine projects across the state that it expects will enhance care delivery transformation and be scalable across the network. The areas that these projects address include mental health, vulnerable populations, technology in rural settings, and specific chronic conditions. Budget Submission, 44. One example is a program in the Bennington area called Psychiatric Urgent

Care for Kids, which aims to provide a more appropriate setting of care for children who are presenting with urgent mental health issues at school and have been receiving care in local emergency rooms. TR, 78-79; 2019 Innovation Fund Q3 GMCB Report Deliverable, 1. Over the next two years OneCare will monitor and evaluate the effectiveness of these programs and determine which investments may be amenable to wider adoption. Budget Submission, 44; TR, 114-15. OneCare's budget includes money to fund additional projects in 2020. Budget Submission, 43; GMCB PowerPoint (Dec. 11, 2019), 63.

32. OneCare also obligated funds in FY19 to support several specialist payment programs relating to care coordination for patients with advanced chronic kidney disease, developing infrastructure for electronic consultation between primary and specialty care practices, and embedding clinical pharmacists in primary care. Budget Submission, 7, 42-43; 2019 Specialist Payment Pilot Q3 GMCB Report Deliverable (Oct. 31, 2019). OneCare is budgeting additional funds to expand support for these programs in FY20. Budget Submission, 42.

33. OneCare's budgeted PHM/payment reform spending is presented in the following table:

PHM/Payment Reform Programs	**FY20 Budgeted Investment**
Basic OneCare PMPM	$8,569,920
Complex Care Coordination Program	$9,423,590
Value-Based Incentive Fund	$8,387,232
Comprehensive Payment Reform Program	$1,606,613
Primary Prevention (RiseVT)	$1,031,752
DULCE	$800,000
Specialist Program Pilot	$3,144,500
Innovation Fund	$1,367,580
Primary Care Engagement Investment	$375,000
PCMH Legacy Payments	$1,894,417
CHT Block Payment	$2,379,711
SASH	$3,968,246
VBIF Quality Initiatives	**$167,505**
Total Investment	**$43,116,066**
Total revenues	$1,362,200,000
Total attributed lives	~250,000

See GMCB PowerPoint (Dec. 11, 2019), 62.

34. While subject to several variables, OneCare projects that, of the $44.3 million in PHM and payment reform investments, approximately $22.7 would go to primary care providers; $5.1 million would go to specialty and acute care providers; $3.9 million would to go SASH; $3.4 would go to DAs; $2.4 million would go to Blueprint CHTs; and $1.9 would go to home health providers; OneCare PowerPoint (Oct. 30, 2019), 20.

35. OneCare has increased the total dollar amount budgeted for population health investments each year since 2018, from $27 million to $43 million. OneCare's budgeted FY20

investments in PHM and payment reform have increased approximately $5.8 million or 16% from FY19, from $37.2 million to $43.1 million. Budget Submission, Appendix 4.2. Due to the large increase in total revenues, OneCare's PHM and payment reform spending represents a smaller percentage of its FY20 total budgeted revenues (3.03%) than its FY19 total budgeted revenues (4.03%). GMCB PowerPoint (Dec. 11, 2019), 65. The following table describes these trends:

Metric	2018 Budget	2018 Actual	2019 Budget	2019 Projected	2020 Budget
Total Revenue	$639 M	$634 M	$899 M	$882 M*	$1,425 M
Pop Health Mgt (PHM) Total	$27 M	$23 M	$37 M	$36 M	$43 M
Blueprint	$7.8 M	$7.8 M	$8.1 M	$8.0 M	$8.2 M
(PHM LESS Blueprint)/Revenues	3.05%	2.40%	3.25%	3.10%	2.45%
PHM/Total Revenues	4.27%	3.63%	4.14%	4.03%	3.03%

36. OneCare's $43.1 million in PHM and payment reform investments are funded by hospital dues (budgeted at approximately $24.5 M) and payer and government contributions. Budget Submission, 30, Appendix 4.2. Some of these investments are tied to attribution. Thus, OneCare's budgeted PHM and payment reform investments may change as OneCare's contract terms and attribution are finalized in the coming months. Responses to Questions (Oct. 25, 2019), 8. Moreover, there is uncertainty regarding $7.8 million in delivery system reform funds ($3.9 million from state funds) that OneCare has budgeted for FY20. TR, 60; OneCare PowerPoint (Oct. 30, 2019), 24.

37. OneCare was asked to provide a monitoring and evaluation plan for each of its PHM programs, including a description of any metrics used. While OneCare described generally how it monitors key process and outcome metrics for the complex care coordination program, as well as its plans to evaluate the projects it has supported through the innovation fund, it did not provide the specific information requested. Responses to Questions (Nov. 22, 2019), 11.

Operating/Administrative Budget

38. OneCare budgeted approximately $19.3 million for operating expenses in FY20, as compared to the approximately $15.9 million that the Board approved in OneCare's FY19 budget. OneCare's operating expense budget includes salaries and benefits (including those of the RiseVT team), contracted services, software, supplies, and risk protection/insurance. Budget Submission, Appendix 4.2; OneCare PowerPoint (Oct. 30, 2019), 21.

39. Though the FY20 budget represents a 21% increase in total operating expenses over the approved FY19 budget, the administrative expense ratio is decreasing from 1.77% to 1.35%. OneCare PowerPoint (Oct. 30, 2019), 22; GMCB PowerPoint (Dec. 11, 2019), 77. Similarly, OneCare's projected FY20 administrative costs amount to $6.44 PMPM, down from $7.69 PMPM in FY19 and $8.49 PMPM in FY18. Budget Submission, 26.

40. The majority of OneCare's FY20 operating budget, 68%, is for network support, including analytics-, clinical-, and quality-related functions, as well as risk protection for the Medicare program. Approximately 24% of the OneCare's operating budget is for ACO administration. OneCare PowerPoint (Oct. 30, 2019), 21.

41. As with most organizations, the majority of OneCare's budgeted operating expenses (61%) are for salaries and benefits. GMCB PowerPoint (Dec. 11, 2019), 75. At the Board's request, OneCare provided salary information with the budget submission. This information shows the number of employees in specified salary ranges. This information has been posted on the Board's website along with other budget materials.[6]

42. GMCB staff performed a sensitivity analysis that looked at holding OneCare's administrative expenses constant and varying assumptions of attribution and other revenue expectations. Under the low growth scenario that was modeled—a reduction in attribution of 15% across payers and no award of DSR/IAPD funding ($13.1 M)—it would not be expected that the administrative expense ratio would increase above 1.60%. In the high growth scenario that was modeled—an increase in attribution of 3% and the full award of DSR/IAPD funding—it would not be expected for the ratio to dip below 1.28%. GMCB PowerPoint (Dec 11, 2019).

Benchmark Trend Rates

43. A "benchmark" or TCOC target is a payer-specific financial target against which expenditures for ACO-aligned beneficiaries are assessed to determine whether an ACO earned savings or is responsible for losses. Rule 5.000, § 5.103(8). The APM Agreement authorizes the Board to prospectively develop the benchmark for the FY20 Medicare program, the 2020 Vermont Medicare ACO Initiative, subject to CMS approval.[7] APM Agreement, § 8.b.ii.

44. The trend rates used to develop the FY20 Medicare program's benchmarks—the rates used to project claims experience to the performance period—must be at least 0.2 percentage points below Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for 2020. APM Agreement, § 8.b.ii.c.i. Furthermore, the FY20 Medicare program's benchmarks must enable achievement of the APM Agreement's financial targets. APM Agreement, § 9.e.

45. Different populations contribute differently to Vermont's All-Payer TCOC. Based on data in the Vermont Health Care Uniform Reporting and Evaluation System, while Medicare

[6] https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY20%20Budget%20Submission%20-%20OCV%20Salary%20Table.pdf.

[7] The APM Agreement grants the Board's authority to set Medicare benchmarks; the authority is distinct from ACO budget review authority which the Board has via statutory mandate.

beneficiaries represent only 27% of the population, the spending for these individuals represents 44% of All-Payer TCOC. Medicaid beneficiaries represent 29% of the overall population but spending on these individuals represents only 16% of All-Payer TCOC. The commercially insured represent 44% of the overall population and spending on these individuals represents 40% of All-Payer TCOC. 2020 Benchmark Recommendation (Dec. 11, 2019) 4.

46. On December 11, 2019, Board staff presented projections of annualized payer-specific TCOC growth rates and All-Payer TCOC growth rates from 2017, the base year of the APM, through 2020. GMCB PowerPoint (Dec. 11, 2019). After considering these projections, as well as Annual Projected National Medicare TCOC per Beneficiary Growth for 2020, the Board voted to approve a 2.9% trend rate for the aged and disabled (A/D) component of the Medicare benchmark and a 3.5% trend rate for the end-stage renal disease (ESRD) component of the Medicare benchmark. GMCB Meeting Minutes (Dec. 18, 2019).

47. OneCare and DVHA were still negotiating the terms of the FY20 Medicaid contract, including the appropriate trend rate, when the Board voted on OneCare's FY20 budget. Due to the state of the negotiations at that time, the Board had received insufficient data to complete the Medicaid advisory rate case required by 18 V.S.A. § 9573.

48. OneCare is involved in negotiations with BCBSVT and MVP regarding the trend rates that will be used to develop the financial targets for FY20 commercial QHP programs. The rates OneCare used to build its budget were derived from the QHP rates that the Board approved in its rate review process this past summer. OneCare cautions that these rates are subject to additional actuarial review. Budget Submission, 21.

49. OneCare is developing a program with BCBSVT to bring in attributed lives from BCBSVT's non-QHP product lines. OneCare states that while the process to collaboratively explore different methodologies to establish benchmarks is underway, the budget model incorporates a PMPM estimate that represents a reasonable spending assumption and trend rates informed by industry experience. Budget Submission, 21.

Scale & Program Alignment

50. The APM Agreement requires Vermont to steadily increase the number of people that are attributed or aligned to an ACO over the life of the model. The APM Agreement establishes attribution targets (scale targets) for two populations—All-Payer Beneficiaries and Medicare Beneficiaries—for each of the model's five performance years. APM Agreement, § 6.a.

51. People that are attributed to an ACO only count towards the APM Agreement's scale targets if they are attributed under a "Scale Target ACO Initiative." APM Agreement, § 6.a. The APM Agreement defines a "Scale Target ACO Initiative" as an ACO arrangement that meets certain minimum standards. *Id.* The APM Agreement also requires the State to ensure that Scale Target ACO Initiatives offered by Medicaid and private payers reasonably align in their design with the Medicare Scale Target Initiative. *Id.* § 6.f.

52. OneCare does not anticipate major changes to existing programs in FY20 that would negatively impact program alignment (apart from geographic attribution in the Medicaid program) or the ability of the programs to quality as Scale Target ACO Initiatives. While OneCare is still negotiating with BCBSVT and MVP on new programs, it expects that both programs will qualify as Scale Target ACO Initiatives. GMCB PowerPoint (Dec. 11, 2019), 36.

53. As a result of additional payer programs and an expanded provider network, OneCare expects to increase the number of people it is accountable for (attributed lives) in FY20 by approximately 90,000 people, from approximately 160,000 to just under 250,000. OneCare PowerPoint (Oct. 30, 2019), 14; Budget Submission, 6.

54. Assuming OneCare's attribution projections are accurate and assuming that the new payer programs OneCare is negotiating will qualify as Scale Target ACO Initiatives, Vermont's scale performance for FY20 is projected to be approximately 48% for All-Payer Beneficiaries and approximately 46% for Medicare Beneficiaries. While this would be a significant improvement over 2019 performance, it would still be below the Performance Year 3 targets under the APM Agreement, which are 58% for All-Payer Beneficiaries and 79% for Medicare Beneficiaries. GMCB PowerPoint (Dec. 11, 2019), 53.

