FIRST AMENDED AND RESTATED VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT

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This first amended and restated Vermont All-Payer Accountable Care Organization ("ACO") Model Agreement is entered into by and between the Centers for Medicare & Medicaid Services ("CMS") and the Governor of Vermont, the Green Mountain Care Board ("GMCB"), and the Vermont Agency of Human Services ("AHS") (collectively, "State" or "Vermont"). Each Vermont entity and CMS are collectively referred to as "the parties."

CMS is the agency within the U.S. Department of Health and Human Services ("HHS") that is charged with administering the Medicare and Medicaid programs. CMS is implementing the Vermont All-Payer ACO Model ("Model") under Section 1115A of the Social Security Act ("the Act"), which authorizes CMS, through its Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models that are expected to reduce Medicare, Medicaid, or Children's Health Insurance Program expenditures while maintaining or improving the quality of beneficiaries' care.

The GMCB is a legislatively created independent healthcare entity whose authority is codified in Title 18, Chapter 220 of the Vermont Statutes Annotated. The GMCB is responsible for overseeing the development and implementation, and evaluating the effectiveness, of health care payment and delivery system reforms that are designed to control the rate of growth in health care costs and maintain health care quality in Vermont. The GMCB's regulatory authority includes payment and delivery system reform oversight, provider rate-setting, health information technology ("HIT") plan approval, workforce plan approval, hospital budget approval, insurer rate approval, certificate of need issuance, and oversight of the State's all-payer claims database ("APCD"). The GMCB does not have regulatory authority over self-insured, Medicare Advantage, federal employee, or TRICARE or other military health plans; it does exercise regulatory authority over all Vermont acute care hospital revenue regardless of payer.

The Vermont Agency of Human Services is the Vermont Medicaid Single State Agency. It was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. The Agency is led by the AHS Secretary, who is appointed by the Governor. The AHS Secretary's Office is responsible for leading the agency and its departments which include the Department of Vermont Health Access (DVHA), the Department of Mental Health, the Department of Health, the Department of Children and Families, the Department of Disabilities, Aging and Independent Living, and the Department of Corrections. AHS manages Vermont's Medicaid program through the terms and conditions of Vermont's Demonstration Waiver under Section 1115 of the Act. The Director of Health Care Reform in the Agency of Human Services is responsible for the coordination of health care system reform efforts among Executive Branch agencies, departments, and offices, and for coordinating with the Green Mountain Care Board.

Through the Vermont All-Payer ACO Model, CMS's purpose is to test whether the health of, and care delivery for, Vermont residents improve and healthcare expenditures for beneficiaries

across payers (including Medicare FFS, Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans) decrease if: a) these payers offer Vermont ACOs (ACOs operating primarily in Vermont, as defined below) aligned risk-based arrangements tied to health outcomes and healthcare expenditures; b) the majority of Vermont providers and suppliers participate under such risk-based arrangements; and c) the majority of Vermont residents across payers are aligned to an ACO bound by such arrangements.

On October 27, 2016, the parties executed an agreement governing their rights and obligations under the Model (the "Agreement") and the model began on January 1, 2017. As part of the Model, a Vermont ACO participated in a modified version of the Next Generation ACO Model for Performance Year 1 of the Model and then in the Vermont Medicare ACO Initiative beginning in Performance Year 2. The Vermont Medicare ACO Initiative was separately executed under a Vermont Medicare ACO Initiative Participation Agreement between CMS and a participating ACO effective starting in Performance Year 2.

On October 12, 2021, CMS notified Vermont that CMS was waiving enforcement of the ACO Scale Targets along with related milestones and deadlines as set forth in certain, specified provisions of the Agreement, stating that it "now believes the ACO Scale Targets set forth in the State Agreement are unattainable for Vermont based on information not available when the State Agreement was drafted, including the significant increase in Medicare Advantage penetration." The parties now wish to further amend the terms of the Agreement to:

(1) Extend the Agreement to add one Performance Year, extending the Performance Period of the Model through December 31, 2023.
(2) Establish that CMS will offer the State a transition period that would allow for an additional Performance Year (PY7) of the Model, ending on December 31, 2024.
(3) For the reasons discussed in the CMS letter dated October 12, 2021, amend section 6.a to provide that the State shall make efforts to maximize performance relative to the ACO Scale Targets, and remove the language in sections 6.k and 21.d.iv specifying that failure to meet the ACO Scale Targets qualifies as a Triggering Event.
(4) Establish that CMS will collaborate with the State to synthesize lessons learned in this model in order to inform potential subsequent models and to explore mechanisms within CMMI authority that may allow additional providers to receive reimbursement for behavioral health services, referred to by Vermont as mental health and substance use disorder services.
(5) Revise the Agreement to reflect the GMCB's duties with respect to Shared Savings Advance Payments.
(6) Revise and update the terms of the Agreement to reflect the extended Performance Period and optional transition period, including updating formulas for calculating statewide financial targets and reporting requirements.
(7) Remove the requirement that AHS submit a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with the All-payer Financial Target Services.

(8) Remove reference to the submission of a proposal for a subsequent 5-year model by GMCB.
(9) Establish an additional termination provision that allows CMS to immediately or with advance notice terminate the Agreement if it determines, at its sole discretion, that there is no entity eligible under Section 8 to participate in the Model in a manner consistent with the elements, parameters, and scope of the Model as set forth in this Agreement.
(10) Revise the timeline for certain reporting requirements.
(11) Amend the Agreement to include the COVID-19 pandemic as an exogenous factor that CMS may take into consideration when assessing performance on financial and quality targets.
(12) Amend the Agreement to reflect changes to the calculation of the Vermont Medicare ACO Initiative Benchmark in light of the COVID-19 Public Health Emergency.
(13) Amend State Health Outcome and Quality of Care Targets to reflect changes in how the quality measures are calculated and benchmarked and the assessment of performance for Performance Years 3 and 4 due to the COVID-19 pandemic.
(14) Make other technical amendments to the Agreement and Appendices.

The parties therefore amend and restate the Agreement as follows:

TERMS OF AGREEMENT

1. Definitions.

a. **"Accountable Care Organization" or "ACO"** means an organization of health care providers that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the beneficiaries assigned to it.

b. **"ACO Benchmark"** means a payer-specific financial target against which the expenditures for healthcare services furnished to an ACO-aligned beneficiary will be assessed. Payer-specific Shared Savings and Shared Losses for an ACO will be determined based on this assessment.

c. **"All-payer(s)"** means Medicare FFS, Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans.

d. **"All-payer Total Cost of Care per Beneficiary"** means the expenditures associated with All-payer Financial Target Services provided to Vermont All-payer Beneficiaries for any given Performance Year divided by the count of Vermont All-payer Beneficiaries for the same Performance Year.

e. **"All-payer Total Cost of Care per Beneficiary Growth"** means the growth rate for All-payer Total Cost of Care per Beneficiary as calculated in accordance with section 9.a.

f. **"All-payer Financial Target Services"** means the Medicare Financial Target Services and the following categories of services for Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans: acute hospital inpatient and outpatient care, post-acute care, professional services, and durable medical equipment. All-payer Financial Target Services includes these services delivered to Vermont residents whether provided in or outside of Vermont. All-payer Financial Target Services excludes dental services covered by Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans; Medicaid Behavioral Health Services; and Medicaid Home and Community-based Services. All-payer Financial Target Services excludes Medicaid Long-Term Institutional Services for Performance Year 1 through Performance Year 3, but includes Medicaid Long-Term Institutional Services for Performance Year 4 and subsequent Performance Years.

g. **"Annual Projected National Medicare Total Cost of Care per Beneficiary Growth"** means the growth rate for Medicare Advantage United States Per Capita Costs Fee-For-Service Projections ("***MA USPCC FFS Projections***") for a given Performance Year, as calculated in accordance with section 9.b.i.2.

h. **"Medicaid Behavioral Health Services"** means the following services: (1) Level 1 inpatient psychiatric stays; (2) psychiatric treatment in Vermont's psychiatric hospital; (3) services from Designated Agencies; and (4) payment for codes H001-H2037. Medicaid Behavioral Health Services also includes mental health and substance use disorder services funded by the following departments within AHS at the time of this Agreement: Department of Mental Health; Department of Health; Department of Disabilities, Aging and Independent Living; and the Vermont Division of Substance Use Programs.

i. **"Medicaid Home and Community-based Services"** means services captured under Medicaid Long-Term Services and Support that are delivered in home and community-based settings. This term excludes Medicaid Long-Term Services and Support delivered in long-term care facility (e.g., nursing home) settings.

j. **"Medicaid Long-Term Institutional Services"** means services captured under Vermont's Medicaid Long-Term Services and Support that are delivered in a

long-term care facility (e.g., nursing home) settings. This term excludes Medicaid Long-Term Services and Support delivered in home and community-based settings.

k. **"Medicaid Long-Term Services and Support"** means Medicaid reimbursed services delivered in a long-term care facility and home and community-based settings. These include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, and transportation paid for by Vermont Medicaid.

l. **"Medicare Fee-for-Service ("Medicare FFS")"** means Medicare Part A and Part B, and does not include Medicare Part C (Medicare Advantage) or Part D.

m. **"Medicare Financial Target Services"** means all Medicare Part A and Part B services, including services provided to Vermont residents outside of Vermont and benefit enhancements authorized under the Medicare Shared Savings Program, the Next Generation ACO Model, and the Vermont Medicare ACO Initiative. Medicare Part C (Medicare Advantage) and Part D services, wherever provided, are excluded from this term.

n. **"Medicare Advantage United States Per Capita Costs Fee-for-Service Projections"** means projected Medicare FFS per beneficiary expenditure growth published annually each spring by the CMS Office of the Actuary in the CMS announcements of Medicare Advantage payment rates.

o. **"National Medicare Beneficiary"** means a Medicare FFS beneficiary enrolled for benefits under Part A and Part B, but not Part C (Medicare Advantage), who resides in one of the U.S. fifty states or the District of Columbia. This term excludes Medicare FFS beneficiaries residing in Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

p. **"National Medicare Total Cost of Care per Beneficiary"** means the expenditures associated with Medicare Financial Target Services provided to National Medicare Beneficiaries for any given Performance Year divided by the count of National Medicare Beneficiaries for the same Performance Year.

q. **"National Medicare Total Cost of Care per Beneficiary Growth"** means the compounded annualized growth rate for National Medicare Total Cost of Care per Beneficiary.

r. **"NQF"** means National Quality Forum.

s. **"Payer Differential"** means the different levels of payments made to providers and suppliers by Medicare FFS, Vermont Medicaid, and Vermont Commercial Plans for similar sets of services. The Payer Differential may be articulated in equivalent manners, such as different ACO/provider profit margins by payer.

t. **"Performance Period"** means the Performance Years this Agreement will be in effect. The Performance Period of this Model will begin on January 1, 2017 and end at either 11:59PM (EST) on December 31, 2023, or in the event of a transition period described in section 2.c, 11:59 PM (EST) on December 31, 2024, unless this Agreement is terminated sooner in accordance with section 21, in which case the Performance Period will conclude on the effective date of termination.

u. **"Performance Year ("PY")"** means the 12-month period beginning on January 1 of each year during the Performance Period of this Agreement. The first Performance Year is Performance Year 0 (2017), and the last Performance Year is either Performance Year 6 (2023), or in the event of a transition period described in section 2.c, Performance Year 7 (2024).

v. **"Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth"** means the growth rate for MA USPCC FFS Projections over the Performance Period, as calculated in accordance with section 9.b.i.2.

w. **"Shared Losses"** means the monetary amount owed to a payer by an ACO as determined by comparing the ACO's expenditures for aligned beneficiaries against the ACO Benchmark for that payer.

x. **"Shared Savings"** means the monetary amount owed to an ACO by a payer as determined by comparing the ACO's expenditures for aligned beneficiaries against the ACO Benchmark for that payer.

y. **"Shared Savings Advance Payment"** means a quarterly payment paid to a VMA ACO by CMS in accordance with the Vermont Medicare ACO Initiative Participation Agreement.

z. **"Vermont ACO"** means an ACO primarily operating in Vermont that has contracts with any of the following payers: Vermont Medicaid, Vermont Commercial Plans; Vermont Self-insured Plans; or Medicare under the Medicare

Shared Savings Program, the Next Generation ACO Model, or the Vermont Medicare ACO Initiative.

aa. **"Vermont All-payer Beneficiary"** means a Vermont resident who is also a Vermont Medicare Beneficiary or enrolled in Vermont Medicaid, a Vermont Commercial Plan, or a Vermont Self-Insured Plan.

bb. **"Vermont All-payer Scale Target Beneficiary"** means a Vermont resident who is also a Vermont Medicare Beneficiary or enrolled in Vermont Medicaid, a Vermont Commercial Plan, or a Vermont Self-insured Scale Target Plan.

cc. **"Vermont Commercial Plan"** means health insurance plans holding a certificate of authority from Vermont's Commissioner of Financial Regulation. This term does not include coverage for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage if benefits for health services are secondary or incidental to other insurance benefits. This term includes Medicare Advantage plans, but does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, and other similar benefits.

