ATTACHMENT A

Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative

Appendix B - Beneficiary Alignment and Benchmarking Methods

Part 1: Benefciary Alignment and Benchmarking Methods for Performance Year 2019

This Part 1 of Appendix B describes the methodologies for Beneficiary alignment conducted pursuant to Section V of this Agreement, the Performance Year Benchmark calculated pursuant to Section XII of this Agreement, and financial settlement of Shared Savings and Shared Losses conducted pursuant to Section XIII.C of this Agreement for Performance Year 2019.

I. Definitions

"**ACO Service Area**" means all counties in the State of Vermont and counties outside the State of Vermont in which Initiative Professionals who are Primary Care Specialists have office locations.

"**Aligned Beneficiary**" means a Beneficiary aligned to the ACO for a Performance Year pursuant to Section V.A of this Agreement and Section II of this Part 1 of Appendix B.

"**Alignment-Eligible Beneficiary**" means a Beneficiary who, for a Base Year or a Performance Year, as applicable:

- Is covered under Part A in every month of the Base Year or the Performance Year, as applicable;
- Has no months of coverage under only Part A;
- Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
- Has no months in which Medicare was the secondary payer; and
- Was a resident of the United States in every month of the Base Year or the Performance Year, as applicable.

"Base Year Alignment Period" means the 2-year period ending six months prior to the first day of the Base Year for which Beneficiary alignment is being performed.

"**Base Year Beneficiary**" means an Alignment-Eligible Beneficiary who is aligned to the ACO for a given Base Year using the methodology set forth in Section II of this Part 1 of Appendix B.

"**Entitlement Category**" means one of the following two entitlement categories of Beneficiaries:

1) Aged and Disabled (A/D) Beneficiaries (Beneficiaries eligible for Medicare by age or disability) who are not End-Stage Renal Disease (ESRD) Beneficiaries ("**A/D Beneficiaries**"); or

2) ESRD Beneficiaries (Beneficiaries eligible for Medicare on the basis of an ESRD diagnosis) ("**ESRD Beneficiaries**"). [1]

"Performance Year Alignment Period" means the 2-year period ending six months prior to the first day of the Performance Year for which Beneficiary alignment is being performed.

"**Primary Care Specialist**" means a physician or non-physician practitioner (NPP) whose principal specialty is listed in Table 1.3 of this Part 1 of Appendix B.

"**Non-Primary Care Specialist**" means a physician or NPP whose principal specialty is listed in Table 1.4 of this Part 1 of Appendix B.

"QEM Services" means Qualified Evaluation & Management (QEM) services identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1.2 of this Part 1 of Appendix B.

II. Beneficiary Alignment Methodology

A. General

Beneficiaries are aligned to the ACO for each Performance Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Performance Year Alignment Period using the alignment algorithm described in Section II.C of this Part 1 of Appendix B. Beneficiaries are similarly aligned to the ACO for each Base Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Base Year Alignment Period using the alignment algorithm described in Section II.C of this Part 1 of Appendix B.

B. Alignment Years

The Performance Year Alignment Period and the Base Year Alignment Period each consist of two alignment years (each an "**Alignment Year**"). The first such Alignment Year is the 12-month period ending 18 months prior to the start of the Performance Year or Base Year, as applicable. The second such Alignment Year is the 12-month period ending 6 months prior to the start of the Performance Year or Base Year, as applicable.

In this Appendix B, an Alignment Year is identified by the calendar year in which the Alignment Year ends. Table 1.1 of this Part 1 of Appendix B specifies the period covered by each Base Year and each Performance Year, and their corresponding Alignment Years.

[1] ESRD status in a month is determined based on Medicare enrollment/eligibility files not dialysis claims. A Beneficiary's experience accrues to the ESRD Entitlement Category if, during a month, the Beneficiary was receiving maintenance dialysis for kidney failure or was in the 3-month period starting in the month when a kidney transplant was performed.

C. Alignment Algorithm

Alignment of a Beneficiary is determined by comparing, for the Performance Year Alignment Period or the Base Year Alignment Period, as applicable:

1. The weighted allowable charge for all QEM Services that the Beneficiary received from an Initiative Professional included on the Participant List for the relevant Performance Year; and
2. The weighted allowable charge for all QEM Services that the Beneficiary received from a provider or supplier not included on the Participant List for the relevant Performance Year.

Alignment is determined for Performance Year 2019 using the initial Participant List described in Section IV.B.4 of the Agreement for Performance Year 2019. As set forth in Section V.A.2 of the Agreement, CMS may, in its sole discretion, adjust the alignment of Initiative Beneficiaries to the ACO for a Performance Year due to the addition or removal of an Initiative Participant from the Participant List during the Performance Year pursuant to Section IV.D or Section XVIII.A of the Agreement.

To determine the weighted allowable charge, the allowable charge on every paid claim for QEM Services received by a Beneficiary during the two Alignment Years that comprise the Base Year Alignment Period or the Performance Year Alignment Period, as applicable, will be weighted as follows:

1. The allowable charge for QEM Services provided during the first (i.e., earlier) of the two Alignment Years will be weighted by a factor of ⅓.
2. The allowable charge for QEM Services provided during the second (i.e., later or more recent) of the two Alignment Years will be weighted by a factor of ⅔.

Only those claims for QEM Services that are identified as being furnished by Primary Care Specialists or, if applicable, Non-Primary Care Specialists will be used in Beneficiary alignment determinations. Specifically:

1. Beneficiary Alignment based on QEM Services furnished by Primary Care Specialists
   If 10% or more of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Primary Care Specialists.

2. Beneficiary Alignment based on QEM Services furnished by Non-Primary Care Specialists
   If less than 10% of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Non-Primary Care Specialists.

A Beneficiary is aligned to the ACO for a Performance Year if the Beneficiary received the plurality of QEM Services during the applicable Performance Year Alignment Period from an Initiative Professional included on the Participant List for that Performance Year.

A Beneficiary is aligned to the ACO for a Base Year if the Beneficiary received the plurality of QEM Services during the applicable Base Year Alignment Period from an Initiative Professional included on the Participant List for the relevant Performance Year.

In the case of a tie in the dollar amount of the weighted allowable charges for QEM Services furnished to a Beneficiary by two or more providers or suppliers, the Beneficiary will be aligned to the provider or supplier from whom the Beneficiary most recently obtained a QEM Service.

D. Initiative Beneficiary Population

Alignment-eligibility of Aligned Beneficiaries will be determined each quarter of a Performance Year based on whether an Aligned Beneficiary satisfies the definition of an Alignment-Eligible Beneficiary for each month of the applicable quarter. During the quarterly identification of Alignment-Eligible Beneficiaries, CMS will also identify Aligned Beneficiaries who have died during the applicable quarter.