55. In 2019, the Board and state partners surveyed Vermont hospitals and FQHCs in order to identify barriers to scale and potential strategies for state, federal, ACO, and local partners to improve the Model. Strategies fell into two broad categories: (1) Payment structure should be more transparent, predictable, and sustainable and (2) Payments from the ACO and participating payers must offset additional administrative and reporting requirements (reduce burden) and incentivize delivery reform, with a greater emphasis on prevention and health improvement (incentivize population health). *See* Memo to Green Mountain Care Board re Insights from Hospital/FQHC Scale Survey: Results and Reactions (Aug. 16, 2019), *available at* https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf.

Risk

56. The magnitude of OneCare's "downside" risk—its risk of having to pay losses—varies by program due to differences in the programs' risk sharing arrangements and spending targets. Because it has a higher spending target, most of OneCare's downside risk in FY20 will be associated with the Medicare program. OneCare expects to bear just over $44.1 million in downside risk across all its FY20 payer programs and, of this, approximately $27.3 million is connected to the Medicare program. Budget Submission, Appendix 2.3. OneCare described this

level risk as a challenge to expanding hospital participation in the Medicare program. OneCare PowerPoint (Oct. 30, 2019), 16.

57. The total downside risk reflected in OneCare's FY20 budget equals approximately 3.2% of the projected spending for its attributed lives. All risk not assumed by OneCare for spending in excess of the targets would reside with payers. GMCB PowerPoint (Dec. 11, 2019), 83.

58. OneCare's strategy for managing downside risk involves delegating this risk, as well as the potential for savings (sometimes referred to as upside risk), to network hospitals. This model is designed to protect smaller network providers and give hospitals the opportunity to offset the dues they pay to OneCare with shared savings. Budget Submission, 15.

59. OneCare implements its risk delegation model by setting spending targets for each HSA participating in a payer program. These targets are based on historical cost of care data blended with the risk profile of the attributed lives in the HSA (and possibly incorporating social determinant scores in the future). Budget Submission, 16, 29. The program risk corridor and sharing terms are then applied to the HSA spending target to calculate a Maximum Risk Limit (MRL). Budget Submission, 16.

60. In last year's budget order, the Board required OneCare to build $3.9 million in reserves by the end of FY19 to fund $3.9 million in risk protection that OneCare sought to provide to three network hospitals. FY19 ACO Budget Order, Docket No. GMCB-18-001-A. Based on current forecasts, OneCare expects to conclude FY19 with approximately $3.9 million in reserves net of any contributions needed to cover these risk mitigation arrangements. OneCare Responses to Questions (Oct. 25, 2019), 4; Budget Submission, 16, Appendix 4.3.

61. OneCare's proposed budget carries the projected year-end reserves of $3.9 million forward into FY20. Budget Submission, 16. However, OneCare will not be responsible for risk mitigation in FY20. While $3.7 million in risk mitigation is expected to be provided to three hospitals in FY20 (limiting their MRLs), this protection will be provided by OneCare's founders, UVMMC and DH-H. OneCare Responses to Questions (Oct. 25, 2019), 4-5. Because OneCare's founders have agreed to assume this risk, the $3.9 million in reserves that OneCare budgets carrying into FY20 is not intended to provide risk mitigation to hospitals, but rather to cover other potential needs, such as to provide general liquidity to manage financial operations. *Id.*; Budget Submission, 16.

62. While the numbers will change as the payer contracts and attribution are finalized, the table below shows each hospital's total MRL in FY20, the effect of any risk mitigation on each hospital's MRL, and each hospital's overall MRL as a percentage of total system risk:

Hospital	Total Risk (MRL)	Risk Mitigation	Est. MRL FY20	% of System MRL
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	2.9%
Central Vermont Medical Center	$ 4,971,384		$ 4,971,384	12.3%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	0.6%
Gifford Medical Center	$ 457,211		$ 457,211	1.1%
Grace Cottage Hospital	$ -		$ -	0.0%
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	5.4%
North Country Hospital	$ 785,616		$ 785,616	1.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	2.0%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	10.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	8.5%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	3.2%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	5.8%
Springfield Hospital	$ 825,283		$ 825,283	2.0%
UVM Medical Center	$ 16,830,645		$ 16,830,645	41.7%
DHMC	$ 640,310		$ 640,310	1.6%
Total	**$ 44,118,441**		**$ 40,348,284**	

GMCB PowerPoint (Dec. 18, 2019), 13.

63. Board staff have compared each hospital's overall MRL to its days cash on hand and overall patient revenue—net patient revenue (NPR) + fixed prospective payments (FPP)—as approved for each hospital in its 2020 budget. This analysis is reflected in the tables below:

Hospital	Total Risk (MRL)	Risk Mitigation	Est. MRL FY20	Days Cash on Hand (DCH)	MRL as % of DCH
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	121.6	1.4%
Central Vermont Medical Center	$ 4,971,384		$ 4,971,384	75.0	2.2%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	72.1	0.3%
Gifford Medical Center	$ 457,211		$ 457,211	241.4	0.9%
Grace Cottage Hospital	$ -		$ -	87.7	N/A
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	134.1	4.0%
North Country Hospital	$ 785,616		$ 785,616	201.8	0.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	114.3	1.0%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	279.2	3.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	125.3	4.0%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	204.6	0.5%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	35.7	1.4%
Springfield Hospital	$ 825,283		$ 825,283	3.7	1.7%
UVM Medical Center	$ 16,830,645		$ 16,830,645	192.7	1.2%
DHMC	$ 640,310		$ 640,310	N/A	N/A
Total	**$ 44,118,441**		**$ 40,348,284**		

* Southwestern VT Medical Center's days cash on hand does not include its parent corporation's days cash on hand figures.

Hospital	Total Risk (MRL)	Risk Mitigation	Est. MRL FY20	NPR + FPP	MRL as % of NPR + FPP
Brattleboro Memorial Hospital	$ 2,368,265	$ 1,184,133	$ 1,184,133	$ 88,145,092	1.3%
Central Vermont Medical Ctr	$ 4,971,384		$ 4,971,384	$ 218,043,247	2.3%
Copley Hospital	$ 475,334	$ 237,667	$ 237,667	$ 72,658,362	0.3%
Gifford Medical Center	$ 457,211		$ 457,211	$ 52,382,984	0.9%
Grace Cottage Hospital	$ -		$ -	$ 19,967,821	0.0%
Mt. Ascutney Hospital & Health Ctr	$ 2,196,835		$ 2,196,835	$ 53,755,559	4.1%
North Country Hospital	$ 785,616		$ 785,616	$ 83,623,249	0.9%
Northeastern VT Regional Hospital	$ 822,304		$ 822,304	$ 87,253,844	0.9%
Northwestern Medical Center	$ 4,303,405		$ 4,303,405	$ 116,926,579	3.7%
Porter Medical Center	$ 3,447,724		$ 3,447,724	$ 87,487,539	3.9%
Rutland Regional Medical Center	$ 1,297,409		$ 1,297,409	$ 267,787,827	0.5%
Southwestern VT Medical Center	$ 4,696,716	$ 2,348,358	$ 2,348,358	$ 172,284,645	1.4%
Springfield Hospital	$ 825,283		$ 825,283	$ 48,889,189	1.7%
UVM Medical Center	$ 16,830,645		$ 16,830,645	$ 1,348,125,703	1.2%
DHMC	$ 640,310		$ 640,310		
Total	**$ 44,118,441**		**$ 40,348,284**	**$ 2,717,331,640**	

GMCB PowerPoint (Dec. 18, 2019), 14-15.

64. Of the $27.3 million in risk that OneCare expects to bear in the 2020 Medicare program (5% of the expected target), the maximum risk faced by OneCare's Medicare-participating hospitals (in aggregate) would be approximately $15 million (2.8% of the target) due to OneCare's purchase of third-party risk protection. GMCB PowerPoint (Dec. 11, 2019), 84.

Public Comments

65. The Board took public comments on OneCare's proposed budget and the budget review process from October 1, 2019 through December 18, 2019.[8] During that time, the Board received 19 public comments regarding the OneCare's FY20 budget and the Board's review. Generally, the themes from public comments included:

- Public support for OneCare's continued investments in disease prevention, primary care, home health, mental health, and other community-level services;
- Interest in evaluating OneCare and addressing issues identified;
- Requests for continued monitoring of ACO programs, expenses (including administrative costs), tools (e.g., Care Navigator), quality measures, and TCOC;
- Suggestions for further implementation of care coordination support;
- Consideration of scale, having not yet been achieved, when reviewing results;
- Desire to ensure OneCare's operational transparency.

[8] https://gmcboard.vermont.gov/content/2020-aco-oversight.

CONCLUSIONS

I. Statutory Criteria

A. Historic and future expenditures and the effects of care models on utilization, including the provision of innovative services;

OneCare's budget is driven primarily by its benchmarks or TCOC targets, which are developed by trending past claims experience forward to estimate future expenditures for the people that will be attributed to the ACO in the performance period. In 2018, the most recent year for which data are available, OneCare's performance against these targets was mixed. OneCare achieved savings in the Medicare program, meaning that the cost of caring for Medicare beneficiaries attributed to OneCare under the program was below the established target. Findings, ¶ 8. OneCare's performance in the Medicaid and BCBSVT QHP programs was above the targets for those programs and, as a result, OneCare paid losses to DVHA and BCSBSVT. Findings, ¶¶ 10, 14. While OneCare was required to pay losses under the Medicaid program, it realized savings against the program's fixed prospective payments. Findings, ¶ 11.

Payers are responsible for evaluating whether OneCare is positively impacting the cost and quality of care provided to their beneficiaries or members. CMS, DVHA, and BCBSVT will each continue their existing programs with OneCare in 2020. Additional programs are expected to be established in 2020 as well, suggesting that public and private payers see promise in an ACO model as way to deliver value for their beneficiaries or members. Indeed, in its 2020 QHP rate filing, BCBSVT projected that its collaboration with OneCare would reduce medical claims for attributed members by 0.4%. Decision and Order, *In re: Blue Cross and Blue Shield of Vermont) GMCB-006-19rr 2020 Individual and Small Group Rate Filing*, Docket No. GMCB-006-19rr, Findings, ¶ 52.

While OneCare's budget submission described progress OneCare has made on its clinical priorities—high-risk patient care coordination and chronic disease management optimization, and prevention and wellness—and while OneCare shared success stories during the budget hearing, the Board and the public need a more systematic way to understand the impacts of ACO programs. We therefore require that OneCare work with Board staff to develop a performance dashboard to report population health and financial data. The Board and the public also need to understand in more detail how OneCare is evaluating the effectiveness of its PHM investments and how it intends to scale those investments that are successful and sunset those that are not. *See* Findings, ¶ 37. Thus, as part of our approval of OneCare's FY20 budget, we require OneCare to consult with Board staff to develop a strategy for this work. Finally, while OneCare analyzes cost and quality differences across its HSAs, it has not adequately described how its community investments address these variations and we therefore impose conditions on our approval of OneCare's FY20 budget to address this issue.

B. The ACO's efforts to strengthen and provide resources to primary care, invest in social determinants of health, address the impact of childhood trauma, integrate community providers, improve care coordination, and reduce duplication of services in partnership with the Blueprint for Health.

OneCare's FY20 budget includes continued investments to strengthen and provide resources to primary care practices, address social determinants of health and the impacts of childhood trauma, integrate community providers, improve care coordination for patients, and reduce duplication of services in partnership with the Blueprint for Health. Findings, ¶¶ 20-35. OneCare expects that primary care providers will receive $22.7 million through its PHM and payment reform programs, more than half of the total FY20 PHM spending of $43 million. Findings, ¶ 34. In many instances, these programs address more than one of the APM Agreement's quality and population health goals. *See* Findings, ¶¶ 20-35. Furthermore, OneCare is modifying several of its programs in FY20, including the VBIF, the complex care coordination program, and the CPR program, to increase accountability and reward quality. Findings, ¶¶ 23-24, 27.

