**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC**
**RISK-BEARING PARTICIPANT & AFFILIATE (PREFERRED PROVIDER) AGREEMENT**

**Participant Name:** _____
**Affiliate Name:** _____
**Participant/Affiliate Address:** _____
**Participant/Affiliate TIN:** _____

**This RISK-BEARING PARTICIPANT / AFFILIATE AGREEMENT** (the "Agreement") is by and between OneCare Vermont Accountable Care Organization, LLC ("ACO"), a Vermont limited liability company, and Participant or Affiliate, a health care provider or organization eligible to participate with ACO as defined below and organized under Vermont or New Hampshire law (collectively, the "Parties") and is effective the date signed by the ACO.

**WHEREAS**, ACO is an accountable care organization that intends to participate in alternative payment programs ("ACO Programs") with governmental and private payers (collectively referred to as "Payers") and to conduct ACO Activities, as that term is defined below;

**WHEREAS,** ACO and Participants and Affiliates agree to participate in an Organized Health Care Arrangement ("OHCA") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as more fully described herein;

**WHEREAS,** Participant and Affiliate agree to participate in the ACO Programs identified herein and ACO, Participant and Affiliate are committed to being accountable for the quality, cost and overall care of the individuals aligned with or attributed to the ACO under each ACO Program and committed to implementing and following processes and procedures to support that accountability and to sharing in the financial benefits or risks that result from those efforts; and

**WHEREAS,** Participant, Affiliate and ACO understand that all ACO Programs made part of this Agreement require ACO and Participant to assume certain risk for the cost of care for Program Beneficiaries and is therefore considered and referred to as a "risk-bearing" arrangement;

**NOW, THEREFORE**, the Parties agree as follows:

## 1.0 DEFINITIONS

For purposes of this Agreement, the following terms shall have the meanings indicated. These definitions apply to the Agreement and all attachments, exhibits and ACO Program Addendums attached hereto. Any changes to the definitions under the ACO Program rules, regulations and laws will modify the following definitions as to that Program.

1.1 "ACO" means OneCare Vermont Accountable Care Organization, LLC, and more generally refers to a legal entity that is recognized and authorized under applicable State, Federal or Tribal law, is identified by a TIN, and is formed by one or more Providers that agree to work together to be accountable for the ACO Activities, as established by the applicable ACO Program.

1.2 "ACO Activities" means activities related to promoting accountability for the quality, cost, and overall care for a patient population of beneficiaries aligned or attributed to the ACO under an ACO Program, including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and carrying out any other obligation or duty of the ACO under this Agreement. Additional examples of these activities include, but are not limited to, providing direct patient care to ACO Program Beneficiaries in a manner that reduces costs and improves quality; promoting evidence-based medicine and patient engagement; reporting on quality and cost measures under this Agreement; coordinating care for ACO Program Beneficiaries, such as through the use of telehealth, remote patient monitoring, and other enabling technologies; establishing and improving clinical and administrative systems for the ACO; meeting ACO Program performance standards by evaluating health needs of ACO Program Beneficiaries; communicating clinical knowledge and evidence-based medicine to ACO Program Beneficiaries; and developing standards for ACO Program Beneficiary access and communication, including ACO Program Beneficiary access to medical records.

1.3 "ACO Other Entity" means any entity that performs functions or services on behalf of an ACO or that works in collaboration with the ACO to accomplish ACO Activities, when that entity is not enrolled as a Participant or Affiliate but has entered into a contractual arrangement to collaborate or perform services with ACO, including, if applicable, a Business Associate Agreement. ACO Other Entities include, but are not limited to, contractors and consultants.

1.4 "ACO Policies" means generally ACO policies and procedures applicable to participation in ACO Programs. ACO Policies include, but are not limited to, privacy and security and data use policies, appeals policies, and the Clinical Model and its supporting policies.

1.5 "ACO Program" means a program between ACO and a Payer for population health management through an alternative payment arrangement or otherwise.

1.6 "ACO Program Addendum" means an addendum, attached hereto, that describes the program terms that govern the parties' obligations for that particular program.

1.7 "ACO Program Beneficiary" means an individual that receives healthcare benefits from a Payer in an ACO Program and is attributed or aligned to ACO.

1.8 "ACO Provider Portal" means the secure interface between ACO and Participant and Participant's Providers and Affiliates where ACO provides access to policies, procedures and other program information.

1.9 "Affiliate" or "Preferred Provider" means an individual or an entity that is: (1) identified by TIN; (2) included on the list of Preferred Providers submitted by ACO to Payers; and (3) that has entered into an Affiliate/Preferred Provider agreement with ACO to participate in ACO Programs. Preferred Provider may be more particularly defined under each ACO Program, for example, as defined by the Medicare NextGen program, Affiliates do not align or attribute lives or quality report, but are eligible for participation in population based payments, coordinated care rewards and waiver programs such as telehealth, 3 day SNF stay and post discharge home visits.

1.10 "Clinical Model" means the written ACO guidelines, processes and procedures for quality and cost effectiveness founded on three inter-related and mutually supporting elements of: (1) quality performance measure management; (2) case management; and (3) clinical data sharing.

1.11 "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

1.12 "NPI" means the National Provider Identifier unique ten-digit identification number required for all licensed health care providers.

