DRAFT REDLINE (ABRIDGED) TO VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT SHOWING PROPOSED REVISIONS FOR ONE-YEAR EXTENSION

VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT

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The Vermont Agency of Human Services is the Vermont Medicaid Single State Agency. It was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. The Agency is led by the AHS Secretary, who is appointed by the Governor. The AHS Secretary's Office is responsible for leading the agency and its departments which include the Department of Vermont Health Access (DVHA), the Department of Mental Health, the Department of Health, the Department of Children and Families, the Department of Disabilities, Aging and Independent Living, and the Department of Corrections. AHS manages Vermont's Medicaid program through the terms and conditions of Vermont's Demonstration Waiver under Section 1115 of the Act.

Through the Vermont All-Payer ACO Model, CMS's purpose is to test whether the health of, and care delivery for, Vermont residents improve and healthcare expenditures for beneficiaries across payers (including Medicare FFS, Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans) decrease if: a) these payers offer Vermont ACOs (ACOs operating primarily in Vermont, as defined below) aligned risk-based arrangements tied to health outcomes and healthcare expenditures; b) the majority of Vermont providers and suppliers participate under such risk-based arrangements; and c) the majority of Vermont residents across payers are aligned to an ACO bound by such arrangements. As part of the Model, the Vermont ACO will participate in a modified version of the Next Generation ACO Model for Performance Year 1 of the Model and then in the Vermont Medicare ACO Initiative for Performance Years 2 through ~~5~~ 6. The Vermont Medicare ACO Initiative shall be separately executed under a Vermont Medicare ACO Initiative Participation Agreement between CMS and the ACO(s) to be effective starting in Performance Year 2.

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1. **Definitions.**

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

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Performance Year 4 and Performance Year ~~5~~ 6.

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t. **"Performance Period"** means the six ~~(6)~~ (7) Performance Years this Agreement will be in effect. The Performance Period of this Model will begin on January 1, 2017 and end at 11:59PM (EST) on December 31, ~~2022~~ 2023, unless this Agreement is terminated sooner in accordance with section 21, in which case the Performance Period will conclude on the effective date of termination.

u. **"Performance Year ("PY")"** means the 12-month period beginning on January 1 of each year during the Performance Period of this Agreement. The first Performance Year is Performance Year 0 (2017), and the last Performance Year is Performance Year ~~5 (2022)~~ 6 (2023).

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dd. **"Vermont Medicare ACO Initiative" or "Initiative"** is the ACO initiative that will start in Performance Years 2 through ~~5~~ 6 of this Model and will be executed under a Vermont Medicare ACO Initiative Participation Agreement, as described in section 8.

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jj. **"VMA ACO"** means an ACO participating in the Vermont Medicare ACO Initiative for Performance Years 2 through ~~5~~ 6.

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2. **Agreement Term.**

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b. Term of Agreement. The term of this Agreement begins on the Effective Date and concludes at the end of Performance Year ~~5~~ 6, or in the case of early termination of this Agreement by either party in accordance with section 21, on the effective date of such termination.

c. The Performance Period of this Model will begin on January 1, 2017, and will end at 11:59PM (EST) on December 31, ~~2022~~ 2023, unless this Agreement is sooner terminated in accordance with section 21 and in which case the Performance Period concludes on the effective date of termination.

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6. **ACO Scale Targets.**

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

Percent (%)	By end of PY1 (2018)	By end of PY2 (2019)	By end of PY3 (2020)	By end of PY4 (2021)	By end of PY5 (2022)	By end of PY6 (2023)
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%	70%
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%	90%

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f. Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii) with the Vermont Modified Next Generation ACO in Performance Year 1 and with the Vermont Medicare ACO Initiative in Performance Years 2 through ~~5~~ 6. CMS and Vermont will work together to design and offer an unreconciled fixed payment mechanism for Performance Year 6 and to explore other modifications to the Vermont Medicare ACO Initiative in order to facilitate design alignment. In accordance with section 8, Vermont may propose such modifications to the Initiative, and CMS may accept such proposals for modifications at its sole discretion.

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

i. In accordance with section 6.f, the GMCB, in collaboration with AHS, shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through ~~5~~ 6, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included for determination of the ACO's Shared Losses and Shared Savings as described in section 6.b.iii, risk arrangement, payment mechanism, quality measures, and beneficiary alignment (***"Annual ACO Scale Targets and Alignment Report"***). This assessment must also describe how the Scale Target ACO Initiatives' designs are aligned across all payers, how they are different, the justification for differences that will remain, and a plan to bridge differences that should not remain. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessment, it may qualify as a Triggering Event as described in section 21.