For purposes of the financial settlement of Shared Savings and Shared Losses, as described in Section IV.C of this Part 1 of Appendix B, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

III. Performance Year Benchmark Methodology

A. Overview

The Performance Year Benchmark is set prospectively for each Performance Year prior to the start of the Performance Year, as described below. The Performance Year Benchmark is determined using included Base Year expenditures for each of the two Entitlement Categories, subject to certain exclusions, and subject to the application of a trend factor and adjustments for quality performance. As stated in Section XII.B of the Agreement, a Performance Year Benchmark may be retroactively modified if CMS determines that exogenous factors during the relevant Performance Year render the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for purposes of assessing the expected level of spending between the Base Year and Performance Year.

B. Role of the Green Mountain Care Board

The GMCB will prospectively develop the Performance Year Benchmark for the ACO in accordance with the standards set forth in the State Agreement and this Appendix B. Prior to the start of the Performance Year for which the Performance Year Benchmark will apply, the GMCB will submit to CMS for approval the proposed Performance Year Benchmark for the ACO. CMS will assess the Performance Year Benchmark to ensure consistency with the standards set forth in the State Agreement and will decide, in its sole discretion, whether to approve or disapprove the Performance Year Benchmark submitted by the GMCB. If CMS disapproves the GMCB's submission for the Performance Year Benchmark, CMS will work with the GMCB to revise the submission to be consistent with the standards set forth in the State Agreement and this Appendix B. Prior to the start of each Performance Year, GMCB will provide the ACO with the CMS-approved Performance Year Benchmark and CMS will provide the ACO with a Performance Year Benchmark Report (as defined in Section XII.A.2 of this Agreement) setting forth the calculation of the ACO's CMS-approved Performance Year Benchmark.

C. Performance Year Benchmark Components

The ACO's Performance Year Benchmark is determined using the Base Year Expenditures for each of the two Entitlement Categories, subject to the application of a trend factor. The total Base Year Expenditure is the sum of thefollowing two amounts:

1. The trended Base Year expenditure for A/D Beneficiaries who are Base Year Beneficiaries, multiplied by the person-months accrued to the A/D Entitlement Category by Base Year Beneficiaries during the Base Year; and
2. The trended Base Year expenditure for ESRD Beneficiaries who are Base Year Beneficiaries, multiplied by the person-months accrued to the ESRD Entitlement Category by Base Year Beneficiaries during the Base Year.

This can be expressed as a per-Beneficiary per-month expenditure by dividing the total Base Year expenditure by the total number of person-months accrued during the Base Year by Base Year Beneficiaries. For a Base Year Beneficiary who dies during a Base Year, this calculation includes person-months and expenditures only for those months of the Base Year that the Base Year Beneficiary was alive. At the time of financial settlement, this amount is then subject to an adjustment based on the ACO's quality performance. The three components of the Performance Year Benchmark calculation are discussed in more detail below.

1. Included and Excluded Base Year Expenditures for Base Year Beneficiaries.

For purposes of calculating the Performance Year Benchmark, the expenditure incurred by a Base Year Beneficiary is the sum of all Medicare claims paid to providers and suppliers:

1. For services covered by Medicare Parts A and/or B;

2. With a date of service during the Base Year; and
3. That are paid within 3 months of the close of the Base Year. The paid date for a claim is the date the claim is loaded into the Integrated Data Repository (IDR).

Indirect Medical Education (IME) and the empirically justified Medicare Disproportionate Share Hospital (DSH) payments are included expenditures for purposes of the calculation of the Performance Year Benchmark.

The following claims are excluded from expenditures for purposes of calculating the Performance Year Benchmark:

A. Payments for services provided to identifiable beneficiaries that are made outside the standard Part A and Part B claims systems; and
B. Uncompensated Care (UCC) payments.

2. Trend factor applied to the Base Year expenditures for Base Year Beneficiaries

The trend factor is the projected growth rate applied to the Base Year expenditures for Base Year Beneficiaries to account for expected increases in per-Beneficiary expenditures for the upcoming Performance Year.

The Medicare FFS United States Per-Capita Cost (USPCC) projection will be used to calculate the trend factor for purposes of calculating the Performance Year Benchmark. Though historical USPCC projections are continuously updated (e.g., 2018-2019 USPCC projection is updated using the April 2019 projection release), USPCC projection calculations used to calculate each Performance Year Benchmark under this Agreement will not be retroactively updated.

For example, for the Performance Year 2019 Performance Year Benchmark, the trend factor will be calculated by dividing the USPCC Parts A&B current estimate for CY2019 by the USPCC Parts A&B current estimate for CY2018.

3. Quality Measures and Quality Score

Appendix K of this Agreement describes quality measures used to assess quality performance. The prospective Performance Year Benchmark will be calculated based on a preliminary quality score of 100%, to be adjusted during financial settlement to reflect the ACO's actual quality performance.

During financial settlement, CMS will apply a downward adjustment to the ACO's Performance Year Benchmark in an amount of up to 0.5% of the Performance Year expenditure calculated in accordance with Section IV of this Part 1 of Appendix B, depending on the ACO's actual quality performance. The amount of any downward adjustment will be based on the ACO's actual quality score for the Performance Year, with a higher quality score resulting in a

smaller downward adjustment. If the ACO receives an actual quality score of 100%, the ACO will not receive a downward adjustment to its Performance Year Benchmark.

IV. Financial Settlement

A. Overview

Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a financial settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses, the amount of Other Monies Owed by CMS or the ACO, and the net amount owed by either CMS or the ACO. The methodology used for purposes of the financial settlement of Shared Savings and Shared Losses is described below.

B. Initiative Beneficiaries for Financial Settlement

As described in Section I.E of this Part 1 of Appendix B, for purposes of the financial settlement of Shared Savings and Shared Losses, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

For purposes of financial settlement of Shared Savings and Shared Losses, Beneficiaries will also be excluded from the population of Initiative Beneficiaries retroactive to the start of the Performance Year if, during the Performance Year, at least 50% of QEM Services received by the Beneficiary were furnished by providers or suppliers practicing outside the ACO Service Area.

C. Performance Year Expenditures

For purposes of conducting financial settlement pursuant to Section VIII.C of the Agreement, expenditures will be calculated separately for each of the two Entitlement Categories: ESRD Beneficiaries and A/D Beneficiaries. CMS will apply the same inclusions and exclusions in determining the Performance Year expenditures as those described in Section III.C of this Part 1 of Appendix B with respect to determining the Base Year expenditures for purposes of the calculation of the Performance Year Benchmark, except that only Medicare claims with a date of service during the Performance Year and that are paid within 3 months of the close of the Performance Year will be included.

The total Performance Year expenditure is the sum of the following two amounts:

1. The Performance Year expenditure for A/D Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the A/D Entitlement Category by Initiative Beneficiaries during the Performance Year; and
2. The Performance Year expenditure for ESRD Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the ESRD Entitlement Category by Initiative Beneficiaries during the Performance Year.