1.13 "OHCA" means an "organized health care arrangement" recognized under HIPAA that allows two or more Covered Entities who are clinically or operationally integrated, to share protected health information about their patients to manage and benefit their joint operations.

1.14 "Participant" means an individual or group of Providers that is: (1) identified by TIN; (2) included on any list of Participants submitted by ACO to Payers; and (3) that has entered into a participation agreement with ACO to participate in ACO Programs. Participant may be more particularly defined under each ACO Program.

1.15 "Payer" means the entity, which may be the ACO under certain ACO Programs, responsible for making financial payments or collecting Shared Risk under an ACO Program.

1.16 "Performance Year" means the twelve (12) month period measured by each ACO Program to determine financial reimbursement.

1.17 "Provider" means a health care practitioner or entity that: (1) meets the terms of participation in an ACO Program; (2) bills for items and services furnished to ACO Program Beneficiaries under a Participant or Preferred Provider's TIN; and (3) is included

on the list of Participants or Preferred Providers submitted by ACO to Payers.

1.18 "Shared Risk" or "Shared Loss" is more particularly defined by each ACO Program but generally means the portion of ACO's Performance Year spending that was greater than expected spending and that must be returned to Payer.

1.19 "Shared Savings" is more particularly defined by each ACO Program, but generally means the portion of ACO's Performance Year spending that was less than expected spending and that is paid to ACO by the Payer.

1.20 "TIN" means a Federal taxpayer identification number or employer identification number or social security number for providers who bill Payers under their social security numbers

## 2.0 ACO PROGRAM PARTICIPATION

2.1 Participation. Participants and Affiliates agree to be accountable for the quality, cost and overall care of ACO Program Beneficiaries by complying with the terms of this Agreement and following ACO Program rules and regulations, ACO Policies, and the Clinical Model. ACO will provide support services to Participants and Affiliates to facilitate efficient participation in the ACO Programs. Such support may include, but is not limited to, data reporting software and support, training, data analysis, data reporting and clinical leadership.

2.2 Qualification to Participate. Participant and Affiliate agree to participate in each ACO Program offered by a Payer for which Participant or Affiliate is an enrolled provider and in good standing. Participant, Providers and Affiliate Providers will maintain good standing to provide services under this Agreement with each Payer and will remain duly licensed in good standing to practice their professions in each state in which they practice. Any Participant who is eligible to align or attribute lives may only participate in one ACO Program per Payer, for example if an eligible aligning Participant is in Medicare NextGen, it may not be in MSSP. Nothing in this Agreement supersedes any of the terms and conditions of Participant's or Affiliate Provider's enrollment in a Payer's program. ACO, may, in its discretion, require additional reasonable verification of professional qualifications. Providers applying to be a Participant or Affiliate who do not meet the Clinical Model criteria, any ACO Program criteria, and Participants or Affiliates who are not renewed for any other reason will receive a written notice explaining the reason for denied participation status including instruction on how to appeal such denial to ACO.

2.3 Authority to Bind Employees. Participant and Affiliate represent and warrant that it has the authority, as an employer, to require its Providers and employees to comply with the applicable terms of this Agreement, ACO Program rules and regulations, and ACO Policies.

2.4 Management of Provider List. ACO retains the right to approve or disapprove new providers and to terminate or suspend Participants, Providers and Affiliates for cause, in accordance with the applicable ACO Program Addendums, Clinical Model or ACO Policies. Participant and Affiliates agree to manage their list of its participating Providers with ACO by providing timely notices of changes, as discussed in Section 8 below. To the extent that any Provider or employee identified by an NPI linked to Participant's or Affiliate's TIN is excluded from an ACO Program, for any reason, disciplinary or otherwise, Participant or Affiliate will cooperate in de-linking or disassociating that Provider's NPI from the Participant's or Affiliate's TIN or ACO Program for purposes of billing applicable Payers.

2.5 Grievances and Appeals. Participants and Affiliates may submit grievances and appeal qualified ACO decisions in accordance with the ACO Appeals Policy, available on the ACO Provider Portal and incorporated herein by reference. To the extent an ACO Program dictates a specific appeals process that conflicts with the ACO Appeals Policy, the more restrictive policy shall apply.

2.6 Participation in ACO Governance. Participant and Affiliate agree to participate in aspects of the ACO's governance by participating in the election or appointment of the Participant and Affiliate representative(s) to ACO's Board of Managers and participating in the selection of member(s) of the ACO clinical and quality committees and/or any sub-geographic or sub-specialty components of those committees.

## 3.0 PAYMENT

Payment terms shall be established in each applicable ACO Program Addendum.

## 4.0 TERM AND TERMINATION

4.1 Term. This Agreement shall commence on the Effective Date and continue until the earlier of: (1) when Participant or Affiliate is no longer participating in an ACO Program and (2) December 31, 2020. In the event that one ACO Program is terminated by ACO but others remain in effect, this Agreement shall continue to be effective as it pertains to the remaining ACO Programs. The termination provisions of each ACO Program Addendum shall govern a Participant's or Affiliate's term with respect to that ACO Program (the Effective Date of each ACO Program Addendum shall be the date on which it is executed by ACO).

