Vermont All-Payer ACO Model

Vermont Medicare ACO Initiative Participation Agreement

Amendments to Sections I, II, X, XVIII and Appendices B, J and K

2022 Amendment No. 3

This amendment is made to the Vermont Medicare ACO Initiative Participation Agreement, as amended (the "Agreement") between the Centers for Medicare & Medicaid Services ("CMS") and OneCare Vermont, an accountable care organization ("ACO").

CMS wishes to amend the Agreement to add one Performance Year, extending the Agreement Performance Period through December 31, 2023. CMS also wishes to amend the Agreement to establish that it may offer to renew the Agreement for an additional Performance Year through December 31, 2024. To align with the 2021 and 2022 Physician Fee Schedules, CMS is also amending the Agreement to reflect updated Qualified Evaluation and Management Services codes utilized in beneficiary alignment, benchmarking, and/or financial settlement methods for Performance Years 2021 and 2022. The parties therefore agree to amend the Agreement as set forth herein.

1. **Effective Date**.
   Unless otherwise specified, this amendment shall be effective when it is signed by the last party to sign it (as indicated by the date associated with that party's signature).

2. **Amendments to the Agreement**.
   a. **Extension of Agreement Performance Period and addition of Renewal Period (Amendments to Section I):**
      i. Section I.C of the Agreement is hereby amended in its entirety to read as follows:

      *C. Agreement Performance Period. The period of performance under this Agreement ("**Agreement Performance Period**") begins on January 1 immediately following the Effective Date (the "**Start Date**") and ends on December 31, 2023, or at the end of the transition period as described in Section 1.D, unless the Agreement is sooner terminated by either party in accordance with Section XVIII.*

      ii. Section I is hereby also amended by adding at the end the following new Section I.D: Transition Period:

      D. Transition Period. CMS may offer to renew the Agreement for a period of an additional Performance Year. The ACO shall accept or reject such an offer in writing by a date and in a form and manner specified by CMS. In the event the ACO accepts such offer, the Agreement Performance Period will end on December 31, 2024, unless the Agreement is sooner terminated by either party in accordance with Section XVIII.

b. **Definitions (Amendments to Section II):** Section II of the Agreement is hereby amended as follows:

i. The definition of "Performance Year" is hereby amended in its entirety to read as follows:

"Performance Year" *means a calendar year during the Agreement Performance Period. The first Performance Year begins on the Start Date and ends on December 31 of that calendar year. Subsequent Performance Years are 12 months in duration, beginning on January 1. The final Performance Year begins on January 1, 2023, and ends on December 31, 2023, subject to a transition period described in Section 1.D, unless this Agreement is sooner terminated in accordance with Section XVIII. In the event of a transition period as described in Section I.D, the final Performance Year will begin on January 1, 2024 and end on December 31, 2024, unless this Agreement is sooner terminated in accordance with Section XVIII.*

ii. The definition of "Savings/Losses Cap" is hereby amended in its entirety to read as follows:

"Savings/Losses Cap" *means 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, as selected by the ACO for Performance Years 2019 and 2020 in accordance with Section X.A.2, as specified in Part 3 of Appendix B for Performance Years 2021 and 2022, and as selected by the ACO for Performance Year 2023 and, in the event of a transition period as described in Section I.D, for Performance Year 2024, in accordance with Section X.A.2, and subject to the application of the Risk Arrangement selected by the ACO in accordance with Section X.A.1.*

c. **ACO Selection of the Savings/Losses Cap (Amendment to Section X):** Section X.A.2 of the Agreement is hereby amended in its entirety to read as follows:

For Performance Years 2019 and 2020, the ACO's selected Savings/Losses Cap, between 5.0% and 15.0%; and for Performance Year 2023 and, in the event of a transition period as described in Section I.D, for Performance Year 2024, the ACO's selected Savings/Losses Cap, between 2.0% and 5.0%.

d. **Termination by CMS (Amendment to Section XVIII):** Section XVIII.B.5 of the Agreement is hereby amended in its entirety to read as follows:

The State Agreement is terminated by any party to the State Agreement or the State fails to renew the State Agreement for Performance Year 2024.

e. **Appendix B.** Appendix B of the Agreement is hereby amended as follows:

i. For Performance Year 2019, Part 1, Section V. of Appendix B is hereby amended by amending Table 1.1 in its entirety to read as follows:

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

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

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

ii. For Performance Years 2021 and 2022, Part 3, Section V of Appendix B is hereby amended by amending Table 1.2 in its entirety to read as follows:

Table 1.2 – Qualified Evaluation & Management Services

Office or Other Outpatient Services	
99201	*New Patient, brief***
99202	*New Patient, limited*
99203	*New Patient, moderate*
99204	*New Patient, comprehensive*
99205	*New Patient, extensive*
99211	*Established Patient, brief*
99212	*Established Patient, limited*
99213	*Established Patient, moderate*
99214	*Established Patient, comprehensive*
99215	*Established Patient, extensive*
99304	*New or Established Patient, brief*
99305	*New or Established Patient, moderate*
99306	*New or Established Patient, comprehensive*
99307	*New or Established Patient, brief*
99308	*New or Established Patient, limited*
99309	*New or Established Patient, comprehensive*
99310	*New or Established Patient, extensive*
99315	*New or Established Patient, brief*
99316	*New or Established Patient, comprehensive*

Office or Other Outpatient Services	
99318	*New or Established Patient*
99421	*Online digital E&M for an est. patient, for up to 7 days, cumul. time 5–10 mins*
99422	*Online digital E&M for an est. patient, for up to 7 days, cumul. time 10–20 mins*
99423	*Online digital E&M for an est. patient, for up to 7 days, cumul. time 21+ mins*
99441	*Phone e/m phys/qhp 5-10 min to est pt*
99442	*Phone e/m phys/qhp 11-20 min to est pt*
99443	*Phone e/m phys/qhp 21-30 min to est pt*
Domiciliary, Rest Home, or Custodial Care Services	
99324	*New Patient, brief*
99325	*New Patient, limited*
99326	*New Patient, moderate*
99327	*New Patient, comprehensive*
99328	*New Patient, extensive*
99334	*Established Patient, brief*
99335	*Established Patient, moderate*
99336	*Established Patient, comprehensive*
99337	*Established Patient, extensive*
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	*Brief*
99340	*Comprehensive*
Home Services	
99341	*New Patient, brief*
99342	*New Patient, limited*
99343	*New Patient, moderate*
99344	*New Patient, comprehensive*
99345	*New Patient, extensive*
99347	*Established Patient, brief*
99348	*Established Patient, moderate*
99349	*Established Patient, comprehensive*
99350	*Established Patient, extensive*
Prolonged Care for Outpatient Visit	
99354	*Prolonged visit, first hour*
99355	*Prolonged visit, add'l 30 mins*
Transitional Care Management Services	
99495	*Communication (14 days of discharge)*
99496	*Communication (7 days of discharge)*
Chronic Care Management Services/ Care Coordination	
99437	*Chronic Care Management*****
99439	*Non-complex CCM***
99490	*Comprehensive care plan establishment/implementations/revision/monitoring*
99487	
99489	
99491	*Chronic Care Management*

Office or Other Outpatient Services	
G2058	*Non-Complex CCM**
G0506	*Comprehensive assessment care plan CCM service*
Advance Care Planning	
99497	*ACP first 30 mins*
99498	*ACP add'l 30 mins*
Wellness Visits	
G0402	*Welcome to Medicare visit*
G0438	*Annual wellness visit*
G0439	*Annual wellness visit*
Virtual check-ins	
G2010	*'Store and forward' - Remote eval of recorded video and/or images submitted by an est. patient*
G2012	*Brief communication technology-based service, 5-10 mins of medical discussion*
Health Risk Assessment (screening and assessment)	
96160	*Administration of HRA*
96161	*Administration of HRA*
Behavioral Health Integration (BHI) Services	
99484	*General, BHI*
99492	*Psychiatric Collaborative Care Model (CoCM), CoCM 1st month*
99493	*CoCM subsequent months*
99494	*Add-on CoCM*
GCOL1	*Psychiatric collaborative care model**
G2214	*Psychiatric collaborative care model***
G0444	*Depression Screening Annual*
Screening and Behavioral Counseling Interventions	
G0442	*Annual alcohol screening 15 mins*
G0443	*Brief alcohol misuse counsel*
Miscellaneous	
G0463	*ETA hospitals*
G2252	*Primary Care Codes and Services****
99424	*Principal Care Management****
99425	*Principal Care Management****
99426	*Principal Care Management****
99427	*Principal Care Management****
99483	*Assessment of and care planning for patients with cognitive impairment*
G2064	*Principal Care Management****
G2065	*Principal Care Management****
G2212	*Office or Other Outpatient Services****

**=code no longer effective beginning January 1, 2021.*

***=code effective beginning January 1, 2021.*

****=code no longer effective beginning January 1, 2022.*

*****=code effective beginning January 1, 2022.*

iii. Appendix B is hereby amended by adding the following new Part 4 at the end of Appendix B to read as follows:

Part 4: Beneficiary Alignment and Benchmarking Methods for Performance Years 2023 and 2024

This Part 4 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 2023 and, in the event of a transition period as described in Section 1.D of this Agreement, Performance Year 2024.

I. Definitions

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

*"**Aligned Beneficiary**" means a Beneficiary aligned to the ACO for a Performance Year pursuant to Section V.A of this Agreement and Section II of this Part 4 of Appendix B.*

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

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

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

*"**Base Year Beneficiary**" means an Alignment-Eligible Beneficiary who is aligned to the ACO for a given Base Year using the methodology set forth in Section II of this Part 4 of Appendix B.*

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

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

2) *ESRD Beneficiaries (Beneficiaries eligible for Medicare on the basis of an ESRD diagnosis) ("**ESRD Beneficiaries**").*[5]

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

*"**Primary Care Specialist**" means a physician or non-physician practitioner (NPP) whose principal specialty is listed in Table 1.3 of this Part 4 of Appendix B.*

*"**Non-Primary Care Specialist**" means a physician or NPP whose principal specialty is listed in Table 1.4 of this Part 4 of Appendix B.*

***"QEM Services"** means Qualified Evaluation & Management (QEM) services identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1.2 of this Part 4 of Appendix B.*

II. Beneficiary Alignment Methodology

A. General

Beneficiaries are aligned to the ACO for each Performance Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Performance Year Alignment Period using the alignment algorithm described in Section II.C of this Part 4 of Appendix B. Beneficiaries are similarly aligned to the ACO for each Base Year on the basis of each Beneficiary's receipt of QEM Services from an Initiative Professional during the Base Year Alignment Period using the alignment algorithm described in Section II.C of this Part 4 of Appendix B.

B. Alignment Years

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

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

In this Appendix B, an Alignment Year is identified by the calendar year in which the Alignment Year ends. Table 1.1 of this Part 4 of Appendix B specifies the period covered by each Base Year and each Performance Year, and their corresponding Alignment Years.

C. Alignment Algorithm

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

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

Alignment is determined for Performance Years 2023 and 2024 using the final Participant List described in Section IV.E.4(g) of the Agreement for the applicable Performance Year. As set forth in Section V.A.2 of the Agreement, CMS may, in its sole discretion, adjust the alignment of Initiative Beneficiaries to the ACO for a Performance Year due to the addition or removal of an Initiative Participant from the Participant List during the Performance Year pursuant to Section IV.D or Section XVIII.A of the Agreement.

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

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 Initiative Professional included on the Participant List for that Performance Year.

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

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

D. Initiative Beneficiary Population

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

For purposes of the financial settlement of Shared Savings and Shared Losses, as described in Section IV.C of this Part 4 of Appendix B, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and

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

III. Calculation of Performance Year Benchmark

A. Overview

The Performance Year Benchmark is set prospectively for each Performance Year prior to the start of the Performance Year. The Performance Year Benchmark is determined by the GMCB, as described in Section III.B of this Part 4 of Appendix B, using included historical expenditures for each of the two Entitlement Categories, subject to certain exclusions, and subject to the application of a trend factor and adjustments for quality performance. CMS will provide the GMCB with the Base Year expenditures for the applicable Base Year for use as a reference point in the GMCB's Performance Year Benchmark methodology. As stated in Section XII.B of the