There is more uncertainty this year than there has been in previous years regarding the amount of money that will be available to fund OneCare's PHM and payment reform investments. In addition to uncertainty regarding attribution estimates, OneCare is still negotiating the terms of two entirely new payer programs. Findings, ¶ 7. There are also questions regarding the availability of certain state/federal funds. Findings, ¶ 36. Given this uncertainty, and given outstanding questions regarding the scaling of investments as attribution changes from the estimates upon which the budget was based, we are not including a PHM/payment reform ratio in the budget order, as we have done in previous years, we will instead require OneCare to submit a revised proposal to the Board by March 31, 2020 if its PHM and payment reform programs are not fully funded as detailed in the FY20 budget.

C. The Goals and Recommendations of HRAP

The Health Resource Allocation Plan (HRAP) was last updated in 2009 and the recommendations in the HRAP were not relevant to OneCare's budget planning. In accordance with Act 167 of 2018, we are currently working to update the HRAP and will review how it can best be utilized in the ACO budget process in the future. *See* 2018 Sess., No. 167. However, we did not find it relevant to our review.

D. Transparency of ACO's Costs

Through the Board's public budget review process, OneCare has been transparent about its expected costs. OneCare has provided a breakdown of its $19.3 million administrative budget, the majority of which is dedicated to network support functions (e.g., analytic and clinical support and risk protection). Findings, ¶¶ 38-40. OneCare has also detailed how its administrative expenses, both on a percentage-of-total-revenue- and a PMPM-basis have decreased from prior years. Findings, ¶ 39.

As with most organizations, salary and benefits make up the majority of OneCare's administrative expenses. This year, OneCare also provided salary information to the Board showing the number of OneCare employees in specified salary ranges. This information has been posted on the Board's website along with other budget materials. Findings, ¶ 41.

In addition to the details regarding its administrative expenses, OneCare has described the estimated amounts each hospital will receive under its fixed prospective payment model, as well as each hospital's projected MRL. *See* Findings, ¶ 62. It has also described the payments it plans to make under its PHM and payment reform programs and the sources of those funds, including payer support and hospital dues. *See* Findings, ¶¶ 33-36.

E. Effects of Medicaid Reimbursement on Other Payers

OneCare's budget includes trend rates for the FY20 MVP and BCBSVT QHP programs that are based on the rate increases that the Board approved in the 2020 health insurance rate review process. Findings, ¶ 48. These health insurance rate increases are affected by the cost shift. *See* GMCB Annual Report for 2019, 27 (calculating the impact of the cost shift, as defined elsewhere in the report, on QHP rate increases to be approximately 14.7%). Thus, through the cost shift, Medicaid reimbursement levels impact the rates between commercial insurers and OneCare.

More time is needed to understand the impact of Medicaid's ACO rates on the rates that other payers negotiate with the ACO. Under the APM Agreement, the Board must report on what impact, if any, rate differentials have on OneCare's profits, the rates other payers pay, and potential options to reduce payer differential. APM Agreement, § 10. However, this reporting is not available yet to inform the Board's regulation.

F. ACO's Solvency and Ability to Assume Financial Risk

OneCare manages the downside risk that it assumes under its payer contracts primarily by delegating that risk to network hospitals. *See* Findings, ¶ 58. Although the numbers will likely change as contracts are finalized in the coming months, OneCare expects to delegate slightly more than $44.1 million in risk to these hospitals in FY20. When third-party risk protection is factored in, the hospitals' aggregate maximum risk drops to $31.8 million. . *See* Findings, ¶¶ 62, 64. Board staff have compared each Vermont hospital's projected MRL to its budgeted days cash on hand and overall patient revenue—NPR + FPP. This analysis showed that no hospital's projected MRL exceeds 4% of its budgeted days cash on hand and only one hospital's projected MRL as a percentage of budgeted NPR + FPP is greater than 4.0% (4.1%). Findings, ¶ 63. While the MRL for any one hospital is relatively small compared to its days cash on hand and total patient revenue, hospitals are currently dealing with a variety of financial pressures. *See generally* FY20 Hospital Budget Orders.[9] We impose several conditions on our approval of OneCare's FY20 budget designed to ensure that OneCare's delegated risk model is implemented as described it the budget submission and that OneCare notifies the Board of any changes to the model.

OneCare projects that it will end FY19 with just under $4.0 million in reserves. Findings, ¶ 60. OneCare seeks to carry these projected reserves forward into FY20. Findings, ¶ 61. While it may be appropriate for OneCare to maintain some reserves to address, for example, potential cash flow problems, these reserves were built for a specific purpose—to provide hospitals with risk mitigation and to thereby expand provider participation in the model. *See* Findings, ¶ 60. The reserves will no longer be used for this specific purpose since risk mitigation in FY20 will

[9] https://gmcboard.vermont.gov/content/FY2020-Budget.

be provided by OneCare's founders. Findings, ¶ 61. Because OneCare's reserves were built to support the model, we impose a condition in our Order establishing OneCare's FY20 budget that is designed to ensure these reserves continue to serve that purpose.

G. ACO's Administrative Costs

Although OneCare's proposed FY20 budget represents a 21% increase in overall operating expenses from the approved FY19 budget, the administrative expense ratio is decreasing from 1.77% to 1.35% for FY20. Findings, ¶ 39. Similarly, on a PMMP basis, administrative costs are decreasing, from $7.69 in the approved FY19 budget to $6.44 in the proposed FY20 budget. Findings, ¶ 39. The majority of OneCare's FY20 administrative budget, 68%, is for network support functions, including analytics-, clinical-, and quality-related functions, as well as risk protection for the Medicare program. Approximately 24% of the FY20 administrative budget is for ACO administration. Findings, ¶ 40.

GMCB staff completed a sensitivity analysis that looked at holding OneCare's administrative expenses constant and varying assumptions of attribution and other revenue expectations. Under the low growth scenario that was modeled—a reduction in attribution of 15% across payers and no award of DSR/IAPD funding (the $13.1 million in Healthcare Reform Investments included in the FY20 budget)—it would not be expected that the current administrative expense ratio would increase above 1.60%. In the high growth scenario that was modeled—an increase in attribution of 3% and the full award of DSR/IAPD funding—it would not be expected for the ratio to dip below 1.28%. Findings, ¶ 42. In our Order establishing OneCare's FY20 budget, we impose a limit on the permissible administrative expense ratio that is informed by this sensitivity analysis.

H. The character, competence, fiscal responsibility and soundness of the ACO and its leaders.

OneCare made several changes to its Board of Managers and executive leadership team in FY19. *See* Findings, ¶¶ 1-3. These changes do not cause us to have concerns about OneCare's management or leadership and our interactions with OneCare's executive team during the budget review process have raised no concerns regarding their competence, character, fiscal responsibility, or professionalism.

I. HCA Participation and Public Comment

We have sought to address some of the concerns raised by the public and the HCA through the conditions we are imposing on our approval of OneCare's FY20 budget. For example, several commenters advocated for more transparency and continued monitoring of OneCare's programs, expenses, quality measures, and TCOC. *See* Findings, ¶ 65. We heard these concerns. For example, we impose a condition in our Order approving OneCare's FY20 budget that requires OneCare to work with Board staff to develop a performance dashboard to present population health and financial data (with input from the HCA). We also impose a condition requiring OneCare to develop a workplan to evaluate its PHM investments, including analysis of how to scale those investments that are successful, sunset those that are not, and report on

opportunities for sustainability. We also require that OneCare report data on its complex care coordination program implementation in FY20, including enrollment, payments, patient satisfaction, challenges and learning opportunities.

II. APM Agreement

A. TCOC Growth Rates

After considering projections of TCOC growth, as well as Annual Projected National Medicare TCOC per Beneficiary Growth for 2020, we approved a 2.9% trend rate for the A/D component of the 2020 Medicare benchmark and a 3.5% trend rate for the ESRD component of the 2020 Medicare benchmark. Findings, ¶ 46. These trend rates are within parameters of the APM Agreement and, based on the Board's best estimates, will enable the State to achieve the APM Agreement's financial targets.

At the time the Board approved OneCare's budget, OneCare was still negotiating with DVHA on the terms of the 2020 contract, including the appropriate trend rate(s). Furthermore, give the state of these negotiations, the Board had not finalized the Medicaid Advisory Rate Case. Findings, ¶ 47. Only around 16% of All-Payer TCOC under the APM Agreement is Medicaid spending. Findings, ¶ 45. We therefore do not expect OneCare's Medicaid rate to have a dramatic impact the State's ability to meet its financial targets for 2020. We require that OneCare ensure the Medicaid contract's trend rate fall within the actuarial range after completion of the Medicaid Advisory Rate Case.

At the time the Board approved OneCare's budget, OneCare was still negotiating final trend rates with commercial payers as well. Findings, ¶ 48. While it is not ideal to move forward with the budget without more information about the 2020 commercial contracts, this uncertainty is not new. Similar to last year, we believe the appropriate course of action is to allow OneCare and commercial payers to negotiate trend rates so long as they are tied to the Board-approved QHP rates, are actuarially sound for the attributed populations and, to the extent possible, align with the All-Payer TCOC target growth rate of 3.5% or less. We therefore impose conditions similar to those we imposed last year on the commercial trend rates.

B. Scale and Program Alignment

We have reviewed OneCare's proposed changes to its existing programs and believe they are unlikely to affect the programs' status as Scale Target ACO Initiatives. With respect to the alignment of these programs, the piloting of a fixed payment model in the BCBVT QHP program should increase the alignment of that program with the Medicare and Medicaid programs and is a positive step in the evolution of the Model. *See* Findings, ¶ 6. While OneCare and DVHA are contemplating a significant change in the Medicaid program's attribution methodology (decreasing alignment), *see* Findings, ¶ 5, this is the type of innovation that is required if the State is to meet the scale targets in the APM Agreement and therefore can likely be justified. So that we can better understand this new attribution approach, we will require that OneCare submit

the Medicaid geographic attribution implementation manual to the Board once the 2020 Medicaid contract is finalized.

We do not have sufficient information at this time to assess whether OneCare's potential new programs with MVP (QHP) and BCBSVT (ASO and large group) will qualify as Scale Target Initiatives or whether they will be reasonably aligned with the Medicare program, as required by the APM Agreement. Findings, ¶¶ 7, 52.

We require as part of our Order below that OneCare report to the Board on how all its payer programs qualify as Scale Target ACO Initiatives and how each program aligns with the Medicare program in key areas (e.g., attribution methodologies, quality measures, payment mechanisms, included services, etc.). If one or more programs are not expected to qualify as a Scale Target ACO Initiative, we require that OneCare justify the arrangement. Finally, to further progress on achieving the APM Agreement's scale targets, we require that OneCare provide a written follow-up on each action item identified in the scale report completed in August 2019. *See* Findings, ¶¶ 53-55.

ORDER

Based on our Findings and Conclusions above, and pursuant to 18 V.S.A. § 9382, we hereby approve OneCare's FY20 budget on the terms, and subject to the conditions, set forth below:

1. No later than April 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must submit a 2021 Network Development Strategy that includes the following elements:
    a. A definition for ACO "network composition" necessary to maximize value-based incentives;
    b. Provider outreach strategy;
    c. Provider recruitment and acceptance criteria;
    d. Network development timeline;
    e. Providers dropping out of the network (quantify) and reasons why; and
    f. Challenges to network development.

2. No later than March 31, 2020, OneCare must submit a written report to the Board, using a template provided by GMCB staff, which demonstrates that OneCare's payer programs (other than the Vermont Medicare ACO Initiative) qualify as Scale Target ACO Initiatives under section 6.b. of the APM Agreement. The report must describe (a) how each program aligns with the Vermont Medicare ACO Initiative in the areas of attribution methodologies, quality measures, payment mechanisms, services included in determining shared savings and losses, patient protections, and provider reimbursement strategies; and (b) the rationale(s) for any differences in these areas. Thereafter, OneCare must update this report no later than 15 days after entering a new payer program covering any portion of 2020. If programs are not expected to qualify as a Scale Target ACO Initiatives under section 6.b. of the APM Agreement, OneCare must include in the report a justification for such an arrangement.