This can be expressed as a per-Beneficiary per-month expenditure by dividing the total Performance Year expenditure by the total number of person-months accrued during the Performance Year by Initiative Beneficiaries.[2]

D. Savings/Losses Amount

The ACO's aggregate gross savings or losses will be determined by subtracting the Performance Year expenditure calculated in accordance with Section IV.C of this Part 1 of Appendix B from the ACO's Performance Year Benchmark calculated in accordance with Section III of this Part 1 of Appendix B.

The Risk Arrangement selected by the ACO in accordance with Section X.A of the Agreement will determine the portion of the aggregate gross savings or losses in relation to the Performance Year Benchmark that accrue to the ACO as Shared Savings or Shared Losses. The Initiative offers two Risk Arrangements:

1. Risk Arrangement A: 80% Shared Savings/Shared Losses, ACO selects a Savings/Losses Cap between 5%-15%.
2. Risk Arrangement B: 100% Shared Savings/Shared Losses, ACO selects a Savings/Losses Cap between 5%-15%.

The Savings/Losses Cap is the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, subject to the application of the Risk Arrangement selected by the ACO. For example, if the ACO selects a 5% Savings/Losses Cap and a 100% Risk Arrangement, the ACO would only share in savings up to 5% of its Performance Year Benchmark, even if it achieved savings equal to 6% of that Performance Year Benchmark. In instances in which aggregate gross ACO savings/losses exceed the Savings/Losses Cap selected by the ACO, the Savings/Losses Cap is first applied to determine the maximum allowable savings/losses, and the Risk Arrangement is then applied to that maximum allowable savings/loss amount. For example, if the ACO selects a 5% Savings/Losses Cap and a 80% Risk Arrangement, the ACO would share in savings/losses

[2] The combined benchmark is, therefore, simply the person-month weighted average of the Aged/Disabled and ESRD PBPM benchmarks.

up to 4% [80% of the 5% maximum allowable savings/losses] of its Performance Year Benchmark.

Budget sequestration will apply to the calculation of Shared Savings, but will not apply to the calculation of Shared Losses. For example, if the budget sequestration rate is 2%, the amount of Shared Savings owed to the ACO would be 98% of any savings calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above, but the amount of Shared Losses owed by the ACO would be 100% of any losses calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above.

V. Tables

Table 1.1 - Period Covered by Each Base Year and Performance Year and Corresponding Alignment Years

Period	**Period covered**[1]	**Corresponding Alignment Years (AYs)**
Base Year	PY2019 Base Year: 01/01/2018 – 12/31/2018	AY1: 07/01/2015 – 06/30/2016 (AY2016) AY2: 07/01/2016 – 06/30/2017 (AY2017)
Performance Year (Current CY)	PY2019 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)

[1] The period covered is the calendar year for which the expenditures will be calculated for purposes of determining Shared Savings or Shared Losses for the Performance Year.

Table 1.2 – Qualified Evaluation & Management Services

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
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
Transitional Care Management Services	

99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Chronic Care Management Services	
99490	Comprehensive care plan establishment/implementation/revision/monitoring
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

Table 1.3 - Specialty codes used to identify Primary Care Specialists

Code[1]	**Specialty**
01	General Practice
08	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

Table 1.4 - Specialty codes used to identify Non-Primary Care Specialists

Code[1]	Specialty
06	Cardiology
12	Osteopathic Manipulative Medicine
13	Neurology
16	Obstetrics/Gynecology
23	Sports Medicine
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
29	Pulmonology
39	Nephrology
46	Endocrinology
70	Multispecialty Clinic or Group Practice
79	Addiction Medicine
82	Hematology
83	Hematology/oncology
84	Preventative Medicine
86	Neuropsychiatry
90	Medical oncology
98	Gynecological/oncology

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

Part 2: Beneficiary Alignment and Benchmarking Methods Beginning Performance Year 2020

This Part 2 of Appendix B describes the methodologies for Beneficiary alignment conducted pursuant to Section V of this Agreement, the Performance Year Benchmark calculated pursuant to Section XII of this Agreement, and financial settlement of Shared Savings and Shared Losses conducted pursuant to Section XIII.C of this Agreement for Performance Year 2020.

I. Definitions

"**ACO Service Area**" means all counties in the State of Vermont and counties outside the State of Vermont in which Initiative Professionals who are Primary Care Specialists have office locations.

"**Aligned Beneficiary**" means a Beneficiary aligned to the ACO for a Performance Year pursuant to Section V.A of this Agreement and Section II of this Part 2 of Appendix B.

"**Alignment-Eligible Beneficiary**" means a Beneficiary who, for a Base Year or a Performance Year, as applicable:

- Is covered under Part A in every month of the Base Year or the Performance Year, as applicable;
- Has no months of coverage under only Part A;
- Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
- Has no months in which Medicare was the secondary payer; and
- Was a resident of the United States in every month of the Base Year or the Performance Year, as applicable.

"Base Year Alignment Period" means the 2-year period ending six months prior to the first day of the Base Year for which Beneficiary alignment is being performed.

"**Base Year Beneficiary**" means an Alignment-Eligible Beneficiary who is aligned to the ACO for a given Base Year using the methodology set forth in Section II of this Part 2 of Appendix B.

"**Entitlement Category**" means one of the following two entitlement categories of Beneficiaries:

1) Aged and Disabled (A/D) Beneficiaries (Beneficiaries eligible for Medicare by age or disability) who are not End-Stage Renal Disease (ESRD) Beneficiaries ("**A/D Beneficiaries**"); or

2) ESRD Beneficiaries (Beneficiaries eligible for Medicare on the basis of an ESRD diagnosis) ("**ESRD Beneficiaries**"). [3]

"Performance Year Alignment Period" means the 2-year period ending six months prior to the first day of the Performance Year for which Beneficiary alignment is being performed.

"**Primary Care Specialist**" means a physician or non-physician practitioner (NPP) whose principal specialty is listed in Table 1.3 of this Part 2 of Appendix B.

"**Non-Primary Care Specialist**" means a physician or NPP whose principal specialty is listed in Table 1.4 of this Part 2 of Appendix B.

"QEM Services" means Qualified Evaluation & Management (QEM) services identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1.2 of this Part 2 of Appendix B.

II. Beneficiary Alignment Methodology

A. General

Beneficiaries are aligned to the ACO for each Performance Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Performance Year Alignment Period using the alignment algorithm described in Section II.C of this Part 2 of Appendix B. Beneficiaries are similarly aligned to the ACO for each Base Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Base Year Alignment Period using the alignment algorithm described in Section II.C of this Part 2 of Appendix B.

B. Alignment Years

The Performance Year Alignment Period and the Base Year Alignment Period each consist of two alignment years (each an "**Alignment Year**"). The first such Alignment Year is the 12-month period ending 18 months prior to the start of the Performance Year or Base Year, as applicable. The second such Alignment Year is the 12-month period ending 6 months prior to the start of the Performance Year or Base Year, as applicable.