dd. **"Vermont Medicaid"** means the program of medical assistance benefits under Title XIX of the Act, as modified by Vermont's demonstration waiver under Section 1115 of the Act, operated by Vermont's Agency for Human Services to provide health coverage to eligible Vermont residents. This term excludes assistance for Vermont residents who receive pharmacy benefits but no other medical benefits under Vermont's demonstration waiver or Title XIX of the Act.

ee. **"Vermont Medicare ACO Initiative" or "Initiative"** is the ACO initiative that will start in Performance Year 2 of this Model and will be executed under a Vermont Medicare ACO Initiative Participation Agreement, as described in section 8.

ff. **"Vermont Medicare ACO Initiative Benchmarks"** means the ACO Benchmarks applicable to VMA ACOs and Vermont Modified Next Generation ACOs.

gg. **"Vermont Medicare Beneficiary"** means a Vermont resident Medicare FFS

beneficiary enrolled for benefits under Part A, and Part B, but not enrolled for benefits under Part C (Medicare Advantage). Residency is determined by CMS based on its data.

hh. **"Vermont Medicare Total Cost of Care per Beneficiary"** means the expenditures associated with Medicare Financial Target Services provided to Vermont Medicare Beneficiaries for any given Performance Year divided by the count of Vermont Medicare Beneficiaries for the same Performance Year, calculated in accordance with section 9.b.i. As described further in section 9.b.i, the Vermont Medicare Beneficiaries included in the calculation of Vermont Medicare Total Cost of Care per Beneficiary will transition over the Performance Period from Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives to all Vermont Medicare Beneficiaries regardless of alignment to Scale Target ACO Initiatives.

ii. **"Vermont Medicare Total Cost of Care per Beneficiary Growth"** means the growth rate for Vermont Medicare Total Cost of Care per Beneficiary, as calculated in accordance with section 9.b.i.

jj. **"Vermont Modified Next Generation ACO"** means an ACO which has executed a Next Generation ACO Model participation agreement with CMS that has the majority of its ACO aligned Medicare beneficiaries residing in Vermont as of the start date of Performance Year 1 of the Model. In accordance with section 8.a.ii, the participation agreement for Vermont Modified Next Generation ACOs will be amended to specify that the GMCB shall have a role in developing the Vermont Medicare ACO Initiative Benchmark. Vermont Modified Next Generation ACOs with these amended participation agreements are considered to be participants in the Next Generation ACO Model.

kk. **"VMA ACO"** means an ACO participating in the Vermont Medicare ACO Initiative.

ll. **"Vermont Self-insured Plan"** means health plans provided to a Vermont resident by an employer operating in Vermont who is self-insured. This term excludes federal employee health benefit plans, TRICARE and other military coverage, and other employer-based plans for employers operating outside of Vermont.

mm. **"Vermont Self-insured Scale Target Plan"** means health benefits provided to a Vermont resident by an employer operating in Vermont who is self-

insured, including the State, federal government, or the military. This term includes federal employee health benefits plans, TRICARE and other military coverage, but excludes employer-based plans for employers operating outside of Vermont.

2. Agreement Term.

a. Effective Date. The Agreement became effective on October 26, 2016, when it was signed by the Parties (the "Effective Date"). Unless otherwise specified, the amendments hereby made to the Agreement will be effective as of the date this amended and restated version of the Agreement is fully executed by all Parties, as indicated by the last signature date.

b. Term of Agreement. The term of this Agreement began on the Effective Date and expires two years after the last day of the Performance Period of the Model.

c. The Performance Period of this Model will begin on January 1, 2017, and will end at 11:59PM (EST) on December 31, 2023 or at the end of a transition period as described in this section, unless this Agreement is sooner terminated in accordance with section 21, in which case the Performance Period concludes on the effective date of termination. CMS will offer the State an optional transition period to allow for an additional Performance Year of the Model. CMS shall make a written offer to renew the Agreement on or before March 31, 2023. The State shall accept or reject such offer in writing by a date and in a form and manner specified by CMS. In the event the State accepts such offer, the Performance Period of this Model will end on December 31, 2024, unless the Agreement is sooner terminated by either party in accordance with section 21.

3. Legal Authority

a. CMS Legal Authority.

i. **General Authority to Test Model.** Section 1115A(b) of the Act authorizes the Center for Medicare and Medicaid Innovation ("Innovation Center") to test innovative payment and service delivery models that are expected to reduce Medicare, Medicaid, or Children's Health Insurance Program ("CHIP") expenditures while maintaining or improving the quality of care for beneficiaries.

ii. **Financial and Payment Model Authorities.** Section 1115A(b)(2) of the Act requires the Secretary of Health and Human Services ("Secretary") to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute provides a non-exhaustive list of examples of models that the Secretary may select that includes, "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals."

iii. **Fraud and Abuse Waiver Authority.** Under Section 1115A(d)(1) of the Act, the Secretary may waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out Section 1115A with respect to testing models described in 1115A(b). For this Model, and consistent with this standard, the Secretary issued on December 20, 2018, a Notice of Waivers of Certain Fraud and Abuse Laws in Connection With the Vermont Medicare ACO Initiative Within the Vermont All-Payer ACO Model ("Notice of Waivers"). Under the terms of the Notice of Waivers, the Secretary waived certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act with respect to specified financial arrangements in the Vermont Medicare ACO Initiative. The Notice of Waivers is publicly available at www.cms.gov/medicare/physician-self-referral-law. Notwithstanding any other provision of this Agreement, all individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any separately documented waiver issued pursuant to Section 1115A(d)(1) specifically for this Model. The Secretary has no authority to waive state fraud and abuse laws that may be implicated by the testing of this Model.

iv. **Medicare Authority.** The Medicare portions of the Model shall operate according to Medicare law, regulation, and sub-regulatory guidance, and are subject to all existing requirements, including financial and program integrity requirements, except to the extent these requirements are waived or modified in separately issued documentation.

v. **Medicaid Authority.** The Medicaid elements of the Model shall operate according to Medicaid law, regulation and sub-regulatory guidance, including but not limited to all requirements of Vermont's Medicaid

demonstration project under Section 1115 of the Act.

b. **Vermont Legal Authority.** The State represents and warrants that it has the legal authority under Titles 8, 18, and 33 of Vermont Statutes Annotated to: implement methodologies for payment reforms; set rates for providers; require payers to comply with those rates; regulate Vermont ACO(s); and perform the regulatory functions consistent with this Agreement. The State represents and warrants that the Model complies with state fraud and abuse laws or will propose changes to state laws that reflect the terms of this Agreement while providing adequate protection against fraud and abuse. The State further represents and warrants that it has the legal authority to enter into this Agreement and shall comply with the applicable terms and conditions of this Agreement and all submissions related to the Model required pursuant to this Agreement.

c. **Vermont Medicaid Authority.** The State represents and warrants that AHS will have the authority under a Section 1115 Medicaid waiver by January 1, 2017, to operate Vermont Medicaid, including Medicaid payment methodologies, to meet the requirements of this Agreement. AHS shall not withdraw or request modification of the Section 1115 Medicaid waiver in such a way as to limit its authority to participate in the Model. In addition, when AHS applies to CMS for a new waiver or a waiver renewal, the application to CMS shall request terms and conditions that are consistent with this Agreement. This Agreement does not limit or modify any rules and regulations or processes applicable to such approvals and as such, CMS intends to support consistency of any new Section 1115 Medicaid waiver or waiver renewal with this Agreement. Additionally, this Agreement does not abrogate the designation of AHS as the Single State Agency as required by 42 C.F.R. § 431.10 or to otherwise alter AHS's responsibilities as the Single State Agency, to include its sole authority to set rates for Vermont Medicaid.

4. **Medicare Beneficiary Protections.** Vermont and CMS shall ensure that Medicare FFS beneficiaries' access to care, services, providers, and suppliers will not be limited under the Model. Specifically, Vermont and CMS shall ensure that Vermont Medicare Beneficiaries will: (1) retain full freedom of choice of providers and suppliers, as well as all rights and beneficiary protections of Medicare, and (2) retain coverage of the same care and services provided under Medicare FFS. Vermont Medicare Beneficiaries will not experience any reductions in their rights to benefits or covered services under this Agreement.

5. **Start-up Funding.** CMS will make available to AHS a single-source funding opportunity for start-up funding in the amount of $9.5M in calendar year 2017 to fund care

coordination, connections to community-based resources, and practice transformation for Medicare FFS beneficiaries in support of the Model. Any such funding will be executed under a separate agreement with AHS and will incorporate terms described in Appendix 2.

6. ACO Scale Targets.

a. **Percentage of Vermont Beneficiaries Aligned to an ACO.** Vermont shall make efforts to maximize the percentage of Vermont Medicare Beneficiaries and the percentage of Vermont All-payer Scale Target Beneficiaries aligned to a Scale Target ACO Initiative, as defined in section 6.b, relative to the following percentages for each Performance Year ("ACO Scale Targets"):

Percent (%)	By end of PY1 (2018)	By end of PY2 (2019)	By end of PY3 (2020)	By end of PY4 (2021)	By end of PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%

There are no ACO Scale Targets for PY6 (2023) or, if applicable, PY7 (2024).

b. **Scale Target ACO Initiatives.** A Scale Target ACO Initiative is an ACO arrangement offered by Vermont Medicaid, Vermont Commercial Plans, Vermont Self-insured Scale Target Plans, or Medicare FFS (e.g., Vermont Medicare ACO Initiative, Next Generation ACO Model, Medicare Shared Savings Program) to a Vermont ACO that incorporates, at minimum, the following:
   i. The possibility of Shared Savings for the Vermont ACO if it achieves goals related to quality of care or utilization;
   ii. The Vermont ACO's Shared Savings, as a percentage of the ACO's expenditures less than the ACO's benchmark, is at minimum 30 percent; if the Vermont ACO is also at risk for Shared Losses, its Shared Losses for which it is responsible to the payer, as a percentage of the ACO's expenditures in excess of its benchmark, is at minimum 30 percent; risk-arrangements similar to all-inclusive population-based payments offered under the Next Generation ACO Model with 100 percent as the percentage of ACO's expenditures below or in excess of its benchmark that is Shared Savings or Shared Losses, respectively, will satisfy this criteria;
   iii. Services comparable to, but not limited to, the All-payer Financial Target

Services and their associated expenditures are included for determination of the ACO's Shared Losses and Shared Savings, as proposed by Vermont and approved by CMS as provided for in section 6.j.i; and

iv. The ACO Benchmark, Shared Savings, Shared Losses, or a combination is tied to the quality of care the ACO delivers, the health of its aligned beneficiaries, or both.

c. **Calculation Methodology.** The percentage of Vermont All-payer Scale Target Beneficiaries and Vermont Medicare Beneficiaries aligned to a Scale Target ACO Initiative will be calculated as follows:

   i. **Vermont All-payer Scale Target Beneficiaries**: the denominator will be the number of Vermont All-payer Scale Target Beneficiaries. The numerator will include any Vermont All-payer Scale Target Beneficiary who is aligned to a Scale Target ACO Initiative.

   ii. **Vermont Medicare Beneficiaries**: the denominator will be the number of Vermont Medicare Beneficiaries. The numerator will include any Vermont Medicare Beneficiary who is aligned to a Scale Target ACO Initiative.

d. AHS shall ensure that Vermont Medicaid offers a Scale Target ACO Initiative to Vermont ACOs no later than January 1, 2018. The State intends for Vermont Medicaid to be a reliable payer within the Model. The GMCB will annually provide its recommendations to the AHS Secretary and the Vermont General Assembly to increase Vermont Medicaid reimbursement rates to levels more comparable to Medicare FFS reimbursement rates. The State intends that payments paid by Vermont Medicaid to Vermont ACOs be set for a calendar year to allow predictability for both the Vermont ACOs and the GMCB's Vermont ACO regulations. Furthermore, AHS intends to work collaboratively with the GMCB within its ACO regulatory process under the direction of the Governor's Director of Health Care Reform, established in 3 V.S.A. § 2222a.

e. Vermont shall encourage opportunities for Vermont Commercial Plans and Vermont Self-insured Scale Target Plans to offer Scale Target ACO Initiatives to Vermont ACOs.

f. Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology,

ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii) with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative beginning in Performance Year 2. CMS and Vermont will work together to explore modifications to the Vermont Medicare ACO Initiative in order to facilitate design alignment. In accordance with section 8, Vermont may propose such modifications to the Initiative, and CMS may accept such proposals for modifications at its sole discretion.

g. CMS shall explore potential opportunities with federal employee health benefits plans and military health plans to offer Scale Target ACO Initiatives to Vermont ACOs to support the achievement of the ACO Scale Targets and ACO design alignment. If federal employee health benefits plans, military health plans, or both do not offer Scale Target ACO Initiatives to Vermont ACOs to the degree necessary to support the achievement of the ACO Scale Targets, CMS and Vermont may exclude from Vermont All-payer Scale Target Beneficiaries Vermont residents enrolled in federal employee health benefits plans, military health plans, or both. Any such modification will be dependent on mutual agreement of both CMS and the State.