3. No later than March 31, 2020, OneCare must submit a one-page document summarizing the benefits self-funded payer programs receive from participating in OneCare.

4. OneCare must submit the Medicaid geographic attribution implementation manual to the Board no later than 15 days after finalizing the manual with the Department of Vermont Health Access.

5. OneCare must ensure that its payer contracts are consistent with the following 2020 benchmark trend rates and related conditions:
    a. Medicare: 3.5% (3.5% for A/D and 2.9% for ESRD);
    b. Medicaid: A trend within the actuarial range after completion of the Medicaid Advisory Rate Case;
    c. Commercial:
        i. The 2020 benchmark trend rates for the BCBSVT and MVP QHP programs must be based on the ACO-attributed population and the BCBSVT and MVP QHP approved rate filings; and
        ii. OneCare must provide the Board with (a) actuarial certifications for each of its commercial (including self-funded) benchmarks stating that the benchmark is adequate but not excessive; (b) an explanation of how its overall rate of growth across all payers fits within the overall APM target rate of growth and, if its overall rate of growth exceeds the APM target, how it plans to achieve the target for the term of APM Agreement (2017 to 2022); and (c) a revised budget based on the finalized benchmarks.

6. The maximum amount of risk OneCare may assume for 2020 is the sum of the following: 5% of the Medicare benchmark; 4% of the Medicaid benchmark; and a percentage of the commercial benchmarks in the ranges set forth in the relevant contracts. OneCare must request and receive an adjustment to its budget prior to executing a contract that would cause it to exceed these risk levels.

7. No later than March 31, 2020, OneCare must provide a written follow-up on each action item identified in the August 16, 2019 "Insights from Hospital/FQHC Scale Survey: Results and Reactions" for which OneCare was designated as the responsible party.[10]

8. No later than April 15, 2020, OneCare must present to the Board on the following topics:
    a. 2020 attribution and payer contracts;
    b. Revised budget, based on final attribution;
    c. Final description of population health initiatives;
    d. Expected hospital dues for 2020 by hospital;
    e. Expected hospital risk for 2020 by hospital and payer;
    f. Any changes to the overall risk model for 2020;
    g. Source(s) of funds for OneCare's 2020 population health management programs; and

[10] https://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/GMCB%20Scale%20Memo%208-15-2019.pdf

h. Any other information the Board deems relevant to ensuring compliance with this order.

9. No later than March 31, 2020, OneCare must provide GMCB staff with the supporting documentation relevant to the topics identified in Condition 8. Among the supporting documentation, OneCare must submit:
    a. Final payer contracts;
    b. Attribution by payer;
    c. A revised budget, using a template provided by GMCB staff;
    d. Final descriptions of OneCare's population health initiatives;
    e. Hospital dues for 2020 by hospital;
    f. Hospital risk for 2020 by hospital and payer;
    g. Documentation of any changes to the overall risk model for 2020;
    h. Source of funds for its 2020 population health management programs; and
    i. Any other information the Board deems relevant to ensuring compliance with this order.

10. If total revenues are projected to increase, the administrative expense ratio must not exceed 1.35%, and if total revenues are projected to decrease, the administrative expenses ratio must not exceed 1.60%, unless otherwise approved by the Board. The Board will review this condition based on final attribution.

11. OneCare must implement the delegated risk model it described in its budget proposal, except that it must:
    a. Submit to the Board copies of the contracts that bind each of the risk-bearing hospitals to OneCare's risk sharing policy;
    b. For the hospitals that are not covering 100% of their assumed risk, provide the Board with irrevocable letters of credit or other documentation specifying how UVMMC and/or DH-H will back the uncovered portion(s) of risk;
    c. Inform the Board whether it has secured aggregate Total Cost of Care protection for Medicare or any other payer programs in 2020; and
    d. Notify the Board staff within 15 days of any changes to OneCare's risk model outlining effects by hospital and by founder.

12. If OneCare uses its $4 million reserve, it must notify the Board within 15 days of such use. Notification must include the reason for drawing down the reserve and, for any use authorized under Condition 12(c), a corresponding cash flow analysis. The use of this reserve shall be limited to:
    a. Additional funding for population health investments;
    b. Financial backing for risk incurred by hospitals engaging in sustainability planning;
    c. Temporary cash flow issues associated with payer revenue delays; and
    d. Other uses pre-approved by the Board.

13. If population health management programs are not fully funded as detailed in OneCare's 2020 budget submission, OneCare must submit a revised proposal no later than March 31, 2020 to the Board. This should include any requests for budget revisions, for changes to OneCare programs, including any funding shortfalls, changes in program scope, and an analysis for each program line item as to whether and why the funding is appropriately scaled by attribution, or some other factor.

14. In 2020, OneCare must fund the SASH and Blueprint for Health (PCMH and CHT) investments in the amount of $8,401,660, at a minimum.

15. OneCare must report quarterly on information required by the Board. This Quarterly reporting will include:
    a. Financial statements to include cash flows, income statement, and balance sheet;
    b. Information on population health investments by Health Service Area, program, and provider type;
    c. Information on the 2020 complex care coordination program implementation, enrollment, payments, patient satisfaction, and, as they arise, relevant challenges and learning opportunities; and
    d. Any other information the Board deems relevant to ensuring compliance with this order.

16. OneCare must use its community-specific quality health investments (VBIF and future variable value-based payments) to address cost and quality differences across Health Service Areas as identified in OneCare's variations-in-care analysis. These programs must be evidence-informed, assessed by OneCare for return on investment, and tracked by the ACO.

17. No later than April 30, 2020, OneCare must provide a report on how its population health investments address cost and quality differences across Health Service Areas as identified in OneCare's variations-in-care analysis.

18. No later than June 30, 2020, or a date agreed to by OneCare and GMCB staff, OneCare must develop a workplan to evaluate the effectiveness of its population health investments including analysis of how to scale those that are successful, sunset those that are not, and report on opportunities for sustainability. This plan must include the identity of each entity receiving funding, the funding amount, any evidence supporting the purpose(s) of the corresponding project, a distribution plan for the funding, the scope of project, relevant timeframe(s) for implementation and evaluation, any measurable outcomes, and any risks, issues, or challenges. This workplan may exclude the Blueprint for Health investments (SASH, CHT, and PCMH). For competitive grants, OneCare should provide an explanation of the criteria by which it evaluates proposals for funding.

19. No later than July 31, 2020, OneCare must submit to the Board a prototype for an ACO performance dashboard and a proposed plan to implement the performance dashboard by December 31, 2020. GMCB staff will work with OneCare to determine the required form and content for the submission and to establish appropriate methodologies for reporting

quality results in such a way to allow for valid comparisons where feasible. At a minimum the dashboard shall profile population health and financial data by HSA and payer in a way that promotes variational analysis across HSAs and readily reconciles to Board approved and projected fiscal year budgets and population health performance targets. The Board will also provide an opportunity for the Health Care Advocate to provide input into the dashboard, including methodologies for quality reporting.

20. Over the duration of the APM Agreement, OneCare's administrative expenses must be less than the health care savings, including an estimate of cost avoidance and the value of improved health, projected to be generated through the Model.

21. OneCare must submit its audited financial statements as soon as they are available and must submit information as required by the Board to monitor OneCare's performance.

22. After notice and an opportunity to be heard, the Board may make such further orders as are necessary to carry out the purposes of this Order and 18 V.S.A. § 9382.

So ordered.

Dated: January 31, 2020 at Montpelier, Vermont

s/ Kevin Mullin, Chair)
)
s/ Jessica Holmes) GREEN MOUNTAIN
) CARE BOARD
s/ Robin Lunge) OF VERMONT
)
s/ Maureen Usifer)
)
s/ Tom Pelham)

Filed: January 31, 2020

Attest: */s/ Jean Stetter*
Green Mountain Care Board
Administrative Services Coordinator

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (Email address: Janeen.Morrison@vermont.gov).

EXHIBIT F

To:	Susan Barrett, Michael Barber, Alena Berube, Melissa Miles, Sara Tewksbury, and Healthcare Advocate Policy Team
From:	Joan Zipko
CC:	Vicki Loner, Sara Barry, Tom Borys, Amy Bodette, Spenser Weppler
Date:	June 19, 2020
Subject:	Budget Order Deliverables 9a-9h

Dear GMCB and Healthcare Advocate Policy Teams:

Enclosed, please find OneCare's submission for deliverables 9a-9h per OneCare's FY2020 Budget Order (2/4/2020) and subsequent FY2020 Budget Order Amendment (4/6/2020) along with the Memorandum entitled "Guidance to OneCare Vermont re: FY2020 Final Budget Presentation" (5/14/2020).

Please note that payer contracts for Medicare, Medicaid, BCBSVT QHP and MVP QHP (item 9a) are not included as they have been previously supplied to the Board.

Please let me know if you have any questions.

Sincerely,

Joan Zipko, MHA
Director, Operations
(802) 847-0732
OneCare Vermont
356 Mountain View Drive, Suite 301
Colchester, VT 05446

Attachments (1)

a) 2020 attribution and payer contracts

OneCare executed all payer contracts noted in the initial submission of the budget with the exception of the BCBSVT Primary agreement. This agreement is in the final review stage and execution is expected later this month. The table below shows the initial January attribution figures. Attribution for the BCBSVT Primary remains an estimate and final data will be available after execution of the contract and submission of the final network roster.

In addition to the ordinary variation between the submitted attribution estimates and the final attribution outcomes, there were two other significant changes. First, the Medicaid program now has two cohorts: Traditional and Expanded. The Traditional cohort attributes based on historical claims with a OneCare PCP. The Expanded cohort is comprised of lives that do not have a historical qualifying PCP visit, but OneCare has agreed to take accountability. Second, the BCBSVT Primary program has been divided into two cohorts as well. There is a "Risk" cohort for lives covered by health plans willing to participate in Vermont's health care reform efforts, and a "Non-Risk" cohort for the remaining lives. In total, 2020 represented another year of significant attribution growth.

Program	Contract Status	Preliminary Attribution	Initial Attribution	Variance
Medicare	Executed	53,014	50,554	-2,460
Medicaid - Traditional	Executed	94,221	82,370	-11,851
Medicaid - Expanded	Executed	0	21,178	21,178
BCBSVT QHP	Executed	23,538	20,221	-3,317
MVP QHP	Executed	12,304	9,944	-2,360
BCBSVT Primary – Risk *	In Process	66,387	38,891	-27,496
Scale Target Attribution		**249,464**	**223,158**	**-26,306**
BCBSVT Primary – Non-Risk **	In Process	0	44,550	44,550
Scale Target Attribution		**249,464**	**267,708**	**18,244**

* Attribution estimated

** Attribution estimated and lives do not count towards Vermont scale targets

b) Revised budget, based on final attribution

The accompanying budget summary represents the latest iteration of OneCare's programs and operations. The components within are accurate as of June 16, 2020 when the budget was

approved by the OneCare Board of Managers. Lastly, note that the presentation layout is designed to transparently show the scope of OneCare programs and operations and is not intended to comply with GAAP.

In ordinary times this budget update would incorporate changes to attribution, benchmarks, and any downstream financial components. This revised budget, however, also includes the response to unrealized Delivery System Reform funding and the COVID-19 pandemic.

The budget changes can be generally classified as either changes to population health management (PHM) investments or operating expenses. In regard to PHM investments, changes required thoughtful decision-making to avoid further financial disruption to the provider network. The following decision criteria were used to guide this process:

1. Sustain existing OneCare programs
2. Sustain committed funding to network participants
3. Target initiatives with significant operational resource demands
4. Prioritize initiatives with potential short-term financial and clinical benefits
5. Target initiatives that are funded by hospital dues

The most substantive changes to the PHM investments include waiver of the requirement to fund 0.5% of the Medicaid All Inclusive Population Based Payment into the Value Based Incentive Fund, and rolling back planned investments in the pharmacy initiative and Innovation Fund. All of these budget modifications were aligned with the criteria outlined above.