In this Appendix B, an Alignment Year is identified by the calendar year in which the Alignment Year ends. Table 1.1 of this Part 2 of Appendix B specifies the period covered by each Base Year and each Performance Year, and their corresponding Alignment Years.

[3] ESRD status in a month is determined based on Medicare enrollment/eligibility files not dialysis claims. A Beneficiary's experience accrues to the ESRD Entitlement Category if, during a month, the Beneficiary was receiving maintenance dialysis for kidney failure or was in the 3-month period starting in the month when a kidney transplant was performed.

C. Alignment Algorithm

Alignment of a Beneficiary is determined by comparing, for the Performance Year Alignment Period or the Base Year Alignment Period, as applicable:

1. The weighted allowable charge for all QEM Services that the Beneficiary received from an Inititiative Professional included on the Participant List for the relevant Performance Year; and
2. The weighted allowable charge for all QEM Services that the Beneficiary received from a provider or supplier not included on the Participant List for the relevant Performance Year.

Alignment is determined for Performance Year2020 using the final Participant List described in Section IV.E.4(g) of the Agreement. As set forth in Section V.A.2 of the Agreement, CMS may, in its sole discretion, adjust the alignment of Initiative Beneficiaries to the ACO for a Performance Year due to the addition or removal of an Initiative Participant from the Participant List during the Performance Year pursuant to Section IV.D or Section XVIII.A of the Agreement.

To determine the weighted allowable charge, the allowable charge on every paid claim for QEM Services received by a Beneficiary during the two Alignment Years that comprise the Base Year Alignment Period or the Performance Year Alignment Period, as applicable, will be weighted as follows:

1. The allowable charge for QEM Services provided during the first (i.e., earlier) of the two Alignment Years will be weighted by a factor of ⅓.
2. The allowable charge for QEM Services provided during the second (i.e., later or more recent) of the two Alignment Years will be weighted by a factor of ⅔.

Only those claims for QEM Services that are identified as being furnished by Primary Care Specialists or, if applicable, Non-Primary Care Specialists will be used in Beneficiary alignment determinations. Specifically:

1. <u>Beneficiary Alignment based on QEM Services furnished by Primary Care Specialists</u>
   If 10% or more of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Primary Care Specialists.

2. <u>Beneficiary Alignment based on QEM Services furnished by Non-Primary Care Specialists</u>
   If less than 10% of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Non-Primary Care Specialists.

A Beneficiary is aligned to the ACO for a Performance Year if the Beneficiary received the plurality of QEM Services during the applicable Performance Year Alignment Period from an Initative Professional included on the Participant List for that Performance Year.

A Beneficiary is aligned to the ACO for a Base Year if the Beneficiary received the plurality of QEM Services during the applicable Base Year Alignment Period from an Initative Professional included on the Participant List for the relevant Performance Year.

In the case of a tie in the dollar amount of the weighted allowable charges for QEM Services furnished to a Beneficiary by two or more providers or suppliers, the Beneficiary will be aligned to the provider or supplier from whom the Beneficiary most recently obtained a QEM Service.

D. Initiative Beneficiary Population

Alignment-eligibility of Aligned Beneficiaries will be determined each quarter of a Performance Year based on whether an Aligned Beneficiary satisfies the definition of an Alignment-Eligible Beneficiary for each month of the applicable quarter. During the quarterly identification of Alignment-Eligible Beneficiaries, CMS will also identify Aligned Beneficiaries who have died during the applicable quarter.

For purposes of the financial settlement of Shared Savings and Shared Losses, as described in Section IV.C of this Part 2 of Appendix B, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

III. Calculation of Performance Year Benchmark

A. Overview

The Performance Year Benchmark is set prospectively for each Performance Year prior to the start of the Performance Year. The Performance Year Benchmark for Performance Year 2020 is determined by the GMCB, as described in Section III.B of this Part 2 of Appendix B, using included historical expenditures for each of the two Entitlement Categories, subject to certain exclusions, and subject to the application of a trend factor and adjustments for quality performance. CMS will provide the GMCB with the Base Year expenditures for the applicable Base Year for use as a reference point in the GMCB's Performance Year Benchmark methodology; however such Base Year expenditures will not be materially used by the GMCB in the calculation of the Performance Year Benchmark for Performance Year 2020. As stated in

Section XII.B of the Agreement, a Performance Year Benchmark may be retroactively modified if CMS determines that exogenous factors during the relevant Performance Year render the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for purposes of assessing the expected level of spending between the period used by the GMCB to calculate the historical expenditures included in the Performance Year Benchmark methodology and the Performance Year.

B. Role of the Green Mountain Care Board and Calculation of the Performance Year Benchmark

The GMCB will prospectively develop the Performance Year Benchmark for the ACO in accordance with the standards set forth in the State Agreement and this Agreement. Prior to the start of the Performance Year for which the Performance Year Benchmark will apply, the GMCB will submit to CMS for approval the proposed Performance Year Benchmark for the ACO. CMS will assess the Performance Year Benchmark to ensure consistency with the standards set forth in the State Agreement and will decide, in its sole discretion, whether to approve or disapprove the Performance Year Benchmark submitted by the GMCB. If CMS disapproves the GMCB's submission for the Performance Year Benchmark, CMS will work with the GMCB to revise the submission to be consistent with the standards set forth in the State Agreement and this Appendix B. Prior to the start of each Performance Year, GMCB will provide the ACO with a report setting forth the CMS-approved Performance Year Benchmark and the methodology used to calculate the ACO's CMS-approved Performance Year Benchmark.

For Performance Year 2020, the GMCB will replace the trend factor used in calculating the Performance Year Benchmark with a regional retrospective trend. The regional retrospective trend will be equal to the growth rate in per-Beneficiary Medicare FFS expenditures for Vermont Alignment-Eligible Beneficiaries between calendar year 2019 and calendar year 2020. The GMCB will determine the regional retrospective trend following the end of Performance Year 2020.

IV. Financial Settlement

A. Overview

Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a financial settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses, the amount of Other Monies Owed by CMS or the ACO, and the net amount owed by either CMS or the ACO. The methodology used for purposes of the financial settlement of Shared Savings and Shared Losses is described below.

B. Initiative Beneficiaries for Financial Settlement

As described in Section IV.E of this Part 2 of Appendix B, for purposes of the financial settlement of Shared Savings and Shared Losses, CMS includes only the following:

3. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
4. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

For purposes of financial settlement of Shared Savings and Shared Losses, Beneficiaries will also be excluded from the population of Initiative Beneficiaries retroactive to the start of the Performance Year if, during the Performance Year, at least 50% of QEM Services received by the Beneficiary were furnished by providers or suppliers practicing outside the ACO Service Area.