4.2 Termination with Cause. Either Party may terminate this Agreement upon a material breach by the other Party by providing sixty (60) days' prior written notice to the Party alleged to be in breach identifying, with specificity, such breach, but only in the event that the alleged breaching Party fails to cure same within the sixty (60) day notice period. In the event an agreement under an ACO Program between ACO and the Payer

terminates or in the event Participant or Affiliate terminates or non-renews an ACO Program Addendum, this Agreement shall only terminate with respect to those terminated or non-renewed ACO Programs and shall otherwise remain in full force and effect. In the event Participant or Affiliate terminates or non-renews all ACO Program Addenda, this Agreement shall also terminate. ACO Program obligations, such as quality reporting and obligations for Shared Risk may survive termination as set forth in ACO Program Addendum.

**5.0 NOTICES**

5.1 Required Notices. In addition to such disclosures as may be required in an ACO Program Addendum, Participant and Affiliate shall notify ACO and ACO shall notify Participant and Affiliate, in writing, as provided below. To the extent a notice requirement in an ACO Program Addendum conflicts with or is more stringent than the notice requirements below, the shorter of the timeframes shall apply.

5.2 Immediate Notices.

5.2.1 ACO shall provide Participant and Affiliate with immediate written notice of the termination of ACO's participation in an ACO Program under this Agreement;

5.2.2 Participant and Affiliate shall provide ACO with immediate written notice in the event Participant, Affiliate or either's Provider is convicted of a fraud or felony, or suspended, barred or excluded from participation in a federal health care program (as defined in 42 U.S.C. § 1320a-7b(f));

5.2.3 Participant and Affiliate shall provide ACO with immediate written notice in the event Participant or Affiliate receives a written notice of any cancellation, non-renewal or change to any insurance policy required under this Agreement; and

5.2.4 Participant and Affiliate shall provide ACO with immediate written notice in the event Participant or Affiliate are subject to discipline from or terminated from participation with any Payer.

5.3 Other Notices.

5.3.1 ACO shall, to the extent possible, provide Participant and Affiliate with thirty (30) days written notice prior to making any changes to terms applicable to ACO Programs, unless such changes are made to comply with a change in applicable law, addressed in more detail in Section 8.

5.3.2 Participant and Affiliate shall provide ACO notice, as soon as reasonably possible but no later than thirty (30) days, in the event of a voluntary surrender or termination of any of Participant's, a Provider's or Affiliate's licenses, certifications, or accreditations;

5.3.3 Participant and Affiliate shall provide ACO notice, as soon as reasonably possible after commencement of an investigation into conduct substantially related to the performance of this Agreement, by any law enforcement entity;

5.3.4 Participant and Affiliate shall provide ACO notice, as soon as reasonably possible after the occurrence of an act of nature or any event beyond Participant's or Affiliate's reasonable control which substantially interrupts all or a portion of Participant's or Affiliate's business or practice, or that has a materially adverse effect on Participant's or Affiliate's ability to perform its or his/her obligations hereunder; and

5.3.5 Participant and Affiliate shall provide ACO notice, as required by the applicable ACO Program Addendum, if any Provider becomes disassociated with Participant's or Affiliate's TIN for any reason.

## 6.0 RECORDS

6.1 Beneficiary and ACO Program Records. Participant and Affiliate shall prepare, maintain, and protect the confidentiality, security, accuracy, completeness and integrity of all appropriate medical and other records related to the provision of care to ACO Program Beneficiaries (including, but not limited to, medical, encounter, financial, accounting, administrative and billing records) in accordance with: (i) applicable state and federal laws and regulations including, but not limited to, applicable confidentiality requirements of the HIPAA; and (ii) ACO Program billing, reimbursement, and administrative requirements. Such records shall include such documentation as may be necessary to monitor and evaluate the quality of care and to conduct medical or other health care evaluations and audits to determine, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided.

6.2 Financial Records. Participant and Affiliate shall maintain such financial and accounting records as shall be necessary, appropriate or convenient for the proper administration of this Agreement, in accordance with generally accepted accounting principles or another acceptable basis of financial accounting, including, but not limited to, income-tax-basis financial statements, cash-basis or modified-cash-basis financial statements, or another basis that is otherwise generally accepted by the accounting industry.

6.3 Sharing Records. Participant and Affiliate acknowledge that by becoming a Participant or Affiliate it is agreeing to participate in an OHCA and further acknowledges that Beneficiary Records may be shared with other Participants, Affiliates, or ACO Other Entities for ACO Activities. In addition to OHCA sharing, Participant and Affiliate shall make the records available to and communicate as appropriate with each Participant, Affiliate, or ACO Other Entity, as needed, for the purpose of facilitating the delivery of appropriate Health Care Services to each ACO Program Beneficiary. Subject to applicable laws regarding confidentiality, Participant or Affiliate hereby authorizes ACO to release

any and all information, records, summaries of records and statistical reports specific to Participants or Affiliate, including but not limited to utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Participant's or Affiliate's performance of services and professional qualifications to federal or state governmental authority(ies) with jurisdiction, or any of their authorized agents, and accreditation agencies, without receiving Participant's or Affiliate's prior consent.