Operating expenses were also modified in order to offer dues relief to the participating hospitals. These changes include a hiring freeze on all vacant positions, leadership compensation reductions, and modification to operating costs. In addition, the decision was made to forego reinsurance in 2020, which also results in material dues reduction for the hospitals.

The end product is a recast budget that responds to the public health emergency, retains the core operability of OneCare, and delivers $6.2M of dues relief to hospitals. The COVID-19 pandemic changed our strategies, but the need for effective population health and payment reform remains essential to manage cost growth, improve quality, and improve patient outcomes.

c) Final description of population health initiatives

Complex Care Coordination Program

OneCare promotes a decentralized, community-based approach for care coordination service delivery with the intent of creating a system of care in which all Vermonters have access to high quality, evidence-informed, interdisciplinary care coordination across the continuum. The foundation of the care coordination model is the Population Health Care Model which segments attributed lives into risk categories of (i) Healthy/well, (ii) Early onset/stable chronic disease, (iii) Full onset chronic disease/rising risk, and (iv) Complex/catastrophic. Care coordination interventions and expectations specific to risk category are defined, taught, supported and tracked across all

health services areas by OneCare's Care Coordination team. Training sessions covering various essential components of care coordination are conducted via in person, virtual, and on line venues. In 2020, the care coordination payment model will advance from a capacity based to a value based model. Originally targeted for April 1, 2020 implementation, the new value-based care coordination payment model implementation date was postponed to July 1, 2020 by OneCare's Board of Managers in response to the uncertainty created from the public health emergency and the desire to facilitate dependable funding streams to hard-hit provider organizations.

In 2020, the Developmental Understanding and Legal Collaboration for Everyone (DULCE) program is operating in four pediatric-serving primary care practices. Since the public health emergency, visits continue at pediatric sites primarily through telemedicine. Family specialists are joining visits through Zoom or video calls with providers and providing phone consults to families.

Another innovative advancement in the care coordination program in 2020 is the addition of the Longitudinal Care Program supporting in-home services provided to Vermonters with chronic disease, a recent hospitalization, and barriers to self-management such as anxiety or depression, who do not otherwise qualify for home health services.

Early in the public health emergency OneCare's Analytics team leveraged clinical guidance coming out of the Centers for Disease Control (CDC), World Health Organization (WHO), and Johns Hopkins to create a new self-service analytics tool that identified those in the population who are most at risk of serious illness or mortality if they were to become infected with COVID-19. The application allows users to select high risk criteria to narrow down their full patient panel and proactively outreach to the most at risk patients to ensure they are triaged, have information to stay safe, and at the same time can determine future needs for regular telemedicine visits. Since the initial release of the application, OneCare has continued to rely on the guidance of the previously mentioned organizations to make enhancements to better serve the needs of vulnerable Vermonters. Examples of application enhancements include the incorporation of COVID-19 test results from the health information exchange, as well as indicators of social complexity (e.g. food access and social isolation) which was a risk criteria coming from the CDC.

Population Health Management Investments

OneCare has continued its investment in primary care through a $3.25 per member per month (PMPM) payment for each attributed life. This funding supports ACO-related activities in primary care to improve population health management, increase the utilization of available data provided by OneCare, and drive continuous quality improvement efforts to advance patient outcomes and experience of care delivered in the patient centered medical home (PCMH). This investment is projected to be nearly $8.4M in 2020, and is funded from both hospital dues and payer contract contributions.

In response to the public health emergency, OneCare's Board approved the pre-payment of monthly PHM payments to its network for May and June 2020. This is intended to provide cash flow to practices hard-hit by the pandemic.

Comprehensive Payment Reform (CPR) Program

OneCare has budgeted $1.2M to support independent primary care practices participating in the Comprehensive Payment Reform (CPR) program. The program is designed to move participating independent primary care practices away from a fee-for-service payment model to a value based payment model with a fixed per member per month payment across payers. This creates revenue predictability and reliability for practices and is intended to provide flexibility to reform care delivery systems alongside the payment reforms.

Changes to this program include a variable payment tied to engagement in the complex care coordination program, and the achievement of quality improvement targets were scheduled to take effect on January 1, 2020 (to be measured one quarter in arrears). As a result of the public health emergency, all provider types, including independent primary care, experienced significant financial hardships. While the CPR practices were partially buffered from this by their fixed payments through the CPR program, for their remaining volume-based revenue, the sharp decrease in utilization and unpredictability of the return of patient demand for care has created fragility in the system of care. On April 15, 2020 OneCare's Board passed a resolution to address the financial needs of CPR participants that provided 100% of the care coordination variable payments for their engagement in the care coordination program for the same time the capacity-based payment model is in place for the rest of OneCare's network. The resolution also noted that CPR participants continue to be measured on quality, but 100% of the variable payment would be released for reporting on the measures.

Expanded Medicaid Population

OneCare has received an additional 28,552 lives through expanded attribution from Medicaid in 2020. This population does not meet the traditional attribution requirement of having a qualifying visit with an ACO participating provider in the lookback period. They do have full Medicaid coverage (non-duals) and are eligible for Medicaid during the contract year. This includes those with no claims, members that are new to Medicaid, and members with some utilization visiting mostly specialists or using hospital services but no connection to a primary care provider. To encourage engagement with this population a one time, $100 engagement payment will be made to a primary care provider that engages one of these members in a qualifying visit in the contract year. The Expanded Medicaid population is also eligible to participate in OneCare's Complex Care Coordination program.

Primary Prevention Programs

OneCare continues to believe that investments in primary prevention are necessary to achieve optimal health and wellbeing of all Vermonters. In 2020, OneCare has continued to support RiseVT through local community activities and programs in collaboration with area hospitals, health department district offices, and other interested community partners. With the advent of the public health emergency, OneCare's RiseVT team quickly reached out to work with these partners to make adjustments with sensitivity to the limitations caused by the pandemic. RiseVT quickly shifted to supporting the wellness of children and families in the home environment. The majority of RiseVT program managers based at hospitals throughout the state have been redeployed to support drive up testing and triaging patients within hospitals. To continue the wellness programming in local communities, the RiseVT state team launched a virtual campaign during this period called "We've

Got You" which offers wellness content through a daily statewide email promoting good health while at home as well as content aimed at preventing the spread of virus, obtaining and stretching food for families experiencing hardship, and strategies to care for your mental health. Over 650 Vermonters subscribe to the campaign with 12,506 followers on social media channels. In addition, the ShedsVT project, an evidence-informed model to reduce social isolation, improve health, and reduce suicide risk, that started in the spring in partnership with the Cigna Foundation, has been put on hold until 2021. As a result of these shifts, OneCare has been able to reduce programming costs for 2020 as reflected in our revised budget.

Specialty Care

OneCare is collaborating in 2020 with many community providers to advance and coordinate provision of specialty care. Due to pre-pandemic uncertainty in full realization of Delivery System Reform funding, OneCare's Board decided not to move forward in 2020 with testing and implementation of an embedded pharmacy program. In response to the public health emergency, OneCare sought to further reduce planned activities in this area with corresponding savings to the overall budget model. In 2020, OneCare is supporting:

- a chronic kidney disease (CKD) care coordination program that fosters patient-centered choices for care of patients with CKD and End Stage Renal Disease.
- a partnership with Vermont Care Partners and three of its designated mental health and substance abuse agencies (Washington County Mental Health Services, Northeast Kingdom Human Services, and Northwestern Counselling and Support Services) to embed mental health staff in local hospitals in an effort to reduce avoidable emergency department (ED) usage and augment access to mental health and substance abuse care for adults identified by the ED as in need for care.
- Continuation of the embedded mental health clinician in congregate housing pilot underway through a collaboration among Supports and Services at Home (SASH) and the Howard Center. Early program outcomes have demonstrated reduced stigma, improved access to mental health services, and a reduction in ED visits from 2017 to 2019.

Innovation Fund

In 2020, OneCare continues to support eight projects funded through the 2019 funding cycles overseen by the Population Health Strategy Committee. As a result of the public health emergency, OneCare's Board has eliminated new innovation project funding for 2020 and several existing project teams requested to pause their planned activities until it is appropriate to resume them in accordance with safe practices.

Blueprint Programs

OneCare continues to fund the Supports and Services at Home (SASH) program as well as the Medicare portion of the Patient Centered Medical Home and Community Health Team payments for a total of $8,401,660. This advanced payment is made possible because of OneCare's contract with the Centers for Medicare and Medicaid Innovation for the 2020 ACO program. The payments are disbursed to Health Service Areas, regardless of participation in the Medicare program with OneCare. In 2020, 6 of the 14 hospitals are not participating in the Medicare program.

d) Expected hospital dues for 2020 by hospital

The following table compares the initial dues estimate to the revised budget. In total, the budget modifications yield $6.2M of dues relief to the participating hospitals.

Hospital	Original Budget	Revised Budget	Change
SVMC	$1,900,307	$1,519,831	($380,475)
CVMC	$3,247,717	$2,403,718	($843,998)
BMH	$1,152,539	$815,747	($336,792)
UVMMC	$9,555,250	$7,340,106	($2,215,144)
DH	$1,153,414	$1,044,146	($109,268)
Porter	$1,259,947	$782,832	($477,115)
Copley	$204,388	$137,162	($67,227)
NCH	$1,062,570	$824,845	($237,725)
Gifford	$245,459	$102,142	($143,317)
RH	$1,430,792	$1,031,701	($399,090)
Springfield	$160,983	$116,153	($44,830)
NMC	$1,571,870	$1,174,600	($397,271)
NVRH	$749,945	$525,519	($224,426)
Mt A	$772,047	$407,268	($364,778)
Total	**$24,467,227**	**$18,225,772**	**($6,241,456)**

e) Expected hospital risk for 2020 by hospital and payer

The COVID-19 pandemic disrupted care delivery patterns dramatically. As a result, OneCare is in active discussions with payers to evaluate appropriate program modifications to protect participating providers from added financial risk. While encouraged by the spirit of the conversations, modifications have not been finalized.

Because changes to the risk terms have not been finalized, the general magnitude of risk presented in the original 2020 budget submission remains in effect. As terms become final, OneCare will submit both the nature of these changes as well as the corresponding hospital and payer breakdowns to the GMCB.

f) Any changes to the overall risk model for 2020

The risk/reward sharing model has been discussed at length with network participants. At this point in time no change has been made. The risk model will continue to be evaluated in the context of the pandemic and the GMCB will be notified of any changes.

g) Source(s) of funds for OneCare Vermont's 2020 population health management programs

The accompanying 2020 Source of Funds table displays the underlying funding for each of OneCare's population health management initiatives. In some cases part of the program is funded using external support and the remainder is funded with hospitals resources. Note that that Specialist Program, Innovation Fund, and VBIF Quality Initiative line items are funded using hospital dollars obligated in a prior year.

h) Any other information the Board deems relevant to ensuring compliance with this order.

No other requests received to date.