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

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

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

IV. Financial Settlement

A. Overview

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

B. Initiative Beneficiaries for Financial Settlement

As described in Section IV.E of this Part 4 of Appendix B, for purposes of the financial settlement of Shared Savings and Shared Losses, CMS includes only the following:

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

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

C. Performance Year Expenditures

For purposes of conducting financial settlement pursuant to Section XIII.C of the Agreement, expenditures will be calculated separately for each of the two Entitlement Categories: ESRD Beneficiaries and A/D Beneficiaries. CMS will apply inclusions and exclusions in determining the Performance Year expenditures as described in Section IV.C.1 of this Part 4 of Appendix B for Medicare claims with a date of service during the Performance Year and that are paid within 6 months of the close of the Performance Year. CMS may, at CMS's sole discretion, modify the inclusions and exclusions used in determining the Performance Year expenditures as needed for consistency with the GMCB's Performance Year Benchmark methodology for purposes of conducting financial settlement.

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

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

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

1. Included and Excluded Expenditures for Initiative Beneficiaries.

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

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

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

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

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

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

D. Quality Measures and Quality Score

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

During financial settlement, CMS will apply a downward adjustment to the ACO's Performance Year Benchmark in an amount of up to 0.5% of the Performance Year expenditure calculated in accordance with Section IV of this Part 4 of Appendix B, depending on the ACO's actual quality performance. The amount of any downward adjustment will be based on the ACO's actual quality score for the Performance Year, with a higher quality score resulting in a smaller downward adjustment. If the ACO receives an actual quality score of 100%, the ACO will not receive a downward adjustment to its Performance Year Benchmark during financial settlement.

E. Savings/Losses Amount

The ACO's aggregate gross savings or losses will be determined by subtracting the Performance Year expenditure calculated in accordance with Section IV.C of this Part 4 of Appendix B from

the ACO's Performance Year Benchmark calculated in accordance with Section III of this Part 4 of Appendix B.

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

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

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 2% Savings/Losses Cap and a 100% Risk Arrangement, the ACO would only share in savings up to 2% of its Performance Year Benchmark, even if it achieved savings equal to 5% of that Performance Year Benchmark. In instances in which aggregate gross ACO savings/losses exceed the Savings/Losses Cap selected by the ACO, the Savings/Losses Cap is first applied to determine the maximum allowable savings/losses, and the Risk Arrangement is then applied to that maximum allowable savings/loss amount. For example, if the ACO selects a 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 payment of Shared Savings, including any related adjustments, that results from a settlement report that is initially issued in a period during which budget sequestration is in effect, but does not apply to the repayment of Shared Losses. For example, if the budget sequestration rate is 2%, the amount of Shared Savings owed to the ACO would be 98% of any savings calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above, but the amount of Shared Losses owed by the ACO would be 100% of any losses calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above.

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

and uncontrollable circumstance has occurred and the affected areas. CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred and the percentage of the ACO's Initiative Beneficiaries residing in the affected areas.

*V. **Tables***

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

Period	***Period covered[1]***	***Corresponding Alignment Years (AYs)***
Base Year	*PY2023* *Base Year:* *01/01/2022 – 12/31/2022*	*AY1: 07/01/2019 – 06/30/2020 (AY2020)* *AY2: 07/01/2020 – 06/30/2021 (AY2021)*
	PY 2024 *Base Year:* *01/01/2023 – 12/31/2023*	*AY1: 07/01/2020 – 6/30/2021 (AY2021)* *AY2: 07/01/2021 – 6/30/2022 (AY2022)*
Performance Year (Current CY)	*PY2023* *01/01/2023 – 12/31/2023*	*AY1: 07/01/2020 – 6/30/2021 (AY2021)* *AY2: 07/01/2021 – 6/30/2022 (AY2022)*
	PY 2024 *01/01/2024 —12/31/2024*	*AY1: 07/01/2021 – 6/30/2022 (AY2022)* *AY2: 07/01/2022 – 6/30/2023 (AY2023)*