6.4 Survival. The provisions of this Section 6 shall survive termination of this Agreement.

**7.0 REPORTING AND MONITORING**

7.1 Reporting. Participant and Affiliate shall report such data from its Electronic Health Records ("EHR") system or medical records as ACO may reasonably require to monitor the cost and quality of services, including care management services. By way of example and not limitation, ACO expects that it will require clinical data from electronic or paper health records, scheduling data, registration data, billing data, patient satisfaction survey data, and care management data. Participant will cooperate in connecting its information systems to ACO, or ACO's designee, in order to facilitate the exchange of clinical and cost related data in furtherance of the requirements of the applicable ACO Program. Participant and Affiliate each agree to enter into an agreement with Vermont Information Technology Leaders, or a successor health information exchange provider ("HIE"), to forward clinical information regarding ACO Beneficiaries from Participant's or Affiliate's EHR to a third-party data repository designated by ACO, or any successor data repository, analytics, or case management system provider ("Data Repository"). Participant and Affiliate authorize ACO to direct HIE to forward clinical information to the Data Repository and authorizes Data Repository to de-identify protected health information sent by Participant and Affiliate, aggregate that de-identified data with other de-identified data and use the aggregated, de-identified data for Data Repository's data reporting, analytics purposes, and other data purposes. Participant and Affiliate authorize ACO to seek individually identifiable health information ("IIHI") regarding ACO Program Beneficiaries from any sources to be directed through the Data Repository for ACO purposes.

7.2 Monitoring. Subject to applicable confidentiality laws and within ten (10) business days following a request by ACO or an ACO Program Payer, Participant and Affiliate shall provide ACO, or its designees (which may include an independent auditor), access during regular business hours for: (i) inspection and copying of all records maintained by Participant or Affiliate related to Participant's or Affiliate's provision of ACO Program covered services to ACO Program Beneficiaries (including, but not limited to, medical, financial, accounting, administrative and billing records); (ii) assessing the quality of care or investigating grievances and complaints of ACO Program Beneficiaries; and (iii) inspection of Participant's or Affiliate's facilities, policies and procedures for quality assurance, utilization review, verification of professional qualifications, claims payment verification, fraud and abuse investigation, financial policies, and other activities

reasonably necessary for the efficient administration of the ACO, and as necessary for compliance with federal and state law or requirements. Participant and Affiliate also agree to cooperate with ACO's assessment of Participant's and Affiliate's qualifications to participate in risk-bearing ACO Programs.

7.3 Survival. The provisions of this Section 7 shall survive termination of this Agreement.

**8.0 COMPLIANCE**

8.1 ACO Program Rules, Clinical Model and ACO Policies. Participant and Affiliate agree to support, comply with, and implement the Clinical Model, the ACO Compliance Program and applicable ACO Program policies. Participant and Affiliate shall cooperate with ACO's case management protocols, which may include: placing in-office case managers at Participant's or Affiliate's practice; permitting ACO to conduct telephonic and on-site utilization management and quality assurance activities; and/or requiring Participant or Affiliate to coordinate with ACO or other Participant or Affiliate hospital's or facility's case managers regarding the care of ACO Program Beneficiaries. Participant and Affiliate acknowledge that sharing of provider identifiable quality and cost data is a core component of ACO's Programs and consent to the sharing of such information. Participant and Affiliate shall implement such cost and quality control protocols or other interventions as may be adopted by ACO regarding the care of ACO Program Beneficiaries. ACO shall, to the extent practicable, make new policies available to Participants on the ACO Provider Portal prior to their implementation, unless those policies are changed to achieve regulatory or legal compliance for which immediate effectiveness is required. Participant and Affiliate also agree to participate in the ACO's Compliance Program including, but not limited to, participating in audits, attending compliance training, ensuring Participant's and Affiliate's policies are consistent or do not conflict with the ACO Program Rules, Clinical Model or ACO Policies, educating Participant's and Affiliate's staff and reporting instances of non-compliance.

8.2 Applicable Law. Participant, Affiliate and ACO shall comply with all applicable laws and regulations governing participation with the ACO which include, but are not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Stark. Participant and Affiliate shall comply with the provisions set forth in the Business Associate and Qualified Service Organization Addendum, attached hereto as **Exhibit A**. Participant and Affiliate also agree to comply with the ACO Policies which are incorporated herein by reference and will be made available to Participant and Affiliate. Such compliance may include Participant and Affiliate compliance training.

8.3 Failure to Comply. Failure to comply with the terms of this Agreement or the applicable ACO Program Addendum may result in remedial processes and penalties which may include progressive discipline, including but not limited to, reductions of payment or termination of this Agreement as to Participant, Affiliate or a Provider.

## 9.0 CONFIDENTIALITY

9.1 Beneficiary Information. Beneficiary information, which may or may not include individually-identifiable protected health information, will be managed in accordance with ACO's HIPAA-compliant Privacy and Security Policy, ACO's Data Use Policy, and the Business Associate and Qualified Service Organization Addendum, attached hereto as **Exhibit A**.

9.2 Proprietary Information. The Parties each acknowledge that each may disclose confidential and proprietary information (by way of example and not limitation, policies and procedures, records, formulas) to the other in the course of performance of this Agreement. All information so disclosed which is not otherwise publicly available shall be deemed confidential and shall not be further disclosed by the receiving Party without the prior written consent of the original disclosing Party. Upon termination of this Agreement, for any reason, each party shall return to the other all electronic and printed materials containing confidential or proprietary information received from the other, that it is not required to retain pursuant to this Agreement or law or certify to the other that those materials have been destroyed.