h. Vermont shall encourage providers and suppliers operating in Vermont to participate in Vermont ACOs to achieve the ACO Scale Targets as specified in sections 6.a, 6.b, and 6.c.

i. CMS and Vermont expect that the majority of providers and suppliers operating in Vermont and participating in Vermont ACOs will choose to participate in a VMA ACO or a Vermont Modified Next Generation ACO.

j. **Annual ACO Scale Targets and Alignment Report.**

    i. In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of Performance Years 1 through 5, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment (***"Annual ACO Scale Targets and Alignment Report"***). This assessment must also describe how the Scale

Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessment, it may qualify as a Triggering Event as described in section 21.

ii. The GMCB shall submit to CMS for its approval (1) no later than June 30th of the year following the conclusion of each of the Performance Years 1 through 5, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c; and (2) no later than June 30th of the year following the conclusion of Performance Year 6 and, in the event of a transition period described in Section 2.c, Performance Year 7, the percentage of Vermont All-Payer Scale Target Beneficiaries aligned to a Scale Target ACO Initiative for each such Performance Year.

k. [RESERVED]

7. Statewide Health Outcomes and Quality of Care Targets.

a. Vermont shall achieve the population-level health outcomes targets, healthcare delivery system quality targets, and process milestones (collectively ***"Statewide Health Outcomes and Quality of Care Targets"***) as described in Appendix 1.

b. **Consequences for not being on track to achieve the population-level health outcomes targets.** CMS may determine that the State is not on track to achieve at least four of the six population-level health targets, as described in Appendix 1.a.i through Appendix 1.a.iv, provided that the three chronic condition targets will be considered separately. If CMS makes such determinations, CMS may initiate the following remedies:
   i. CMS may determine it is a Triggering Event and issue the State a Warning Notice as described in section 21.
   ii. Any State CAP in response to this Triggering Event, as set forth in section 21, shall include the methodology the State will use to improve its performance against the population-level health outcomes targets for which the State is not on track to achieve. The State's plan to improve its performance against the population-level health outcomes targets may include, but is not limited to, any or all of the following: increasing the State's investments into community-based resources, or increasing the Vermont Medicare ACO Initiative Benchmark's weight given to ACO quality performance.

c. **Consequences for not being on track to achieve the healthcare delivery system quality targets.** CMS may determine that the State is not on track to achieve at least five of the nine healthcare delivery system quality targets, as described in Appendix 1.b.i through Appendix 1.b.vi, provided that Initiation and Engagement of Alcohol and Other Drug Dependence Treatment are considered separately, as are each of the Chronic Condition Targets for diabetes, hypertension, and multiple chronic conditions. If CMS makes such determinations, CMS may initiate the following remedies:

   i. CMS may determine it is a Triggering Event and issue the State a Warning Notice as described in section 21.

   ii. Any State CAP in response to this Triggering Event, as set forth in section 21, shall include the methodology the State will use to improve its performance against the healthcare delivery system quality targets for which the State is not on track to achieve. The State's plan to improve its performance against the population-level health outcomes targets may include, but is not limited to, any or all of the following: increasing the State's investments into community-based resources, increasing the Vermont ACO's investments into community-based resources, or increasing the Vermont Medicare ACO Initiative Benchmark's weight given to ACO quality performance.

   iii. If after implementation of the CAP for one year from its approval by CMS, CMS determines that the State is still not on track to achieve at least five of the nine healthcare delivery system quality targets, or if CMS rejects the CAP, CMS may take the following actions:

      1) Establish or modify the quality measures and targets to which the Vermont Medicare ACO Initiative Benchmark is tied.
      2) Directly set the percentage of the Vermont Medicare ACO Initiative Benchmark that is tied to quality for Medicare FFS beneficiaries aligned to the VMA ACO or Modified Next Generation ACO.

d. **Consequences for not being on track to achieve the process milestones.** CMS may determine that the State is not on track to achieve at least five of the seven process milestones, as described in Appendix 1.c.i through Appendix 1.c.vii. If CMS makes such determinations, CMS may initiate the following remedies:

   i. CMS may determine it is a Triggering Event and issue the State a Warning Notice as described in section 21.

   ii. Any State CAP in response to this Triggering Event, as set forth in section

21, shall include the methodology the State will use to improve its performance against the process milestones for which the State is not on track to achieve.

e. **Annual Health Outcomes and Quality of Care Report.** The GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than 18 months following Performance Year 1 and each subsequent Performance Year, an annual report on the State's efforts to achieve the Statewide Health Outcomes and Quality of Care Targets (***"Annual Health Outcomes and Quality of Care Report"***). At a minimum, the State shall describe the following in this annual report:
    i. For all Performance Years, Vermont's progress on achieving Statewide Health Outcomes and Quality of Care Targets set forth in Appendix 1;
    ii. For Performance Years 1 through 5, how Scale Target ACO Initiatives hold Vermont ACOs accountable for quality of care, the health of their aligned beneficiaries (section 6.b.iv), or both; and
    iii. For Performance Years 1 through 5, how the State holds Vermont ACOs accountable to allocate funding for and invest in community health services to achieve the Statewide Health Outcomes and Quality of Care Targets.

f. **Collaboration with Public Health.** The State shall submit by June 30th of Performance Year 3 a plan signed by Vermont's Department of Health, AHS, the GMCB, and Vermont ACO(s) that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to community health services is being used towards achieving the Statewide Health Outcomes and Quality of Care Targets.

g. **Potential additional Healthcare Delivery System Quality Target measure.** AHS, in collaboration with the GMCB, shall develop with CMS by December 31, 2017, a measure to monitor Medicaid patient caseload for specialist and non-specialist physicians. CMS, and the GMCB in consultation with AHS, may choose by the end of Performance Year 2 to add this measure and an associated target as an additional healthcare delivery system quality target.

h. **Exogenous factors.** The GMCB, in consultation with AHS where appropriate, may submit, in writing to CMS, a request that exogenous factor(s) (e.g., changes in Medicare law and regulation, Vermont-localized health or economic shocks, the COVID-19 pandemic and resulting disruption to the health care system) be taken into consideration when assessing performance on the Statewide Health

Outcome and Quality of Care Targets. Vermont shall explain the impact of such factors on the Model, including any recommendations as to how CMS should adjust the Model to reflect these exogenous factors, including how performance on the Statewide Health Outcome or Quality of Care Targets should be assessed. Any such adjustment will be at the sole discretion of CMS.

8. **Vermont Medicare ACO Initiative ("Initiative").** CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019. CMS shall require Vermont ACOs participating in the Initiative (VMA ACOs) to accept beneficiary alignment methodology, ACO quality measures, payment mechanisms, and risk arrangements for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the ACO. The GMCB may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans. CMS may accept such proposals at its sole discretion.

    a. **CMS Duties**.
        i. CMS, in collaboration with the GMCB, will determine the parameters and requirements of the Initiative including governance, beneficiary alignment methodology, payment mechanisms, risk arrangements, and benefit enhancements. CMS may exercise its authority to modify or set the Vermont Medicare ACO Initiative Benchmarks as articulated in sections 7.c and 9.d.
        ii. For Performance Year 1 of the Model, CMS shall execute Vermont Modified Next Generation ACO participation agreements with eligible Vermont ACOs that are based on the Next Generation ACO Model participation agreements, but are amended to reflect the GMCB's role in setting the Vermont Medicare ACO Initiative Benchmark in accordance with the terms of this Agreement, except as described in sections 7.c and 9.d.
        iii. For Performance Year 2 and subsequent Performance Years of the Model, CMS shall execute with VMA ACOs separate Vermont Medicare ACO Initiative participation agreements that are based on the amended participation agreements executed by the Vermont Modified Next Generation ACOs for Performance Year 1. The Vermont Medicare ACO Initiative participation agreements may include additional modifications developed in collaboration with the State to support greater alignment across Scale Target ACO Programs, per section 6.f. GMCB, after consultation with AHS, may propose such modifications to the Initiative, and CMS may accept such proposals for modifications at its sole

discretion.

iv. CMS will include as part of the Vermont Medicare ACO Initiative the following benefit enhancements: Telehealth, Care Management Home Visits, Post-discharge home visits, and 3-day SNF Rule payment waivers.

v. For Performance Year 2 and subsequent Performance Years of the Model, CMS will include the payment mechanism of all-inclusive population-based payments as part of the Vermont Medicare ACO Initiative.

vi. CMS shall collaborate with the GMCB to analyze and understand data to inform how Vermont Medicare ACO Initiative Benchmarks are set for Vermont Modified Next Generation ACOs and VMA ACOs.

vii. CMS will assess the Vermont Medicare ACO Initiative Benchmarks to ensure consistency with standards set forth in section 8.b.ii.1 and will make a decision on whether to approve the Vermont Medicare ACO Initiative Benchmarks submitted by the GMCB, as discussed in section 8.b.ii.

b. **GMCB Duties**.

i. In order for a Vermont ACO to be eligible to participate in the Vermont Medicare ACO Initiative or be eligible to become a Vermont Modified Next Generation ACO, the GMCB must submit to CMS a letter jointly signed by the GMCB and the Vermont ACO attesting that the two entities will work together to achieve the ACO Scale Targets, Statewide Financial Targets, and Statewide Health Outcomes and Quality of Care Targets of the Vermont All-payer ACO Model. The GMCB and the Vermont ACO shall submit the letter in a manner and by a deadline determined by CMS.

ii. Except as described in sections 7.c and 9.d, the GMCB shall prospectively develop the Vermont Medicare ACO Initiative Benchmarks for both Vermont Modified Next Generation ACOs and VMA ACOs for Performance Year 1 and subsequent Performance Years in accordance with the terms of this Agreement and subject to CMS approval.

1. The methodology for developing the Vermont Medicare ACO Initiative Benchmarks must be consistent with each of the following principles and criteria:
    a. The Vermont Medicare ACO Initiative Benchmarks should incentivize high-quality care, promote efficient care, and support improvement in the health of aligned beneficiaries.
    b. For Performance Year 1:
        i. If the Annual Projected National Medicare Total

Cost of Care per Beneficiary Growth for Performance Year 1 is calculated to be less than 2.7 percent, as discussed in section 9.b.iv, the growth rates for the Vermont Medicare ACO Initiative Benchmarks for Performance Year 1 must be no greater than 1.0 percentage point above the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1; or

ii. If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1 is calculated to be less than 3.7 percent but greater than or equal to 2.7 percent, as discussed in section 9.b.iv, the growth rates for Vermont Medicare ACO Initiative Benchmarks for Performance Year 1 must be no more than 3.5 percent; or

iii. If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1 is calculated to be greater than or equal to 3.7 percent, the growth rates for Vermont Medicare ACO Initiative Benchmarks for Performance Year 1 must be at least 0.1 percentage points below the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1.

c. For Performance Year 2 and subsequent Performance Years, except as otherwise agreed to by CMS, the Vermont Medicare ACO Initiative Benchmarks must be established as follows:

i. If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1 is less than 3.7 percent, as discussed in section 9.b.iv, the growth rates for Vermont Medicare ACO Initiative Benchmarks must be at least 0.2 percentage points below the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for the Performance Year during which the Vermont Medicare ACO Initiative Benchmark would be applicable; or

ii. If the Annual Projected National Medicare Total

Cost of Care per Beneficiary Growth for Performance Year 1 is greater than or equal to 3.7 percent, as discussed in section 9.b.iv, the growth rates for the Vermont Medicare ACO Initiative Benchmarks must be at least 0.1 percentage points below the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for the Performance Year during which the Vermont Medicare ACO Initiative Benchmark would be applicable; or

iii. The Vermont Medicare ACO Initiative Benchmarks must be such that the compounded annualized growth rates for Vermont Medicare ACO Initiative Benchmarks over Performance Year 1 through the Performance Year in question are less than 0.1 percentage points above the compounded annualized growth rate for the cumulative Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth over the same period of time.

d. Except as provided in Sections 8.b.ii.1.d.i-ii below, the growth rates for Vermont Medicare ACO Initiative Benchmarks, discussed in (b) and (c), above, must be applied to the best estimate available on Medicare FFS expenditures incurred during the year prior to the Performance Year in question for the Medicare FFS beneficiaries who would have been aligned during the year prior to the Performance Year in question to the Vermont Modified Next Generation ACOs and VMA ACOs, given the same alignment methodology and providers and suppliers participating in the Vermont Modified Next Generation ACOs and VMA ACOs during the Performance Year in question.

i. For Performance Year 3, the parties agreed that the Vermont Medicare ACO Initiative Benchmark would be established by using a regional retrospective trend factor equal to the growth rate in per-beneficiary Medicare FFS expenditures for VMA ACO alignment-eligible beneficiaries between calendar year 2019-2020.

ii. For Performance Year 4, the parties agreed that the Vermont Medicare ACO Initiative Benchmark would be established by using a regional retrospective trend factor equal to the growth rate in per-beneficiary Medicare FFS expenditures for VMA ACO-aligned beneficiaries between calendar year 2020-2021.

e. The Vermont Medicare ACO Initiative Benchmarks must enable achievement of the Financial Targets described in section 9.

f. The Vermont Medicare ACO Initiative Benchmarks must incorporate ACO quality performance as described in section 7.

g. The Vermont Medicare ACO Initiative Benchmarks must have a percentage of the benchmarks at risk due to ACO quality performance that at minimum meets the percentage tied to ACO quality scores for ACOs participating in the Next Generation ACO Model.

h. The Vermont Medicare ACO Initiative Benchmarks must mitigate adverse patient selection by the ACO or its network providers, or any provider behavior that increases the alignment of healthier beneficiaries while avoiding more medically complex beneficiaries.

i. The GMCB must provide Vermont Medicare ACO Initiative Benchmarks to the ACO(s) prospectively.

j. Vermont Medicare ACO Initiative Benchmarks must be set separately for Medicare FFS Aged and Disabled beneficiaries and ESRD beneficiaries.