C. Performance Year Expenditures

For purposes of conducting financial settlement pursuant to Section XIII.C of the Agreement, expenditures will be calculated separately for each of the two Entitlement Categories: ESRD Beneficiaries and A/D Beneficiaries. CMS will apply inclusions and exclusions in determining the Performance Year expenditures as described in Section IV.C.1 of this Part 2 of Appendix B for Medicare claims with a date of service during the Performance Year and that are paid within 6 months of the close of the Performance Year. CMS may, at CMS's sole discretion, modify the inclusions and exclusions used in determining the Performance Year expenditures as needed for consistency with the GMCB's Performance Year Benchmark methodology for purposes of conducting financial settlement.

The total Performance Year expenditure is the sum of the following two amounts:

3. The Performance Year expenditure for A/D Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the A/D Entitlement Category by Initiative Beneficiaries during the Performance Year; and
4. The Performance Year expenditure for ESRD Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the ESRD Entitlement Category by Initiative Beneficiaries during the Performance Year.

This can be expressed as a per-Beneficiary per-month expenditure by dividing the total Performance Year expenditure by the total number of person-months accrued during the Performance Year by Initiative Beneficiaries.

1. **Included and Excluded Expenditures for Initiative Beneficiaries.**

For purposes of calculating the Performance Year expenditures, the expenditure incurred by a Initiative Beneficiary is the sum of all Medicare claims paid to providers and suppliers:

A. For services covered by Medicare Parts A and/or B;
B. With a date of service during the Performance Year; and
C. That are paid within 6 months of the close of the Performance Year. The paid date for a claim is the date the claim is loaded into the Integrated Data Repository (IDR).

Indirect Medical Education (IME) and the empirically justified Medicare Disproportionate Share Hospital (DSH) payments are <u>included</u> expenditures for purposes of the calculation of the Performance Year expenditures.

The following claims are <u>excluded</u> from expenditures for purposes of calculating the Performance Year expenditures:

C. Payments for services provided to identifiable beneficiaries that are made outside the standard Part A and Part B claims systems;
D. Uncompensated Care (UCC) payments; and
E. Payment for outlier cases.

CMS will exclude from the Performance Year expenditures calculations for the Performance Year all Parts A and B payment amounts for an episode of care for treatment of COVID-19, as specified on Parts A and B claims with dates of service during the episode. All Parts A and B payment amounts with dates of service during the months in a COVID-19 episode of care will be removed from Performance Year expenditure calculations. CMS will identify an episode of care for treatment of COVID-19, based on the criteria specified in 42 C.F.R. § 425.611(b)(1). Episodes of care for treatment of COVID-19 will be triggered by an inpatient admission for acute care either at an acute care hospital or other healthcare facility, which may include temporary expansion sites, Medicare-enrolled ambulatory surgical centers (ASCs) providing hospital services to help address the urgent need to increase hospital capacity to treat COVID-19 patients, CAHs, and potentially other types of providers. CMS will define the episode of care as starting in the month in which the inpatient stay begins as identified by the admission date, all months during the inpatient stay, and the month following the end of the inpatient stay as indicated by the discharge date.

D. Quality Measures and Quality Score

Appendix K of this Agreement describes quality measures used to assess quality performance. The Performance Year Benchmark will be calculated based on a preliminary quality score of

100%, to be adjusted during financial settlement to reflect the ACO's actual quality performance.

During financial settlement, CMS will apply a downward adjustment to the ACO's Performance Year Benchmark in an amount of up to 0.5% of the Performance Year expenditure calculated in accordance with Section IV of this Part 2 of Appendix B, depending on the ACO's actual quality performance. The amount of any downward adjustment will be based on the ACO's actual quality score for the Performance Year, with a higher quality score resulting in a smaller downward adjustment. If the ACO receives an actual quality score of 100%, the ACO will not receive a downward adjustment to its Performance Year Benchmark during financial settlement.

E. Savings/Losses Amount

The ACO's aggregate gross savings or losses will be determined by subtracting the Performance Year expenditure calculated in accordance with Section IV.C of this Part 2 of Appendix B from the ACO's Performance Year Benchmark calculated in accordance with Section III of this Part 2 of Appendix B.

The Risk Arrangement selected by the ACO in accordance with Section X.A of the Agreement will determine the portion of the aggregate gross savings or losses in relation to the Performance Year Benchmark that accrue to the ACO as Shared Savings or Shared Losses. The Initiative offers two Risk Arrangements:

3. Risk Arrangement A: 80% Shared Savings/Shared Losses, ACO selects a Savings/Losses Cap between 5%-15%.
4. Risk Arrangement B: 100% Shared Savings/Shared Losses, ACO selects a Savings/Losses Cap between 5%-15%.

The Savings/Losses Cap is the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, subject to the application of the Risk Arrangement selected by the ACO. For example, if the ACO selects a 5% Savings/Losses Cap and a 100% Risk Arrangement, the ACO would only share in savings up to 5% of its Performance Year Benchmark, even if it achieved savings equal to 6% of that Performance Year Benchmark. In instances in which aggregate gross ACO savings/losses exceed the Savings/Losses Cap selected by the ACO, the Savings/Losses Cap is first applied to determine the maximum allowable savings/losses, and the Risk Arrangement is then applied to that maximum allowable savings/loss amount. For example, if the ACO selects a 5% Savings/Losses Cap and a 80% Risk Arrangement, the ACO would share in savings/losses up to 4% [80% of the 5% maximum allowable savings/losses] of its Performance Year Benchmark.

Budget sequestration will apply to the calculation of Shared Savings, but will not apply to the calculation of Shared Losses. For example, if the budget sequestration rate is 2%, the amount of Shared Savings owed to the ACO would be 98% of any savings calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above, but the amount of Shared Losses owed by the ACO would be 100% of any losses calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above.

After the application of the ACO's selected Risk Arrangement, the Shared Losses, if any, will be reduced prior to recoupment by an amount determined by multiplying the Shared Losses by the percentage of total months during the Performance Year affected by an extreme and uncontrollable circumstance, such as the Public Health Emergency (PHE) for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200, and the percentage of Initiative Beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance. CMS applies determinations made under the Quality Payment Program with respect to whether an extreme and uncontrollable circumstance has occurred and the affected areas. CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's Initiative Beneficiaries residing in the affected areas.

V. Tables

Table 1.1 - Period Covered by Each Base Year and Performance Year and Corresponding Alignment Years

Period	**Period covered**[1]	**Corresponding Alignment Years (AYs)**
Base Year	PY2020 Base Year: 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)
Performance Year (Current CY)	PY2020 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)

[1] The period covered is the calendar year for which the expenditures will be calculated for purposes of determining Shared Savings or Shared Losses for the Performance Year.