9.3 Survival. The obligations of this Section 9 shall survive termination of this Agreement.

## 10.0 INSURANCE

10.1 Professional Insurance. Participant or Affiliate who is not a hospital or ambulatory service center or a Federally Qualified Health Center enjoying the privileges of Federal Tort Claim Act immunity, at its sole cost and expense, shall procure and maintain such professional liability insurance as is necessary to insure Participant, Affiliate and each of its respective Providers, employees, agents and representatives with coverage limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in annual aggregate in the performance of any act relating to this Agreement. Upon request, Participant, Affiliate or Provider, as appropriate, agree to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such professional liability policy is a "claims made" policy, Participant or Affiliate will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Participant and Affiliate agree to provide ACO with immediate written notice of any cancellation, non-renewal or change to such policy.

10.2 Hospital Insurance. Participant who is a hospital or ambulatory service center, at its sole cost and expense, shall procure and maintain such policies of insurance as are necessary

to insure Participant and its Providers, employees, agents and representatives with coverage limits of not less than one million dollars ($1,000,000) per occurrence, three million dollars ($3,000,000) in annual aggregate, and five million dollars ($5,000,000) excess coverage in the performance of any act relating to this Agreement. Upon request, Participant agrees to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such liability policy is a "claims made" policy, Participant will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available.

## 11.0 INDEMNIFICATION

Unless prohibited by Federal Tort Claim immunity or other law(s), Participant and Affiliate, on behalf of itself and its Providers, shall indemnify, defend and hold harmless ACO, its subsidiaries and affiliates and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the "ACO Parties") from and against any and all claims, suits, actions, liabilities, losses, injuries, damages, costs and expenses, interest, awards or judgments, incurred by ACO (including reasonable attorney's fees) in connection with the performance of this Agreement or any negligence or breach of the obligations and/or warranties of Participant or Preferred Provider, except to the extent the claims or losses are caused by the negligence or willful misconduct of ACO.

ACO shall defend, indemnify and hold harmless Participant or Affiliate, its subsidiaries and affiliates and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the "Participant Party/ies") from and against any and all claims and losses incurred by Participant Party/ies as a result of any claim made by a third party against Participant Party/ies to the extent arising out of or relating to the ACO's negligence or breach of its obligations, representations or warranties set forth in this Agreement, except to the extent such claims or losses are caused by or result from the negligence of willful misconduct of any Participant Party.

If any claim or action is asserted that would entitle a Party to indemnification, the Parties shall give written notice thereof to the indemnifying party promptly; provided however, that the failure of the Party seeking indemnification to give timely notice hereunder shall not affect rights to indemnification hereunder, except to the extent that the indemnifying party is materially prejudiced by such failure. The indemnifying party shall have sole control over the defense of the claim, provided that the indemnifying party shall not settle, or make any admission of liability or guilt without first obtaining the Indemnified Party's written consent which consent shall not be unreasonably withheld or delayed. The obligation of this Indemnification provision shall survive expiration or termination of the Agreement.

## 12.0 GENERAL PROVISIONS

12.1 Entire Agreement. This Agreement, including exhibits, ACO Program Addendums or other attachments as well as any documents incorporated by reference, constitute the entire agreement between the Parties regarding participation in ACO Programs and supersedes any agreements prior its execution.

12.2 Successors and Assigns. This Agreement shall not be assigned by either Party without the written consent of the other Party, which consent shall not be unreasonably withheld, provided that ACO may assign its rights and obligations under the Agreement to an entity that it controls or is controlled by or is under common control with ACO.

12.3 Amendments. This Agreement may be amended or modified in writing as mutually agreed upon by the Parties, or as provided in this Agreement. In addition, ACO may unilaterally modify any provision of this Agreement and its exhibits, addendums or attachments upon thirty (30) days prior written notice to Participant or as required in Section 8 to comply with federal or state laws or regulations.

12.4 Independent Contractor Relationship. None of the provisions of this Agreement between or among ACO, Participant, Affiliate, Providers, or Payers is intended to create a relationship other than that of an independent contractor relationship.

12.5 No Third-Party Beneficiaries. Except as specifically provided herein by express language, no person or entity shall have any rights, claims, benefits, or powers under this Agreement, and this Agreement shall not be construed or interpreted to confer any rights, claims, benefits or powers upon any third party.

12.6 Section Headings. All Section headings contained herein are for convenience and are not intended to limit, define or extend the scope of any provisions of this Agreement.

12.7 Severability. In the event any part of this Agreement shall be determined to be invalid, illegal or unenforceable under any federal or state law or regulation, or declared null and void by any court of competent jurisdiction, then such part shall be reformed, if possible, to conform with the law and, in any event, the remaining parts of this Agreement shall be fully effective and operative so far as reasonably possible to carry out the contractual purposes and terms set forth herein.

12.8 Waiver of Breach. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation of this Agreement.

12.9 Notices. Notices and other communications required by this Agreement shall be deemed to have been properly given if mailed by first-class mail, postage prepaid, or

hand delivered to the following address:

ACO: OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301, Colchester, VT 05446
Attn: Director of ACO Program Strategy and Network Development

Participant/Affiliate: Address located on title page of this Agreement

12.10 Counterparts, Signatures: This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Any signature delivered by facsimile machine, or by .pdf, .tif, .gif, .peg or other similar attachment shall be treated in all manners and respects as an original executed counterpart and shall be considered to have the same binding legal effect as if it were the original signed version thereof delivered in person.