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ii. The GMCB shall submit to CMS for its approval, no later than June 30th of the year following the conclusion of each of the Performance Years 1 through ~~5~~ 6, the State's performance on the ACO Scale Targets described in sections 6.a, 6.b, and 6.c.

~~k. **Consequences for Not Achieving ACO Scale Targets.** If the State fails to achieve the ACO Scale Targets described in sections 6.a, 6.b, and 6.c for two consecutive Performance Years excluding Performance Year 0, it will qualify as a Triggering Event as described in section 21. Any corrective action plan (CAP) submitted by the GMCB in response to this Triggering Event, as set forth in section 21, shall include the methodology the State will use to improve its performance against the ACO Scale Targets.~~

7. **Statewide Health Outcomes and Quality of Care Targets.**

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

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

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e. **Annual Health Outcomes and Quality of Care Report.** The GMCB, in collaboration with AHS, shall submit to CMS for its approval, on or before ~~September 30th~~ December 31st following each Performance Year 1 through ~~5~~ 6, an annual report on the State's efforts to achieve the Statewide Health Outcomes and Quality of Care Targets (***"Annual Health Outcomes and Quality of Care Report"***). At a minimum, the State shall describe the following in this annual report:

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8. **Vermont Medicare ACO Initiative ("Initiative").** CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019, and its performance period will align with Performance Years 2 through ~~5~~ 6 of this Agreement. CMS shall require Vermont ACOs participating in the Initiative (VMA ACOs) to accept beneficiary alignment methodology, ACO quality measures, payment mechanisms, and risk arrangements for the overall quality and cost of

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medical care furnished to Medicare FFS beneficiaries aligned to the ACO. The GMCB may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Vermont Commercial Plans, and participating Vermont Self-insured Plans. CMS may accept such proposals at its sole discretion.

a. **CMS Duties.**

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iii. For Performance Years 2 through ~~5~~ 6 of the Model, CMS shall execute with VMA ACOs separate Vermont Medicare ACO Initiative participation agreements that are based on the amended participation agreements executed by the Vermont Modified Next Generation ACOs for Performance Year 1. The Vermont Medicare ACO Initiative participation agreements may include additional modifications developed in collaboration with the State to support greater alignment across Scale Target ACO Programs, per section 6.f. GMCB, after consultation with AHS, may propose such modifications to the Initiative, and CMS may accept such proposals for modifications at its sole discretion.

iv. CMS will include as part of the Vermont Medicare ACO Initiative benefit enhancements ~~that are also included in~~ of the Next Generation ACO Model~~: Telehealth, Post-discharge home visits, and 3-day SNF Rule payment waivers~~.

v. Unless modified per sections 6.f. and 8.a.iii., CMS will include as part of the Vermont Medicare ACO Initiative the following payment mechanisms of ~~that are also included in~~ the Next Generation ACO Model: population-based payments and all-inclusive population-based payments.

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viii. By the start of Performance Year 6, CMS will issue written guidance on cost reporting for Critical Access Hospitals receiving prospective Medicare payments. The guidance will allow Critical Access Hospitals participating in the Vermont Medicare ACO Initiative to maintain current cost settlement methodologies.

b. **GMCB Duties.**

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ii. Except as described in sections 7.c and 9.d, the GMCB shall prospectively develop the Vermont Medicare ACO Initiative Benchmarks for both Vermont Modified Next Generation ACOs and VMA ACOs for Performance Years 1 through ~~5~~ 6 in accordance with the terms of this Agreement and subject to CMS approval.

1. The methodology for developing the Vermont Medicare ACO Initiative Benchmarks must be consistent with each of the following principles and criteria:

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c. For Performance Years 2 through ~~5~~ 6, the Vermont Medicare ACO Initiative Benchmarks must be established as follows:

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

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

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

      i. **Calculation Methodology.** All-payer Total Cost of Care per Beneficiary Growth will be calculated by Vermont and CMS in aggregate as a compounded annualized growth rate of All-payer Total Cost of Care per Beneficiary across Performance Years 1 through ~~5~~ 6 of this Model, using 2017 as a baseline and adjusted in section 9.c. All-payer Total Cost of Care per Beneficiary for any given Performance Year will incorporate the count of all Vermont All-payer Beneficiaries (referenced as "Vermont all-payer beneficiaries" in the formula, below) and the expenditures associated with All-payer Financial Target Services for all Vermont All-payer Beneficiaries (referenced as "Vermont all-payer TCOC" in the formula, below). Vermont's performance on the All-payer Total Cost of Care per Beneficiary Growth Target will be calculated by the following formula:

$$\left(\frac{\left(\frac{Vermont\ all-payer\ TCOC_{202\underline{3}\cancel{2}}}{Vermont\ all-payer\ beneficiaries_{202\underline{3}\cancel{2}}}\right)}{\left(\frac{Vermont\ all-payer\ TCOC_{2017}}{Vermont\ all-payer\ beneficiaries_{2017}}\right)}\right)^{\frac{1}{\underline{6}\cancel{5}}} - 1 \leq 0.035$$

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

      i. **Calculation Methodology**.