2. The GMCB shall submit to CMS for approval the Vermont Medicare ACO Initiative Benchmarks for each VMA ACO at least 30 calendar days prior to the beginning of each Performance Year for which the benchmarks would be applicable. CMS will assess the Vermont Medicare ACO Initiative Benchmarks to ensure consistency with standards set forth in section 8.b.ii.1 and will make a written decision within 10 calendar days of the GMCB's submission on whether to approve the Vermont Medicare ACO Initiative Benchmarks. If CMS does not provide a written decision within 10 calendar days, the Vermont Medicare ACO Initiative Benchmarks will be deemed approved. If CMS disapproves the GMCB's submission for the Vermont Medicare ACO Initiative

Benchmarks, CMS will work with the GMCB to revise the submission to be consistent with the standards set forth in section 8.b.ii.1.

iii. To the extent it has the authority, the GMCB may direct a VMA ACO, a Vermont Modified Next Generation ACO, or both to make specific infrastructure and care delivery investments.

iv. Beginning with Performance Year 3, the GMCB will calculate, for each VMA ACO, the total amount of Shared Shavings Advance Payments that the VMA ACO will receive for the Performance Year ("***Total Shared Savings Advance Amount***"). The Total Shared Savings Advance Amount for each Performance Year is subject to CMS approval.

v. The GMCB shall submit to CMS for approval the Total Shared Savings Advance Amount for each VMA ACO, along with the numerical inputs used in calculation of the Total Shared Savings Advance Amount, by December 20 or as otherwise agreed to by CMS prior to the beginning of each Performance Year. CMS will make a written decision within 10 calendar days of the GMCB's submission on whether to approve the Total Shared Savings Advance Amount for each VMA ACO. If CMS does not provide a written decision within 10 calendar days, the Total Shared Savings Advance Amount for each VMA ACO will be deemed approved. If CMS disapproves the GMCB's submission for the Total Advance Shared Savings Amount for a VMA ACO, CMS will work with the GMCB to revise the submission.

vi. To the extent it has the authority, the GMCB will review and approve an annual budget for each VMA ACO, according to which budget, or as authorized by GMCB Rule 5.000, section 5.40, the ACO shall expend Shared Savings Advance Payments.

vii. The GMCB shall collaborate with CMS to analyze and understand data to inform how Vermont Medicare ACO Initiative Benchmarks are set for Vermont Modified Next Generation ACOs and VMA ACOs.

9. **Statewide Financial Targets.**

The calculation of performance on the All-payer Total Cost of Care per Beneficiary Growth Target and the Medicare Total Cost of Care per Beneficiary Growth Target (collectively, the ***"Statewide Financial Targets"***) described in this section will be performed retrospectively.

a. **All-payer Total Cost of Care per Beneficiary Growth Target.** Vermont shall limit All-payer Total Cost of Care per Beneficiary Growth to 3.5 percent (the "***All-payer Total Cost of Care per Beneficiary Growth Target***").

i. **Calculation Methodology.** All-payer Total Cost of Care per Beneficiary Growth will be calculated by Vermont and CMS in aggregate as a compounded annualized growth rate of All-payer Total Cost of Care per Beneficiary across Performance Year 1 and subsequent Performance Years of this Model, using 2017 as a baseline and adjusted in section 9.c. All-payer Total Cost of Care per Beneficiary for any given Performance Year will incorporate the count of all Vermont All-payer Beneficiaries (referenced as "Vermont all-payer beneficiaries" in the formula, below) and the expenditures associated with All-payer Financial Target Services for all Vermont All-payer Beneficiaries (referenced as "Vermont all-payer TCOC" in the formula, below). Vermont's performance on the All-payer Total Cost of Care per Beneficiary Growth Target will be calculated by the following formula, where "20xx" is the Performance Year for which the All-payer Total Cost of Care per Beneficiary is being calculated, and "z" is the total number of Performance Years:

$$\left(\frac{\left(\frac{Vermont\ all-payer\ TCOC_{20xx}}{Vermont\ all-payer\ beneficiaries_{20xx}}\right)}{\left(\frac{Vermont\ all-payer\ TCOC_{2017}}{Vermont\ all-payer\ beneficiaries_{2017}}\right)}\right)^{\frac{1}{z}} - 1 \leq 0.035$$

b. **Medicare Total Cost of Care per Beneficiary Growth Target.** Vermont shall limit Vermont Medicare Total Cost of Care per Beneficiary Growth to at least 0.2 percentage points less than Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth (the "***Medicare Total Cost of Care per Beneficiary Growth Target***"), except as adjusted in section 9.b.iv.

i. **Calculation Methodology.**

1. **Calculating Vermont Medicare Total Cost of Care per Beneficiary Growth.** For Performance Years 1 and 2, the Vermont Medicare Total Cost of Care per Beneficiary will include only Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives operating pursuant to executed participation agreements with CMS. Vermont Medicare Total Cost of Care per Beneficiary Growth for Performance Years 1 and 2 will be calculated by comparing: (a) Vermont Medicare Total Cost of Care per Beneficiary for Vermont Medicare Beneficiaries who are aligned to such Scale Target ACO Initiatives in a given Performance Year (referenced as "Vermont ACO-aligned Medicare beneficiaries" in the applicable formula, below) with (b)

the Vermont Medicare Total Cost of Care per Beneficiary for Vermont Medicare Beneficiaries who would have been aligned to such Scale Target ACO Initiatives in the year prior to the Performance Year given the same alignment methodology and providers who participated in the Vermont ACO during the Performance Year (referenced as "Vermont ACO comparison Medicare beneficiaries" in the applicable formula, below).

For Performance Year 4 and subsequent Performance Years, the Vermont Medicare Total Cost of Care per Beneficiary will include all Vermont Medicare Beneficiaries. Vermont Medicare Total Cost of Care per Beneficiary Growth for Performance Year 4 and subsequent Performance Years will be calculated by comparing Vermont Medicare Total Cost of Care per Beneficiary for all Vermont Medicare Beneficiaries who are residing in Vermont in the Performance Year to Vermont Medicare Total Cost of Care per Beneficiary for all Vermont Medicare beneficiaries who were residing in Vermont in the year prior to the Performance Year according to CMS data, regardless of alignment to Scale Target ACO Initiatives.

If Vermont achieves at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries in Performance Year 3, then the Vermont Medicare Total Cost of Care per Beneficiary for Performance Year 3 will include all Vermont Medicare Beneficiaries, and Vermont Medicare Total Cost of Care per Beneficiary Growth for that Performance Year will be calculated in a similar manner as for Performance Year 4 and subsequent Performance Years. If Vermont does not achieve at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries in Performance Year 3, then the Vermont Medicare Total Cost of Care per Beneficiary for Performance Year 3 will include only Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives operating pursuant to executed participation agreements with CMS, and Vermont Medicare Total Cost of Care per Beneficiary Growth for that year will be calculated in a similar manner as for Performance Years 1 and 2 by comparing: (a) Vermont Medicare Total Cost of Care per Beneficiary for Vermont Medicare Beneficiaries who are aligned to such Scale Target ACO Initiatives in a given Performance Year (referenced as "Vermont ACO-aligned

Medicare beneficiaries" in the applicable formula, below) with (b) the Vermont Medicare Total Cost of Care per Beneficiary for Vermont Medicare Beneficiaries who would have been aligned to such Scale Target ACO Initiatives in the year prior to the Performance Year given the same alignment methodology and providers who participated in the Vermont ACO during the Performance Year (referenced as "Vermont ACO comparison Medicare beneficiaries" in the applicable formula, below).

Vermont Medicare Total Cost of Care per Beneficiary Growth will be calculated as a compounded annualized growth rate in aggregate across Performance Year 1 and subsequent Performance Years of this Model, using 2017 as a baseline. The parties acknowledge that Vermont did not achieve at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries in Performance Year 3. Therefore, Vermont Medicare Total Cost of Care per Beneficiary Growth will be calculated in accordance with the applicable formula below, except as adjusted in 9.b.ii and 9.c:

Vermont Medicare Total Cost of Care per Beneficiary Growth:

For PYs 1-6:

$$\left(\frac{\left(\frac{Vermont\ Medicare\ TCOC_{2018}}{Vermont\ ACO-aligned\ Medicare\ beneficiaries_{2018}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2017}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2017}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2019}}{Vermont\ ACO-aligned\ Medicare\ beneficiaries_{2019}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2018}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2018}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2020}}{Vermont\ Medicare\ ACO-aligned\ \ Medicare\ beneficiaries_{2020}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2019}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2019}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2021}}{Vermont\ Medicare\ beneficiaries_{2021}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2020}}{Vermont\ Medicare\ beneficiaries_{2020}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2022}}{Vermont\ Medicare\ beneficiaries_{2022}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2021}}{Vermont\ Medicare\ beneficiaries_{2021}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2023}}{Vermont\ Medicare\ beneficiaries_{2023}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2022}}{Vermont\ Medicare\ beneficiaries_{2022}}\right)}\right)^{\frac{1}{6}} - 1$$

For PY 7, as applicable, in the event of a transition period described in section 2.c:

$$\left(\frac{\left(\frac{Vermont\ Medicare\ TCOC_{2018}}{Vermont\ ACO-aligned\ Medicare\ beneficiaries_{2018}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2017}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2017}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2019}}{Vermont\ ACO-aligned\ Medicare\ beneficiaries_{2019}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2018}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2018}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2020}}{Vermont\ Medicare\ ACO-aligned\ beneficiaries_{2020}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2019}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2019}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2021}}{Vermont\ Medicare\ beneficiaries_{2021}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2020}}{Vermont\ Medicare\ beneficiaries_{2020}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2022}}{Vermont\ Medicare\ beneficiaries_{2022}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2021}}{Vermont\ Medicare\ beneficiaries_{2021}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2023}}{Vermont\ Medicare\ beneficiaries_{2023}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2022}}{Vermont\ Medicare\ beneficiaries_{2022}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2024}}{Vermont\ Medicare\ beneficiaries_{2024}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2023}}{Vermont\ Medicare\ beneficiaries_{2023}}\right)}\right)^{\frac{1}{7}} - 1$$

2. **Calculating Projected National Medicare Total Cost of Care per Beneficiary Growth.** The Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for any given Performance Year will be determined based on the MA USPCC FFS Projections published in the year prior to the Performance Year. The Annual Projected National Medicare Total Cost of Care per Beneficiary Growth calculation is summarized by the following formula, except as adjusted in sections 9.b.iii, 9.b.iv, and 9.c:

Annual Projected National Medicare Total Cost of Care per Beneficiary Growth:

$$\left(\frac{MA\ USPCC\ FFS_{20xx}}{MA\ USPCC\ FFS_{20xx-1}}\right)_{Announced\ in\ 20xx-1}$$

The Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth will be calculated as a compounded annualized growth rate in aggregate across Performance Year 1 and subsequent Performance Years of this Model, using 2017 as a baseline and summarized by the following formula, except as adjusted in sections 9.b.iii, 9.b.iv, and 9.c.

Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth:

PYs 1-6:

$$\left(\left(\frac{MA\ USPCC\ FFS_{2018}}{MA\ USPCC\ FFS_{2017}}\right)_{Announced\ in\ 2017} * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022}\right)^{\frac{1}{6}} - 1$$

For PYs 1-7, as applicable, in the event of a transition period described in section 2.c:

$$\left(\left(\frac{MA\ USPCC\ FFS_{2018}}{MA\ USPCC\ FFS_{2017}}\right)_{Announced\ in\ 2017} * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022} * \left(\frac{MA\ USPCC\ FFS_{2024}}{MA\ USPCC\ FFS_{2023}}\right)_{Announced\ in\ 2023}\right)^{\frac{1}{7}} - 1$$

3. **Calculating Vermont's performance on the Medicare Total Cost of Care per Beneficiary Growth Target.** Except as adjusted in section 9.b.iv, Vermont's performance on the Medicare Total Cost of Care per Beneficiary Growth Target will be calculated as a difference between Vermont Medicare Total Cost of Care per Beneficiary Growth and Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth.