Table 1.2 – Qualified Evaluation & Management Services

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
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
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Chronic Care Management Services	
99490	Comprehensive care plan establishment/implementation/revision/monitoring
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

Table 1.3 - Specialty codes used to identify Primary Care Specialists

Code[1]	**Specialty**
01	General Practice
08	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical Nurse Specialist
97	Physician Assistant

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

Table 1.4 - Specialty codes used to identify Non-Primary Care Specialists

Code[1]	Specialty
06	Cardiology
12	Osteopathic Manipulative Medicine
13	Neurology
16	Obstetrics/Gynecology
23	Sports Medicine
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
29	Pulmonology
39	Nephrology
46	Endocrinology
70	Multispecialty Clinic or Group Practice
79	Addiction Medicine
82	Hematology
83	Hematology/oncology
84	Preventative Medicine
86	Neuropsychiatry
90	Medical oncology
98	Gynecological/oncology

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

Vermont All-Payer ACO Model

Vermont Medicare ACO Initiative

Appendix B - Beneficiary Alignment and Benchmarking Methods

Part 3: Beneficiary Alignment and Benchmarking Methods for Performance Years 2021 and 2022

This Part 3 of Appendix B describes the methodologies for Beneficiary alignment conducted pursuant to Section V of this Agreement, the Performance Year Benchmark calculated pursuant to Section XII of this Agreement, and financial settlement of Shared Savings and Shared Losses conducted pursuant to Section XIII.C of this Agreement for Performance Years 2021 and 2022.

I. Definitions

"**ACO Service Area**" means all counties in the State of Vermont and counties outside the State of Vermont in which Initiative Professionals who are Primary Care Specialists have office locations.

"**Aligned Beneficiary**" means a Beneficiary aligned to the ACO for a Performance Year pursuant to Section V.A of this Agreement and Section II of this Part 3 of Appendix B.

"**Alignment-Eligible Beneficiary**" means a Beneficiary who, for a Base Year or a Performance Year, as applicable:

- Is covered under Part A in every month of the Base Year or the Performance Year, as applicable;
- Has no months of coverage under only Part A;
- Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
- Has no months in which Medicare was the secondary payer; and
- Was a resident of the United States in every month of the Base Year or the Performance Year, as applicable.

"Base Year Alignment Period" means the 2-year period ending six months prior to the first day of the Base Year for which Beneficiary alignment is being performed.

"**Base Year Beneficiary**" means an Alignment-Eligible Beneficiary who is aligned to the ACO for a given Base Year using the methodology set forth in Section II of this Part 3 of Appendix B.

"**Entitlement Category**" means one of the following two entitlement categories of Beneficiaries:

3) Aged and Disabled (A/D) Beneficiaries (Beneficiaries eligible for Medicare by age or disability) who are not End-Stage Renal Disease (ESRD) Beneficiaries ("**A/D Beneficiaries**"); or

4) ESRD Beneficiaries (Beneficiaries eligible for Medicare on the basis of an ESRD diagnosis) ("**ESRD Beneficiaries**"). [4]

"Performance Year Alignment Period" means the 2-year period ending six months prior to the first day of the Performance Year for which Beneficiary alignment is being performed.

"**Primary Care Specialist**" means a physician or non-physician practitioner (NPP) whose principal specialty is listed in Table 1.3 of this Part 3 of Appendix B.

"**Non-Primary Care Specialist**" means a physician or NPP whose principal specialty is listed in Table 1.4 of this Part 3 of Appendix B.

"QEM Services" means Qualified Evaluation & Management (QEM) services identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1.2 of this Part 3 of Appendix B.

II. Beneficiary Alignment Methodology

A. General

Beneficiaries are aligned to the ACO for each Performance Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Performance Year Alignment Period using the alignment algorithm described in Section II.C of this Part 3 of Appendix B. Beneficiaries are similarly aligned to the ACO for each Base Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Base Year Alignment Period using the alignment algorithm described in Section II.C of this Part 3 of Appendix B.

B. Alignment Years

The Performance Year Alignment Period and the Base Year Alignment Period each consist of two alignment years (each an "**Alignment Year**"). The first such Alignment Year is the 12-month period ending 18 months prior to the start of the Performance Year or Base Year, as applicable. The second such Alignment Year is the 12-month period ending 6 months prior to the start of the Performance Year or Base Year, as applicable.

[4] ESRD status in a month is determined based on Medicare enrollment/eligibility files not dialysis claims. A Beneficiary's experience accrues to the ESRD Entitlement Category if, during a month, the Beneficiary was receiving maintenance dialysis for kidney failure or was in the 3-month period starting in the month when a kidney transplant was performed.

In this Appendix B, an Alignment Year is identified by the calendar year in which the Alignment Year ends. Table 1.1 of this Part 3 of Appendix B specifies the period covered by each Base Year and each Performance Year, and their corresponding Alignment Years.

C. Alignment Algorithm

Alignment of a Beneficiary is determined by comparing, for the Performance Year Alignment Period or the Base Year Alignment Period, as applicable:

3. The weighted allowable charge for all QEM Services that the Beneficiary received from an Inititiative Professional included on the Participant List for the relevant Performance Year; and
4. The weighted allowable charge for all QEM Services that the Beneficiary received from a provider or supplier not included on the Participant List for the relevant Performance Year.

Alignment is determined for Performance Years 2021 and 2022 using the final Participant List described in Section IV.E.4(g) of the Agreement for the applicable Performance Year. As set forth in Section V.A.2 of the Agreement, CMS may, in its sole discretion, adjust the alignment of Initiative Beneficiaries to the ACO for a Performance Year due to the addition or removal of an Initiative Participant from the Participant List during the Performance Year pursuant to Section IV.D or Section XVIII.A of the Agreement.

To determine the weighted allowable charge, the allowable charge on every paid claim for QEM Services received by a Beneficiary during the two Alignment Years that comprise the Base Year Alignment Period or the Performance Year Alignment Period, as applicable, will be weighted as follows:

3. The allowable charge for QEM Services provided during the first (i.e., earlier) of the two Alignment Years will be weighted by a factor of ⅓.
4. The allowable charge for QEM Services provided during the second (i.e., later or more recent) of the two Alignment Years will be weighted by a factor of ⅔.

Only those claims for QEM Services that are identified as being furnished by Primary Care Specialists or, if applicable, Non-Primary Care Specialists will be used in Beneficiary alignment determinations. Specifically:

3. <u>Beneficiary Alignment based on QEM Services furnished by Primary Care Specialists</u> If 10% or more of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Primary Care Specialists.

4. <u>Beneficiary Alignment based on QEM Services furnished by Non-Primary Care Specialists</u>

If less than 10% of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Non-Primary Care Specialists.

A Beneficiary is aligned to the ACO for a Performance Year if the Beneficiary received the plurality of QEM Services during the applicable Performance Year Alignment Period from an Initiative Professional included on the Participant List for that Performance Year.

A Beneficiary is aligned to the ACO for a Base Year if the Beneficiary received the plurality of QEM Services during the applicable Base Year Alignment Period from an Initiative Professional included on the Participant List for the relevant Performance Year.