         1. **Calculating Vermont Medicare Total Cost of Care per Beneficiary Growth.**

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For Performance Years 4 ~~and 5~~ through 6, the Vermont Medicare Total Cost of Care per Beneficiary will include all Vermont Medicare Beneficiaries. Vermont Medicare Total Cost of Care per Beneficiary Growth for Performance Years 4 ~~and 5~~ through 6 will be calculated by comparing Vermont Medicare Total Cost of Care per Beneficiary for all Vermont Medicare Beneficiaries who are residing in Vermont in the Performance Year to Vermont Medicare Total Cost of Care per Beneficiary for all Vermont Medicare beneficiaries who were residing in Vermont in the year prior to the Performance Year according to CMS data, regardless of alignment to Scale Target ACO Initiatives.

If Vermont achieves at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries in Performance Year 3, then the Vermont Medicare Total Cost of Care per Beneficiary for Performance Year 3 will include all Vermont Medicare Beneficiaries, and Vermont Medicare Total Cost of Care per Beneficiary Growth for that Performance Year will be calculated in a similar manner as for Performance Years 4 ~~and 5~~ through 6. If Vermont does not achieve at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries in Performance Year 3, then the Vermont Medicare Total Cost of Care per Beneficiary for Performance Year 3 will include only Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives operating pursuant to executed participation agreements with CMS, and Vermont Medicare Total Cost of Care per Beneficiary Growth for that year will be calculated in a similar manner as for Performance Years 1 and 2.

Vermont Medicare Total Cost of Care per Beneficiary Growth will be calculated as a compounded annualized growth rate in aggregate across Performance Years 1 through ~~5~~ 6 of this Model, using 2017 as a baseline. The following formula, summarizing the calculation of the Vermont Medicare Total Cost of Care per Beneficiary Growth except as adjusted in sections 9.b.ii and 9.c, assumes that Vermont does achieve at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries in Performance Year 3.

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Vermont Medicare Total Cost of Care per Beneficiary Growth:

$$\left(\frac{\left(\frac{Vermont\ Medicare\ TCOC_{2018}}{Vermont\ ACO-aligned\ Medicare\ beneficiaries_{2018}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2017}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2017}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2019}}{Vermont\ ACO-aligned\ Medicare\ beneficiaries_{2019}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2018}}{Vermont\ ACO\ comparison\ Medicare\ beneficiaries_{2018}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2020}}{Vermont\ Medicare\ beneficiaries_{2020}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2019}}{Vermont\ Medicare\ beneficiaries_{2019}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2021}}{Vermont\ Medicare\ beneficiaries_{2021}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2020}}{Vermont\ Medicare\ beneficiaries_{2020}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2022}}{Vermont\ Medicare\ beneficiaries_{2022}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2021}}{Vermont\ Medicare\ beneficiaries_{2021}}\right)} * \frac{\left(\frac{Vermont\ Medicare\ TCOC_{2023}}{Vermont\ Medicare\ beneficiaries_{2023}}\right)}{\left(\frac{Vermont\ Medicare\ TCOC_{2022}}{Vermont\ Medicare\ beneficiaries_{2022}}\right)}\right)^{\frac{1}{\cancel{5}6}} - 1$$

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

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

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

The Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth will be calculated as a compounded annualized growth rate in aggregate across Performance Years 1 through ~~5~~ 6 of this Model, using 2017 as a baseline and summarized by the following formula, except as adjusted in sections 9.b.iii, 9.b.iv, and 9.c.