Medicare Total Cost of Care per Beneficiary Growth Target performance:

$$Performance\ Period\ Projected\ National\ Medicare\ Total\ Cost\ of\ Care\ per\ Beneficiary\ Growth$$
$$Vermont\ Medicare\ Total\ Cost\ of\ Care\ per\ Beneficiary\ Growth\ \geq 0.002$$

ii. **Age Band Adjustment.** Vermont Medicare Total Cost of Care per Beneficiary Growth calculations will be adjusted for age differences between Vermont Medicare Beneficiaries and National Medicare Beneficiaries. This age adjustment will be performed by calculating Vermont Medicare Total Cost of Care per Beneficiary Growth separately for the following age bands, and weighting the age bands according to the age distribution of National Medicare Beneficiaries: under 65, 65-74, 75-84, 85 and over. CMS and the GMCB will jointly agree upon a methodology to calculate the age band adjustment.

iii. **Aged and Disabled and ESRD Adjustment.** The MA USPCC FFS Projections provide for separate projections for Medicare FFS beneficiaries with and without end-stage renal disease (ESRD). The

Annual Projected National Medicare Total Cost of Care per Beneficiary Growth and Performance Period National Medicare Total Cost of Care per Beneficiary Growth calculations will be based on a blend of the ESRD and non-ESRD MA USPCC FFS Projections according to the relative proportions of Vermont Medicare Beneficiaries included in the Vermont Medicare Total Cost of Care per Beneficiary Growth calculations who have, and do not have, ESRD. The following formula summarizes how the ESRD and non-ESRD MA USPCC FFS Projections will be blended:

Blended MA USPCC FFS Projections:

$$\left(MA\ USPCC\ FFS_{20xx,ESRD} * Percent\ ESRD\ beneficiaries_{20xx}\right) + \left(MA\ USPCC\ FFS_{20xx,non-ESRD} * Percent\ non-ESRD\ beneficiaries_{20xx}\right)$$

iv. **Projected National Medicare Total Cost of Care per Beneficiary Growth Target Floor for Performance Year 1.** If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1, calculated as a growth rate using 2017 as a baseline, is less than 3.7 percent but greater than or equal to 2.7 percent, then 3.7 percent will be used as the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth for purposes of calculating Vermont's performance in Performance Year 1 on the Medicare Total Cost of Care per Beneficiary Growth Target. In such a case, the following formula will be used to calculate Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, except as adjusted in sections 9.b.iii and 9.c. The Medicare Total Cost of Care per Beneficiary Growth Target shall remain as 0.2 percentage points less than Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, as described in section 9.b.i.3.

Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth:

<u>For PYs 1-6</u>:

$$\left(1.037 * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022}\right)^{\frac{1}{6}} - 1$$

<u>For PYs 1-7, as applicable, in the event of a transition period described in section 2.c</u>:

$$\left(1.037 * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022} * \left(\frac{MA\ USPCC\ FFS_{2024}}{MA\ USPCC\ FFS_{2023}}\right)_{Announced\ in\ 2023}\right)^{\frac{1}{7}} - 1$$

If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth in Performance Year 1, calculated as a growth rate using 2017 as a baseline, is less than 2.7 percent, then for purposes of calculating Vermont's performance on the Medicare Total Cost of Care per Beneficiary Growth Target, the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1 will be calculated as 1.2 percentage points above the MA USPCC FFS Projections for the same time period. In such a case, the below formula will be used to calculate Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, except as adjusted in sections 9.b.iii and 9.c. The Medicare Total Cost of Care per Beneficiary Growth Target shall remain as 0.2 percentage points less than Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, as described in section 9.b.i.3.

Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth:

For PYs 1-6:

$$\left(\left[\left(\frac{MA\ USPCC\ FFS_{2018}}{MA\ USPCC\ FFS_{2017}}\right)_{Announced\ in\ 2017} + 0.012\right] * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022}\right)^{\frac{1}{6}} - 1$$

For PYs 1-7, as applicable, in the event of a transition period described in section 2.c:

$$\left(\left[\left(\frac{MA\ USPCC\ FFS_{2018}}{MA\ USPCC\ FFS_{2017}}\right)_{Announced\ in\ 2017} + 0.012\right] * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022} * \left(\frac{MA\ USPCC\ FFS_{2024}}{MA\ USPCC\ FFS_{2023}}\right)_{Announced\ in\ 2023}\right)^{\frac{1}{7}} - 1$$

If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth in Performance Year 1, calculated as a growth rate using 2017 as a baseline, is equal to or greater than 3.7 percent, then the Medicare Total Cost of Care per Beneficiary Growth Target shall be 0.1 percentage points less than the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth. That is, Vermont shall limit the Vermont Medicare Total Cost of Care per Beneficiary Growth to at least 0.1 percentage points less than the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth. In such a case, the following formula will be used in lieu of the formula described in 9.b.i.3. to calculate Vermont's performance on the Medicare Total Cost of Care per Beneficiary Growth Target:

Medicare Total Cost of Care per Beneficiary Growth Target performance:

$$\frac{Performance\ Period\ Projected\ National\ Medicare\ Total\ Cost\ of\ Care\ per\ Beneficiary\ Growth}{Vermont\ Medicare\ Total\ Cost\ of\ Care\ per\ Beneficiary\ Growth} \geq 0.001$$

v. The parties acknowledge that CMS determined the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1 to be less than 3.7 percent but greater than or equal to 2.7 percent and, therefore, 3.7 percent will be used as the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth for purposes of calculating Vermont's performance in Performance Year 1 on the Medicare Total Cost of Care per Beneficiary Growth Target and the applicable formula as set forth in Section 9.b.iv. will be used to calculate Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth. In accordance with Section 9.b.iv, the Medicare Total Cost of Care per Beneficiary Growth Target shall remain as 0.2 percentage points less than Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, as described in Section 9.b.1.3.

c. **Adjustments to All-Payer and Medicare Total Cost of Care per Beneficiary Growth Target Calculations.**

i. **Payments Made under the Medicare Program and Medicare Demonstrations or Models.** CMS may adjust the Vermont Medicare Total Cost of Care per Beneficiary Growth calculation as necessary to avoid duplicative accounting for, and payment of, amounts made to or

received by providers, suppliers, or both in the State that are participating in any existing or future Medicare program, demonstration or model, including but not limited to those that involve Shared Savings or incentive payments.

1. **ACO Shared Savings and Shared Losses Adjustment.** The Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth calculations will be adjusted to incorporate any Shared Losses or Shared Savings for any Vermont ACOs participating in a Medicare FFS ACO initiative (e.g., Vermont Medicare ACO Initiative, Next Generation ACO Model, and Medicare Shared Savings Program). Such Shared Losses would be considered as reductions in expenditures and such Shared Savings as additional expenditures for purposes of calculating the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth.

ii. **Medicare payments made under the Multipayer Advanced Primary Care Practice demonstration.** During the baseline year of 2017, CMS will include $7.5M in the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth calculations, approximately the sum of Medicare payments made to Vermont providers in 2016 as part of the Multipayer Advanced Primary Care Practice demonstration.

iii. The All-Payer Total Cost of Care per Beneficiary Growth Target calculations shall be adjusted to exclude growth attributable to efforts by Vermont to increase Vermont Medicaid reimbursement rates, as more fully described in and subject to the reporting provisions of section 10.

iv. Starting in Performance Year 3, CMS or the GMCB may request modifications to the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth calculation if the MA USPCC FFS Projections differ by at least one (1) percentage point from National Medicare per Beneficiary Total Cost of Care Growth as calculated over the Performance Years that have concluded. Any such modifications must be intended to reduce the difference between Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth and National Medicare per Beneficiary Total Cost of Care Growth. Any

such modification will be subject to mutual agreement of CMS and the GMCB.

v. **Exogenous Factors.** The GMCB, in consultation with AHS where appropriate, may submit, in writing to CMS, a request that exogenous factor(s) (e.g., changes in Medicare law and regulation or Vermont-localized health or economic shocks, the COVID-19 pandemic and resulting disruption to the health care system) be taken into consideration when assessing performance on the All-payer or Medicare Total Cost of Care per Beneficiary Growth Targets. Vermont shall explain the impact of such factors on the Model, including any recommendations as to how CMS should adjust the Model to reflect these exogenous factors. Any such adjustment will be at the sole discretion of CMS.

d. **Consequences for not being on track to achieve Financial Targets.** If CMS makes a determination that Vermont is not on track to achieve the All-payer or Medicare Total Cost of Care per Beneficiary Growth Targets, as described in section 9.d.i and 9.d.ii, respectively, CMS may determine it is a Triggering Event and issue the State a Warning Notice as described in section 21. Any State CAP in response to this Triggering Event, as set forth in section 21, shall include the methodology the State will use to improve its performance against the financial target(s). If CMS does not approve the CAP, or if the included corrective actions failed to successfully place the State on track for its performance against the financial targets by one year from CMS's approval of the CAP, CMS shall directly set the Vermont Medicare ACO Initiative Benchmarks for the remaining Performance Year(s).

i. Beginning in Performance Year 2, CMS shall determine that the State is not on track to meet the All-payer Total Cost of Care per Beneficiary Growth Target if the cumulative All-payer Total Cost of Care per Beneficiary Growth, measured as a compounded annualized growth rate across Performance Years 1 through the most recently completed Performance Year, is greater than 4.3 percent.

ii. Beginning in Performance Year 2, CMS shall determine that the State is not on track to meet the Medicare Total Cost of Care per Beneficiary Growth Target if the cumulative Vermont Medicare Total Cost of Care per Beneficiary Growth exceeds 0.1 percentage point above the cumulative Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth. The cumulative Vermont Medicare Total Cost of

Care per Beneficiary Growth and Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth would be measured as compounded annualized growth rates across Performance Year 1 through the most recently completed Performance Year.

e. **Request for modifications to Medicare and All-payer Financial Target Services.** The GMCB, in consultation with AHS, may request modifications to the definitions of Medicare Financial Target Services and All-payer Financial Target Services, subject to CMS approval, by proposing an amendment to this Agreement at least six (6) months before the beginning of the Performance Year for which the proposed modifications would apply.

f. **Financial Reports:** For Performance Years 1 through 4, the GMCB, in collaboration with AHS, shall submit to CMS quarterly reports on the State's performance on the All-payer Total Cost of Care per Beneficiary Growth Target (***"Quarterly Financial Report"***). For Performance Years 5 and 6 and, if applicable, Performance Year 7, the GMCB, in collaboration with AHS, shall submit to CMS two reports on the State's performance on the All-payer Total Cost of Care per Beneficiary Growth Target (***"Semi-Annual Financial Report"***). The first report will capture the State's performance over the first six months of the PY, with six months of claims runout. The second report will capture the State's performance for the entire PY, with six months of claims runout. The second report will include information relevant to changes to Medicaid payment rates, if any. Each Performance Year's All-payer Total Cost of Care per Beneficiary Growth Target performance results shall be finalized by December 31st of the following year. The Semi-Annual Financial Report shall be submitted in a form and manner proposed by the State and approved by CMS, and by a deadline determined by CMS.

10. **Payer Differential.**

a. In Performance Year 2, the GMCB, after collaboration with AHS, shall submit to CMS, no later than 90 calendar days after the start of the Performance Year, the percent ACO Benchmarks will increase by payer for Vermont ACOs, an explanation for any differences in ACO Benchmark increases between payers, and the impact such differences may have on the Payer Differential as it affects Vermont ACOs.

b. The GMCB, after collaboration with AHS, shall submit to CMS by the end of Performance Year 2 an assessment of the Payer Differential as it affects Vermont ACOs. This assessment may include, but is not limited to, payment rates and ACO profit margins by payer.

c. The GMCB and AHS shall submit to CMS by the end of Performance Year 3 a report on options to reduce the Payer Differential between payers during and after the Performance Period.

d. In order to encourage Vermont to address the Payer Differential, CMS shall make adjustments to the All-payer Total Cost of Care per Beneficiary Growth Target Calculation, as necessary and as specified in this subsection, to recognize that cumulative All-payer Financial Target Services growth may be attributable to efforts by Vermont to increase Vermont Medicaid reimbursement rates to levels comparable to or greater than Medicare reimbursement rates, where a comparable service is available, or to rates sufficient to ensure greater access by Medicaid beneficiaries. The GMCB, after collaboration with AHS, may submit a written request that specific changes in payments to Medicaid providers be taken into consideration when assessing performance on the All-payer Total Cost of Care per Beneficiary Growth Target. Vermont must explain the impact of such factors on the All-payer Total Cost of Care per Beneficiary Growth Target performance and recommend how CMS should adjust the All-payer Total Cost of Care per Beneficiary Growth calculation to reflect these factors. CMS will accept such requests that it determines are consistent with the aforementioned goal of increasing Vermont Medicaid reimbursement rates to levels comparable to or greater than Medicare reimbursement rates, when comparable services are available, or to rates sufficient to ensure greater access by Medicaid beneficiaries.

e. The purpose of this subsection is to ensure Medicaid beneficiaries have access to ACO network providers that is equal to access of those with Medicare or commercial coverage. This subsection is not intended to modify the services covered by a payer nor to limit access to providers of services that are not covered by all payers. The GMCB shall ensure that a Vermont ACO shall not interfere with a patient's choice of health care providers under the patient's health plan, regardless of whether a provider is participating in the ACO.
    i. The State shall ensure that Vermont ACOs have a single network of providers, regardless of payer, for All-payer Financial Target Services. If a payer covers services that are excluded by other payers, the State shall ensure that Vermont ACO(s) have a broader network of providers for that payer to ensure beneficiaries have full access to the services covered by their health plan.
    ii. If any Vermont ACO does not have a single network of providers for All-payer Financial Target Services regardless of payer by the beginning of Performance Year 2, then AHS shall require the Vermont ACO, as a

condition of its Medicaid contract, to ensure that at least 90 percent of all providers in the Vermont ACO's network accept Vermont Medicaid beneficiaries.

iii. If neither of the network access tests set forth in sections 10.e.i and 10.e.ii are satisfied, then CMS shall determine it a Triggering Event and issue the State a Warning Notice as described in section 21. The GMCB and AHS shall submit to CMS, for its approval, a CAP for this Triggering Event as set forth in section 21. The State shall include in such CAPs options for satisfying the network access tests set forth in either section 10.e.i or 10.e.ii. The State may include options that have the effect of increasing Medicaid rates to reduce the Payer Differential as a means of improving access. The State's CAP shall include criteria for completion and release of the CAP.

11. **Collaboration on Behavioral Health.** CMS will collaborate with Vermont to explore mechanisms within CMMI authority that may allow additional providers to receive reimbursement for mental health and substance use disorder services under the Model beginning in PY7, if applicable.

12. **Collaboration to Inform Potential Future Model.** CMS will collaborate with GMCB and AHS such that lessons learned from this Model are able to inform CMS' development of a potential future model.

13. **Request for Medicare Payment Waivers.**

    The GMCB may request, and the CMS may consider, Medicare payment waivers as may be necessary solely for purposes of carrying out this Model. Any such request by the GMCB shall include the rationale for the payment waivers. CMS may grant these Medicare payment waivers at its sole discretion. Such Medicare payment waivers, if any, would be set forth as an amendment to this Agreement or in separately issued documentation specific to this Agreement and may be pursued through CMS rulemaking as necessary. Any such Medicare payment waiver would apply solely to this Model and could differ in scope from Medicare payment waivers granted in other CMS models.

14. **Revocation of Medicare Payment Waivers.**

    CMS reserves the right to withdraw any Medicare payment waivers issued by CMS, or as applicable, to terminate the Agreement, pursuant to the procedures set forth in section 21, if Vermont does not comply with the conditions associated with the terms of the applicable waivers as set forth in the Agreement or in separately issued Medicare payment waiver documentation.

15. **Data Sharing.**

a. **State of Vermont Data Sharing.** As described in sections 6, 7, and 9, the GMCB, in collaboration with AHS, shall supply CMS reports, information, and data on ACO Scale Targets, Statewide Health Outcomes and Quality of Care Targets, and Statewide Financial Targets. The GMCB, in collaboration with AHS, shall submit this information on a regular basis to support CMS's monitoring and evaluation of the Model and retain such documentation in accordance with section 19. The data shall include certain Vermont Medicaid claims data, Vermont Commercial Plan claims data and any available Vermont Self-insured Plan claims data specified in separately provided guidance by CMS that the State will submit on an annual basis to support CMS's monitoring and evaluation of the Model. Vermont may provide these claims data from a combination of sources, including its APCD, the Vermont ACOs, Vermont Medicaid, Vermont Commercial Plans, or Vermont Self-insured Plans. All information will be provided to CMS in a manner consistent with all applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations.

i. CMS also may use these reports, information, and data to conduct analyses and may publish, and potentially co-publish with Vermont, the data and analyses in de-identified form.

ii. The State shall ensure that for each Performance Year the State's APCD captures any available claims data from Vermont Commercial Plans and Vermont Self-insured Plans such that it represents claims data for at least 80 percent of Vermont residents with health insurance provided under Vermont Commercial Plans or Vermont Self-insured Plans. If the State cannot ensure such a condition, Vermont shall notify CMS within 90 days after the Performance Year ends and shall thereafter work with CMS to secure, within 180 calendar days after such notification is made, separate arrangements with appropriate payers to collect claims data for at least 80 percent of Vermont residents with health insurance provided under Vermont Commercial Plans or Vermont Self-insured Plans.

b. **CMS Data Sharing.** Over the Performance Period of the Model, CMS is willing to accept requests from the GMCB for Medicare data necessary to achieve the purposes of the Model. This Medicare data may include individually-identifiable Medicare eligibility status and demographic information of all Medicare FFS beneficiaries residing in Vermont, and claim and claim line data for services furnished by Medicare-enrolled providers and suppliers to Medicare FFS

beneficiaries residing in Vermont. CMS may, upon request of the GMCB, provide additional reports that include the following: utilization, expenditures, quality of care, Medicare FFS eligibility type, VMA ACO alignment, and performance summary comparisons to other states. The GMCB may request individually-identifiable health information that is necessary for carrying out health oversight activities under 45 C.F.R. § 164.512(d)(1). All such requests for individually-identifiable health information must clearly state the HIPAA basis for the requested disclosure and include an assertion that the data requested constitutes the minimum necessary to carry out those activities. CMS will make best efforts to approve, deny, or request additional information regarding data requests within 60 calendar days after the State's request. CMS will accept or reject such requests on a case-by-case basis and at CMS's sole discretion. All information will be provided consistent with all applicable laws and regulations, including HIPAA and the regulations governing the confidentiality of substance use disorder patient records under 42 C.F.R. part 2. Appropriate privacy and security protections will be required for any data disclosed under this Agreement.

i. **Health Oversight Agency.** The GMCB acknowledges that it has provided assertions to CMS as to its status as "health oversight agency" (as defined in 45 C.F.R. § 164.501) in the context of this Model.

ii. The GMCB is expected to use the requested data in its efforts to monitor and oversee Vermont's health care system as it pertains to this Agreement. Notwithstanding any other provision of this Agreement, and in accordance with applicable law, GMCB may disclose original or derivative data received under this Agreement without prior written authorization from CMS if such disclosure is necessary to enable GMCB's oversight of the Model, or to enable quality improvement activities or health care provider incentive implementation.

c. **Public Disclosure of Provider Performance Data.** CMS will share with the GMCB certain information that has been de-identified in accordance with HIPAA requirements and is necessary to determine provider performance on the Statewide Health Outcomes and Quality of Care Targets as described in section 7 and the Medicare Total Cost of Care per Beneficiary Growth Target as described in section 9, including performance summary comparisons to other states. The State may publicly disclose, with consent from CMS, provider-specific performance and performance summary comparisons to other states for purposes of provider accountability for the quality of care delivered under the Model. Any such public disclosure of provider-specific performance information by the State

shall be de-identified in accordance with HIPAA standards and be subject to a 30-day review period by the named provider(s), prior to public disclosure of the information. Any such public disclosure of purportedly de-identified data must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g. admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no use of percentage or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.

16. **Confidentiality.** The State shall develop procedures to protect the confidentiality of all information that identifies individual Medicare and Medicaid beneficiaries in accordance with all applicable laws.

17. **Model Evaluation.**

    a. **CMS Evaluation.** CMS shall evaluate the Model in accordance with Section 1115A(b)(4) of the Act. CMS and the State agree that the State and its agents shall cooperate with CMS and its contractor(s) and provide all data needed by CMS to monitor and evaluate the Model in accordance with applicable law, including, but not limited to, individually-identifiable health information. The State shall ensure the production of such data through statutory or regulatory mandates on entities holding the required data, or through alternative legal arrangements. The State must ensure that all written agreements or legal relationships have been secured with any relevant entities (e.g., Vermont Commercial Plans and Vermont Self-insured Plans) and with institutional review boards that are necessary to ensure that CMS or its designee(s) can access individual-level, identifiable data to carry out monitoring and evaluation activities to the extent allowable by law. CMS shall have the authority to share all Model data, documents, and other information with its designees for evaluation, monitoring, oversight, and other purposes, in accordance with applicable law. CMS shall have the authority to use any data obtained pursuant to the Model to publicly disseminate quantitative and qualitative results, in accordance with applicable law.

    b. **Reports and Data for CMS Evaluation.** The GMCB shall submit to CMS the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the Quarterly and Semi-Annual Financial Reports, as described in sections 6, 7, and 9, respectively. Additionally, as described in section 15.a, the GMCB, in collaboration with AHS, shall provide CMS with Vermont Medicaid claims data, Vermont Commercial Plans claims data, and available Vermont Self-insured Plan claims data that are necessary for

CMS to monitor and evaluate the Model. The State must make available to CMS and CMS's contractors, for validation and oversight purposes, the datasets and methodologies used by the State to make calculations required under this Agreement, including and as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under this Agreement.

18. **CMS Monitoring of the Model.**

CMS shall monitor the State's compliance with the terms of this Agreement and reserves the right to conduct monitoring activities.

a. Such monitoring activities may include, but are not limited to:
    i. Interviews with any members of the State involved in operating the Vermont Medicare All-payer ACO Model;
    ii. Interviews with beneficiaries and their caregivers;
    iii. Audits of the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the Quarterly and Semi-Annual Financial Reports;
    iv. Audits of regulatory approach, implementation plans, and other data from the State, including data from Vermont ACOs;
    v. Site visits to the State; and
    vi. Documentation requests sent to the State.

b. CMS shall provide the State, to the extent practicable and as soon as practicable, a detailed schedule of planned comprehensive annual audits related to compliance with this Agreement.

    i. Such schedule shall not preclude the ability of CMS to conduct more limited, targeted or ad hoc audits as necessary.
    ii. CMS may alter such schedule without the consent of the State. CMS shall notify the State at least 15 calendar days prior to altering such schedule.

c. The State shall cooperate with all CMS monitoring and oversight requests and activities, and ensure that all Vermont ACOs similarly cooperate to the extent allowed by law.

19. **Maintenance of Records.**

In accordance with applicable law, the State shall maintain, ensure Vermont ACOs

maintain, and provide to the Federal Government including CMS, HHS, the Department of Justice, the Government Accountability Office, and other federal agencies or their designees, access to all books, contracts, records, documents, software systems, and other information (including data related to calculations required under this Agreement, Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the State's compliance with the requirements of this Agreement. The State shall maintain and ensure Vermont ACOs maintain such books, contracts, records, documents, and other information for a period of ten (10) years after the final date of the Performance Period or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:

a. CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the State at least 30 calendar days prior to the date the record is scheduled to be destroyed; or

b. There has been a termination, dispute or allegation of fraud or similar fault against the State or a Vermont ACO or other individuals or entities performing functions or services related to the Model, in which case the records shall be maintained for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

20. **Modification.**

The parties may amend this Agreement, including any appendix to this Agreement, at any time by mutual written consent. CMS may amend this Agreement without the consent of the State as specified in this Agreement or any appendix to this Agreement, or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS shall include with any proposed amendment an explanation of the reasons for the proposed amendment. To the extent practicable, CMS shall provide the State with a minimum of 30 calendar days advance written notice of the effective date of such amendment, which notice shall specify the amendment's effective date. If State law precludes application of the amendment to this Agreement, the parties will promptly seek modification of the amendment. If modification of the amendment is impracticable or consensus cannot be reached, CMS or the State may terminate this Agreement under section 21.

21. **Termination and Corrective Action Triggers.**

a. **Warning Notice and Corrective Action Plan (CAP).** If CMS determines that a Triggering Event has occurred, CMS will provide written notice to the GMCB or

AHS, as applicable, that Vermont is not meeting a requirement of the Agreement ("Warning Notice") with an explanation and data supporting its determination. CMS shall provide the State with the Warning Notice for any Triggering Event no later than six (6) months following a determination by CMS that the Triggering Event has occurred. Unless otherwise specified in this Agreement, within 90 calendar days of receipt of the Warning Notice, the State will submit a written response to CMS. CMS will review the State's response within 90 calendar days of receipt and will either accept the response as sufficient or require the State to submit a CAP. If CMS has not responded within 90 calendar days of the State's response, the State's response will be deemed accepted by CMS. If CMS requires the State to submit a CAP, the State shall do so within 30 calendar days of CMS notice that the State's response is not sufficient. In its CAP, the State shall address all actions the State will take that will include, but are not limited to, implementation of new safeguards or programmatic features to correct any deficiencies and remain in compliance with the Agreement. The State's CAP shall propose criteria for completion and release of the CAP. CMS will review and approve, or request modification of, the CAP within 30 calendar days of its receipt. If CMS has not responded within 30 calendar days of receipt, the CAP will be deemed approved by CMS. The approved CAP shall provide for criteria and a process for completion and release of the CAP.

b. **Review Factors Considered by CMS.** A Triggering Event may or may not require corrective action, depending on the totality of the circumstances. CMS will consider whether the State can demonstrate that a factor unrelated to this Agreement caused the Triggering Event. Notwithstanding the foregoing, CMS, at its sole discretion, will determine the sufficiency of the State's response to any Warning Notice issued pursuant to this section.

c. **Implementation of CAP.** Unless otherwise specified in this Agreement, the State shall successfully implement any required CAP as approved by CMS no later than one year from the date of the Warning Notice unless otherwise modified or agreed to by CMS. If the Triggering Event is related to an aspect of the Model involving a payment waiver from the Act issued as an amendment to this Agreement or in a subsequent document, CMS, at its sole discretion, may decide whether to allow the State to utilize such a payment waiver during the time period that the State is under the CAP.