[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*

Office or Other Outpatient Services	
99213	*Established Patient, moderate*
99214	*Established Patient, comprehensive*
99215	*Established Patient, extensive*
99304	*New or Established Patient, brief*
99305	*New or Established Patient, moderate*
99306	*New or Established Patient, comprehensive*
99307	*New or Established Patient, brief*
99308	*New or Established Patient, limited*
99309	*New or Established Patient, comprehensive*
99310	*New or Established Patient, extensive*
99315	*New or Established Patient, brief*
99316	*New or Established Patient, comprehensive*
99318	*New or Established Patient*
99421	*Online digital E&M for an est. patient, for up to 7 days, cumul. time 5–10 mins*
99422	*Online digital E&M for an est. patient, for up to 7 days, cumul. time 10–20 mins*
99423	*Online digital E&M for an est. patient, for up to 7 days, cumul. time 21+ mins*
99441	*Phone e/m phys/qhp 5-10 min to est pt*
99442	*Phone e/m phys/qhp 11-20 min to est pt*
99443	*Phone e/m phys/qhp 21-30 min to est pt*
Domiciliary, Rest Home, or Custodial Care Services	
99324	*New Patient, brief*
99325	*New Patient, limited*
99326	*New Patient, moderate*
99327	*New Patient, comprehensive*
99328	*New Patient, extensive*
99334	*Established Patient, brief*
99335	*Established Patient, moderate*
99336	*Established Patient, comprehensive*
99337	*Established Patient, extensive*
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
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*

Office or Other Outpatient Services	
Prolonged Care for Outpatient Visit	
99354	*Prolonged visit, first hour*
99355	*Prolonged visit, add'l 30 mins*
Transitional Care Management Services	
99495	*Communication (14 days of discharge)*
99496	*Communication (7 days of discharge)*
Chronic Care Management Services/ Care Coordination	
99437	*Chronic Care Management*****
99439	*Non-complex CCM***
99490	*Comprehensive care plan establishment/implementations/revision/monitoring*
99487	
99489	
99491	*Chronic Care Management*
G2058	*Non-Complex CCM**
G0506	*Comprehensive assessment care plan CCM service*
Advance Care Planning	
99497	*ACP first 30 mins*
99498	*ACP add'l 30 mins*
Wellness Visits	
G0402	*Welcome to Medicare visit*
G0438	*Annual wellness visit*
G0439	*Annual wellness visit*
Virtual check-ins	
G2010	*'Store and forward' - Remote eval of recorded video and/or images submitted by an est. patient*
G2012	*Brief communication technology-based service, 5-10 mins of medical discussion*
Health Risk Assessment (screening and assessment)	
96160	*Administration of HRA*
96161	*Administration of HRA*
Behavioral Health Integration (BHI) Services	
99484	*General, BHI*
99492	*Psychiatric Collaborative Care Model (CoCM), CoCM 1st month*
99493	*CoCM subsequent months*
99494	*Add-on CoCM*
GCOL1	*Psychiatric collaborative care model**
G2214	*Psychiatric collaborative care model***
G0444	*Depression Screening Annual*
Screening and Behavioral Counseling Interventions	
G0442	*Annual alcohol screening 15 mins*
G0443	*Brief alcohol misuse counsel*
Miscellaneous	
G0463	*ETA hospitals*
G2252	*Primary Care Codes and Services*****

Office or Other Outpatient Services	
99424	*Principal Care Management*****
99425	*Principal Care Management*****
99426	*Principal Care Management*****
99427	*Principal Care Management*****
99483	*Assessment of and care planning for patients with cognitive impairment*
G2064	*Principal Care Management****
G2065	*Principal Care Management****
G2212	*Office or Other Outpatient Services*****

**=code not longer effective beginning January 1, 2021.*

***=code effective beginning January 1, 2021.*

****=code not longer effective beginning January 1, 2022.*

*****=code effective beginning January 1, 2022.*

Table 1.3 - Specialty codes used to identify Primary Care Specialists

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

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

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

Code[1]	***Specialty***
06	*Cardiology*
12	*Osteopathic manipulative medicine*
13	*Neurology*
16	*Obstetrics/gynecology*
23	*Sports medicine*
25	*Physical medicine and rehabilitation*
26	*Psychiatry*
27	*Geriatric psychiatry*
29	*Pulmonology*

