ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL
ACO PROGRAM ADDENDUM

THIS DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM ("ACO Program Addendum") is attached to and made part of the First Amended and Restated 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, the applicable terms of this ACO Program Addendum or the ACO Program rules applicable to the Participant or Preferred Provider shall control. To the extent any of the terms of this ACO Program Addendum conflict with the Department of Vermont Health Access ("DVHA") General Provider Agreement (between the Participant or Preferred Provider and DVHA), the DVHA General Provider Agreement shall control.

BACKGROUND

ACO has entered into an agreement with DVHA through which the ACO will participate in the Vermont Medicaid Next Generation Model (the "Program"), an alternative payment and population health management program with Medicaid, as described in Vermont Medicaid Next Generation Program Agreement that will be available on the ACO Provider Portal and is 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 Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 MEDICAID NEXT GENERATION ACO PROGRAM PARTICIPATION

1.1 Participation. 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 Vermont Medicaid Next Generation Participation Agreement between ACO and DVHA and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the authorities listed below including the provisions of the Vermont Medicaid Next Generation Program Agreement relating 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 freedom of choice; (6) benefit enhancements; (7) participation in evaluation, shared learning, monitoring and oversight activities; (8) the ACO Compliance Plan; (9) continuity of benefits; (10) ACO Policies and (11) audit and record retention requirements. Participant and Preferred Provider further agree that as part of their participation in the Program and their Vermont Medicaid provider agreements that they will not terminate a patient for any cause related to his/her health status or his/her need for medical services that result in utilization risk for the Participant or Preferred Provider.

1.2 Updating Information. Participant and Preferred Provider are each required to update

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its Medicaid enrollment information (including the addition and deletion of Providers, identified at the NPI level, that have reassigned to the Participant or Preferred Provider their right to Medicaid payment) on a timely basis in accordance with Medicaid program requirements.

1.3 Authority to Bind. Participant warrants that it has the authority to and does bind itself and its employees, including each Provider with an NPI number billing under its TIN who is included on the Vermont Medicaid Next Generation Program Participant List to the Participant Agreement and this Program Addendum. Preferred Provider warrants that it has the authority to and does bind itself and its employees, including each Provider with an NPI number whose services are billed under the Preferred Provider's TIN, to the terms of the Participant Agreement and this Program Addendum.

1.4 Providers in Good Standing with Vermont and Medicaid. Participant and Preferred Provider will each, for itself and for each Provider associated with and billing individually or collectively under its TIN, maintain a current DVHA General Provider Agreement in good standing and be duly licensed and remain in good standing with the appropriate state licensing board.

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 contractors.

1.6 Patient Record Requests. Participants and Preferred Providers will provide a Beneficiary with a copy of his/her medical records at no charge upon request by the Beneficiary, and facilitate the transfer of Beneficiary's medical record to another provider at Beneficiary's request.

1.7 Required Notices. Participants and Preferred Providers will provide ACO with the following notices:

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

1.7.2 All pertinent information about any investigation or sanction 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 Medicaid billing privileges) that could materially impact the ability to perform under this Program Addendum immediately upon becoming aware of the triggering event.

1.8 Exclusivity. Participants whose TIN includes NPIs of a "Primary Care Practitioner" who bills "Qualified Evaluation and Management Services" (as both terms are defined by the Vermont Medicaid Next Generation Participation Agreement) may not participate in more than one Medicaid Next Generation Model Program, or any other Medicaid ACO-based payment reform program or with any other accountable care organization in which they attribute or align lives. Nothing in this paragraph shall be interpreted to preclude a Participant, whose TIN does not include NPIs of Primary Care Practitioners, from membership in more than one accountable care organization participating in the

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Program. These exclusivity provisions are based on the Program rules and are subject to change if the Program rules change.

1.9 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 and Preferred Provider will be paid according to Medicaid’s normal payment methodology unless otherwise provided in the Program of Payment. Annually, at least 60 days before the Performance Year 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, Medicaid, 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 DVHA. 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 DVHA changing its financial commitments to ACO mid-Performance Year or a regulatory directive to make changes.