In the case of a tie in the dollar amount of the weighted allowable charges for QEM Services furnished to a Beneficiary by two or more providers or suppliers, the Beneficiary will be aligned to the provider or supplier from whom the Beneficiary most recently obtained a QEM Service.

D. Initiative Beneficiary Population

Alignment-eligibility of Aligned Beneficiaries will be determined each quarter of a Performance Year based on whether an Aligned Beneficiary satisfies the definition of an Alignment-Eligible Beneficiary for each month of the applicable quarter. During the quarterly identification of Alignment-Eligible Beneficiaries, CMS will also identify Aligned Beneficiaries who have died during the applicable quarter.

For purposes of the financial settlement of Shared Savings and Shared Losses, as described in Section IV.C of this Part 3 of Appendix B, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

III. Calculation of Performance Year Benchmark

A. Overview

The Performance Year Benchmark is set prospectively for each Performance Year prior to the start of the Performance Year. The Performance Year Benchmark is determined by the GMCB, as described in Section III.B of this Part 3 of Appendix B, using included historical expenditures for each of the two Entitlement Categories, subject to certain exclusions, and subject to the application of a trend factor and adjustments for quality performance. CMS will

provide the GMCB with the Base Year expenditures for the applicable Base Year for use as a reference point in the GMCB's Performance Year Benchmark methodology. As stated in Section XII.B of the Agreement, a Performance Year Benchmark may be retroactively modified if CMS determines that exogenous factors during the relevant Performance Year render the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for purposes of assessing the expected level of spending between the period used by the GMCB to calculate the historical expenditures included in the Performance Year Benchmark methodology and the Performance Year.

B. Role of the Green Mountain Care Board and Calculation of the Performance Year Benchmark

The GMCB will prospectively develop the Performance Year Benchmark for the ACO in accordance with the standards set forth in the State Agreement and this Agreement. Prior to the start of the Performance Year for which the Performance Year Benchmark will apply, the GMCB will submit to CMS for approval the proposed Performance Year Benchmark for the ACO. CMS will assess the Performance Year Benchmark to ensure consistency with the standards set forth in the State Agreement and will decide, in its sole discretion, whether to approve or disapprove the Performance Year Benchmark submitted by the GMCB. If CMS disapproves the GMCB's submission for the Performance Year Benchmark, CMS will work with the GMCB to revise the submission to be consistent with the standards set forth in the State Agreement and this Appendix B. Prior to the start of each Performance Year, GMCB will provide the ACO with a report setting forth the CMS-approved Performance Year Benchmark and the methodology used to calculate the ACO's CMS-approved Performance Year Benchmark.

For Performance Year 2021, the GMCB may replace the trend factor used in calculating the Performance Year Benchmark with a regional retrospective trend. The regional retrospective trend will be equal to the growth rate in per-Beneficiary Medicare FFS expenditures for Vermont Alignment-Eligible Beneficiaries between calendar year 2020 and calendar year 2021. The GMCB will determine the regional retrospective trend following the end of Performance Year 2021.

IV. Financial Settlement

A. Overview

Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a financial settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses, the amount of Other Monies Owed by CMS or the ACO, and the net amount owed by either CMS or the ACO. The methodology used for purposes of the financial settlement of Shared Savings and Shared Losses is described below.

B. Initiative Beneficiaries for Financial Settlement

As described in Section IV.E of this Part 3 of Appendix B, for purposes of the financial settlement of Shared Savings and Shared Losses, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

For purposes of financial settlement of Shared Savings and Shared Losses, Beneficiaries will also be excluded from the population of Initiative Beneficiaries retroactive to the start of the Performance Year if, during the Performance Year, at least 50% of QEM Services received by the Beneficiary were furnished by providers or suppliers practicing outside the ACO Service Area.

C. Performance Year Expenditures

For purposes of conducting financial settlement pursuant to Section XIII.C of the Agreement, expenditures will be calculated separately for each of the two Entitlement Categories: ESRD Beneficiaries and A/D Beneficiaries. CMS will apply inclusions and exclusions in determining the Performance Year expenditures as described in Section IV.C.1 of this Part 3 of Appendix B for Medicare claims with a date of service during the Performance Year and that are paid within 6 months of the close of the Performance Year. CMS may, at CMS's sole discretion, modify the inclusions and exclusions used in determining the Performance Year expenditures as needed for consistency with the GMCB's Performance Year Benchmark methodology for purposes of conducting financial settlement.

The total Performance Year expenditure is the sum of the following two amounts:

1. The Performance Year expenditure for A/D Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the A/D Entitlement Category by Initiative Beneficiaries during the Performance Year; and
2. The Performance Year expenditure for ESRD Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the ESRD Entitlement Category by Initiative Beneficiaries during the Performance Year.

This can be expressed as a per-Beneficiary per-month expenditure by dividing the total Performance Year expenditure by the total number of person-months accrued during the Performance Year by Initiative Beneficiaries.

1. Included and Excluded Expenditures for Initiative Beneficiaries.

For purposes of calculating the Performance Year expenditures, the expenditure incurred by an Initiative Beneficiary is the sum of all Medicare claims paid to providers and suppliers:

A. For services covered by Medicare Parts A and/or B;
B. With a date of service during the Performance Year; and
C. That are paid within 6 months of the close of the Performance Year. The paid date for a claim is the date the claim is loaded into the Integrated Data Repository (IDR).

Indirect Medical Education (IME) and the empirically justified Medicare Disproportionate Share Hospital (DSH) payments are included expenditures for purposes of the calculation of the Performance Year expenditures.

The following claims are excluded from expenditures for purposes of calculating the Performance Year expenditures:

A. Payments for services provided to identifiable beneficiaries that are made outside the standard Part A and Part B claims systems;
B. Uncompensated Care (UCC) payments; and
C. Payment for outlier cases.

CMS may exclude from the Performance Year expenditures calculations for the Performance Year all Parts A and B payment amounts for an episode of care for treatment of COVID-19, as specified on Parts A and B claims with dates of service during the episode, in which case all Parts A and B payment amounts with dates of service during the months in a COVID-19 episode of care will be removed from Performance Year expenditure calculations. CMS will identify an episode of care for treatment of COVID-19, based on the criteria specified in 42 C.F.R. § 425.611(b)(1). If applicable, episodes of care for treatment of COVID-19 will be triggered by an inpatient admission for acute care either at an acute care hospital or other healthcare facility, which may include temporary expansion sites, Medicare-enrolled ambulatory surgical centers (ASCs) providing hospital services to help address the urgent need to increase hospital capacity to treat COVID-19 patients, CAHs, and potentially other types of providers. If applicable, CMS will define the episode of care as starting in the month in which the inpatient stay begins as identified by the admission date, all months during the inpatient stay, and the month following the end of the inpatient stay as indicated by the discharge date.

D. Quality Measures and Quality Score

Appendix K of this Agreement describes quality measures used to assess quality performance. The Performance Year Benchmark will be calculated based on a preliminary quality score of 100%, to be adjusted during financial settlement to reflect the ACO's actual quality performance.