OneCare Vermont

2020 Budget
Summary P&L
6/24/2020

Revenue Category	2020 GMCB #1	2020 GMCB #2	Change
Medicare TCOC	$537,956,206	$526,275,110	($11,681,096)
Medicare - Blueprint Obligation	$8,242,374	$8,401,660	$159,285
Medicaid - Traditional TCOC	$282,844,678	$248,513,292	($34,331,387)
Medicaid - Expanded TCOC	$0	$57,569,236	$57,569,236
BCBSVT QHP TCOC	$120,866,992	$100,320,855	($20,546,137)
MVP QHP TCOC	$46,830,443	$46,728,978	($101,466)
BCBSVT Primary - Risk	$373,742,964	$225,249,708	($148,493,256)
TCOC Targets Total	**$1,370,483,658**	**$1,213,058,838**	**($157,424,820)**
Payer Program Support	$10,757,375	$11,477,109	$719,734
DSR Funding	$7,800,000	$3,900,000	($3,900,000)
Fixed Payment Allocation	$5,300,000	$4,300,000	($1,000,000)
Health Information Technology	$3,500,000	$2,800,000	($700,000)
Other Revenues	$2,325,838	$1,829,074	($496,764)
Hospital Dues	$24,467,227	$18,225,772	($6,241,456)
Total Revenue	**$1,424,634,098**	**$1,255,590,792**	**($169,043,306)**
FFS Spend	$890,593,232	$811,574,481	($79,018,751)
Fixed Payment Spend	$471,648,052	$393,082,697	($78,565,355)
Health Services Spending Total	**$1,362,241,283**	**$1,204,657,178**	**($157,584,106)**
Base OCV PMPM	$8,569,920	$8,420,662	($149,258)
Complex Care Coordination Program	$10,223,590	$9,672,306	($551,283)
Value-Based Incentive Fund	$8,387,232	$5,640,553	($2,746,679)
Primary Prevention Programs	$1,031,752	$540,000	($491,752)
Comp. Payment Reform Program	$1,606,613	$1,192,196	($414,418)
Specialist Program	$3,144,500	$754,800	($2,389,700)
Innovation Fund	$1,367,580	$725,521	($642,059)
VBIF Quality Initiatives	$167,505	$33,000	($134,505)
PCMH Payments	$1,894,417	$1,993,092	$98,675
Community Health Team Payments	$2,379,711	$2,440,322	$60,611
SASH	$3,968,246	$3,968,246	$0
Primary Care Engagement	$375,000	$636,436	$261,436
Total PHM Investments	**$43,116,066**	**$36,017,134**	**($7,098,932)**
General Operations	$18,200,836	$14,916,480	($3,284,356)
Risk Protection	$1,075,912	$0	($1,075,912)
Total Infrastructure	**$19,276,749**	**$14,916,480**	**($4,360,268)**
Total Expenses	**$1,424,634,098**	**$1,255,590,792**	**($169,043,306)**
Gain (Loss)	**$0**	**$0**	**$0**

OneCare Vermont

2020 PHM Source of Funds Table

6/24/2020

Initiative	Cost	External Revenue Source	External Funding	Hospital Funding
Base OCV PMPM	$8,420,662	Payer Contract Support	$7,021,961	$1,398,702
Complex Care Coordination Program	$9,672,306	Fixed Payment Allocation; DSR; Payer Contract Support	$4,846,872	$4,825,434
Value-Based Incentive Fund	$5,640,553	None	$0	$5,640,553
Primary Prevention Programs	$540,000	None	$0	$540,000
Comp. Payment Reform Program	$1,192,196	None	$0	$1,192,196
Specialist Program	$754,800	None	$0	$754,800
Innovation Fund	$725,521	None	$0	$725,521
VBIF Quality Initiatives	$33,000	None	$0	$33,000
PCMH Payments	$1,993,092	Medicare Shared Savings (if earned)	$1,993,092	$0
Community Health Team Payments	$2,440,322	Medicare Shared Savings (if earned)	$2,440,322	$0
SASH	$3,968,246	Medicare Shared Savings (if earned)	$3,968,246	$0
Primary Care Engagement	$636,436	Payer Contract Support	$636,436	$0
Total	**$36,017,134**		**$20,906,929**	**$15,110,205**

EXHIBIT G

Part 4
Attachment B

Part 4. ACO Financial Plan - Appendix 4.2: Income Statement																		
Income Statement	**2016**		**2017**		**2018**		**2019**			**2020**	**2019B - 2019P**	**2019B - 2019P**	**2019B - 2020B**	**2019B - 2020B**	**2019P - 2020B**	**2019P - 2020B**
	Budget	**Actual**	**Budget**	**Actual**	**Budget**	**Actual**	**Budget Submitted**	**Budget Approved**	**Projected**	**Budget Submitted**	**$ Change**	**% Change**	**$ Change**	**% Change**	**$ Change**	**% Change**
Revenues																		
Program Target Revenue																		
Medicare - Claims	$ -	$ -	$ -	$ -	$ 347,240,276	$ 377,155,427	$ 460,866,439	$ 460,866,439	$ 522,370,668	$ 537,956,206	$ 61,504,229	13.3%	$ 77,089,767	16.7%	$ 15,585,538	3.0%
Medicare - Blueprint Obligation	-	-	-	-	7,762,500	7,776,760	6,445,980	6,445,980	6,445,980	8,242,374	-	0.0%	1,796,394	27.9%	1,796,394	27.9%
Medicaid	-	-	-	-	118,833,295	117,249,629	193,327,432	193,327,432	201,150,937	282,844,678	7,823,505	4.0%	89,517,246	46.3%	81,693,741	40.6%
Commercial - QHP	-	-	-	-	133,395,719	103,251,399	124,784,779	124,784,779	105,322,820	167,697,435	(19,461,959)	-15.6%	42,912,656	34.4%	62,374,615	59.2%
Commercial - Self-Funded	-	-	-	-	-	-	65,289,304	65,289,304	Data Pending	373,742,964	#VALUE!	#VALUE!	308,453,660	472.4%	#VALUE!	#VALUE!
Other - (Enter Account Here)	-	-	-	-	-	-	-		-	-						
Total	-	-	-	-	607,231,790	605,433,215	850,713,934	850,713,934	835,290,406	1,370,483,657	(15,423,529)	-1.8%	519,769,723	61.1%	535,193,251	64.1%
Payer Program Support Revenue																		
VHCIP	-	2,091,144	1,200,000	1,500,000	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
VMNG PMPM General Revenue	-	-	2,184,000	2,077,783	3,134,352	3,084,621	5,045,917	5,045,917	5,432,492	6,864,188	386,575	7.7%	1,818,272	36.0%	1,431,696	26.4%
VMNG PHM Program Pilot - Complex CC	-	-	1,300,000	1,307,983	2,980,045	2,901,190	5,579,347	5,579,347	5,500,000	-	(79,347)	-1.4%	(5,579,347)	-100.0%	(5,500,000)	-100.0%
Commercial - QHP Program Reform Pilot Support	-	-	-	-	1,000,000	743,600	851,213	851,213	739,131	1,377,624	(112,082)	-13.2%	526,411	61.8%	638,493	86.4%
Commercial - Self-Funded Programs Revenue	-	-	-	-	-	750,972	1,361,275	1,361,275	361,981	2,515,563	(999,294)	-73.4%	1,154,288	84.8%	2,153,582	594.9%
Primary Prevention Revenue	-	-	-	-	1,500,000	-	1,000,000	1,000,000	1,100,000	-	100,000	10.0%	(1,000,000)	-100.0%	(1,100,000)	-100.0%
OUD Investment Revenue	-	-	-	-	-	-	1,200,000	1,200,000	-	-	(1,200,000)	-100.0%	(1,200,000)	-100.0%	-	#DIV/0!
UVMMC Self-Funded Pilot Revenue	-	-	-	-	1,075,896	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
CMMI Revenue	-	-	2,000,000	1,999,548	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Value Based Incentive Fund	-	-	-	412,070	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
BCBSVT Primary Revenue	-	-	-	-	-	-	-	-	1,421,875	-						
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Total	-	2,091,144	6,684,000	7,297,384	9,690,293	7,480,382	15,037,751	15,037,751	14,555,479	10,757,376	(482,272)	-3.2%	(4,280,376)	-28.5%	(3,798,104)	-26.1%
State Support																		
Informatics Infrastructure Support	-	-	1,500,000	1,500,000	3,500,000	3,500,000	4,250,000	4,250,000	4,250,000	3,500,000	0	0.0%	(750,000)	-17.6%	(750,000)	-17.6%
Healthcare Reform Investments	-	-	-	-	-		-	-	-	13,100,000	-					
Other - (Enter Account Here)	-	-	-	-	-		-	-	-	-	-					
Total	-	-	1,500,000	1,500,000	3,500,000	3,500,000	4,250,000	4,250,000	4,250,000	16,600,000	0	0.0%	12,350,000	290.6%	12,350,000	290.6%
Grant Revenue																		
Robert Wood Johnson	-	-	124,443	-	51,851	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Total	-	-	124,443	-	51,851	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
MSO Revenues																		
Adirondack ACO Revenues	-	-	216,000	216,000	216,000	216,000	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
CAC Revenues	-	-	104,000	-	104,000	-	-	-	-	146,253	-	#DIV/0!	146,253	#DIV/0!	146,253	#DIV/0!
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Total	-	-	320,000	216,000	320,000	216,000	-	-	-	146,253	-	#DIV/0!	146,253	#DIV/0!	146,253	#DIV/0!
Other Revenue																		
Member Contributions	5,833,357	5,192,956	-	-	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Hospital Participation Fee	2,000,000	2,000,000	4,318,597	2,459,389	18,459,071	17,399,336	28,617,281	28,617,281	27,745,386	24,467,227	(871,895)	-3.0%	(4,150,054)	-14.5%	(3,278,159)	-11.8%
Other Misc. Revenues	-	-	-	-	-	-	-	-	99,985	-	99,985	#DIV/0!	-	#DIV/0!	(99,985)	-100.0%
Use of deferred revenues - 2019 Par Fees	-	-	-	1,397,134	-	-	-	-	-	2,012,080	-	#DIV/0!	2,012,080	#DIV/0!	2,012,080	#DIV/0!
Use of deferred revenues - 2019 VBIF	-	-	-	600	-	282,516	-	-	-	167,505	-	#DIV/0!	167,505	#DIV/0!	167,505	#DIV/0!
UVMMC Funding	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
DHH Funding	-	-	-	-	-	-	-	-	-	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Grant Revenue	2,090,000	-	-	-	-	-	-	-	-	-						
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Total	9,923,357	7,192,956	4,318,597	3,857,123	18,459,071	17,681,853	28,617,281	28,617,281	27,845,371	26,646,813	(771,910)	-2.7%	(1,970,469)	-6.9%	(1,198,559)	-4.3%
Total Revenues	9,923,357	9,284,100	12,947,040	12,870,507	639,253,005	634,311,450	898,618,967	898,618,967	881,941,256	1,424,634,098	(16,677,710)	-1.9%	526,015,131	58.5%	542,692,842	61.5%