39	*Nephrology*
46	*Endocrinology*
70	*Multispecialty clinic or group practice*
79	*Addiction medicine*
82	*Hematology*
83	*Hematology/oncology*
84	*Preventative medicine*
90	*Medical oncology*
98	*Gynecological/oncology*
86	*Neuropsychiatry*

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

f. **Appendix J**. The last paragraph of Section VI.B.1 of Appendix J of the Agreement is hereby amended in its entirety to read as follows:

The calibration period for Performance Year 4 (CY 2021) and subsequent Performance Years may be extended or shortened at the sole discretion of CMS to account for anomalies and shifts in service utilization due to the Public Health Emergency (PHE) for the COVID-19 pandemic as defined in 42 C.F.R. § 400.200.

g. **Appendix K.** Appendix K is hereby amended by striking "The following quality measures are the measures for use in establishing quality performance standards for the fourth Performance Year of the Initiative (CY2022)", striking the table of quality measures that follows, and adding at the end the following:

The following quality measures are the measures for use in establishing quality performance standards for the fifth and sixth Performance Years of the Initiative (CYs 2022 and 2023) and, in the event of a transition period as described in Section 1.D of this Agreement, for the seventh Performance Year of the Initiative (CY 2024).

	Quality ID	***Measure Title****	***Method of Data Submission***	***Pay for Performance Status*** ***R—Reporting; P—Performance***
	321	*CAHPS: Getting Timely Care, Appointments, and Information*	*Survey*	*P*
	321	*CAHPS: How Well Your Providers Communicate*	*Survey*	*P*

	Quality ID	Measure Title*	Method of Data Submission	Pay for Performance Status R—Reporting; P—Performance
Access to Care	321	CAHPS: Patients' Rating of Provider	Survey	P
	321	CAHPS: Access to Specialists	Survey	P
	321	CAHPS: Health Promotion and Education	Survey	P
	321	CAHPS: Shared Decision Making	Survey	P
	321	CAHPS: Health Status/Functional Status	Survey	P
	321	CAHPS: Stewardship of Patient Resources	Survey	P
	321	CAHPS: Courteous and Helpful Office Staff	Survey	P
	321	CAHPS: Care Coordination	Survey	P
Reduce Deaths Due to Drug Overdose and Suicide	134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	EFT via ACO-OS	P
	NQF #2605 VT – 1	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (30-day)	Claims	R
	305 VT – 2	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims	R
Reduce Prevalence of Chronic Disease for COPD, Hypertension, Diabetes	001	Diabetes Hemoglobin (HbA1c) Poor Control (>9%)	EFT via ACO-OS	P
	236	Hypertension: Controlling High Blood Pressure	EFT via ACO-OS	P
	484	Clinician and Clinician Group Risk-Standardized, Acute Admission Rate for Patients with Multiple Chronic Conditions	Claims	R
	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	EFT via ACO-OS	P

	Quality ID	***Measure Title****	***Method of Data Submission***	***Pay for Performance Status*** ***R—Reporting; P—Performance***
Care Coordination/Patient Safety	*479*	*Hospital-wide, 30-day, All Cause Unplanned Readmission (HWR)*	*Claims*	*R*
Preventive Health	*110*	*Preventive Care and Screening: Influenza Immunization*	*EFT via ACO-OS*	*P*
	113	*Colorectal Cancer Screening*	*EFT via ACO-OS*	*P*

** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications#quality-resources-and-information*

3. **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.

[SIGNATURE PAGE FOLLOWS]

The signatory for the ACO certifies that he or she is authorized by the ACO to execute this amendment to legally bind the ACO. This amendment may be signed by autopen or electronic signature (e.g., DocuSign or similar electronic signature technology) and may be transmitted by electronic means. Copies of this amendment that are so executed and delivered have the same force and effect as if executed with handwritten signatures and physically delivered. 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: 12/29/2022

By: Vicki Loner

Vicki Loner
Name of authorized signatory

Chief Executive Officer, OneCare Vermont LLC
Title

CMS:

Date: 12/21/2022

By: Elizabeth Fowler

Elizabeth Fowler
Name of authorized signatory

Director, CMS Innovation Center
Title