During financial settlement, CMS will apply a downward adjustment to the ACO's Performance Year Benchmark in an amount of up to 0.5% of the Performance Year expenditure

calculated in accordance with Section IV of this Part 3 of Appendix B, depending on the ACO's actual quality performance. The amount of any downward adjustment will be based on the ACO's actual quality score for the Performance Year, with a higher quality score resulting in a smaller downward adjustment. If the ACO receives an actual quality score of 100%, the ACO will not receive a downward adjustment to its Performance Year Benchmark during financial settlement.

E. Savings/Losses Amount

The ACO's aggregate gross savings or losses will be determined by subtracting the Performance Year expenditure calculated in accordance with Section IV.C of this Part 3 of Appendix B from the ACO's Performance Year Benchmark calculated in accordance with Section III of this Part 3 of Appendix B.

The Risk Arrangement selected by the ACO in accordance with Section X.A of the Agreement will determine the portion of the aggregate gross savings or losses in relation to the Performance Year Benchmark that accrue to the ACO as Shared Savings or Shared Losses. The Initiative offers two Risk Arrangements:

1. Risk Arrangement A: 80% Shared Savings/Shared Losses, with a Savings/Losses Cap of 2%.
2. Risk Arrangement B: 100% Shared Savings/Shared Losses, with a Savings/Losses Cap of 2%.

The Savings/Losses Cap is the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, subject to the application of the Risk Arrangement selected by the ACO. For example, if the ACO selects a 100% Risk Arrangement, given a Savings/Losses Cap of 2%, the ACO would only share in savings up to 2% of its Performance Year Benchmark, even if it achieved savings equal to 5% of that Performance Year Benchmark. In instances in which aggregate gross ACO savings/losses exceed the Savings/Losses Cap selected by the ACO, the Savings/Losses Cap is first applied to determine the maximum allowable savings/losses, and the Risk Arrangement is then applied to that maximum allowable savings/loss amount. For example, if the ACO selects a 80% Risk Arrangement, given a Savings/Losses Cap of 2%, the ACO would share in savings/losses up to 1.5% [80% of the 2% maximum allowable savings/losses] of its Performance Year Benchmark.

Budget sequestration will apply to the calculation of Shared Savings, but will not apply to the calculation of Shared Losses. For example, if the budget sequestration rate is 2%, the amount of Shared Savings owed to the ACO would be 98% of any savings calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above, but the amount of Shared Losses owed by the ACO would be 100% of any losses calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above.

After the application of the ACO's selected Risk Arrangement, the Shared Losses, if any, will be reduced prior to recoupment by an amount determined by multiplying the Shared Losses by the percentage of total months during the Performance Year affected by an extreme and uncontrollable circumstance, such as the Public Health Emergency (PHE) for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200, and the percentage of Initiative Beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance. CMS applies determinations made under the Quality Payment Program with respect to whether an extreme and uncontrollable circumstance has occurred and the affected areas. CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's Initiative Beneficiaries residing in the affected areas.

V. Tables

Table 1.1 - Period Covered by Each Base Year and Performance Year and Corresponding Alignment Years

Period	**Period covered**[1]	**Corresponding Alignment Years (AYs)**
Base Year	PY2021 Base Year: 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)
	PY2022 Base Year: 01/01/2021 – 12/31/2021	AY1: 07/01/2018 – 06/30/2019 (AY2019) AY2: 07/01/2019 – 06/30/2020 (AY2020)
Performance Year (Current CY)	PY2021 01/01/2021 – 12/31/2021	AY1: 07/01/2018 – 06/30/2019 (AY2019) AY2: 07/01/2019 – 06/30/2020 (AY2020)
	PY2022 01/01/2022 – 12/31/2022	AY1: 07/01/2019 – 06/30/2020 (AY2020) AY2: 07/01/2020 – 06/30/2021 (AY2021)

[1] The period covered is the calendar year for which the expenditures will be calculated for purposes of determining Shared Savings or Shared Losses for the Performance Year.

Table 1.2 – Qualified Evaluation & Management Services

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
99304	New or Established Patient, brief
99305	New or Established Patient, moderate
99306	New or Established Patient, comprehensive
99307	New or Established Patient, brief
99308	New or Established Patient, limited
99309	New or Established Patient, comprehensive
99310	New or Established Patient, extensive
99315	New or Established Patient, brief
99316	New or Established Patient, comprehensive
99318	New or Established Patient
99421	Online digital E&M for an est. patient, for up to 7 days, cumul. time 5–10 mins
99422	Online digital E&M for an est. patient, for up to 7 days, cumul. time 10–20 mins
99423	Online digital E&M for an est. patient, for up to 7 days, cumul. time 21+ mins
99441	Phone e/m phys/qhp 5-10 min to est pt
99442	Phone e/m phys/qhp 11-20 min to est pt
99443	Phone e/m phys/qhp 21-30 min to est pt
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	

Office or Other Outpatient 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
Prolonged Care for Outpatient Visit	
99354	Prolonged visit, first hour
99355	Prolonged visit, add'l 30 mins
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Chronic Care Management Services	
99490	Comprehensive care plan establishment/implementations/revision/monitoring
99487	
99489	
99491	Chronic Care Management
G2058	Non-Complex CCM
G0506	Comprehensive assessment care plan CCM service
Advance Care Planning	
99497	ACP first 30 mins
99498	ACP add'l 30 mins
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
Virtual check-ins	
G2010	'Store and forward' - Remote eval of recorded video and/or images submitted by an est. patient
G2012	Brief communication technology-based service, 5-10 mins of medical discussion
Health Risk Assessment (screening and assessment)	
96160	Administration of HRA

Office or Other Outpatient Services	
96161	Administration of HRA
Behavioral Health Integration (BHI) Services	
99484	General, BHI
99492	Psychiatric Collaborative Care Model (CoCM), CoCM 1st month
99493	CoCM subsequent months
99494	Add-on CoCM
GCOL1	Psychiatric collaborative care model
G0444	Depression Screening Annual
Screening and Behavioral Counseling Interventions	
G0442	Annual alcohol screening 15 mins
G0443	Brief alcohol misuse counsel
Miscellaneous	
G0463	ETA hospitals
99483	Assessment of and care planning for patients with cognitive impairment
G2064	Principal Care Management
G2065	Principal Care Management

Table 1.3 - Specialty codes used to identify Primary Care Specialists

Code[1]	**Specialty**
01	General Practice
08	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical nurse specialist
97	Physician Assistant

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

Table 1.4 - Specialty codes used to identify Non-Primary Care Specialists

Code[1]	**Specialty**
06	Cardiology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonology
39	Nephrology
46	Endocrinology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology
84	Preventative medicine
90	Medical oncology
98	Gynecological/oncology
86	Neuropsychiatry

[1] The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf