Vermont All-Payer ACO Model

Vermont Medicare ACO Initiative Participation Agreement

Amendment to Definitions, Sections III, IV, V, VIII, XII, XIII, XVIII, Appendix B, Appendix E, Appendix H, Appendix J, Appendix K, and Appendix L.

This amendment is made to the Vermont Medicare ACO Initiative Participation Agreement between the CENTERS FOR MEDICARE & MEDICAID SERVICES ("**CMS**") and OneCare Vermont ACO, LLC, an accountable care organization ("**ACO**") (the "Agreement"). CMS wishes to amend the terms of the Agreement to clarify and update the policies that govern financial settlement upon termination, the Beneficiary Alignment and Benchmarking Methods, and the All-Inclusive Population-Based Payments; to carve out services covered under section 1899(l) of the Social Security Act (the "Act") from the scope of services covered under the Telehealth Expansion Benefit Enhancement beginning January 1, 2020; to set forth the terms and conditions under which Initiative Participants may receive payment for telehealth services furnished to Initiative Beneficiaries pursuant to section 1899(l) of the Act; to provide for a waiver of the originating site requirements to allow for Medicare payment for otherwise covered telehealth services furnished to Beneficiaries by Initiative Participants during a grace period; to incorporate Beneficiary safeguards to ensure that Beneficiaries are not charged for certain non-covered telehealth services furnished by an Initiative Participant; and to make certain technical and conforming revisions. The parties therefore agree to amend the Agreement as set forth herein.

1. **Effective Date.** Unless otherwise specified, the amendments hereby made to the Agreement are effective as of the Effective Date of the Agreement.

2. **Effect of Amendment.** All other terms and conditions of the Agreement shall remain in full force and effect. In the event of any inconsistency between the provisions of this amendment and the provisions of the Agreement, the provisions of this amendment shall prevail.

3. **Definitions.** The term "Base Year" of the Agreement is hereby amended by replacing "two years" with "one year".

4. **ACO Composition.** Section III.D.6 of the Agreement is hereby amended in its entirety to read as follows:

    6. By the date specified in Section III.D.7, below, the ACO shall have a written agreement with each of the entities that are approved by CMS to be Initiative Participants or Preferred Providers, as well as a written agreement with each of the entities that employs, contracts with, or otherwise has arrangements with each of the individuals approved by CMS to be Initiative Participants or Preferred Providers, that complies with the following criteria:

(a) The only parties to the agreement are the ACO and the Initiative Participant or Preferred Provider or, if applicable, the ACO and the entity that employs, contracts with, or otherwise has arrangements with the Initiative Participant or Preferred Provider.

(b) The agreement requires the Initiative Participant or Preferred Provider to agree to participate in the Initiative, to engage in ACO Activities, to comply with the applicable terms of the Initiative as set forth in this Agreement, and to comply with all applicable laws and regulations (including, but not limited to, those specified at Section XVI.D). The ACO shall provide a copy of this Agreement and any amendments hereto to each Initiative Participant and Preferred Provider or, if applicable, the entity that employs, contracts with, or otherwise has arrangements with the Initiative Participant or Preferred Provider.

(c) The agreement expressly sets forth the Initiative Participant's or Preferred Provider's obligation to comply with the applicable terms of this Agreement, including provisions regarding the following: participant exclusivity, quality measure reporting, and continuous care improvement objectives for Initiative Participants and Preferred Providers; Beneficiary freedom of choice; Benefit Enhancements; participation in evaluation, shared learning, monitoring, and oversight activities; the ACO compliance plan; and audit and record retention requirements.

(d) The agreement requires the Initiative Participant or Preferred Provider to update its Medicare enrollment information (including the addition and deletion of Initiative Professionals that have reassigned to the Initiative Participant or Preferred Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.

(e) The agreement requires the Initiative Participant or Preferred Provider to notify the ACO of any changes to its Medicare enrollment information within 30 days after the change. Beginning on January 1, 2020, the agreement requires the Initiative Participant or Preferred Provider to notify the ACO if the Initiative Participant or Preferred Provider ceases to satisfy the definition of an Initiative Participant or Preferred Provider.

(f) The agreement requires the Initiative Participant or Preferred Provider to notify the ACO within seven days of becoming aware that it is under investigation or has been sanctioned by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges).

(g) The agreement permits the ACO to take remedial action against the Initiative Participant or Preferred Provider (including the imposition of a corrective action plan, denial of incentive payments such as Shared Savings distributions, and termination of the ACO's agreement with the Initiative Participant or Preferred Provider) to address noncompliance with the terms of the Agreement or program integrity issues identified by CMS.

(h) The agreement is for a term of at least one year, but permits early termination if CMS requires the ACO to remove the Initiative Participant or Preferred Provider pursuant to Section XVIII.A.1.

(i) The agreement requires the Initiative Participant to complete a close-out process upon termination or expiration of the agreement that requires the Initiative Participant to furnish all quality measure reporting data.

7. **Initiative Participants and Preferred Providers.** Section IV of the Agreement is hereby amended as follows:

a. Section IV.D.1(a)(i) is hereby amended by replacing "July 31 of the Performance Year in which the addition would take effect" with "a date specified by CMS during the Performance Year in which the addition would take effect".

b. Section IV.D.1(a)(iv) is hereby amended in its entirety to read as follows:

iv. The ACO certifies that it has furnished a written notice to each entity that employs, contracts, or otherwise has arrangements with each proposed Initiative Participant that is a physician or non-physician practitioner and to the executive of the TIN through which such individual bills Medicare indicating that the ACO has proposed to add such individual to the ACO's Participant List. In the case of a request to add an entity to the Participant List, the ACO certifies that it has furnished a written notice to the executive of each TIN through which such entity bills Medicare indicating that the ACO has proposed to add such entity to the ACO's Participant List. The notice to the TIN must identify by name and NPI each individual or entity who is identified on the request for addition as billing through the TIN.

c. Section IV.D.1(b)(i) is hereby amended by replacing "September 30 of the Performance Year in which the addition would take effect" with "a date specified by CMS during the Performance Year in which the addition would take effect".

d. Section IV.D.2 is hereby amended by inserting "the ACO has been notified that" after "notify CMS no later than 30 days after".

e. Section IV.E.2 is hereby amended in its entirety to read as follows:

2. *At least 7 days prior to submitting its Proposed Participant List to CMS, the ACO shall furnish written notification to each entity the ACO wishes to include on the Proposed Participant List, as well as to each of the entities that employs, contracts, or otherwise has arrangements with each individual that the ACO wishes to include on the Proposed Participant List. Such notice shall –*
    1. *State that the individual or entity and the relevant TIN through which it bills Medicare will be identified on the Proposed Participant List; and*
    2. *State that participation in the Initiative may preclude the individual or entity from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.*

8. **Beneficiary Alignment, Engagement, and Protections.** Section V.D.1 of the Agreement is hereby amended in its entirety to read as follows:

    For Performance Year 1, in a form and manner and by a date specified by CMS, the ACO shall provide all Initiative Beneficiaries notice in writing that they have been aligned to the ACO for the Performance Year. For each subsequent Performance Year, the ACO shall provide such written notice to all newly aligned Initiative Beneficiaries for the applicable Performance Year.

9. **ACO Quality Performance.** Section VIII of the Agreement is hereby amended as follows:

    a. Section VIII.C.1 is hereby amended in its entirety to read as follows:

    1. *The ACO shall completely and accurately report quality measures for each Performance Year and shall require its Initiative Participants to cooperate in quality measure reporting. Complete reporting means that the ACO meets all of the reporting requirements including timely reporting the requested data for all measures.*

    b. Section VIII.C.2 is hereby amended in its entirety to read as follows:

    2. *[RESERVED]*

10. **Telehealth Expansion Benefit Enhancement.** Effective January 1, 2020, Section XI.A of the Agreement is hereby amended by adding at the end the following new paragraph:

    5. *Beginning January 1, 2020, regardless of whether the ACO selects to provide the Telehealth Expansion Benefit Enhancement under Section X for a Performance Year,*

payment to Initiative Participants for telehealth services furnished to Beneficiaries pursuant to Section 1899(l) of the Act is governed by the terms and conditions of Appendix L of this Agreement.

11. **ACO Benchmark.** Section XII of the Agreement is hereby amended as follows:

a. Section XII.A.2 is hereby amended in its entirety to read as follows:

2. *Prior to the start of each Performance Year, GMCB shall provide the ACO with a report consisting of the ACO's CMS-approved Performance Year Benchmark and the methodology used to calculate the Performance Year Benchmark.*

b. Section XII.A.3 is hereby amended in its entirety to read as follows:

3. *On a quarterly basis during each Performance Year, CMS shall provide the ACO with financial reports. The reports may include adjustments to the Performance Year Benchmark resulting from updated information regarding any factors that affect the Performance Year Benchmark calculation.*

c. Section XII.B.1 is hereby amended in its entirety to read as follows:

1. *CMS may, at CMS's sole discretion, retroactively modify a CMS-approved Performance Year Benchmark if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change, and/or other similarly unforeseen circumstance during the relevant Performance Year renders the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for assessing the expected level of spending between the Base Year and the Performance Year for Performance Year 2019, or for assessing the expected level of spending between the period used to calculate the historical expenditures included in the Performance Year Benchmark methodology and the Performance Year for Performance Year 2020 and each subsequent Performance Year.*

12. **Remedial Action and Termination.** Section XVIII of the Agreement is hereby amended as follows:

a. Section XVIII.A.1(e) is hereby amended in its entirety to read as follows:

(e) Require the ACO to remove an Initiative Participant or Preferred Provider from the Participant List or Preferred Provider List and to terminate its agreement, immediately or within a timeframe specified by

CMS, with such Initiative Participant or Preferred Provider or, if applicable, the entity that employs, contracts with, or otherwise has entered into arrangements with the Initiative Participant or Preferred Provider, with respect to this Initiative;

b. Section XVIII.D.3 is hereby amended in its entirety to read as follows:

3. *If the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C prior to the end of a Performance Year by providing notice to CMS on or before March 31 of that Performance Year, with an effective date no later than 30 days after the date of that notice, no annual settlement will be conducted for such Performance Year in accordance with Section XIII.C.1, and the ACO shall neither be eligible to receive Shared Savings nor liable for Shared Losses for such Performance Year. If the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C prior to the end of a Performance Year by providing notice to CMS after March 31 of that Performance Year or if such termination has an effective date after April 30, but prior to the end of that Performance Year, the ACO shall not be eligible to receive Shared Savings but shall remain liable for Shared Losses for such Performance Year. If the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C with an effective date at the end of that Performance Year, CMS shall conduct settlement for the Performance Year in which the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C.*

13. **Appendix B - Initiative Beneficiary Alignment and Benchmarking Methods.** Appendix B of the Agreement is hereby stricken in its entirety and replaced with the Appendix B included as Attachment A to this amendment.

14. **Appendix E - Telehealth Expansion Benefit Enhancement.** Effective January 1, 2020, Appendix E of the Agreement is hereby stricken and replaced in full with the Appendix E included as Attachment B to this amendment.

15. **Appendix H - Financial Guarantee.** Appendix H of the Agreement is hereby amended as follows:

a. Section 2.2 is hereby amended in its entirety to read as follows:

2.2 CMS shall provide written notice to the ACO in January of each Performance Year, of the amount that must be funded by the financial guarantee for the applicable Performance Year, which will be equal to one percent of the ACO's estimated total Medicare Parts A and B fee-for-service expenditures for Initiative Beneficiaries for the Performance Year. The amount is based on the ACO's

Performance Year Benchmark and will be calculated by CMS.

b. Section 3.2 is hereby amended by replacing the period at the end of subsection (b) with "; or" and inserting after subsection (b) the following new subsection (c):

(c) A date determined by CMS.

16. **Appendix J - Alternative Payment Mechanism – All-Inclusive Population-Based Payments (AIPBP).** Appendix J of the Agreement is hereby stricken in its entirety and replaced with the Appendix J included as Attachment C to this amendment.

17. **Appendix K - Quality Measures.** Appendix K of the Agreement is hereby stricken in its entirety and replaced with the Appendix K included as Attachment D to this amendment.

18. **Appendix L - Payment for Telehealth Services under Section 1899(l).** Effective January 1, 2020, the Agreement is hereby amended to add after Appendix K a new Appendix L included as Attachment E to this amendment.

The signatory for the ACO certifies that he or she is authorized by the ACO to execute this amendment and to legally bind the ACO. Each party is signing this amendment on the date stated opposite that party's signature. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed this amendment.

ACO:

Date: 12/27/19

By: Vicki Loner

Vicki Loner
Name of authorized signatory

CEO, OneCare Vermont
Title

CMS:

Date: 12/16/19

By: Amy Bassano

Amy Bassano
Name of authorized signatory

Acting Director, CMMI, CMS
Title

VERMONT ALL-PAYER ACO MODEL
VERMONT MEDICARE ACO INITIATIVE PARTICIPATION AGREEMENT
ATTACHMENT A

Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative

Appendix B - Beneficiary Alignment and Benchmarking Methods

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

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

I. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Beneficiary Alignment Methodology

A. General

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

B. Alignment Years

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

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

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

C. Alignment Algorithm

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

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

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

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

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

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

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

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

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

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

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

D. Initiative Beneficiary Population

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

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

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

III. Performance Year Benchmark Methodology

A. Overview

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

Benchmark inaccurate or inappropriate for purposes of assessing the expected level of spending between the Base Year and Performance Year.

B. Role of the Green Mountain Care Board

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

C. Performance Year Benchmark Components

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

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

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

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

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

1. For services covered by Medicare Parts A and/or B;
2. With a date of service during the Base Year; and
3. That are paid within 3 months of the close of the Base Year. The paid date for a claim is the date the claim is loaded into the Integrated Data Repository (IDR).

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

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

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

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

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

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

For example, for the Performance Year 2019 Performance Year Benchmark, the trend factor will be calculated by dividing the USPCC Parts A&B current estimate for CY2019 by the USPCC Parts A&B current estimate for CY2018. For the Performance Year 2020 Performance Year Benchmark, the trend factor will similarly be calculated by dividing the Parts A&B current estimate for CY2020 by the Parts A&B current estimate for CY2019.

3. Quality Measures and Quality Score

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

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

IV. Financial Settlement

A. Overview

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

B. Initiative Beneficiaries for Financial Settlement

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

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

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

C. Performance Year Expenditures

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

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

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

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

D. Savings/Losses Amount

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

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

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

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

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

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

V. Tables

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

Period	**Period covered[1]**	**Corresponding Alignment Years (AYs)**
Base Year	PY2019 Base Year: 01/01/2018 – 12/31/2018	AY1: 07/01/2015 – 06/30/2016 (AY2016) AY2: 07/01/2016 – 06/30/2017 (AY2017)
	PY2020 Base Year: 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)
	PY2021 Base Year: 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)
	PY2022	AY1: 07/01/2018 – 06/30/2019 (AY2019)

	Base Year: 01/01/2021 – 12/31/2021	AY2: 07/01/2019 – 06/30/2020 (AY2020)
Performance Year (Current CY)	PY2019 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)
	PY2020 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)
	PY2021 01/01/2021 – 12/31/2021	AY1: 07/01/2018 – 06/30/2019 (AY2019) AY2: 07/01/2019 – 06/30/2020 (AY2020)
	PY2022 01/01/2022 – 12/31/2022	AY1: 07/01/2019 – 06/30/2020 (AY2020) AY2: 07/01/2020 – 06/30/2021 (AY2021)

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

Table 1.2 – Qualified Evaluation & Management Services

Office or Other Outpatient Services	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive

99215	Established Patient, extensive
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)

Chronic Care Management Services	
99490	Comprehensive care plan establishment/implementation/revision/monitoring
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

Table 1.3 - Specialty codes used to identify Primary Care Specialists

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

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

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

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

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

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

I. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Beneficiary Alignment Methodology

A. General

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

B. Alignment Years

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

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

C. Alignment Algorithm

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

1. The weighted allowable charge for all QEM Services that the Beneficiary received from an Inititiative Professional included on the Participant List for the relevant Performance Year; and

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

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

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

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

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

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

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

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

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

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

D. Initiative Beneficiary Population

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

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

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

III. Calculation of Performance Year Benchmark

A. Overview

The Performance Year Benchmark is set prospectively for each Performance Year prior to the start of the Performance Year. The Performance Year Benchmark is determined by the GMCB, as described in Section III.B of this Appendix B, using included historical expenditures for each of the two Entitlement Categories, subject to certain exclusions, and subject to the application of a trend factor and adjustments for quality performance. CMS will provide the GMCB with the Base Year expenditures for the applicable Base Year for use as a reference point in the GMCB's Performance Year Benchmark methodology; however such Base Year expenditures will not be materially used by the GMCB in the calculation of the Performance Year Benchmark for Performance Year 2020 or subsequent Performance Years. As stated in Section XII.B of the Agreement, a Performance Year Benchmark may be retroactively modified if CMS determines that exogenous factors during the relevant Performance Year render the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for purposes of assessing the expected level of spending between the period used by the GMCB to calculate the historical expenditures included in the Performance Year Benchmark methodology and the Performance Year.

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

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

IV. Financial Settlement

A. Overview

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

B. Initiative Beneficiaries for Financial Settlement

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

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

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

C. Performance Year Expenditures

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

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

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

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

1. Included and Excluded Expenditures for Initiative Beneficiaries.

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

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

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

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

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

E. Payment for outlier cases.

D. Quality Measures and Quality Score

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

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

E. Savings/Losses Amount

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

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

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

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

a 5% Savings/Losses Cap and a 80% Risk Arrangement, the ACO would share in savings/losses up to 4% [80% of the 5% maximum allowable savings/losses] of its Performance Year Benchmark.

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

V. Tables

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

Period	**Period covered[1]**	**Corresponding Alignment Years (AYs)**
Base Year	PY2019 Base Year: 01/01/2018 – 12/31/2018	AY1: 07/01/2015 – 06/30/2016 (AY2016) AY2: 07/01/2016 – 06/30/2017 (AY2017)
	PY2020 Base Year: 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)
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	PY2022 Base Year: 01/01/2021 – 12/31/2021	AY1: 07/01/2018 – 06/30/2019 (AY2019) AY2: 07/01/2019 – 06/30/2020 (AY2020)
Performance Year (Current CY)	PY2019 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017)

		AY2: 07/01/2017 – 06/30/2018 (AY2018)
	PY2020 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)
	PY2021 01/01/2021 – 12/31/2021	AY1: 07/01/2018 – 06/30/2019 (AY2019) AY2: 07/01/2019 – 06/30/2020 (AY2020)
	PY2022 01/01/2022 – 12/31/2022	AY1: 07/01/2019 – 06/30/2020 (AY2020) AY2: 07/01/2020 – 06/30/2021 (AY2021)

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

Table 1.2 – Qualified Evaluation & Management Services

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99201	New Patient, brief
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99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Chronic Care Management Services	

99490	Comprehensive care plan establishment/implementation/revision/monitoring
Wellness Visits	
G0402	Welcome to Medicare visit
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Table 1.3 - Specialty codes used to identify Primary Care Specialists

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

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

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VERMONT ALL-PAYER ACO MODEL
VERMONT MEDICARE ACO INITIATIVE PARTICIPATION AGREEMENT
ATTACHMENT B

Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative

Appendix E - Telehealth Expansion Benefit Enhancement

Appendix L of the Agreement governs payment pursuant to Section 1899(l) of the Act for telehealth services furnished by a physician or other practitioner who is an Initiative Participant on or after January 1, 2020. If the ACO has elected the Telehealth Expansion Benefit Enhancement in accordance with Section I of this Appendix E, this Telehealth Expansion Benefit Enhancement further increases the availability to Beneficiaries of otherwise covered telehealth services furnished via interactive telecommunications systems while also providing flexibility for Beneficiaries to receive certain teledermatology and teleopthalmology services furnished using asynchronous store and forward technologies.

I. Election of the Telehealth Expansion Benefit Enhancement

If the ACO wishes to offer the Telehealth Expansion Benefit Enhancement during a Performance Year, the ACO must –

A. Timely submit to CMS its election of the Telehealth Expansion Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement for the Telehealth Expansion Benefit Enhancement; and

B. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Initiative Participants that have agreed to participate in the Telehealth Expansion Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Telehealth Expansion Benefit Enhancement.

II. Waiver

A. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to otherwise covered telehealth services furnished by an Eligible Telehealth Provider (as that term is defined in Section III.A of this Appendix) in accordance with the terms and conditions set forth in this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 C.F.R. § 410.78(b)(3)–(4) with respect to telehealth services furnished in accordance with this Appendix.
2. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be “furnished at an originating site” when the services are furnished in accordance with this Appendix.

3. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 C.F.R. § 414.65(b) with respect to telehealth services furnished to a Beneficiary at his/her home or place of residence when furnished in accordance with this Appendix.

B. Waiver of Interactive Telecommunications System Requirement: CMS waives the following requirements with respect to otherwise covered teledermatology and teleophthalmology services furnished by an Eligible Asynchronous Telehealth Provider (as that term is defined in Section III.B. of this Appendix) using asynchronous store and forward technologies, in accordance with the terms and conditions set forth in this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirement in Section 1834(m)(4)(C)(i) of the Act regarding the location of the originating site and the requirements of 42 C.F.R. § 410.78(b)(4) with respect to covered teledermatology and teleophthalmology furnished using asynchronous store and forward technologies in accordance with this Appendix.

2. Waiver of Interactive Telecommunications System Requirement: CMS waives the requirement under Section 1834(m)(1) of the Act and 42 C.F.R. § 410.78(b) that telehealth services be furnished via an "interactive telecommunication system," as that term is defined under 42 C.F.R. § 410.78(a)(3), when such services are furnished in accordance with this Appendix.

C. The waivers described in Section II.A and II.B of this Appendix are collectively referred to as the "**Telehealth Expansion Benefit Enhancement**".

III. Eligible Telehealth Providers and Eligible Asynchronous Telehealth Providers

A. For purposes of this Telehealth Expansion Benefit Enhancement, an "**Eligible Telehealth Provider**" is a Preferred Provider who meets the requirements under Section XI.C.2 of the Agreement.

B. For the purposes of this Telehealth Expansion Benefit Enhancement, an "**Eligible Asynchronous Telehealth Provider**" is an Initiative Participant or Preferred Provider who meets the requirements under Section XI.C.4 of the Agreement.

C. CMS review and approval of an Initiative Participant or a Preferred Provider to provide services in accordance with the Telehealth Expansion Benefit Enhancement under Section II of this Appendix includes consideration of the program integrity history of the Initiative Participant or Preferred Provider and any other factors that CMS determines may affect the qualifications of the Initiative Participant or Preferred Provider to provide telehealth services under the terms of the Telehealth Expansion Benefit Enhancement.

IV. Eligibility Requirements

A. In order for telehealth services to be eligible for reimbursement under the terms of the waivers under Section II.A of this Appendix, the Beneficiary must be:

1. An Initiative Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
2. Located at an originating site that is either:
    a. One of the sites listed in section 1834(m)(4)(C)(ii) of the Act; or
    b. The Beneficiary's home or place of residence.

B. In order for telehealth services to be eligible for reimbursement under the terms of the waiver under Section II.B of this Appendix, the Beneficiary must be:
    1. An Initiative Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
    2. Located at an originating site that is one of the sites listed in Section 1834(m)(4)(C)(ii) of the Act.

C. Claims for telehealth services furnished under the terms of the waiver under Section II.A of this Appendix for which the originating site is a Beneficiary's home or place of residence will be denied unless submitted using one of the HCPCS codes G9481-G9489.

D. Claims for asynchronous teledermatology and teleophthalmology services furnished under the terms of the waiver under Section II.B of this Appendix will be denied unless submitted using one of the HCPCS codes G9868-G9870.

E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider shall not submit a claim for such telehealth services.

F. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining requirements of Section 1834(m) of the Act and 42 C.F.R. §§ 410.78 and 414.65.

G. An Eligible Telehealth Provider or an Eligible Asynchronous Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knows or should know in person services are medically necessary.

V. Grace Period for Excluded Beneficiaries

In the case of a Beneficiary who had been aligned with the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO during the Performance Year, CMS shall make payment for telehealth services furnished to such Beneficiary under the terms of the Telehealth Expansion Benefit Enhancement as if the Beneficiary were still an Initiative Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

VI. Responsibility for Denied Claims

A. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider under the Telehealth Expansion Benefit Enhancement is denied as a result of a CMS error and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred.

B. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider is denied for any reason other than a CMS error and CMS determines that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

   1. CMS shall, notwithstanding such denial, pay for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;

   2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

   3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

C. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:

   1. CMS shall not make payment to the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider for such services;

   2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

   3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

D. If an Initiative Participant or Preferred Provider that is not an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider submits claims for telehealth

services for which CMS only would have made payment if the Initiative Participant or Preferred Provider was an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider participating in this Telehealth Expansion Benefit Enhancement at the time of service:

1. CMS shall not make payment to the Initiative Participant or Preferred Provider for such services;
2. The ACO shall ensure that the Initiative Participant or Preferred Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
3. The ACO shall ensure that the Initiative Participant or Preferred Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Compliance and Enforcement

A. CMS may reject the ACO's designation of a Preferred Provider as an Eligible Telehealth Provider or of an Initiative Participant or Preferred Provider as an Eligible Asynchronous Telehealth Provider at any time if the Initiative Participant or Preferred Provider's participation in this Telehealth Expansion Benefit Enhancement might compromise the integrity of the Initiative .

B. The ACO must have appropriate procedures in place to ensure that Initiative Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.

C. [RESERVED]

D. CMS will monitor the ACO's use of the Telehealth Expansion Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.

E. In accordance with Section XVIII of this Agreement, CMS may terminate or suspend one or more of the waivers under Section II of this Appendix or take other remedial action if the ACO or any of its Initiative Participants or Preferred Providers fails to comply with the terms and conditions of the Telehealth Expansion Benefit Enhancement.

VERMONT ALL-PAYER ACO MODEL
VERMONT MEDICARE ACO INITIATIVE PARTICIPATION AGREEMENT
ATTACHMENT C

Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative

Appendix J - Alternative Payment Mechanism – All-Inclusive Population-Based Payments (AIPBP)

I. AIPBP Election

A. To participate in AIPBP, the ACO must, by a time and in a manner specified by CMS, --
   1. Timely submit to CMS its selection of AIPBP as the Alternative Payment Mechanism for a Performance Year in accordance with Section X.A of this Agreement;
   2. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Initiative Participants that have agreed to participate in AIPBP and a true, accurate, and complete list of Preferred Providers that have agreed to participate in AIPBP;
   3. Timely submit a fully executed "Vermont Medicare ACO Initiative: All-Inclusive Population-Based Payments Fee Reduction Agreement" (described in Section II.J of this Appendix) for each Initiative Participant and Preferred Provider that is identified as participating in AIPBP, as set forth on the lists submitted in accordance with Section I.A.2 of this Appendix;
   4. Timely submit by a date and in a manner specified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.B of this Appendix; and
   5. Timely submit by a date and in a manner specified by CMS a certification that the ACO has the necessary infrastructure to be able to pay its AIPBP-participating Initiative Participants and Preferred Providers promptly in accordance with Section III.G of this Appendix.

B. CMS may reject the ACO's selection to participate in AIPBP for a Performance Year if:
   1. CMS has identified any noncompliance with the terms of this Agreement, regardless of whether the ACO resolves the noncompliant activity;
   2. CMS has taken any remedial actions against the ACO in connection with its participation in another CMS initiative involving Medicare ACOs during either of the ACO's last two performance years in that initiative;
   3. CMS determines on the basis of a program integrity screening or other information that the ACO's participation in AIPBP might compromise the integrity of the Initiative;
   4. The ACO's selection to participate in AIPBP is for the ACO's first Performance Year participating in the Initiative and the ACO has not participated in any CMS initiative involving Medicare ACOs prior to its participation in the Initiative; or
   5. The ACO has failed to timely submit the documentation and certifications described in Section I.A of this Appendix

C. CMS may prohibit the ACO from having an AIPBP Payment Arrangement (as defined in Section III of this Appendix) with an Initiative Participant or Preferred Provider if:

1. The conduct of the Initiative Participant or Preferred Provider has caused CMS to impose remedial action pursuant to Section XVIII of this Agreement or to impose a sanction under any CMS administrative authority; or
2. CMS determines on the basis of a program integrity screening or other information that the Initiative Participant's or Preferred Provider's participation in AIPBP might compromise the integrity of the Initiative.

D. If CMS rejects or later terminates the ACO's selection to participate in AIPBP for a Performance Year (in accordance with Section X.C or Section XVIII.A of this Agreement, respectively), payments to the ACO's Initiative Participants and Preferred Providers will default to traditional FFS for the Performance Year or the remainder of the Performance Year, as applicable.

II. AIPBP Fee Reduction

A. [RESERVED]

B. If the ACO has selected to participate in AIPBP for a Performance Year in accordance with Section I.A of this Appendix, the ACO shall, by a date specified by CMS, notify and educate all Initiative Participants and Preferred Providers about the ACO's intended participation in AIPBP and the associated AIPBP Fee Reduction. Providing a copy of the Vermont Medicare ACO Initiative: All-Inclusive Population-Based Payments Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in AIPBP for a Performance Year is rejected or later terminated, the ACO shall notify all Initiative Participants and Preferred Providers that it is not participating in AIPBP for that Performance Year or the remainder of that Performance Year, as applicable.

C. An Initiative Participant or Preferred Provider may participate in AIPBP for a Performance Year only if the Initiative Participant or Preferred Provider was included on the ACO's Participant List or Preferred Provider List, respectively, at the start of that Performance Year. Initiative Participants and Preferred Providers who were added to the ACO's Participant List or Preferred Provider List during a Performance Year may participate in AIPBP in a subsequent Performance Year only if they are included on the ACO's Participant List or Preferred Provider List at the start of the subsequent Performance Year.

D. Not all Initiative Participants and Preferred Providers must agree to participate in AIPBP for the ACO to participate in AIPBP.

E. Not all Initiative Participants and Preferred Providers billing under a TIN must agree to participate in AIPBP for other Initiative Participants and Preferred Providers billing under the same TIN to participate in AIPBP.

F. CMS will reduce FFS payments on claims for services furnished to Initiative Beneficiaries by 100% only for those Initiative Participants and Preferred Providers that have consented to receive the AIPBP Fee Reduction pursuant to Section II.J of this Appendix and with whom the ACO is not prohibited under Section I.C of this Appendix from having an AIPBP Payment Arrangement.

G. A hospital paid under the Inpatient Prospective Payment System that is an Initiative Participant or Preferred Provider that has agreed to receive the AIPBP Fee Reduction will continue to receive IME, DSH, inpatient outlier, and inpatient new technology add-on payments calculated in accordance with the applicable statutory and regulatory provisions.

H. For certain types of institutional providers, such as Method II CAHs and FQHCs, that are Initiative Participants or Preferred Providers and are participating in AIPBP, CMS will reduce by 100% all FFS payments for services furnished to Initiative Beneficiaries that are billed under that institution's CCN and organizational NPI regardless of whether the individual NPIs rendering the service are Initiative Participants or Preferred Providers.

I. CMS will not reduce FFS payments on claims for services furnished to Initiative Beneficiaries who elect to decline data sharing or for claims for services related to the diagnosis and treatment of substance use disorder furnished to Initiative Beneficiaries.

J. Written Confirmation of Consent

1. The ACO shall obtain written confirmation that each AIPBP-participating Initiative Participant and Preferred Provider has consented to receive the AIPBP Fee Reduction. Such written confirmation of consent must be in the form of a completed Vermont Medicare ACO Initiative: All-Inclusive Population-Based Payments Fee Reduction Agreement signed by an individual legally authorized to act for the entity through whose TIN the Initiative Participant or Preferred Provider bills Medicare.

2. As part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN the Initiative Participant or Preferred Provider bills Medicare must verify the accuracy of the list of Initiative Participants and Preferred Providers billing under that TIN that have affirmatively consented to receiving the AIPBP Fee Reduction.

3. An Initiative Participant's or Preferred Provider's consent to receive the AIPBP Fee Reduction must apply for the full Performance Year and must be renewed annually in order for the Initiative Participant or Preferred Provider to continue to participate in AIPBP.

4. Consent to participate in AIPBP by an Initiative Participant or Preferred Provider must be voluntary and must not be contingent on or related to receipt of referrals from the ACO, its Initiative Participants, or Preferred Providers.

III. AIPBP Payment Arrangements

A. The ACO shall have a written payment arrangement with each AIPBP-participating Initiative Participant or Preferred Provider that establishes how the ACO will make payments to the AIPBP-participating Initiative Participant or Preferred Provider for Covered Services that are subject to the AIPBP Fee Reduction ("**AIPBP Payment Arrangement**").

B. In establishing the terms of any AIPBP Payment Arrangement, neither party gives or receives remuneration in return for or to induce business other than business covered by the AIPBP Payment Arrangement.

C. The payments made by the ACO under an AIPBP Payment Arrangement may not be made knowingly to induce the AIPBP-participating Initiative Participant or Preferred Provider to reduce or limit Medically Necessary items or services to Beneficiaries.

D. All payments made by the ACO for Covered Services under an AIPBP Payment Arrangement must be monetary payments that have been negotiated in good faith and are consistent with fair market value (which may be more or less than the Medicare payment amount for a given Medicare-reimbursable service).

E. The ACO shall maintain, in accordance with Section XVII.B of the Agreement, records of all payments made or received pursuant to each AIPBP Payment Arrangement.

F. The AIPBP Payment Arrangement must:

1. Require the ACO to reimburse Initiative Participants and Preferred Providers for all Covered Services that Medicare would have otherwise paid for, but for the AIPBP Fee Reduction.

2. Require the ACO to pay for Covered Services furnished by AIPBP-participating Initiative Participants and Preferred Providers no later than 30 days after receiving notice of the processed claim, as indicated on a weekly report from CMS to the ACO.

3. Require the Initiative Participant or Preferred Provider to make Medically Necessary Covered Services available to Initiative Beneficiaries in accordance with all applicable laws and regulations.

4. Prohibit the ACO from requiring prior authorization for services furnished to Initiative Beneficiaries.

5. Prohibit the ACO and the Initiative Participant or Preferred Provider from interfering with an Initiative Beneficiary's freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in AIPBP or with the ACO.

6. Require the Initiative Participant or Preferred Provider to maintain records regarding the AIPBP Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section XVII.B of the Agreement.

7. Require the Initiative Participant or Preferred Provider to provide the government with access to records regarding the AIPBP Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section XVII.A of the Agreement.

G. The ACO shall ensure that it has and will maintain the capability and funds to reimburse AIPBP-participating Initiative Participants and Preferred Providers for all Covered Services that they furnish, and that it will promptly make such payments in accordance with Section III.F.2 of this Appendix.

H. The ACO shall, on a schedule and in a manner determined by CMS, report to CMS an accounting of the AIPBP payments received by the ACO from CMS and the payments made by the ACO to Initative Participants and Preferred Providers.

IV. Beneficiary Disputes

A. CMS will process all claims submitted by AIPBP-participating Initiative Participants and Preferred Providers, and assess coverage for such services and any Beneficiary liability using the same standards that apply under traditional Medicare fee-for-service.

B. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claims appeals process at 42 C.F.R. Part 405, subpart I.

V. Provider Payment Dispute Resolution

The ACO must establish procedures under which AIPBP-participating Initiative Participants and Preferred Providers may request reconsideration by the ACO of a payment determination. The procedures for requesting reconsideration must be included in the written AIPBP Payment Arrangement between the ACO and the AIPBP-participating Initiative Participant or Preferred Provider required under Section III.A of this Appendix.

VI. Calculation of the All-Inclusive Population-Based Payment

A. Overview

1. CMS shall calculate the Monthly AIPBP Payment in accordance with Section VI.B of this Appendix.
2. CMS will make a Monthly AIPBP Payment to the ACO for each month that the ACO participates in AIPBP during the Performance Year.
3. CMS shall not make any Monthly AIPBP Payments to the ACO after the effective date of the termination of this Agreement.
4. CMS shall not make any Monthly AIPBP Payments after the effective date of CMS' termination (in accordance with Section XVIII.A of this Agreement) of the ACO's selection to participate in AIPBP.

B. AIPBP Payment Calculation

1. FFS Expenditures Used to Estimate the Reduction in FFS Payments

To estimate the reduction in FFS payments to AIPBP-participating Initiative Participants and Preferred Providers for Part A and Part B services furnished to Initiative Beneficiaries during the applicable Performance Year, CMS will use the aggregate Part A and Part B payments made for services furnished to the applicable population of Beneficiaries (described in Section VI.B.2 of this Appendix) by all AIPBP-participating Initiative Participants and Preferred Providers during a calibration period. A forecast model will be used to estimate Performance Year Per Beneficiary Per Month (PBPM) expenditures for Part A and Part B services furnished to Initiative Beneficiaries by AIPBP-participating Initiative Participants and Preferred Providers from prior quarters of incurred and paid claims during the applicable calibration period and to estimate a growth factor to reflect changes in price, volume and mix of services.

The calibration period is defined as claims paid and incurred January 1 through September 30 four years prior to the start of the Performance Year. For example, for

Performance Year 1 (CY2019), the calibration period runs from January 1, 2014 through September 30, 2018.

2. Beneficiary Population Used to Estimate the Reduction in FFS Payments

To estimate the reduction in FFS payments to AIPBP-participating Initiative Participants and Preferred Providers for Performance Year 1 and subsequent Performance Years, CMS will use the population of Beneficiaries aligned to the ACO under the terms of this Agreement for the upcoming Performance Year.

3. Estimate of Initiative Beneficiary Member Months

To estimate total member months for Initiative Beneficiaries, CMS will use data on historical member months for all Vermont Medicare Beneficiaries (as that term is defined in the State Agreement) during the calibration period ("**Total Projected Member Months**"). Historical member months represent the total number of months of Medicare eligibility during the calibration period.

4. Calculation of Total AIPBP Payment and Monthly AIPBP Payment

The total amount of AIPBP payments to the ACO for a Performance Year is equal to:

i. The projected Part A and Part B PBPM payments made for services furnished by all AIPBP-participating Initiative Participants and Preferred Providers calculated in accordance with Sections VI.B.1 and VI.B.2 of this Appendix;

ii. Multiplied by the Total Projected Member Months calculated in accordance with Section VI.B.3 of this Appendix ; and

iii. Multiplied by 0.98 (i.e., reduced by 2%) if budget sequestration is in effect for the Performance Year.

The resulting amount is then divided by 12 to determine the "**Monthly AIPBP Payment.**"

C. AIPBP Payment Recalculation

1. Except as provided for in this Section VI.C of this Appendix, CMS will not recalculate the total amount of the AIPBP payment or the Monthly AIPBP Payment calculated under Section VI.B.4 of this Appendix during the applicable Performance Year.

2. CMS will review actual AIPBP Fee Reductions during the Performance Year. If during a Performance Year, data shows that the total Monthly AIPBP Payments received are at least 10% greater or at least 10% less than the total actual amount of AIPBP Fee Reductions taken, CMS may recalculate and revise the total amount of the AIPBP payment for the Performance Year and the amount of the Monthly AIPBP Payment calculated under Section VI.B.4 of this Appendix based on Performance Year data. Such revised amount may be adjusted to account for overpayment or underpayment of Monthly AIPBP Payments during the Performance Year. CMS will provide a report of the recalculated amounts to the ACO.

VII. Reconciliation of the Total Monthly AIPBP Payments

A. Following each Performance Year the ACO participates in AIPBP, CMS will reconcile total Monthly AIPBP Payments with total amount of AIPBP Fee Reductions for such Performance Year by calculating the difference between the total amount of Monthly AIPBP Payments CMS paid to the ACO during the Performance Year and the total AIPBP Fee Reductions taken by CMS during the Performance Year. Any difference will constitute Other Monies Owed and may be subject to collection after settlement under Section XIV.C of this Agreement.

B. The AIPBP Fee Reductions do not affect the calculation of Shared Savings or Shared Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the AIPBP Fee Reduction. The reconciliation of total Monthly AIPBP Payments and the total AIPBP Fee Reductions does not affect and is not affected by the ACO's selected Risk Arrangement or selected Savings/Losses Cap.

C. CMS will include any Other Monies Owed, including Other Monies Owed due to the reconciliation of the total Monthly AIPBP Payments, on the settlement report issued under Section XVIII.C.1 of this Agreement, such that the settlement report will set forth the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.

D. [RESERVED]

E. [RESERVED]

F. In the event that the ACO elects to terminate this Agreement pursuant to Section XVIII.C of the Agreement prior to the end of a Performance Year in which the ACO participates in AIPBP by providing notice to CMS on or before March 31 of that Performance Year with effect no later than 30 days from that notice, there will be no annual financial settlement for that Performance Year in accordance with Section XIII.C.1 of the Agreement, CMS will reconcile total onthly AIPBP Payments as part of a settlement reopening for a prior Performance Year, and the ACO must pay any Other Monies Owed to CMS in accordance with Section XIII.C.5 of the Agreement.

G. CMS will include in the reconciliation of total Monthly AIPBP Payments any AIPBP Fee Reductions for services furnished to Beneficiaries who were aligned to the ACO at the time the services were furnished but were later excluded from the aligned population during the Performance Year because they did not meet alignment-eligibility requirements.

H. Adjusted Settlement

1. For each Performance Year in which the ACO participates in AIPBP, CMS shall conduct a second AIPBP reconciliation one year after the original AIPBP reconciliation at the same time that CMS issues the settlement report for the subsequent Performance Year.

2. If, as a result of the second reconciliation of total Monthly AIPBP Payments, CMS determines that:

   a. The total AIPBP Fee Reductions taken by CMS during the Performance Year exceed the total Monthly AIPBP Payments made to the ACO during the

Performance Year, as reconciled during the initial reconciliation of total Monthly AIPBP Payments for the applicable Performance Year under Section VII.A of this Appendix, the difference will be deemed Other Monies Owed by CMS and included on the next settlement report;

b. The total Monthly AIPBP Payments made to the ACO during the Performance Year, as reconciled during the initial reconciliation of total Monthly AIPBP Payments for the applicable Performance Year under Section VII.A of this Appendix, exceeds the total AIPBP Fee Reductions during the Performance Year, the difference will be deemed Other Monies Owed by the ACO and included on the next settlement report.

3. In the case of the final Performance Year of the Agreement Performance Period:

a. CMS will make reasonable efforts to conduct the second reconciliation of total Monthly AIPBP Payments within 12 months after the initial reconciliation of total Monthly AIPBP Payments described in Section VII.A of this Appendix;

b. CMS will issue an adjusted settlement report to the ACO setting forth the results of the second reconciliation of total Monthly AIPBP Payments and identifying any Other Monies Owed by the ACO to CMS, or by CMS to the ACO, as a result of this second reconciliation of total Monthly AIPBP Payments.

c. Any amounts owed by the ACO to CMS, or by CMS to the ACO, as a result of this second reconciliation of total Monthly AIPBP Payments will be payable in accordance with Section XIII.C of the Agreement.

VERMONT ALL-PAYER ACO MODEL
VERMONT MEDICARE ACO INITIATIVE PARTICIPATION AGREEMENT
ATTACHMENT D

Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative

Appendix K - Quality Measures

The following quality measures are the measures for use in establishing quality performance standards beginning with the first Performance Year of the Initiative (CY2019).

	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Status R—Reporting; P—Performance
Access to Care	ACO – 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	P
	ACO – 2	CAHPS: How Well Your Providers Communicate	Survey	P
	ACO – 3	CAHPS: Patients' Rating of Provider	Survey	P
	ACO – 4	CAHPS: Access to Specialists	Survey	P
	ACO – 5	CAHPS: Health Promotion and Education	Survey	P
	ACO – 6	CAHPS: Shared Decision Making	Survey	P
	ACO – 7	CAHPS: Health Status/Functional Status	Survey	R
	ACO – 34	CAHPS: Stewardship of Patient Resources	Survey	R
	ACO-45	CAHPS: Courteous and Helpful Office Staff	Survey	R
	ACO-46	CAHPS: Care Coordination	Survey	R
Reduce Deaths Due to Drug Overdose and Suicide	ACO – 18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	EFT via ACO-OS	P
	VT – 1*	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (30-day)	Claims	R
	VT – 2*	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims	R
Reduce Prevalence of Chronic Disease for COPD, Hypertension, Diabetes	ACO - 27	Diabetes Hemoglobin (HbA1c) Poor Control (>9%)	EFT via ACO-OS	P
	ACO - 28	Hypertension: Controlling High Blood Pressure	EFT via ACO-OS	P
	ACO - 38	Risk-Standardized, Acute Admission Rate for Patients with Multiple Chronic Conditions	Claims	P
	ACO – 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	EFT via ACO-OS	R
Care Coordination/Patient Safety	ACO – 8	Risk-Standardized, All Condition Readmission	Claims	P
Preventive Health	ACO – 14	Preventive Care and Screening: Influenza Immunization	EFT via ACO-OS	P
	ACO – 19	Colorectal Cancer Screening	EFT via ACO-OS	P

*These measures are not included in the 2019 Physician Fee Schedule final rule.

VERMONT ALL-PAYER ACO MODEL

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ATTACHMENT E

Vermont All-Payer ACO Model
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Appendix L

Payment for Telehealth Services under Section 1899(l)

Section 50324 of the Bipartisan Budget Act of 2018 (Pub. L. No. 115-123) (codified at Section 1899(l) of the Act) provides for Medicare payment for certain telehealth services furnished by a physician or other practitioner participating in an applicable ACO to Beneficiaries who are prospectively aligned to that ACO without regard for the geographic requirements under Section 1834(m)(4)(C)(i) of the Act, effective January 1, 2020. This Appendix sets forth the terms and conditions under which Initiative Participants may receive payment for telehealth services furnished to Initiative Beneficiaries pursuant to Section 1899(l) of the Act, provides for a waiver of the originating site requirements to allow for Medicare payment for otherwise covered telehealth services furnished to Beneficiaries by Initiative Participants during a grace period, and incorporates Beneficiary safeguards to ensure Beneficiaries are not charged for certain non-covered telehealth services furnished by an Initiative Participant.

I. General

Payment is available for otherwise covered telehealth services furnished on or after January 1, 2020, without regard for the geographic requirements of Section 1834(m)(4)(C)(i) of the Act in accordance with the following requirements:

A. The telehealth service must furnished by a physician or other practitioner who is an Initiative Participant.

B. The Beneficiary must be:

   1. An Initiative Beneficiary at the time the telehealth services are furnished or within a grace period under Section II of this Appendix; and

   2. Located at an originating site that is either:

      a. One of the sites listed in Section 1834(m)(4)(C)(ii) of the Act; or

      b. The place of residence used as the home of the beneficiary (the "Beneficiary's home").

C. Claims for telehealth services for which the originating site is the Beneficiary's home will be denied if such services are inappropriate to furnish in the home setting, such as services that are typically furnished in inpatient settings.

D. CMS does not pay a facility fee under Section 1834(m)(2)(B) when the originating site is the Beneficiary's home.

E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to furnish such telehealth services, the Initiative Participant shall not submit a claim for such telehealth services.

F. The telehealth services must be furnished in accordance with all applicable state and Federal laws and all other Medicare coverage and payment criteria, including the applicable requirements of Section 1834(m) of the Act and 42 CFR §§ 410.78 and 414.65.

G. An Initiative Participant shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Initiative Participant knows or should know that in person services are medically necessary.

II. Grace Period for Excluded Beneficiaries

A. In the case of a Beneficiary who is excluded from alignment to the ACO during the Performance Year, CMS shall make payment for telehealth services furnished to such Beneficiary as if the Beneficiary were still an Initiative Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section I of this Appendix are met.

B. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to telehealth services furnished in accordance with Section I of this Appendix solely as necessary to allow for Medicare payment for such telehealth services furnished during the grace period under Section II.A of this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 CFR § 410.78(b)(3)–(4).

2. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be "furnished at an originating site."

3. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 CFR § 414.65(b) with respect to telehealth services furnished in the Beneficiary's home.

III. Responsibility for Denied Claims

In the event CMS makes no payment for a telehealth service furnished by a physician or practitioner who is an Initiative Participant, and the only reason the claim was non-covered is that the Beneficiary is not an Initiative Beneficiary or in the 90-day grace period under Section II of this Appendix at the time the telehealth service was furnished, the following beneficiary protections apply:

A. The ACO shall ensure that the Initiative Participant that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

B. The ACO shall ensure that the Initiative Participant that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.