2.1.1 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 Beneficiaries in accordance with their Medicaid benefits which are not affected by this ACO Program and agree to accept any

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applicable copayment, coinsurance and/or deductible together with the payments provided for under this Agreement as full reimbursement for services rendered.

2.3 Claims Submission. Participants and Preferred Providers will submit claims to DVHA in accordance with timely filing rules and in accordance with DVHA'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 following services are excluded by DVHA from Program payments, and will be excluded from the payments by ACO and will be reimbursed by DVHA directly to Participants:

2.4.1 Services Not Covered in the Program. The following services are paid for by DVHA but are not included in the Program:

2.4.1.1 Pharmacy;
2.4.1.2 Nursing Facility Care;
2.4.1.3 Psychiatric Treatment in State Psychiatric Hospital;
2.4.1.4 Level 1 (involuntary placement) Inpatient Psychiatric Stays (in any hospital when paid for by DVHA);
2.4.1.5 Dental Services;
2.4.1.6 Non-emergency Transportation (ambulance transportation not included);
2.4.1.7 Smoking Cessation Services.

2.4.2 Other Services Not Covered. Other services offered to Beneficiaries but paid for by Vermont government departments other than DVHA are not covered in the program. This includes, but is not limited to, the following services:

2.4.2.1 Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by agencies other than DVHA;
2.4.2.2 Other services administered and paid for by the Vermont Department of Mental Health;
2.4.2.3 Services administered and paid for by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network;
2.4.2.4 Services administered by the Vermont Department of Disabilities, Aging and Independent Living;
2.4.2.5 Services administered and paid for by the Vermont Agency of Education;
2.4.2.6 Services administered and paid for by the Vermont Department of Health, including smoking cessation services.

2.5 Beneficiary Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with the terms of the DVHA Member Handbook and Participant and Preferred Provider remain bound by the terms of the DVHA General Provider Agreement as to Beneficiary grievances and appeals. Participant and Preferred Provider will direct all appeals and/or grievances or payment disputes related to this Program to ACO and ACO will manage them in accordance with an ACO Appeals Policy that complies with Program requirements. The appeals policy includes

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a written initial appeal and a second level of appeal with the opportunity to be heard in person. Participant and Preferred Provider will continue to cooperate with DVHA in the resolution of Beneficiary grievances and disputes.

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 last Performance Year for the Program, or December 31, 2025. Thereafter, this Agreement may be extended as agreed by the Parties.

3.2 Remedial Action.

a. ACO may take remedial action against the Participant or Preferred Provider including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, elimination of payments, offset of payments, denied access to ACO data systems, and termination of the ACO's 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 DVHA.

b. Participant or Preferred Provider with a dispute relating to ACO's performance of its obligations under this Program Addendum may appeal through the ACO Appeals Policy, if applicable, or initiate a dispute under the dispute resolution clause of the applicable Program Agreement. Participant or Preferred Provider may not appeal or dispute any matter that ACO may not appeal or dispute under the Vermont Medicaid Next Generation Program Agreement.

3.3 Termination. This Program Addendum will automatically terminate if the Participant Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in Vermont Medicaid, for any reason. This Program Addendum will terminate prior to the end of the Term if DVHA requires the ACO to remove the Participant or Preferred Provider from the approved list of providers.

a. Participant or Preferred Provider may terminate this Program Addendum, consistent with the Participant Agreement's provisions and ACO Policies 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 or Preferred Provider must provide written notice to ACO on or before July 23rd of the year before the Performance Year commences (should DVHA provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by the Program). By way of example, if a Participant or Preferred Provider wishes to terminate effective 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 obligation to ACO for the Performance Year as to which it terminated or non-renewed but must comply with Section 3.4.

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

3.4 Close-Out, Performance Year Obligations. In the event this Program Addendum is terminated or expires, Participant and Preferred Provider agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries, to ACO and to DVHA's fiscal agent. Moreover, Participant, Preferred Provider and ACO will be required to meet all financial obligations for any Performance Year in which it participated in ACO for any period of time, even if not the full Performance Year, including Shared Losses and Savings.

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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