**IN WITNESS WHEREOF**, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the date executed by ACO indicated above.

**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC**

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

**PARTICIPANT/AFFILIATE**

By: _____ Date: _____
Authorized Signature

Print Name: _____
Title: _____
Legal Business Name: _____
TIN: _____

**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC**
**MEDICARE NEXT GENERATION MODEL ACO PROGRAM ADDENDUM**

**THIS NEXT GENERATION MODEL ACO PROGRAM ADDEDNUM** ("ACO Program Addendum") is attached and made part of the Risk Bearing Participant and Affiliate Participant Agreement ("the Participant Agreement") in place between ACO and Participant or Affiliate (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 materials applicable to the Participant or Affiliate, shall control.

**BACKGROUND**

ACO has entered into an agreement with the Centers for Medicare and Medicaid Services ("CMS") through which the ACO will participate in the Next Generation ACO Model (the "Program"), an alternative payment and population health management program with Medicare, as described in the agreement between ACO and CMS ("Next Generation Participation Agreement") available on the ACO Provider Portal and incorporated by reference into this ACO Program Addendum. ACO, Participant and Affiliate agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Participant Agreement.

**NOW, THEREFORE**, the Parties agree as follows:

## 1.0 NEXT GENERATION ACO PROGRAM PARTICIPATION

1.1 Participation. Participant and Affiliate 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 Next Generation Participation Agreement between ACO and CMS and to comply with all applicable laws and regulations. This compliance includes but is not limited to, compliance with the provisions in the Next Generation Participation Agreement relating to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Affiliates(4) voluntary alignment; (5) Beneficiary freedom of choice; (6) benefit enhancements; (7) the coordinated care reward; (8) participation in evaluation, shared learning, monitoring and oversight activities; (9) the ACO Compliance Plan; and (10) audit and record retention requirements.

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

1.3 Authority to Bind. Participant warrants that, in addition to the authority to bind providers under the Participant Agreement, it has the authority to and will bind each Participant and Provider, with an NPI number billing under the Participant's TIN and included on the Next Generation Participant List approved by CMS.

Affiliate warrants that, in addition to the authority to bind Providers under the Participant Agreement, it has the authority to and will bind each Provider with an NPI number and each employee whose services are billed under Affiliate's TIN and included on the Next Generation Preferred Provider list approved by CMS.

1.4 Providers in Good Standing with Vermont and Medicare. Participant and Affiliate will each individually maintain a current Medicare provider agreement in good standing and be duly licensed and remain in good standing with the appropriate state licensing board. Participant will require each provider whose NPI is associated with Participant to maintain a current Medicare provider agreement in good standing and to be duly licensed and remain in good standing with the appropriate state licensing board. Affiliate agrees to require each person performing services that are individually or collectively billed under Affiliate's TIN to be duly licensed and in good standing with the appropriate state licensing board and Medicare.

1.5 Patient Record Requests. Participants and Affiliate 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.

1.6 Required Notices. Participants and Affiliates will provide ACO with the following notices:

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

1.6.2 All relevant information about any investigation sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges), within seven (7) days of becoming aware of the triggering event.

1.7 Exclusivity. Participants whose TIN includes NPIs of a Primary Care Practitioner (as determined by the Next Generation Participation Agreement, but generally a physician, physician assistant, or nurse practitioner designated as general practice, family medicine, internal medicine or geriatric medicine) who bills Qualified Evaluation and Management Services (as determined by the Next Generation Participation Agreement and including evaluation and management codes) may not participate in more than one Next Generation Model Program, or any other payment reform program in which they attribute or align lives, or with any other accountable care organization. Nothing in this paragraph shall be interpreted to

preclude Participants, whose TIN does not include NPIs of Primary Care Practitioners, from membership in more than one accountable care organization participating in the Program. These exclusivity provisions are based on the Program rules and are subject to change if the Program rules change.

**2.0 PAYMENT**

2.1 Form of Payment. Affiliates will be paid fee for service. Before the beginning of each Performance Year, ACO will develop a program of payment for Participants. Participation in ACO may result in a change in the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, Medicare or a combination of the two. 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 Medicare. The Board of Managers reserves the right to amend or alter payment methodology during the term of this Agreement.

a. Annually, before the required decision to participate for the Performance Year, each non fee for service Participant will be provided, in writing, a description of the payment methodology and preliminary model of payment that is specific for the individual Participant. As soon as practical prior to the first day of a Performance Year, the Board of Managers will approve a final budget and program of payments for Participants and a final payment model will be issued to each Participant based on the information available from Payer. The Board of Managers reserves the right to adjust, amend or alter the final payment model as appropriate if the ACO financial model is changed, CMS changes its commitment or for other reasons.

2.2 Payment in Full. Participants and Affiliates will collect applicable copayments, coinsurance and/or deductibles from Beneficiaries in accordance with their Medicare benefits which are not affected by this ACO Program and agrees to accept any 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 Affiliates will submit claims to CMS or ACO's delegate for processing in accordance with Medicare's applicable policies, including Medicare's timely filing requirements, but will receive reimbursement from ACO, as outlined in this Section 2.0.