***Not part of OCV Financial Statement - Illustrative for Comparison

Part 4

Income Statement	2016		2017		2018		2019			2020	2019B - 2019P		2019B - 2020B		2019P - 2020B	
	Budget	Actual	Budget	Actual	Budget	Actual	Budget Submitted	Budget Approved	Projected	Budget Submitted	$ Change	% Change	$ Change	% Change	$ Change	% Change
Expenses																
Payer-Paid FFS***	-	-	-	-	228,417,540	360,265,990	517,906,948	517,906,948	475,369,301	890,593,230	(42,537,647)	-8.2%	372,686,282	72.0%	415,223,929	87.3%
Fixed Prospective Payments***	-	-	-	-	371,051,749	237,390,466	313,676,394	313,676,394	351,903,853	471,648,053	38,227,459	12 2%	157,971,659	50.4%	119,744,200	34.0%
Expected Spending Under (Over) Claims Target****	-	-	-	-	-	-	11,073,117	11,073,117	-	-	(11,073,117)	-100.0%	(11,073,117)	-100.0%	-	#DIV/0!
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Total	-	-	-	-	599,469,289	597,656,455	842,656,459	842,656,459	827,273,154	1,362,241,283	(15,383,305)	-1.8%	519,584,824	61.7%	534,968,129	64.7%
Operational Expenses																
Salaries and Benefits	6,051,827	5,299,659	5,839,224	4,922,769	6,583,992	6,600,698	8,868,076	8,868,076	7,448,284	11,776,602	(1,419,792)	-16.0%	2,908,525	32.8%	4,328,318	58.1%
Contracted Services	845,002	722,060	2,953,115	2,568,450	817,507	1,304,899	2,163,124	2,163,124	1,213,421	1,173,970	(949,703)	-43.9%	(989,154)	-45.7%	(39,451)	-3.3%
Software	-	-	-	-	-	-	3,163,190	3,163,190	3,709,501	3,726,889	546,311	17 3%	563,699	17.8%	17,388	0.5%
Insurance/Risk Protection	-	-	-	-	1,500,000	785,018	84,531	84,531	84,531	150,000	0	0.0%	65,469	77.5%	65,469	77.4%
Supplies	-	-	-	-	-	-	152,414	152,414	416,013	188,830	263,599	172 9%	36,416	23.9%	(227,183)	-54.6%
Travel	-	-	-	-	-	-	138,245	138,245	125,832	103,250	(12,413)	-9.0%	(34,995)	-25.3%	(22,582)	-17.9%
Occupancy	-	-	-	-	-	-	393,439	393,439	356,144	456,859	(37,294)	-9.5%	63,421	16.1%	100,715	28.3%
Other	-	-	-	-	-	-	184,337	184,337	832,026	485,500	647,689	351.4%	301,163	163.4%	(346,526)	-41.6%
Meetings	-	-	978,250	847,440	-	-	-	-	-	35,700	-	#DIV/0!	35,700	#DIV/0!	35,700	#DIV/0!
Professional Development	2,726,528	3,262,381	784,451	692,279	3,591,161	2,976,510	-	-	-	103,238	-	#DIV/0!	103,238	#DIV/0!	103,238	#DIV/0!
Reinsurance / Risk Protection	-	-	-	-	-	-	767,833	767,833	1,015,100	1,075,912	247,267	32 2%	308,079	40.1%	60,812	6.0%
Total	9,623,357	9,284,100	10,555,040	9,030,938	12,492,660	11,667,125	15,915,189	15,915,189	15,200,852	19,276,749	(714,337)	-4.5%	3,361,560	21.1%	4,075,897	26.8%
PHM/Payment Reform Programs																
Basic OCV PMPM	-	-	1,092,000	1,038,892	4,781,010	4,040,439	5,935,530	5,935,530	6,586,952	8,569,920	651,422	11 0%	2,634,390	44.4%	1,982,968	30.1%
Complex Care Coordination Program	-	-	1,300,000	977,616	7,064,722	5,618,420	9,181,362	9,181,362	9,106,207	10,223,590	(75,155)	-0.8%	1,042,228	11.4%	1,117,383	12.3%
Value-Based Incentive Fund - Total	-	-	-	412,070	4,305,223	4,243,973	7,537,231	7,537,231	7,009,529	8,387,232	(527,702)	-7.0%	850,001	11.3%	1,377,703	19.7%
Comprehensive Payment Reform Program	-	-	-	-	1,800,000	715,806	2,250,000	2,250,000	1,381,674	1,606,613	(868,326)	-38.6%	(643,387)	-28.6%	224,939	16.3%
Primary Prevention	300,000	-	-	-	1,577,600	620,381	910,720	910,720	707,029	1,031,752	(203,691)	-22.4%	121,032	13.3%	324,723	45.9%
Specialist Program	-	-	-	-	-	-	2,000,000	2,000,000	605,500	3,144,500	(1,394,500)	-69.7%	1,144,500	57.2%	2,539,000	419.3%
Innovation Fund	-	-	-	-	-	-	1,000,000	1,000,000	382,420	1,367,580	(617,580)	-61.8%	367,580	36.8%	985,160	257.6%
RCRs	-	-	-	-	-	-	375,000	375,000	350,000	-	(25,000)	-6.7%	(375,000)	-100.0%	(350,000)	-100.0%
VBIF Quality Initiatives	-	-	-	-	-	-	-	-	-	167,505	-	#DIV/0!	167,505	#DIV/0!	167,505	#DIV/0!
PCMH Payments	-	-	-	-	1,973,649	1,830,264	1,830,264	1,830,264	1,831,528	1,894,417	1,264	0.1%	64,153	3.5%	62,889	3.4%
Community Health Team Payments	-	-	-	-	2,518,898	2,245,852	2,411,679	2,411,679	2,321,670	2,379,711	(90,009)	-3.7%	(31,968)	-1.3%	58,041	2.5%
SASH	-	-	-	13,857	3,269,954	3,704,400	3,815,532	3,815,532	3,864,054	3,968,246	48,522	1.3%	152,714	4.0%	104,192	2.7%
Primary Care Engagement Investment	-	-	-	-	-	-	-	-	1,421,875	375,000						
Other - (Enter Account Here)	-	-	-	-	-	-	-	-	-	-						
Total	300,000	-	2,392,000	2,442,435	27,291,056	23,019,535	37,247,319	37,247,319	35,568,438	43,116,066	(1,678,881)	-4.5%	5,868,748	15.8%	7,547,628	21.2%
Total Expenses	9,923,357	9,284,100	12,947,040	11,473,373	639,253,005	632,343,115	895,818,967	895,818,967	878,042,444	1,424,634,098	(17,776,523)	-2.0%	528,815,131	59.0%	546,591,654	62.3%
Net Income	**$ - $ -**		**$ - $ 1,397,134**		**$ - $ 1,968,335**		**$ 2,800,000 $ 2,800,000 $ 3,898,812**			**$ -**	**$ 1,098,813**	**39.2%**	**$ (2,800,000)**	**-100.0%**	**$ (3,898,812)**	**-100.0%**
										$ -						
Other Reportables					0.7%											
FTEs		40 30		44.00	49.50	51.00	62.63	62.63	58.00	77.75	-4.63	-7.4%	15.12	24.1%	19.75	34.1%
Monitoring Items*																
Administrative (Operating) Expense Ratio+						1.84%	1.77%	1.77%	1.72%	1.35%						
PHM/Payment Reform (less MC SASH & Bpt)/Revenues						2.40%	3 2%	3.2%	3.1%	3.03%						
Operating Margin							0 3%	0.3%	0.4%	0 0%						
Total Margin							0 3%	0.3%	0.4%	0 0%						

*Will self-calculate with conditional formatting

**** Does not factor in risk corridor limits or upside/downside arrangement adjustments; Excludes Medicare advanced shared savings

+Administrative Expense Ratio is calculated as Total Operating Expenses (row 84) divided by Total Revenues (row 62)

Observations:

Questions:

EXHIBIT H

From: Loner, Victoria E. <Victoria.Loner@OneCareVT.org>
Sent: Friday, May 15, 2020 5:18 PM
To: Hoffer, Doug <Doug.Hoffer@vermont.gov>
Cc: Bodette, Amy <Amy.Bodette@onecarevt.org>; Barrett, Susan <Susan.Barrett@vermont.gov>; Mullin, Kevin <Kevin.Mullin@vermont.gov>; Gustafson, Cory <Cory.Gustafson@vermont.gov>; Stein, Andrew <Andrew.Stein@vermont.gov>; 'Linda J. Cohen (lcohen@DINSE.COM)' (lcohen@DINSE.COM) <lcohen@DINSE.COM>
Subject: RE: follow-up

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.
Dear Auditor Hoffer,

Thank you for your message. OneCare, in cooperation with our regulators and the Agency of Human Services, has committed to disclosing salary information in a manner akin to a 990 filing and requesting recognition by the IRS as a 501(c)(3) entity even though it cannot be a Vermont non-profit corporation. OneCare is in the process of developing the IRS request, which will be available to the public and your office once filed. In parallel, we are working with our regulator to finalize salary information close to 990 reporting while we work through the filing and recognition process. We will submit the salary information to our regulator directly. That information will also be available. In the past, OneCare has also provided numerous salary views and information to the Green Mountain Care Board including the year end average salary information for all employees and forecasted aggregate salary information by department (pg. 21) within OneCare. That information is available to the public as well.

The Auditor's office has requested, "a list of all current employees by job title (we don't need names) with a breakout of salaries and benefits for each." This information is exempt from public disclosure under Vermont's Public Records Act. 3 V.S.A. §317(7) and could not be published or commented on even if provided. As recognized by Vermont law, OneCare's staff and OneCare itself as an organization have an expectation of privacy in the salary information you have requested. The potential harm is not cured by a request for a listing by position. For example, if there are two administrative assistants at OneCare and their salary bands are shared, it would be easy to reverse engineer which assistant makes what which could lead to significant internal disruption. Or if there is only one Quality Management Program Coordinator, that person's salary would be clear. The relevance and probative value of the information requested is unclear to me, particularly given what OneCare is preparing to make available and what we have already made available and the self-described scope of the audit which is limited to describing the model, the oversight and the basis of payments.

OneCare remains willing to work with your office in good faith to respond to your requests for information. OneCare has worked hard to cooperate with your office by answering many questions, providing documents, and meeting with representatives of the Auditor's office in response to many requests. As you recognize, these are unprecedented times for health care providers in Vermont, and OneCare's efforts will continue focusing on supporting providers so they can take care of Vermonters.

Vicki

Vicki Loner RN.C, MHCDS

Chief Executive Officer
Phone: (802) 847-6255
Cell: (802) 324-9069
Executive Assistant: Janie Hall (802) 847-8205
OneCare Vermont
356 Mountain View Drive, Colchester, VT 05446
www.onecarevt.org

From: Hoffer, Doug <Doug.Hoffer@vermont.gov>
Sent: Friday, April 3, 2020 10:37 AM
To: Loner, Victoria E. <Victoria.Loner@OneCareVT.org>
Cc: Bodette, Amy <Amy.Bodette@onecarevt.org>; Barrett, Susan <Susan.Barrett@vermont.gov>; Mullin, Kevin <Kevin.Mullin@vermont.gov>; Gustafson, Cory <Cory.Gustafson@vermont.gov>; Stein, Andrew <Andrew.Stein@vermont.gov>
Subject: follow-up

Ms. Loner

Thank you for responding and answering one of the two questions. As for the second, I did not ask to "discuss" the matter of salaries; only that you provide records. And while I have acknowledged the challenge of these times (for all of us, not just OCV), my request does not require OneCare to gather or analyze new information. Indeed, what I requested is something that your organization (or a vendor) produces every time you pay those 61 employees. That is, payroll is a routine task and the records we seek already exist, so satisfying our request will not divert your focus from COVID-related matters.

If we were asking for something that required staff resources better directed to the crisis, I would unquestionably accept your offer to wait until the COVID crisis subsides. But that is not the case here, so I refer you to the contract, which requires that "Copies of any accounting records pertaining to the Contract shall be made available by the Contractor within ten (10) calendar days of receiving a written request from the State for specified records."

I look forward to hearing from you.

Respectfully,

Doug Hoffer
Vermont State Auditor
132 State Street
Montpelier, VT 05633-5101
802.828.2281 Office
802.828.2198 Fax
877.290.1400
doug.hoffer@vermont.gov

From: Loner, Victoria E. <Victoria.Loner@OneCareVT.org>
Sent: Thursday, April 2, 2020 7:04 PM
To: Hoffer, Doug <Doug.Hoffer@vermont.gov>
Cc: Bodette, Amy <Amy.Bodette@onecarevt.org>; Barrett, Susan <Susan.Barrett@vermont.gov>; Mullin, Kevin <Kevin.Mullin@vermont.gov>; Gustafson, Cory <Cory.Gustafson@vermont.gov>; Stein, Andrew <Andrew.Stein@vermont.gov>
Subject: RE: draft to OneCare

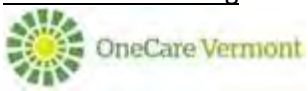
EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.
Dear Mr. Hoffer,

These are indeed unprecedented times, and all of our staff's energies are now focused entirely are on finding solutions at the State, Federal, and Payer level to assure provider solvency while they are tirelessly working on the front lines to save lives. Our current staff count is 61. Once the COVID crisis subsides, we would be happy to discuss the other details of your request. Until then, I am sure you understand that all of our focus needs to be on work that is in support of our providers and the healthcare needs of Vermonters.