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

$$\left(\left(\frac{MA\ USPCC\ FFS_{2018}}{MA\ USPCC\ FFS_{2017}}\right)_{Announced\ in\ 2017} * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022}\right)^{\frac{1}{6\cancel{5}}} - 1$$

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iv. **Projected National Medicare Total Cost of Care per Beneficiary Growth Target Floor for Performance Year 1.** If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1, calculated as a growth rate using 2017 as a baseline, is less than 3.7 percent but greater than or equal to 2.7 percent, then 3.7 percent will be used as the Performance Period Projected National Medicare

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Total Cost of Care per Beneficiary Growth for purposes of calculating Vermont's performance in Performance Year 1 on the Medicare Total Cost of Care per Beneficiary Growth Target. In such a case, the following formula will be used to calculate Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, except as adjusted in sections 9.b.iii and 9.c. The Medicare Total Cost of Care per Beneficiary Growth Target shall remain as 0.2 percentage points less than Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth, as described in section 9.b.i.3.

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

$$\left(1.037 * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022}\right)^{\frac{1}{\cancel{5}6}} - 1$$

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

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

$$\left(\left[\left(\frac{MA\ USPCC\ FFS_{2018}}{MA\ USPCC\ FFS_{2017}}\right)_{Announced\ in\ 2017} + 0.012\right] * \left(\frac{MA\ USPCC\ FFS_{2019}}{MA\ USPCC\ FFS_{2018}}\right)_{Announced\ in\ 2018} * \left(\frac{MA\ USPCC\ FFS_{2020}}{MA\ USPCC\ FFS_{2019}}\right)_{Announced\ in\ 2019} * \left(\frac{MA\ USPCC\ FFS_{2021}}{MA\ USPCC\ FFS_{2020}}\right)_{Announced\ in\ 2020} * \left(\frac{MA\ USPCC\ FFS_{2022}}{MA\ USPCC\ FFS_{2021}}\right)_{Announced\ in\ 2021} * \left(\frac{MA\ USPCC\ FFS_{2023}}{MA\ USPCC\ FFS_{2022}}\right)_{Announced\ in\ 2022}\right)^{\frac{1}{6\cancel{5}}} - 1$$

If the Annual Projected National Medicare Total Cost of Care per Beneficiary Growth in Performance Year 1, calculated as a growth rate using 2017 as a baseline, is equal to or greater than 3.7 percent, then the Medicare Total Cost of Care per Beneficiary Growth Target shall be 0.1 percentage points less than the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth. That is, Vermont shall limit the Vermont Medicare Total Cost of Care per Beneficiary Growth to at least 0.1 percentage

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points less than the Performance Period Projected National Medicare Total Cost of Care per Beneficiary Growth. In such a case, the following formula will be used in lieu of the formula described in 9.b.i.3. to calculate Vermont's performance on the Medicare Total Cost of Care per Beneficiary Growth Target:

Medicare Total Cost of Care per Beneficiary Growth Target performance:

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

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

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ii. **Medicare payments made under the Multipayer Advanced Primary Care Practice demonstration.** During the baseline year of 2017, CMS will include $7.5M in the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth calculations, approximately the sum of Medicare payments made to Vermont providers in 2016 as part of the Multipayer Advanced Primary Care Practice (MAPCP) demonstration. In Performance Year 6, CMS will make $10.0M available to AHS to fund the Vermont programs previously funded through the MAPCP demonstration, continuing funding included in the ACO Benchmark for the Vermont Medicare ACO Initiative in Performance Years 1 through 5. In Performance Year 6, these payments will be considered included as expenditures when calculating the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth but will no longer be included in the ACO Benchmark for the Vermont Medicare ACO Initiative.

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f. **~~Quarterly~~ Semi-Annual Financial Report.** The GMCB, in collaboration with AHS, shall submit to CMS ~~quarterly~~ two reports on the State's performance on the All-payer Total Cost of Care per Beneficiary Growth Target (***"~~Quarterly~~ Semi-Annual Financial Report"***). The first report will capture the State's performance over the first six months of the PY, with six months of claims runout. The second report will capture the State's performance for the entire PY, with six months of cliams runout. Each Performance Year's All-payer Total Cost of Care per Beneficiary Growth Target performance results shall be finalized by ~~June 30th~~ December 31st of the following year.

10. Payer Differential.

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

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11. **[Deleted]** ~~**Medicaid Behavioral Health and Long-Term Services and Supports.** By the end of Performance Year 3, AHS, in collaboration with the GMCB, shall submit to CMS a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with the All-payer Financial Target Services. The plan shall describe a strategy for including Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the State's delivery system reform efforts and for supporting the inclusion of such Medicaid services in the definition of All-payer Financial Target Services in a subsequent agreement, as described in Section 12.~~

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12. **Proposal for Subsequent Agreement.** Before December 31 of Performance Year ~~4~~ 5, the GMCB, in collaboration with AHS, may submit to CMS a proposal for a subsequent model spanning five (5) performance years and detailing operations to be effective beginning ~~2023~~ 2024 through ~~2027~~ 2028. CMS reserves the right at its sole discretion to accept, reject, or put forth a revised proposal. Vermont reserves the right at its sole discretion to accept or reject any such revised proposal. The proposal, if submitted by the GMCB, shall include, at minimum, the following:

a. A Medicare total cost of care per beneficiary growth target that is similar to the one described in section 9;

b. An all-payer total cost of care per beneficiary growth target that is similar to the one described in section 9;~~, but that also includes expenditures related to~~

~~b.~~c. A plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid ~~the~~ Home and Community-based Services with all-payer financial target services; and

~~c.~~d. Statewide health outcomes and quality of care targets that are similar in scope to the ones described in section 7.

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15. **Data Sharing.**

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

for services furnished by Medicare-enrolled providers and suppliers to Medicare FFS beneficiaries residing in Vermont. CMS may, upon request of the GMCB, provide additional reports that include the following: utilization, expenditures, quality of care, Medicare FFS eligibility type, VMA ACO alignment, and performance summary comparisons to other states. All such requests for individually-identifiable health information must clearly state the HIPAA basis for the requested disclosure (e.g., for research purposes under 45 C.F.R. § 164.512(i) or for carrying out health oversight activities under 45 C.F.R. § 164.512(d)(1)). CMS will make best efforts to approve, deny, or request additional information regarding data requests within 60 calendar days after the State's request. All information will be provided consistent with all applicable laws and regulations, including HIPAA and the Part 2 regulations governing the use of information regarding diagnosis and treatment for substance abuse. Appropriate privacy and security protections will be required for any data disclosed under this Agreement.

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17. **Model Evaluation.**

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b. **Reports and Data for CMS Evaluation.** The GMCB shall submit to CMS the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the ~~Quarterly~~ Semi-Annual Financial Report, as described in sections 6, 7, and 9, respectively. Additionally, as described in section 15.a, the GMCB, in collaboration with AHS, shall provide CMS with Vermont Medicaid claims data, Vermont Commercial Plans claims data, and available Vermont Self-insured Plan claims data that are necessary for CMS to monitor and evaluate the Model. The State must make available to CMS and CMS's contractors, for validation and oversight purposes, the datasets and methodologies used by the State to make calculations required under this Agreement, including and as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under this Agreement.

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

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

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v. Site visits to the State; and

vi. Documentation requests sent to the State.

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

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

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

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

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

~~iv. A determination by CMS that Vermont has failed to achieve the ACO Scale Targets for two consecutive Performance Years (excluding Performance Year 0), as specified in section 6.k.~~ [Deleted].

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Appendix 1 – Statewide Health Outcomes and Quality of Care Targets

a. Population-level Health Outcomes Targets

i. **Substance Use Disorder Target.** The State must reduce deaths of Vermont residents related to drug overdose by 10 percent in aggregate over the Performance Period of this Model, using ~~2015~~ 2016 as the baseline.

1) **Calculation methodology.** The State's performance, measured as an age-adjusted rate per 100,000 Vermont residents, will be calculated using the Centers for Disease Control (CDC) National Vital Statistics System Mortality File's methodology and data or a comparable methodology and data source for calculating deaths related to drug overdose.

2) CMS may determine that the State is not on track to meet this target if, cumulatively across Performance Year 1 and Performance Year 2, the State experiences an increase in deaths related to substance use disorder. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between

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Vermont's ~~2015~~ 2016 (baseline year) age-adjusted death rate and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

ii. **Suicide Target.** The State must reduce the number of deaths due to suicide to 16 per 100,000 Vermont residents, or reduce the State's ranking on suicide rate from the 7th to the 20th highest by state across the United States.

1) **Calculation methodology.** The State's performance will be calculated using the CDC National Vital Statistics System Mortality File's methodology and data for calculating deaths due to suicide.

2) CMS may determine that the State is not on track to meet this target if, cumulatively across Performance Year 1 and Performance Year 2, the State experiences an increase in its suicide rate relative to its ~~2015~~ 2016 baseline. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2015~~ 2016 suicide rate and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

iii. **Chronic Conditions Targets.** The State must not increase prevalence of COPD, diabetes, and hypertension for Vermont residents 18 years of age or older, each measured separately as a percent of state population, by more than 1 percentage point, using ~~2016~~ 2017 as a baseline.

1) **Calculation methodology.** The State's performance will be calculated separately for each of the three chronic conditions using the CDC Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, based on the responses to the following questions:

   a. Diabetes prevalence: "Have you been told that you have diabetes?"

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

   c. Hypertension prevalence: "Have you been told that you have hypertension?"

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

2) For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. CMS may determine that the State is not on track to meet this target if, starting in Performance Year ~~3~~ 5, the prevalence of diabetes, COPD, or hypertension among Vermont residents is more than 1 percentage point greater than the prevalence of said chronic conditions in ~~2016~~ 2017.

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

1) **Calculation methodology.** The State's performance will be calculated, using the CDC BRFSS questionnaire, as the percent of Vermont resident respondents who answer "yes" to the following question: "Do you have one person you think of as your personal doctor or health care provider?"
2) CMS may determine that the State is not on track to meet this target if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases the percent of adults who have a personal doctor or health care provider. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2017 (baseline year) percentage of adults that report that they have a usual primary care physician and the target percentage: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

b. Healthcare Delivery System Quality Targets

i. **Suicide and Substance Use Disorder Target - Initiation and engagement of alcohol and other drug dependence (AOD) treatment.** The State must achieve 40.8 percent of the ~~50th percentile, as compared to healthcare plans nationally,~~ Vermont ACO-aligned residents on initiation and ~~the 75th percentile~~ 14.6 percent on engagement of alcohol and other drug dependence treatment for Vermont ACO-aligned residents.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Initiation and Engagement of Alcohol and Other Drug Dependence Treatment" (endorsed by NQF as Measure #4). Performance on initiation and engagement will be assessed separately. ~~The State's performance for each Performance Year will be measured against healthcare plans nationally using performance data for NQF Measure #4 reported in NCQA's Quality Compass for Performance Year 1 of this Model. Vermont's performance and the national 50th or 75th percentile comparison data for each payer type will each be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State's performance calculation.~~
2) CMS may determine that the State is not on track to meet these initiation target, engagement target, or both, if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases initiation rates, engagement rates, or both. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on

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utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet these two targets if the differences between the State's performance for a Performance Year and the targets do not decrease by amounts equal to the following percentages of the differences between Vermont's ~~2016~~ 2018 (baseline year) rates of initiation and engagement of alcohol and other drug dependence treatment and the target rates: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

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

1) **Calculation methodology**. The State's performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence" (endorsed by NQF as Measure #2605). ~~Vermont's performance for each payer type will be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State's performance calculation.~~

2) CMS may determine that the State is not on track to meet this target if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases this rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2018 (baseline year) rate of follow-up after discharge from the emergency department and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

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

1) **Calculation methodology**. The State's performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or

Other Drug Dependence" (endorsed by NQF as Measure #2605). ~~Vermont's performance for each payer type will be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State's performance calculation.~~

2) CMS may determine that the State is not on track to meet this target if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases this rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2018 (baseline year) rate of follow-up after discharge from the emergency department and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

iv. **Suicide and Substance Use Disorder Target – Mental Health and Substance Abuse-related Emergency Department Visits.** The State must reduce the rate of growth of emergency department (ED) visits with a primary diagnosis of mental health or substance abuse condition across payers in Vermont hospitals to 5% in PY 1-2, 4% in PY 3-4 and 3% in PY 5, using 2016-2017 growth as a baseline. ~~Vermont and CMS shall establish a target by June 30, 2017.~~

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using Vermont Department of Health's hospital discharge data and counting the number of ED visits at Vermont hospitals with a primary diagnosis of mental health or substance abuse condition.

2) CMS may determine that the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State increases the rate of growth of ED visits due to mental health and substance abuse across payers. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between the growth rate in ED visits with a primary diagnosis of mental health or substance abuse condition growth rate and the target growth rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

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v. **Chronic Conditions Target – ~~Composite of~~ Diabetes, Hypertension, and Multiple Chronic Conditions.** The State must achieve between the ~~75th percentile~~ 70th and 80th percentiles, as compared to national Medicare performance, for ~~a composite measure~~ each of the measures ~~comprising~~ of diabetes, hypertension, and multiple chronic condition morbidity of VMA ACO or Modified Next Generation ACO-aligned Vermont Medicare Beneficiaries. Each measures will be calculated and reported separately.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measures ACO 27 ("Diabetes: Hemoglobin A1c Poor Control"), ACO 28 ("Controlling High Blood Pressure"), and ACO 38 ("All-cause Unplanned Admissions for Patients with Multiple Chronic Conditions"). The ~~State's performance on ACO 28, ACO 38, and ACO 27~~ target for each ~~Performance Year~~ measure will ~~each~~ be between ~~assessed against~~ the ~~national Medicare performance 75th percentile information~~ 70th and 80th percentiles used for the Medicare Shared Savings Program quality measure benchmarks ~~for Performance Year 1 of this Model, and each of the measures will be assigned a percentile~~ based on the comparison to the national Medicare performance percentile information. ~~The State's percentiles for ACO 28, ACO 38, and ACO 27 will be averaged together. This averaged percentile will then be compared to the target of 75th percentile of national Medicare performance used for the Medicare Shared Savings Program quality measure benchmarks for Performance Year 1 of this Model.~~