2.4 Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with 42 C.F.R. § 405, Subpart I. Participant and Affiliate will direct all appeals and/or grievances or payment disputes, related to ACO Program contractual issues, to ACO and ACO will manage them in accordance with an ACO

appeals policy that complies with Program requirements. Participant and Affiliate will continue to cooperate with CMS in the resolution of a Beneficiary's claim.

2.5 Shared Savings. Shared Savings if earned will be contributed to a Value Based Incentive Pool which shall be distributed to Participants and/or Affiliates in a manner consistent with ACO strategy and approved by the Board of Managers. The Board of Managers may alter or amend the policies for Shared Savings during this Agreement.

2.6 Shared Losses. Losses, if incurred, will be paid by ACO and Participants in a manner consistent with ACO strategy and approved by the Board of Managers. The Board of Managers may alter or amend the policies for Shared Losses during this Agreement.

## 3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on the Effective Date. The Initial Term shall be from the Effective Date through the last date of the last Performance Year for the Program, or December 31, 2020. Thereafter, this Agreement may be extended for additional one (1) year terms, as agreed by the Parties.

3.2 Remedial Action. ACO may take remedial action against the Participant or Affiliate (including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, denied access to ACO data systems, and termination of the ACO's Participant Agreement or this Program Addendum with the Participant or Affiliate) to address noncompliance with the terms of the Program or program integrity issues identified by ACO or CMS.

3.3 Termination. This Program Addendum will automatically terminate if the Participation Agreement terminates or if the Participant or Affiliate becomes ineligible to participate in Medicare, for any reason. This Program Addendum will terminate prior to the end of the Initial Term or Term, as applicable, if CMMI requires the ACO to remove the Participant or Affiliate from the approved list of providers, pursuant to the terms of the Next Generation Participation Agreement.

a. Participant may terminate this Agreement for the first Performance Year or non-renew for any subsequent Performance Year, if after receiving the applicable program of payment as approved by the Board of Managers it does not wish to participate, by providing written notice to ACO on or before September 1st of the year before the Performance Year commences (should CMMI 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 Participant wishes to non-renew for Performance Year 2019, and ACO does not extend the deadline, notice must be given by September 1, 2018. If Participant terminates timely before its first Performance Year, it shall have no obligations to ACO for that or any

subsequent Performance Year. Should, Participant non-renew for any Performance Year, it will have no financial obligation to ACO for the Performance Year as to which it 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 CMS, it determines not to participate in the ACO Program and provides that notice to CMS 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, non-renewed, or expires, Participant and Affiliate 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. Moreover, a Participant or Affiliate 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.

**IN WITNESS WHEREOF**, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the date executed by ACO indicated below.

**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC**

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

**PARTICIPANT/AFFILIATE**

By: _____ Date: _____
Authorized Signature

Print Name: _____
Title: _____
Legal Business Name: _____
TIN: _____

**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 ADDEDNUM** ("ACO Program Addendum") is attached to and made part of the Risk Bearing Participant and Affiliate Agreement ("Participant Agreement") in place between ACO and Participant or Affiliate (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 shall control. The ACO Program Agreement or policies from Vermont Medicaid applicable to the Participant or Affiliate shall control in the event of any conflict with the contractual provisions between ACO and Participant or Affiliate. 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 Affiliate 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 the agreement between ACO and DVHA ("Vermont Medicaid Next Generation Participation Agreement" or "Participation Agreement") available on the ACO Provider Portal and incorporated by reference into this ACO Program Addendum. ACO, Participant and Affiliate agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Participant Agreement.

**NOW, THEREFORE**, the Parties agree as follows:

## 1.0 MEDICAID NEXT GENERATION ACO PROGRAM PARTICIPATION

1.1 Participation. Participant and Affiliate 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 provisions of the Vermont Medicaid Next Generation Participation Agreement relating to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Affiliates; (4) voluntary attribution; (5) Beneficiary freedom of choice; (6) benefit enhancements; (7) the coordinated care reward; (8) participation in evaluation, shared learning, monitoring and oversight activities; (9) the ACO Compliance Plan; (10) continuity of benefits and (11) audit and record retention requirements. Participant and Affiliate further agree that as part of their participation in the Program

and their Vermont Medicaid provider agreements that they will be prohibited from terminating a patient for any cause related to their health status or their need for medical services that result in health risk utilization of the Participant or Affiliate.

1.2 Updating Information. Participant and Affiliate are each required to update its Medicaid enrollment information (including the addition and deletion of Vermont Medicaid Next Generation Participants or providers, identified at the NPI level, that have reassigned to the Participant or Affiliate their right to Medicaid payment) on a timely basis in accordance with Medicaid program requirements.

1.3 Authority to Bind. Participant warrants that, in addition to the authority to bind providers under the Participant Agreement, it has the authority to and will bind each Next Generation Participant and provider, with an NPI number billing under the Participant's TIN and included on the Vermont Medicaid Next Generation Participant List approved by DVHA to the terms of this Program Addendum.

Affiliate warrants that, in addition to the authority to bind providers under the Participation Agreement, it has the authority to and will bind each Provider with an NPI number and each employee whose services are billed under Affiliate's TIN and included on the Vermont Medicaid Next Generation Participant List approved by DVHA to the terms of this Program Addendum.