d. **Triggering Event.** A Triggering Event may include the following:

    i. A material breach by any party to this Agreement of any provision set

forth in this Agreement.

ii. A determination by CMS that Vermont is not on track, as specified in section 9.d, to achieve the All-payer or Medicare Total Cost of Care per Beneficiary Growth Targets.

iii. A determination by CMS that Vermont is not making sufficient progress on the Statewide Health Outcomes and Quality of Care Targets, as specified in sections 7.b, 7.c, and 7.d.

iv. [RESERVED]

v. A disapproval by CMS of the State's assessment describing how the Scale Target ACO Initiatives' designs align across payers on key design dimensions, as specified in section 6.j.

vi. A determination by CMS that Vermont has not satisfied either of the network access tests as described in section 10.

vii. A determination by CMS that the quality of care provided to Medicare, Medicaid or CHIP beneficiaries has deteriorated.

viii. A determination by CMS that the State has taken actions that compromise Medicare trust funds.

e. **Rescission or Modification of Aspects of the Model.** If CMS determines, at its sole discretion, that the State has not successfully implemented a required CAP in the time period specified in section 21.c or otherwise specified in this Agreement, CMS may amend or rescind the relevant aspect of the Model, any or all payment waivers of existing law made pursuant to Section 1115A(d)(1) of the Act, or both.

i. In particular, if CMS determines, at its sole discretion, that a Triggering Event described in section 7.c or 9.d has occurred and that the State has not successfully implemented a required CAP in the time period specified in section 7.c or 9.d, respectively, CMS may modify or take control over setting benchmarks for a Vermont Medicare ACO, including how benchmarks are tied to quality performance, as described in sections 7.c and 9.d.

f. Termination of the Agreement.

i. **Termination by CMS.** If CMS determines, at its sole discretion, that the State has not successfully implemented a required CAP or complied with an alternative CMS-provided corrective action in the time period specified in section 21.c or otherwise specified in this Agreement, CMS may immediately terminate this Agreement. CMS may also immediately or with advance notice terminate this Agreement if it determines, at its sole discretion, that there is no entity eligible under Section 8 to participate in the Model in a manner consistent with the elements,

parameters, and scope of the Model as set forth in this Agreement.

ii. **Termination by the State**. The State may terminate this Agreement at any time for any reason with at least 180 calendar days written advance notice to CMS.

iii. **Survival**. Termination of this Agreement shall not affect the rights and obligations of the parties accrued prior to the effective date of the termination or expiration of this Agreement, except as provided in this Agreement. The rights and duties under the following sections of this Agreement shall survive its termination and apply thereafter:

a. Section 15 (Data Sharing)
b. Section 17 (Model Evaluation)
c. Section 18 (CMS Monitoring of Model)
d. Section 19 (Maintenance of Records)

g. **Termination under Section 1115A(b)(3)(B).** CMS may terminate this Agreement immediately if the Secretary makes findings under Section 1115A(b)(3)(B) of the Act requiring the termination of the Model.

h. Federal Government Enforcement.

i. Nothing contained in this Agreement is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of the Inspector General (OIG), or CMS, of any right to institute any proceeding or action for violations of any statutes, rules or regulations administered by the federal government, or to prevent or limit the rights of the federal government to obtain relief under any other federal statutes or regulations, or on account of any violation of this Agreement or any other provision of law.

ii. This Agreement shall not be construed to bind any federal government agency except CMS, and this Agreement binds CMS only to the extent provided herein. The failure by CMS to require performance of any provision shall not affect CMS's right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself. None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the State, Vermont hospitals, Vermont

providers, Vermont suppliers, or individuals or entities performing functions or services related to activities under this Agreement.

iii. CMS provides no opinion on the legality of any contractual or financial arrangement that the State or a Vermont ACO has proposed, implemented or documented. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or a modification of any applicable laws, rules or regulations and will not preclude CMS, HHS, or the OIG, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

22. **Limitations on Review and Dispute Resolution.**

a. **Limitations on Review.** There is no administrative or judicial review under Sections 1869 or 1878 of the Act or otherwise for the following:

i. The selection of states, organizations, sites, or participants in the Model and Initiative, including the decision by CMS to terminate this Agreement or to require the termination of any individual's or entity's status in the Model or Initiative;
ii. The elements, parameters, scope, and duration of the Model and the Initiative, including the benchmarks developed under this Model;
iii. The termination or modification of the design and implementation of the Model and Initiative under Section 1115A(b)(3)(B) of the Act;
iv. The selection of models for testing or expansion under Section 1115A of the Act;
v. Determinations regarding budget neutrality under Section 1115A(b)(3) of the Act; and
vi. Determinations about expansion of the duration and scope of the Model under Section 1115A(c) of the Act, including the determination that the Model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

b. **Dispute Resolution**

i. The parties agree to the following procedures for any dispute that is not subject to preclusion of administrative or judicial review as set forth in section 22.a. The State shall notify CMS of any such dispute in writing within 30 calendar days of the date on which the State becomes aware, or should have become aware, of the act giving rise to the dispute. This

written notification must provide a detailed explanation of the basis for the dispute and supporting documentation.

ii. If the parties cannot resolve any such dispute within 30 calendar days after CMS receives written notice of the dispute, then the State shall submit within 30 subsequent calendar days a request for an informal hearing to an independent CMS hearing officer, or an independent CMS designee, including the detailed explanation of the basis for the dispute and supporting documentation.

iii. After receiving the State's request for an informal hearing, the independent CMS hearing officer shall issue a notice within 30 calendar days to the State and CMS for a hearing scheduled no fewer than 30 calendar days after the date of the notice. This notice will specify the date, time and location of the hearing, and the issues in dispute.

iv. Within 30 calendar days of the hearing, the independent CMS hearing officer shall issue a written notice to the State containing its final determination on the issue, and announcing the effective date of the determination, if applicable.

v. The State may request the CMS Administrator's review of the independent CMS hearing officer's determination within 30 days of the issuance of the written notification of the independent CMS hearing officer's determination. If the CMS Administrator declines to review the independent CMS hearing officer's determination, the independent CMS hearing officer's determination becomes final and binding 30 days after the issuance of the written notification of the independent CMS hearing officer's determination. The CMS Administrator's decision is final and binding.

vi. The parties shall proceed diligently with the performance of this Agreement during the course of any dispute arising under this Agreement.

23. **Severability.**

In the event that any one or more of the provisions of this Agreement is, for any reason, held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Agreement, and this

Agreement shall be construed as if such invalid, illegal, or unenforceable provision(s) had never been included in the Agreement, unless the deletion of such provision or provisions would result in such a material change to the Agreement so as to cause continued participation under the terms of the Agreement to be unreasonable.

24. **Agency Notifications and Submission of Reports.**

Unless otherwise stated in writing after the Effective Date, all notifications and reports under this Agreement shall be submitted to the parties at the addresses set forth below:

CMS:
Tequila Terry or successor
Director, Prevention and Population Health Group (PPHG), Acting Director, State Innovations Group (SIG)
Center for Medicare and Medicaid Innovation
Tequila.Terry@cms.hhs.gov
2810 Lord Baltimore Drive
Windsor Mill, MD 21244
(410) 786-1876

GMCB:
Jessica A. Holmes or successor
Chair, Green Mountain Care Board
jessica.holmes@vermont.gov
Green Mountain Care Board
89 Main Street
3rd Floor
Montpelier, VT 05620
(802) 828-2177

AHS:
Jenney Samuelson or successor
Secretary, Agency of Human Services
280 State Drive - Center Building
Waterbury, VT 05671-1000
802-241-0440

25. **Entire Agreement.**

This Agreement, including all appendices, constitutes the entire agreement between the parties. The parties may amend or terminate this Agreement as set forth in sections 20 and 21. In accordance with section 3.a.iii, any waiver issued by the Secretary pursuant to Section 1115A(d)(1) specifically for this Model will be set forth in separate documentation.

26. **Precedence.**

If any provision of this Agreement conflicts with a provision of any document incorporated herein by reference, the provision of this Agreement shall prevail.

[SIGNATURE PAGE FOLLOWS]

Each party is signing this Agreement on the date stated above that party's signature. If a party signs but fails to date a signature, the date that the party receives the signing party's signature will be deemed to be the date that the signing party signed this Agreement. This Agreement and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. This Agreement and any amendments hereto may be signed by autopen or electronic signature (e.g., DocuSign or similar electronic signature technology) and may be transmitted by electronic means. Copies of this Agreement and any amendments hereto that are so executed and delivered have the same force and effect as if executed with handwritten signatures and physically delivered.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date _____

By: _____

Liz Fowler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF THE STATE OF VERMONT

Date _____

By: _____

Phil Scott, Governor

GREEN MOUNTAIN CARE BOARD

Date _____

By: _____

Owen Foster, Chair, Green Mountain Care Board

VERMONT AGENCY OF HUMAN SERVICES

Date _____

By: _____

Jenney Samuelson, Secretary, Vermont Agency of Human Services

Appendix 1 – Statewide Health Outcomes and Quality of Care Targets

a. **Population-level Health Outcomes Targets**

i. **Substance Use Disorder Target.** The State must reduce deaths of Vermont residents related to opioid overdose by 10 percent in aggregate over the Performance Period of this Model, using 2017 as the baseline.
   1) **Calculation methodology.** The State's performance, measured as an age-adjusted rate per 100,000 Vermont residents, will be calculated using the Centers for Disease Control (CDC) National Vital Statistics System Mortality File's methodology and data or, as determined by CMS, a comparable methodology and data source for calculating deaths related to drug overdose.
   2) CMS may determine that the State is not on track to meet this target if, from Performance Year to Performance Year, the State experiences an increase in deaths related to substance use disorder. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any increase relative to the preceding Performance Year will not be considered in determining a Triggering Event.

ii. **Suicide Target.** The State must reduce the number of deaths due to suicide to 16 per 100,000 Vermont residents or reduce the State's ranking on suicide rate from the 7th to the 20th highest by state across the United States.
   1) **Calculation methodology.** The State's performance will be calculated using the CDC National Vital Statistics System Mortality File's methodology and data for calculating deaths due to suicide.
   2) CMS may determine that the State is not on track to meet this target if, from Performance Year to Performance Year, the State experiences an increase in its suicide rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any increase as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

iii. **Chronic Conditions Targets.** The State must not increase prevalence of COPD, diabetes, and hypertension for Vermont residents 18 years of age or older, each measured separately as a percent of state population, by more than 1 percentage point, using 2017 as a baseline.
   1) **Calculation methodology.** The State's performance will be calculated separately for each of the three chronic conditions using the CDC Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, based on the responses to the following questions:
      a. Diabetes prevalence: "Have you been told that you have

diabetes?"

b. COPD prevalence: "Have you been told that you have COPD, emphysema, or chronic bronchitis?"
c. Hypertension prevalence: "Have you been told that you have hypertension?"

The percent prevalence for diabetes, COPD, and hypertension will each be separately calculated as the percentage of Vermont resident respondents who answer "yes" to the respective questions.

2) For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, performance changes with respect to this target will not be considered in determining a Triggering Event. CMS may determine that the State is not on track to meet this target if, in any other Performance Year, the prevalence of diabetes, COPD, or hypertension among Vermont residents is more than 1 percentage point greater than the prevalence of said chronic conditions in 2017.

iv. **Access to Care Target.** The State must achieve a target of 89 percent of Vermont adult residents 18 years of age or older reporting that they have a personal doctor or care provider.

1) **Calculation methodology.** The State's performance will be calculated, using the CDC BRFSS questionnaire, as the percent of Vermont resident respondents who answer "yes" to the following question: "Do you have one person you think of as your personal doctor or health care provider?"
2) CMS may determine that the State is not on track to meet this target if, from Performance Year to Performance Year, the State decreases the percent of adults who have a personal doctor or health care provider. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

b. **Healthcare Delivery System Quality Targets**

i. **Suicide and Substance Use Disorder Target - Initiation and engagement of alcohol and other drug dependence (AOD) treatment.** For Vermont ACO-aligned residents with a new episode of drug or alcohol dependence, the state must achieve 40.8 percent of adults and adolescents ages 13 years or older with a new episode of AOD initiating alcohol and other drug dependence treatment, and 14.6 percent on engagement with such treatment.

1) Calculation methodology. The State's performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Initiation and Engagement of Alcohol

and Other Drug Dependence Treatment" (endorsed by NQF as Measure #4). Performance on initiation and engagement will be assessed separately.

2) CMS may determine that the State is not on track to meet the initiation target, engagement target, or both, if, from Performance Year to Performance Year, the State decreases initiation rates, engagement rates, or both. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

ii. **Suicide and Substance Use Disorder Target - Follow-up after discharge from the emergency department for mental health.** The State must achieve 60 percent as the percent of Vermont ACO-aligned residents receiving follow-up care within 30 calendar days after discharge from a hospital emergency department for mental health.