2) CMS may determine that the State is not on track to meet this target if, ~~cumulatively~~ for two of the three measures across Performance Year 1 and Performance Year 2, the State decreases its average percentile. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease for two of the three measures by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2017 (baseline year) Medicare average percentile and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year 6~~4; or at least 100 percent by the end of Performance Year 5~~.

vi. **Access to Care Target – Getting Timely Care, Appointments, and Information.** The State must achieve between the ~~75th percentile~~ 70th and 80th percentiles, as compared to national Medicare performance, for the percent of VMA ACO or Modified Next Generation ACO-aligned Medicare beneficiaries who state that they are getting timely care, appointments, and information.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measure, specifications, and data for ACO-1 ("Getting Timely Care, Appointments, and

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Information"). The ~~national Medicare 75th percentile for each Performance Year~~ target will be between ~~equal to~~ the ~~national Medicare 75th percentile~~ 70th and 80th percentiles used for the Medicare Shared Savings Program quality measure benchmarks ~~for Performance Year 1 of this Model~~ based on the comparison to the national Medicare performance percentile information.

2) CMS may determine that the State is not on track to meet this target if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases the percent of Medicare beneficiaries who state that they are getting timely care, appointments, and information. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's 2016 (baseline year) Medicare rate of Medicare beneficiaries who state that they are getting timely care, appointments, and information and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

c. Process Milestones.

i. **Substance Use Disorder Milestone – Prescription Drug Monitoring Initiative Utilization.** The State must increase the utilization of Vermont's prescription drug monitoring program, using 2017 as a baseline~~. Vermont and CMS shall establish a target by June 30, 2017~~ to a ratio of 1.80.

1) **Calculation methodology.** The State's performance will be measured as the number of times prescribers ~~(or their delegates)~~ who have written at least one opioid analgesic prescription query the prescription drug monitoring ~~program~~ system divided by the number of unique patients ~~for whom a prescriber writes prescriptions for opioids~~ who have received at least one opioid analgesic prescription.

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases its prescription drug monitoring program utilization. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's 2017 (baseline year) rate of utilization and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 4; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

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ii. **Substance Use Disorder Milestone – Medication-assisted Treatment Utilization.** The State must increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use disorder to 150 per 10,000 Vermont residents of ages 18-64 (or up to the rate of demand).

1) **Calculation methodology.** The State's performance will be calculated, using Vermont Department of Health data, as the unique number of Vermont residents of ages 18-64 receiving MAT. CMS shall consider Vermont to have achieved this target if MAT utilization is less than 150 per 10,000 residents of ages 18-64 but no residents remain on the MAT waitlist (proxy for demand being satisfied).

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases the number of Vermont residents (per 10,000, ages 18-64) receiving MAT. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's 2016 (baseline year) rate of MAT utilization and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

iii. **Suicide Milestone – Screening for Clinical Depression.** The State must achieve between the ~~75th percentile~~ 70th and 80th percentiles, as compared to national Medicare performance, for the percent of Vermont ACO-aligned residents ~~beneficiaries~~ who received a screening for clinical depression, and if depression was detected, a follow-up plan.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measure and specifications for ACO-18 ("Screening for Clinical Depression and Follow-up Plan"). The milestone's performance will include Vermont ~~All-payer Beneficiaries~~ ACO-aligned residents who are ~~also aligned to a Vermont ACO~~ enrolled in a payer program that reports this measure. The ~~national Medicare performance 75th percentile for each Performance Year~~ target will be between ~~equal to~~ the ~~national Medicare 75th percentile~~ 70th and 80th percentiles used for the Medicare Shared Savings Program quality measure benchmarks ~~for Performance Year 1 of this Model~~ based on the comparison to the national Medicare performance percnetiles information. The following steps will be done to determine Vermont's performance on this milestone:

- Assign percentile to each of the payers for this measure as compared to the ~~Performance Year 1~~ national Medicare performance.
- Average the percentiles for each of the payers weighted by the relative proportion of attributed population.