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

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

1.6 Patient Record Requests. Participants and Affiliates 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 Affiliates 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 relevant information about any investigation sanctioned by the Government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicaid billing privileges) within seven (7) days of becoming aware of the triggering event.

1.8 Exclusivity. Participants whose TIN includes NPIs of a Primary Care Practitioner (as determined by the Participation Agreement, but generally physician, physician assistant, or nurse practitioner designated as general practice, family medicine, internal medicine or geriatric medicine) who bills Qualified Evaluation and Management Services (as determined by the Participation Agreement and including evaluation and management codes) may not participate in more than one Medicaid Next Generation Model Program, or any other payment reform program in which they attribute or align lives, with another accountable care organization. Nothing in this paragraph shall be interpreted to preclude Participants, whose TIN does not include NPIs of Primary Care Practitioners, from membership in more than one accountable care organization participating in the Program. These exclusivity provisions are based on the Program rules and are subject to change if the Program rules change.

## 2.0 PAYMENT

2.1 Form of Payment. Affiliate will be paid fee-for-service. Before the beginning of each Performance Year, ACO will develop a program of payment for Participants. 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 payment methodology during the term of this Agreement.

a. Annually, before the required decision to participate for the Performance year, each non fee-for-service Participant will be provided with, in writing, a description of the payment methodology and preliminary model of payment that is specific for the individual Participant. As soon as practical prior to the first day of a Performance Year, the Board of Managers will approve a final budget and program of payments for Participants and a final payment model will be issued to each Participant based on the information available from Payer. The Board of Managers reserves the right to adjust, amend or alter the final payment model as appropriate if the ACO financial model is changed, DVHA changes its commitment or for other reasons.

2.2 Payment in Full. Participant and Affiliate 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 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 Affiliates 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.

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 Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with the terms of the DVHA Member Handbook and Participants and Affiliates remain bound by the terms of the DVHA General Provider Agreement as to Beneficiary grievances and appeals. Participant and Affiliate will direct all appeals and/or grievances or payment disputes to ACO and ACO will manage them in accordance with an ACO appeals policy that complies with Program requirements. The appeals policy includes a written initial appeal, and a second level of appeal with the opportunity to be heard in person. Participant and Affiliate will continue to cooperate with DVHA in the resolution of Beneficiary grievances and disputes.

2.6 Shared Savings. Shared Savings, if earned, will be contributed to a Value Base Incentive Pool which shall be distributed to Participants and/or Affiliates in a manner consistent with ACO strategy and approved by the Board of Managers. The Board of Managers may alter or amend the policies for Shared Savings during the term of this Agreement.

2.7 Shared Losses. Losses, if incurred, will be paid by ACO and Participants in a manner consistent with ACO strategy and approved by the Board of Managers. The Board of Managers may alter or amend the policies for Shared Losses during the term of this Agreement.

## 3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on the Effective Date. The Initial Term shall be from the Effective Date through the last date of the last Performance Year for the Program, or December 31, 2020. Thereafter, this Agreement may be extended for additional one (1) year terms, as agreed by the Parties.

3.2 Remedial Action. ACO may take remedial action against the Participant or Affiliate including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, denied access to ACO data systems, and termination of the ACO's Participant Agreement or this Program Addendum with the Participant or Affiliate to address noncompliance with the terms of the Program or program integrity issues identified by ACO or DVHA.

3.3 Termination. This Program Addendum will automatically terminate if the Participation Agreement terminates or if the Participant or Affiliate becomes ineligible to participate in Vermont Medicaid, for any reason. This Program Addendum will terminate prior to the end of the Initial Term or Term, as applicable, if DVHA requires the ACO to remove the Next Generation Participant from the approved list of providers, pursuant to the terms of the Next Generation Participation Agreement.

a. Participant may terminate this Agreement for the first Performance Year of participation or non-renew for any subsequent Performance Year, if after receiving the applicable program of payment as approved by the Board of

Managers it does not wish to participate, by providing written notice to ACO on or before September 1st 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 ACO Program). By way of example, if Participant wishes to non-renew for Performance Year 2019, and ACO does not extend the deadline, notice must be given by September 1, 2018. If Participant terminates timely before its first Performance Year, it shall have no obligations to ACO for that or any subsequent Performance Year. Should, Participant non-renew for any Performance Year, it will have no financial obligation to ACO for the Performance Year as to which it 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 DVHA, it determines not to participate in the ACO Program and provides that notice to DVHA 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 and Affiliate 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 and Affiliate will be required to meet all financial obligations for the Performance Year of termination, including Shared Losses.

**IN WITNESS WHEREOF**, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the date executed by ACO indicated below.

**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC**

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

**PARTICIPANT/AFFILIATE**

By: _____ Date: _____
Authorized Signature

Print Name: _____
Title: _____
Legal Business Name: «contract_desc»
TIN: «tin»

**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC**
**BLUE CROSS & BLUE SHIELF OF VERMONT COMMERCIAL NEXT GENERATION-LIKE MODEL**
**ACO PROGRAM ADDENDUM**

**This ACO Program Addendum will be drafted accordingly upon completion of negotiations with Blue Cross & Blue Shield of Vermont.**