ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
MVP HEALTHCARE, INC. QHP POPULATION BASED
ACO PROGRAM ADDENDUM

THIS MVP HEALTHCARE, INC. ("MVP") QHP POPULATION BASED ACO PROGRAM ADDENDUM ("ACO Program Addendum") is attached to and made part of the First Amended and Restated OneCare Vermont Accountable Care Organization, LLC ("ACO") Risk Bearing Participant and Preferred Provider Agreement ("Participant Agreement") in place between ACO and Participant or Preferred Provider (collectively, the "Parties"). To the extent any terms of this ACO Program Addendum conflict with terms of the Participant Agreement that are not explicitly amended herein, the applicable terms of this ACO Program Addendum shall control. Where amendments are explicitly made, the terms of the ACO Program Addendum shall control.

BACKGROUND

ACO will enter into an agreement with MVP through which the ACO will participate in an alternative payment and population health management program with MVP (the "Program"), as described in the MVP QHP Population Program Agreement ("Program Agreement") to be available on the ACO Provider Portal and incorporated by reference into this ACO Program Addendum. ACO, Participant and Preferred Provider agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Program Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 MVP QHP POPULATION ACO PROGRAM PARTICIPATION

1.1 Participation. Participant and Preferred Provider must be enrolled and participating with MVP. Participant and Preferred Provider agree to participate in the Program, to engage in ACO Activities, to comply with the applicable terms of the Program as set forth in the Program Agreement between ACO and MVP and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the provisions of the Program Agreement, Participant Agreement, the ACO Compliance Plan, ACO reporting requirements, the ACO Clinical Model, ACO policies and procedures, and this Addendum related to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Preferred Providers; (4) voluntary attribution; (5) Beneficiary/Member freedom of choice; (6) participation in evaluation, shared learning, monitoring and oversight activities; (7) the ACO Compliance Plan; (8) continuity of benefits; (9) ACO Policies; (10) audit and record retention requirements; and (11) cooperation with ACO staff providing actionable data

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analysis for MVP QHP Program members. Participant and Preferred Provider further agree that as part of their participation in the MVP QHP Program and their MVP provider agreements, they will be prohibited from terminating an ACO Program Beneficiary for any cause related to their health status or their need for medical services that result in health risk utilization of the Participant or Preferred Provider.

1.2 Updating Information. Participant and Preferred Provider are each required to update its MVP enrollment information (including the addition and deletion of ACO Participants or Preferred Providers, identified at the NPI level, that have reassigned to the Participant or Preferred Provider their right to an MVP payment) on a timely basis in accordance with applicable MVP requirements.

1.3 Authority to Bind. Participant warrants that it has the authority to bind providers under the Participant Agreement and has the authority to, and will, bind itself and its employees, including each Participant and provider with an NPI number and each employee billing under the Participant's TIN to be included on the MVP QHP Population Participant List to the terms of the Program Agreement and this Program Addendum.

Preferred Provider warrants that it has the authority to bind providers under the Participant Agreement and has the authority to, and will, bind itself and its employees, including each Provider with an NPI number and each employee whose services are billed under Preferred Provider's TIN and included on the MVP QHP Population Participant List to the terms of the Program Agreement and this Program Addendum.

1.4 Providers in Good Standing with Plan. Participant agrees to require each provider whose NPI is associated with the Participant to maintain a current provider agreement with MVP in good standing and to be duly licensed and remain in good standing with the appropriate state licensing board. Preferred Provider agrees to require each person performing services that are individually or collectively billed under Preferred Provider's TIN to be duly licensed and in good standing with the appropriate state licensing board and MVP and, as applicable, maintain a current MVP provider agreement. Participant and Preferred Provider shall maintain a current MVP provider agreement.

1.5 Contracting Exclusivity. Subject to the Program exclusivity requirements, ACO will not prohibit a Participant, Preferred Provider or provider from contracting with other state or commercial contractors.

1.6 Required Notices. Participant and Preferred Provider will provide ACO with the

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following notices:

1.6.1 All relevant information about any changes to MVP enrollment information, within thirty (30) days after the change.

1.6.2 All relevant information about any investigation sanctioned by the Government, MVP or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of billing privileges) that may materially affect its ability to perform hereunder immediately upon becoming aware of the triggering event.

1.7 Exclusivity. The exclusivity of the ACO Participants and ACO Preferred Providers is based on MVP QHP Population Program exclusivity requirements. ACO Participants or ACO Preferred Provider Participants that are themselves, or who include within their TIN, Providers who are "Primary Care Providers", as defined by the MVP QHP Population Program Agreement, may not participate in any other MVP QHP Population participating ACO while a party to this Program Addendum. By way of examples, an individual Primary Care Provider who bills primary care services under an individual TIN must be exclusive to a single ACO. An individual Primary Care Provider who assigns billing or collection to a group practice with a separate TIN must be exclusive to the same ACO and the ACO Participant that contains the Primary Care Provider must also be exclusive to the same ACO. If an ACO Participant and the associated Providers who assign billings to the ACO Participant do not contain Primary Care Providers, the ACO Participant and the non-Primary Care Providers are not required to be exclusive.

1.8 Accounting for Primary Care Support Funds. The Green Mountain Care Board (GMCB) has directed OneCare to require each hospital Participant TIN that receives primary care funds from OneCare to provide a written plan ("Plan") to demonstrate how it plans to use those primary care funds for the required purposes of enhancing primary care initiatives that would not otherwise have been funded to the same extent. Accordingly, by executing this agreement, hospital Participant agrees to provide OneCare with its Plan in alignment with broader goals and expectations of this Agreement. For purposes of developing the Plan, OneCare will provide hospital Participant with an estimate of primary care-related funding for 2025 no later than September 1, 2024, and hospital Participant will provide OneCare its Plan no later than October 1, 2024. The Plan will be provided to the GMCB upon its request.

2.0 PAYMENT

2.1 Form of Payment. Participant Agreement, Participant and Preferred Provider will be paid according to the MVP normal payment methodology unless otherwise provided in the Program of Payment. Annually, at least 60 days before the Performance Year

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termination or non-renewal deadline, as set forth in the Participant Agreement, ACO will develop and provide Participants and Preferred Providers with a Program of Payment. Participation in ACO may result in a change to the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, MVP, a combination of the two, or ACO's delegate. All payment methodologies and formulas will be made pursuant to a Program of Payment approved by the Board of Managers after receiving the necessary Program financial information from MVP. The Board of Managers reserves the right to amend or alter the Program of Payment at any time as a result of material changes in ACO's circumstances, such as MVP changing its financial commitments to ACO mid-Performance Year or a regulatory directive to make changes.

a. Additionally, on the schedule set forth in Section 2.1 above, ACO will provide each non-fee-for-service Participant, in writing, a description of the preliminary Program of Payment applied to the individual Participant and an estimated Maximum Risk and Sharing Limit specific for the individual Participant, based on the information available from Payer and other available data sources at that time. These estimates will contain sufficient data for an informed decision on participation and to be used for budgeting and planning by Participants. As soon as practical after the first day of a Performance Year when final attribution information has been provided to ACO by Payer, the Board of Managers will approve a final budget and Program of Payment for Participants. Each Participant will then execute an Exhibit 1 to this Program Addendum encompassing its individual final payment model and Final Maximum Risk and Sharing Limit. A Participant's Final Maximum Risk and Sharing Limit may not be amended without the Participant's consent.

2.2 Payment in Full. Participant and Preferred Provider will collect applicable copayments, coinsurance and/or deductibles from MVP Beneficiaries/Members in accordance with the terms of the MVP plan which are not affected by this MVP QHP Program and agree to accept any applicable copayment, coinsurance and/or deductible together with the payments provided for under this ACO Program Addendum as full reimbursement for services rendered.

2.3 Claims Submission. Participant and Preferred Provider will submit claims to MVP in accordance with timely filing rules and in accordance with the MVP's applicable policies, but will receive reimbursement for services within the Program as outlined in this Section 2.0 and the Program of Payment for the applicable Performance Year.

2.4 Services Outside the Program. The services included in the Program will be based on the allowed claims incurred by MVP for each Exchange-offered Vermont product and the negotiated fee schedules with MVP for those claims in a manner consistent with ACO strategy and approved by the Board of Managers. Exclusions include retail

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pharmacy claims and claims allowable under separate benefit riders.

2.5 Beneficiary Appeals and/or Grievances. MVP Beneficiaries/Members retain their rights to appeal claims determinations in accordance with the terms of their benefit policies and Participants and Preferred Providers remain bound by the terms of their MVP provider agreements and applicable law as to Plan Beneficiary/Member grievances and appeals.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on January 1, 2025, and shall run through the last date of the Performance Year for the Program, or December 31, 2025. Thereafter, this Agreement may be extended or a new agreement created as agreed by the Parties.

3.2 Remedial Action. If ACO determines that Participant or Preferred Provider is failing to meet any requirements set forth under the terms of this Agreement,

a. ACO may take remedial action against Participant or Preferred Provider including, but not limited to: imposition of a corrective action plan (“CAP”), reduction of payments or denial of Shared Savings (as applicable), denied access to ACO data systems, and termination of the Participant Agreement or this Program Addendum with the Participant or Preferred Provider to address material noncompliance with the terms of the Program or program integrity issues identified by ACO, the Green Mountain Care Board, or MVP.

b. To the extent a Party is aggrieved by a remedial action relating to ACO’s performance of its obligations under this ACO Program Addendum, the action may be appealed through the ACO Appeals Policy, if applicable. Otherwise all disputes will be resolved in accordance with the Dispute Resolution Process set forth in the applicable Program Agreement. Participant or Preferred Provider may not appeal or dispute any matter that ACO may not appeal or dispute under the MVP QHP Population Program Agreement.

3.3 Termination. This MVP QHP Population Program Addendum will automatically terminate if the Program Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate with MVP, for any reason. This MVP QHP Population Program Addendum will terminate prior to the end of Term, if MVP requires the ACO to remove the Participant or Preferred Provider from the approved list of providers, pursuant to the terms of the Program Agreement.

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a. Participant or Preferred Provider may terminate this Program Addendum, consistent with the Participant Agreement's provisions relating to Core ACO Programs, for any Performance Year, if after receiving the initial Program of Payment and preliminary Maximum Risk and Sharing Limit, it does not wish to remain in this ACO Program. To terminate under this provision, Participant must provide written notice to ACO on or before July 23rd of the year before the Performance Year commences (should MVP provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by ACO Program). By way of example, if a Participant wishes to terminate effective for Performance Year 2025, and ACO does not extend the deadline, notice must be given by July 23, 2024. Should Participant or Preferred Provider terminate or non-renew for any Performance Year, it will have no financial obligations to ACO for the Performance Year as to which it terminated or non-renewed but must comply with Section 3.4.

b. ACO may terminate this ACO Program Addendum if, after evaluating the network of participants and the final financial terms for the ACO Program from MVP, it determines not to participate in the ACO Program and provides that notice to MVP in accordance with their deadline for ACOs to decline participation.

3.4 Close-Out, Performance Year Obligations. In the event this Program Addendum is terminated or expires, Participant, Preferred Provider and ACO agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries/Members, to ACO and to MVP. Moreover, Participant, Preferred Provider and ACO will be required to meet all financial obligations for the Performance Year when notice is given, including Shared Losses and Savings.

3.5 Notices from ACO. ACO will provide Participant/Preferred Provider with relevant information about any investigation sanctioned by the Government or any licensing authority that may materially affect its ability to perform hereunder within seven (7) days of becoming aware of the triggering event.

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IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of January 1, 2025.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _________________________ Date: ______________________
Abe Berman
Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _________________________ Date: ______________________
Authorized Signature

Print Name: ________________________
Title: ____________________________
Legal Business Name:
TIN:

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