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- Determine whether the percentile is ~~greater than or equal to 75 percent~~ between the Medicare 70th and 80th percnetiles for that performance period.

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

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases its depression screening rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2018 (baseline year) rate of screening for clinical depression and follow-up plan and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

iv. **Chronic Conditions Milestone - Tobacco Use Assessment and Cessation Intervention.** The State must achieve between the ~~75th percentile~~ 70th and 80th percentiles, as compared to national Medicare performance, for the percent of Vermont ACO-aligned ~~beneficiaries~~ residents who were screened for tobacco use and who received cessation counseling intervention if identified as a tobacco user.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measure and specifications for ACO-17 ("Tobacco Use: Screening and Cessation Intervention"). The milestone's performance will include Vermont All-payer Beneficiaries who are also aligned to a Vermont ACO payer program that reports this measure. The ~~national Medicare performance 75th percentile for each Performance Year~~ target will be between ~~equal to~~ the ~~national Medicare 75th percentile~~ 70th and 80th percentiles used for the Medicare Shared Savings Program quality measure benchmarks ~~for Performance Year 1 of this Model~~ based on the comparison to the national Medicare performance percentile information. The following steps will be done to determine Vermont's performance on this milestone:
   - Assign percentile to each of the payers for the measure as compared to Medicare National Benchmark.
   - Average the percentiles for each of the payers weighted by the relative proportion of attributed population.
   - Determine whether the percentile is ~~greater than or equal to 75 percent~~ between the Medicare 70th and 80th percentiles for that performance period.

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

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases its tobacco use assessment and cessation intervention rate. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2018 (baseline year) rate of tobacco use assessment and cessation intervention and the target rate: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

v. **Chronic Conditions Milestone –Medication Management for People with Asthma.** The State must achieve ~~the 25th percentile, as compared to healthcare plans nationally, for the~~ 65 percent of Vermont ~~All-payer Beneficiaries~~ ACO-aligned residents receiving appropriate asthma medication management.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured according to measure specifications for NCQA HEDIS measure "Medication Management for People with Asthma – 50% compliance." ~~The State's performance for each Performance Year will be measured against healthcare plans nationally using performance data for HEDIS measure "Medication Management for People with Asthma" recorded in the NCQA's Quality Compass data for Performance Year 1 of this Model. Vermont's performance and the national comparison data for each payer type will each be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State's performance calculation.~~

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases the percent of Vermont residents receiving appropriate asthma medication management. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2018 (baseline year) rate of medication management for people with asthma and the target rate: at least 30

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percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

vi. **Access to Care Milestone – Medicaid Adolescents with Well-Care Visits.** The State must achieve ~~the 50th percentile, as compared to Medicaid plans nationally, for the percentage~~ 53 percent of Vermont adolescents enrolled in Vermont Medicaid who have a well-care visit.

1) **Calculation methodology.** The State's performance for any given Performance Year will be measured for Vermont Medicaid adolescents according to measure specifications for NCQA HEDIS measure "Adolescents with Well-Care Visits." ~~The State's performance for each Performance Year will be measured against Medicaid plans nationally using Medicaid performance data for HEDIS measure "Adolescents with Well-Care Visits" recorded in the NCQA's Quality Compass data for Performance Year 1 of this Model.~~

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases the percentage of Medicaid adolescents with well-care visits. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the following percentages of the difference between Vermont's ~~2016~~ 2017 (baseline year) percentage of Medicaid adolescents with well-care visits and the target rate ~~does not decrease by~~: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

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

1) **Calculation methodology.** The State's performance will be comparing in any given Performance Year the percentage of Vermont residents enrolled in Vermont Medicaid who are aligned to a Scale Target ACO Initiative to the percentage of Vermont Medicare Beneficiaries who are aligned to a Scale Target ACO Initiative.

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across Performance Year 1 and Performance Year 2, the State decreases the percentage of Vermont Medicaid beneficiaries aligned to a Vermont ACO. For Performance Years 3 and 4, due to the COVID-19 pandemic and its impact on utilization and care patterns, no performance changes will result in a triggering event. For ~~through~~ Performance Years 5 and 6, CMS may determine that the State is not on track to meet this target if the difference between the State's performance for a Performance Year and the target does not decrease by an amount equal to the

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following percentages of the difference between the percentage of Medicaid beneficiaries attributed to a Vermont ACO and 15 percentage points less than that of Medicare beneficiaries decreases by: at least 30 percent by the end of Performance Year ~~3~~ 5; or at least 65 percent by the end of Performance Year ~~4~~ 6~~; or at least 100 percent by the end of Performance Year 5~~.

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