Respectfully,

Vicki

Vicki Loner RN.C, MHCDS
Chief Executive Officer
Phone: (802) 847-6255
Cell: (802) 324-9069
Executive Assistant: Janie Hall (802) 847-8205
OneCare Vermont
356 Mountain View Drive, Colchester, VT 05446
www.onecarevt.org



From: Hoffer, Doug <Doug.Hoffer@vermont.gov>
Sent: Wednesday, April 1, 2020 2:14 PM
To: Loner, Victoria E. <Victoria.Loner@OneCareVT.org>
Cc: Bodette, Amy <Amy.Bodette@onecarevt.org>; Barrett, Susan <Susan.Barrett@vermont.gov>; Mullin, Kevin <Kevin.Mullin@vermont.gov>; Gustafson, Cory <Cory.Gustafson@vermont.gov>; Stein, Andrew <Andrew.Stein@vermont.gov>
Subject: RE: draft to OneCare

Dear Ms. Loner,

I am sure there's a lot of stress in your corner of the world right now. I hope you and your family and colleagues are well.

I am following up on Ms. Bodette's response to our request for information (see below) because she did not answer two of the questions posed.

1. She did not tell us how many employees are at OneCare.
2. She provided no salary data.

I'm curious why OneCare would respond as it did because, in my view, it is irrelevant what "other health care organizations share" because: 1) OneCare is not like other health care organizations; 2) the State Auditor's office is not like other parties seeking information; and 3) IRS 990s do not include the information we requested. And while I doubt it was intentional, I found the response discourteous.

As you know, OneCare's contract with the State (#32318) includes several provisions requiring OneCare to provide information to agents of the State upon request. For the questions posed, the relevant Section is 2.7.3 (p.16).

> "*Authorized representatives or agents of the State and the federal government shall have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction*" (emphasis added).

Payroll is unquestionably an accounting record, and the State Auditor's Office is an agent of the State. Please send us a list of all current employees by job title (we don't need names) with a breakout of salaries and benefits for each.

Thank you,
Doug

Doug Hoffer
Vermont State Auditor
132 State Street
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doug.hoffer@vermont.gov

From: Bodette, Amy <Amy.Bodette@onecarevt.org>
Sent: Monday, March 30, 2020 1:32 PM
To: Kingston, Jonathan <Jonathan.Kingston@vermont.gov>
Cc: Stevenson, Courtney <Courtney.Stevenson@vermont.gov>
Subject: RE: Non-Profit Request

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.
Hi Jonathan,

Answers below in red.

Could you please explain why there has such a significant increase in the salary and benefits budget, and how many employees OneCare currently has?

The OneCare budget model is scaled appropriately in relation to its current network, programs and number of attributed lives. This increase in the proposed budget is due to repatriating positions that were split with the Adirondack ACO in 2019, converting a legal services contract to an employed position, annualizing positions that were scheduled mid-year hires in 2019, and regular annual comp increases for all staff filling vacancies.

Also, OneCare submitted a 2018 salary table as part of their 2020 budget submission. The table shows that 61 employees were within the salary range of 0$ - $199,999 and had an average annual salary of $69,681.

May I please get a more precise breakout for that range (e.g., $0 - $49,999, $50,000 - $100,000, etc.)
OneCare will release a IRS 990 form (or equivalent) with salary information at the same level of detail that other health care organizations share.

Also, if OneCare has submitted a 501(c)(3) request to the IRS may I please get a copy of that request.
The application is still in process and will be made public once it has been submitted.

From: Kingston, Jonathan <Jonathan.Kingston@vermont.gov>
Sent: Thursday, March 19, 2020 2:02 PM
To: Bodette, Amy <Amy.Bodette@onecarevt.org>
Cc: Stevenson, Courtney <Courtney.Stevenson@vermont.gov>; Hoffer, Doug <Doug.Hoffer@vermont.gov>
Subject: FW: Non-Profit Request

Hi Amy,

I am following-up on my previous information requests. I have not heard from you and want to make certain that you had received them.

Could you please explain why there has such a significant increase in the salary and benefits budget, and how many employees OneCare currently has?

Also, OneCare submitted a 2018 salary table as part of their 2020 budget submission. The table shows that 61 employees were within the salary range of 0$ - $199,999 and had an average annual salary of $69,681.

May I please get a more precise breakout for that range (e.g., $0 - $49,999, $50,000 - $100,000, etc.)

Also, if OneCare has submitted a 501(c)(3) request to the IRS may I please get a copy of that request.

Because of everything going on with the COVID-19 virus, could please acknowledge receipt of this e-mail so that I know that you did receive it?

Thank you,

Jonathan
Senior Auditor
State Auditor's Office
State of Vermont
Phone: 802-828-0763
Fax: 802-828-5599

From: Kingston, Jonathan
Sent: Thursday, March 12, 2020 12:05 PM
To: Bodette, Amy <Amy.Bodette@onecarevt.org>

Cc: Stevenson, Courtney <Courtney.Stevenson@vermont.gov>
Subject: RE: Non-Profit Request

Hi Amy,

I also have a follow-on question regarding the salary and wages budget.

Our understanding is that OneCare currently has 63 employees which was the same as reported on the previously attached salary table. However, the salary and benefits budget has increase from $6.6 million in 2018 to $11.8 million for 2020 which is approximately an 80% increase.

Could you please explain why there has been a significant change to the salary budget?

Thank you,

Jonathan
Senior Auditor
State Auditor's Office
State of Vermont
Phone: 802-828-0763
Fax: 802-828-5599

From: Kingston, Jonathan
Sent: Thursday, March 12, 2020 11:05 AM
To: Bodette, Amy <Amy.Bodette@onecarevt.org>
Cc: Stevenson, Courtney <Courtney.Stevenson@vermont.gov>
Subject: Non-Profit Request

Hi Amy,

It is our understanding that OneCare is applying for 501(c)(3) non-profit status with the IRS. If OneCare has made that request may we please get a copy of that request?

Also, OneCare submitted the attached salary table as part of their 2020 budget submission. The table shows that 61 employees are within the salary range of 0$ - $199,999 with an average annual salary of $69,681.

May we please get a more precise breakout for that range (e.g., $0 - $74,999, $75,000 - $125,000, etc.)

Thank you,

Jonathan
Senior Auditor
State Auditor's Office
State of Vermont
Phone: 802-828-0763
Fax: 802-828-5599

reply to this message to notify the Sender that the message was received by you in error, and then permanently delete this message from all storage media, without forwarding or retaining a copy.

EXHIBIT I

Provide Headcount & Box 5 Wages from 2018 W2s				Employer Portion (allocation method allowed):**	
Salary Range	Total # of Staff	Total Salaries (includes incentives, bonuses, severance, CTO, etc.)	Average Salary within Range	Health Insurance Coverage	Retirement Contributions
$0 - $199,999	61.0	$ 4,250,526	$ 69,681	$ 676,632	$ 297,537
$200,000 - $299,999	1.0	$ 290,558	$ 290,558	$ 11,092	$ 20,339
$300,000 - $499,999	1.0	$ 392,735	$ 392,735	$ 11,092	$ 27,491
$500,000 - $999,999	0.0	$ -	$ -	$ -	$ -
$1,000,000 +	0.0	$ -	$ -	$ -	
Sum (check figures)	**63**	**$ 4,933,818**		**$ 698,817**	**$ 345,367**

**** allocation method used,**
medical only.

Salary Table

For the Employer Portion of Health Insurance Coverage and Retirement Contributions: This can be a combination of Medical, Dental and Vision – or Medical only. For your hospital specifically, please note at the bottom of the chart exactly what is included.

Also, in the same section of the table you see the words "allocation method allowed". While the Board prefers the actual real amounts, we understand that sometimes that is not possible and in that case, we would accept an allocation based on the number of people. For your hospital, please note at the bottom whether you are reporting real numbers or if the numbers are an allocation.

EXHIBIT J

June 5, 2020

Kevin Mullin
Chair
Green Mountain Care Board
144 State Street
Montpelier, Vermont 05602

Dear Chair Mullin,

OneCare Vermont is committed to transparency in our service to Vermont in support of the All Payer ACO Model. As we have discussed as part of our continued transparency efforts, I am submitting 2019 compensation information for officers, key employees, and the five highest compensated employees in the organization in the agreed upon format of a document similar to an IRS 990 form.

Compensation for OneCare employees is determined using current market research. A third party consultant is used for benchmarking executive positions. When setting base pay for executives, we target the market median (50th percentile) rate. When setting total direct compensation (base pay plus variable pay) for executives, we target the market 65th percentile. A third party consultant is occasionally used to benchmark director level roles, but the rest are benchmarked in-house using over 18 market surveys and utilizing software which aggregates all the survey data. For non-executive pay, we target the market median (50th percentile).

OneCare Vermont
2019 Employee Income Disclosure Form

Name	Title	Individual Trustee or Director	Institutional Trustee	Officer	Key Employee	Highest Compensated Employee	Former	2019 Total Reportable W-2 Compensation *
Bennett, Dan	Board Member	X						$0
Berry Bowen, Jill	Board Member	X						$0
Brumsted, John MD	Board Chair	X		X				$0
Calderara, Allison	Board Member	X						$0
Costa, Michael	Board Member	X						$0
Davis, Betsy RNMPH	Board Member	X						$0
Dee, Tom	Board Member	X						$0
Gordon, Steve	Board Member	X						$0
Haddock, Joe MD	Board Member	X						$0
Jankowski, Tomasz	Board Member	X						$0
Keating, Todd	Board Member	X						$0

Kohaut, Coleen	Board Member	X						$0
Kraft, Sally MD	Board Member	X						$0
LeBlanc, Steve	Board Member	X						$0
Leffler, Steve MD	Board Member	X						$0
Lowell, Sierra	Board Member	X						$0
Morton, Judy	Board Member	X						$0
Moulton, Mary	Board Member	X						$0
Parsons, Pamela	Board Member	X						$0
Perras, Joseph MD	Board Member	X						$0
Peterson, Judy	Board Member	X						$0
Sadkin, Toby MD	Board Member	X						$0
Sayles, John	Board Member	X						$0
Stone, Kevin	Board Chair	X		X				$0
Whitmer, Grant	Board Member	X						$0
Loner, Victoria	COO (thru 7/19) CEO (as of 8/19)			X				$408,774
Moore, Todd	CEO (thru 01/19)			X				$64,810
Ward, Norman	CMO				X			$382,367
Barry, Sara	Sr. Dir Value Base Care (thru 9/19) COO (as of 10/19)				X			$253,056
Daniels, Gregory	CCO **			X				$160,079
Lee, Karen	VP Finance & Strategy (thru 4/19) CEO Adirondacks ACO (as of 5/19) **				X			$405,117
Borys, Thomas	Dir Fin & Analysis (thru 8/19) Sr. Dir Finance and Payment Reform (as of 9/19)				X			$162,614
Giard, Martita	Dir Strategy & Planning **					X		$178,945
Zipko, Joan	Dir Operations					X		$183,003
Shane, Susan	Medical Director					X		$141,287
Gauthier, Tyler	Asst. Dir Value Based Care (thru 10/19) Dir Value Based Care (as of (11/19)					X		$144,283
Parisi, Marissa	Exec Dir RiseVT					X		$142,714

* Sourced from the University of Vermont Medical Center Form W-2 Wage and Tax Statements, Box 5
** Position includes material contracted effort outside of OneCare Vermont

This document shows compensation earned by OneCare employees in a manner similar to that required by a 501(c)(3) organization. This is not to be considered an official tax document, is not intended to meet all 990 reporting requirements and is prepared for the sole purpose of the GMCB's regulatory oversight of ACOs in Vermont.

Please contact me if you have questions regarding this submission. We will look to provide this level of salary information in 2021 in a similar manner, if we are still awaiting approval from the IRS on our 501(c)(3) tax status, to reflect the 2020 total compensation packet. Please understand that the compensation information reflective in this report will look different with our next submission since our entire leadership team took material reductions in salary and benefits for the 2020 calendar year.

Respectfully,

Vicki Loner

Vicki Loner, RN.C, MHCDS
Chief Executive Officer