1) **Calculation methodology**. The State's performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence" (endorsed by NQF as Measure #2605).
2) CMS may determine that the State is not on track to meet this target if, from Performance Year to Performance Year, the State decreases this rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

iii. **Suicide and Substance Use Disorder Target - Follow-up after discharge from the emergency department for alcohol or other drug dependence.** The State must achieve 40 percent as the percent of Vermont ACO-aligned residents receiving follow-up care within 30 calendar days after discharge from a hospital emergency department for alcohol or other drug dependence.

1) **Calculation methodology**. The State's performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence" (endorsed by NQF as Measure #2605).
2) CMS may determine that the State is not on track to meet this target if, from Performance Year to Performance Year, the State decreases this rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding

Performance Year will not be considered in determining a Triggering Event.

iv. **Suicide and Substance Use Disorder Target – Mental Health and Substance Abuse-related Emergency Department Visits.** The State must reduce the rate of growth of emergency department (ED) visits with a primary diagnosis of mental health or substance abuse condition across payers in Vermont hospitals to 5% in PYs 1 and 2, 4% in PYs 3 and 4, and 3% in PYs 5 and 6 and, if applicable, PY7, using 2016-2017 growth as a baseline.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using Vermont Department of Health's hospital discharge data and counting the number of ED visits at Vermont hospitals with a primary diagnosis of mental health or substance abuse condition.
2) CMS may determine that the State is not on track to meet this milestone if, from Performance Year to Performance Year, the State increases the rate of growth of ED visits due to mental health and substance abuse across payers. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such increase as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

v. **Chronic Conditions Target –Diabetes, Hypertension, and Multiple Chronic Conditions.** The State must achieve at least between the 70th and 80th percentile, as compared to national Medicare performance, for each of diabetes, hypertension, and multiple chronic condition morbidity of VMA ACO aligned Medicare beneficiaries. Each measure will be calculated and reported separately.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Quality Payment Program quality measures Quality ID # 001: "Diabetes: Hemoglobin A1c Poor Control", Quality ID #236: "Controlling High Blood Pressure", and Quality ID #479: "All-cause Unplanned Admissions for Patients with Multiple Chronic Conditions". The target for each measure will be at least between 70th and 80th percentiles using Quality Payment Program quality measure benchmarks based on the comparison to the national Medicare performance percentile information.
2) CMS may determine that the State is not on track to meet these

targets if, from Performance Year to Performance Year, the State decreases its percentile. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

vi. **Access to Care Target – Getting Timely Care, Appointments, and Information.** The State must at least achieve between the 70th and 80th percentiles, as compared to national Medicare performance, for the percent of VMA ACO-aligned Medicare beneficiaries who state that they are getting timely care, appointments, and information.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Quality Payment Program quality measure, specifications, and data for Quality ID #321: "Getting Timely Care, Appointments, and Information". The target will be between the 70th and 80th percentiles used for the Quality Payment Program quality measure benchmarks based on the comparison to the national Medicare performance percentile information.
2) CMS may determine that the State is not on track to meet this target if, from Performance Year to Performance Year, the State decreases the percent of VMA ACO-aligned Medicare beneficiaries who state that they are getting timely care, appointments, and information. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

c. **Process Milestones.**

i. **Substance Use Disorder Milestone – Use of Morphine Milligram Equivalents.** The State must decrease the rate of use of Morphine Milligram Equivalents (MMEs) dispensed per 100 Vermont residents, using 2017 as a baseline.

1) **Calculation methodology.** The State's performance will be measured as the number of MMEs dispensed per 100 Vermont residents.
2) CMS may determine that the State is not on track to meet this milestone if, from Performance Year to Performance Year, the

State increases the annual rate of use of MMEs per 100 residents. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such increase as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

ii. **Substance Use Disorder Milestone – Medication-assisted Treatment Utilization.** The State must increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use disorder to 150 per 10,000 Vermont residents of ages 18-64 (or up to the rate of demand).
    1) **Calculation methodology.** The State's performance will be calculated, using Vermont Department of Health data, as the unique number of Vermont residents of ages 18-64 receiving MAT. CMS shall consider Vermont to have achieved this target if MAT utilization is less than 150 per 10,000 residents of ages 18-64 but no residents remain on the MAT waitlist (proxy for demand being satisfied).
    2) CMS may determine that the State is not on track to meet this milestone if, from Performance Year to Performance Year, the State decreases the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use disorder to below 150 per 10,000 Vermont residents of ages 18-64 and there are residents on the MAT waitlist. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

iii. **Suicide Milestone – Screening for Clinical Depression.** The State must achieve at least between the 70th and 80th percentiles, as compared to national Medicare performance, for the percent of Vermont ACO-aligned residents who received a screening for clinical depression, and if depression was detected, a follow-up plan.
    1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Quality Payment Program quality measure and specifications for Quality ID # 134: "Screening for Clinical Depression and Follow-up Plan". The milestone's performance will include Vermont ACO-aligned

residents who are enrolled in a payer program that supports this measure. The target will be at least between the 70th and 80th percentiles used for Quality Payment Program quality measure benchmarks based on comparison to the national Medicare performance percentiles information. The following steps will be done to determine Vermont's performance on this milestone:

- Assign percentile to each of the payers for this measure as compared to the national Medicare performance.
- Average the percentiles for each of the payers weighted by the relative proportion of attributed population.
- Determine whether the percentile is at least between the Medicare 70th and 80th percentile for that Performance Year.

If multi-payer national benchmarks become available, CMS and Vermont may compare Vermont's performance to these benchmarks, instead of using national Medicare performance. CMS and Vermont agree to regularly assess the availability of multi-payer national benchmarks.

2) CMS may determine the State is not on track to meet this milestone if, from Performance Year to Performance Year, the State decreases its depression screening rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

iv. **Chronic Conditions Milestone - Tobacco Use Assessment and Cessation Intervention.** The State must achieve at least between the 70th and 80th percentiles, as compared to national Medicare performance, for the percent of Vermont ACO-aligned residents who were screened for tobacco use and who received cessation counseling intervention if identified as a tobacco user.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Quality Payment Program quality measure and specifications for Quality ID #226: "Tobacco Use: Screening and Cessation Intervention". The milestone's performance will include Vermont All-payer Beneficiaries who are also aligned to a Vermont ACO payer program that reports this measure. The target will be at least between the 70th and 80th percentiles used for the Quality Payment

Program quality measure benchmarks based on the comparison to the national Medicare performance percentile information. The following steps will be done to determine Vermont's performance on this milestone:

- Assign percentile to each of the payers for the measure as compared to national Medicare performance percentile information.
- Average the percentiles for each of the payers weighted by the relative proportion of attributed population.
- Determine whether the percentile is between the Medicare 70th and 80th percentiles for that Performance Year.

If multi-payer national benchmarks become available, CMS and Vermont may compare Vermont's performance to these benchmarks, instead of using national Medicare performance. CMS and Vermont agree to regularly assess the availability of multi-payer national benchmarks.

2) CMS may determine the State is not on track to meet this milestone if, from Performance Year to Performance Year, the State decreases its tobacco use assessment and cessation intervention rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

v. **Chronic Conditions Milestone –Asthma Medication Ratio.** In Performance Years 1 and 2, the State must achieve the 25th percentile, as compared to healthcare plans nationally, for the percent of Vermont All-payer Beneficiaries receiving appropriate asthma medication management. In Performance Year 3, the state must work toward maximizing the percent of ACO-aligned residents with an asthma medication ratio of .5 or higher and establish a 2020 baseline. In Performance Year 4 and subsequent Performance Years, the State must monitor the percent of ACO-aligned residents with an asthma medication ratio of .5 or higher using the 2020 baseline.

1) **Calculation methodology.** In Performance Years 1 and 2, the State's performance will be measured according to measure specifications for NCQA HEDIS measure "Medication Management for People with Asthma – 50% Compliance." In Performance Year 3, the State will establish a new baseline for the

NCQA HEDIS measure "Asthma Medication Ratio." In Performance Year 4 and subsequent Performance Years, the state will monitor performance on the NCQA HEDIS measure "Asthma Medication Ratio" against the 2020 baseline.

2) CMS may determine the State is not on track to meet this milestone if, in Performance Years 1 and 2, the State decreases the number of Vermont All-Payer Beneficiaries receiving appropriate asthma medication management. In Performance Year 3, the State will establish a baseline for NCQA HEDIS measure "Asthma Medication Ratio." For Performance Year 4 and subsequent Performance Years, CMS may determine the State is not on track to meet this milestone if the State does not report the percentage of Vermont ACO-aligned residents with an asthma medication ratio of .5 or higher.

vi. **Access to Care Milestone – Percent of Children and Adolescents with Well-Care Visits.** In Performance Years 1 and 2, the State must achieve the 50th percentile, as compared to Medicaid plans nationally, for percentage of Vermont adolescents enrolled in Vermont Medicaid who have a well-care visit. In Performance Year 3, the State must work toward maximizing the percent of children and adolescents enrolled in Vermont Medicaid who have a well-care visit and establish a 2020 baseline. In Performance Year 4 and subsequent Performance Years, the State must monitor the percent of Vermont children and adolescents enrolled in Vermont Medicaid who have a well-care visit using the 2020 baseline.

1) **Calculation methodology.** Prior to Performance Year 3, the State's performance will be measured against Medicaid plans nationally for NCQA HEDIS measure "Adolescents with Well-Care Visits," using Medicaid performance data for HEDIS measure "Adolescents with Well-Care Visits" recorded in the NCQA's Quality Compass data for Performance Year 1 of the model. In Performance Year 3 and subsequent Performance Years, the State's performance will be measured for Vermont Medicaid children and adolescents according to measure specifications for NCQA HEDIS measure "Child and Adolescent Well-Care Visits."
2) CMS may determine the State is not on track to meet this milestone if, from Performance Year 1 to Performance Year 2, the State decreases the percentage of Medicaid adolescents with well-care visits. In Performance Year 3, the State will establish a baseline for the NCQA HEDIS measure "Child and Adolescent

Well Care Visits." For Performance Year 4 and subsequent Performance Years, CMS may determine that the State is not on track to meet this target if the State does not report the percent of Vermont children and adolescents who have a well-care visit.

vii. **Access to Care Milestone – Medicaid Beneficiaries Aligned to a Scale Target ACO Initiative.** The State must ensure that the percent of Vermont Medicaid beneficiaries aligned to a Scale Target ACO Initiative not be less than that of Vermont Medicare Beneficiaries aligned to a Scale Target ACO Initiative by more than 15 percentage points.

1) **Calculation methodology.** The State's performance will be measured by comparing in any given Performance Year the percentage of Vermont residents enrolled in Vermont Medicaid who are aligned to a Scale Target ACO Initiative to the percentage of Vermont Medicare Beneficiaries who are aligned to a Scale Target ACO Initiative.
2) CMS may determine that the State is not on track to meet this milestone if, from Performance Year to Performance Year, the State decreases the percentage of Vermont Medicaid beneficiaries aligned to a Vermont ACO. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, any such decrease as compared to the preceding Performance Year will not be considered in determining a Triggering Event.

Appendix 2 – Start-up Funding Terms

Permissible Uses for Start-up Funding. Subject to the terms of the forthcoming funding opportunity announcement, CMS will make available to AHS a single-source funding opportunity for the Start-up Funding to support Medicare FFS beneficiaries through programs that incorporate one or more of the following activities:

a. Connect patients with community-based resources. Examples include the below.
    - Develop and maintain up-to-date local information about formal and informal resources beyond those covered by Medicare, including peer and community-based programs.
    - Assist and support access to community resources based on individual patient needs and goals. Community resources include transportation services for patients with restricted mobility, nutritional counseling and support, housing subsidies, and food assistance.
    - Provide information and supporting participation in vocational and employment services to promote economic self-sufficiency.
b. Coordinate transitions across care settings with appropriate involvement of the patient's primary care provider. Examples include the below.
    - Develop and maintain collaborative relationships between providers such as hospital emergency departments, hospital discharge departments, and primary care providers.
    - Reconcile medication.
    - Plan follow-up with primary care provider and other necessary providers.
    - Review post-discharge care management plan with patient.
c. Coordinate care across providers. Examples include the below.
    - Schedule appointments and perform outreach to support attendance at scheduled treatment and human services appointments.
    - Monitor treatment progress, implementation of the care management plan, and medication adherence.
    - Coordinate with other providers to monitor individuals' health status and participation in treatment.
d. Support health promotion and self-management by patients. Examples include the below.
    - Provide health education specific to a patient's chronic conditions
    - Identify health and life goals and develop of self-management plans with the patient.
    - Provide health promoting lifestyle interventions including but not limited to nutritional counseling, obesity reduction, and increasing physical activity.
    - Teach patients to use their DME equipment.
    - Review medications.
    - Ensure patients are following self-management plans.

e. Support practice improvement, practice transformation, and team-based care. Examples include the below.
    - Meet nationally recognized patient medical home standards.
    - Respond to data to reduce variation and improve care.
    - Collaborate with community health teams and community-based care coordinators to identify and link community-based services for high risk patients.

Restrictions on Start-up Funding. The Start-up Funding may not be used for the following activities:

a. Pay for any community services (e.g., housing, food, violence intervention programs, or transportation).
b. Provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.
c. Match any federal funds.
d. Provide services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.