

FIRST AMENDED AND RESTATED
ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
RISK-BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT

Legal Business Name:

Contractual Address:

TIN:

This First Amended and Restated RISK-BEARING PARTICIPANT / PREFERRED PROVIDER AGREEMENT (the “Agreement”) is by and between OneCare Vermont Accountable Care Organization, LLC (“ACO”), a Vermont limited liability company, and Participant or Preferred Provider, a health care provider or organization eligible to participate with ACO as defined below and organized under Vermont or New Hampshire law (each a “Party” and collectively, the “Parties”) and is effective the date signed by the ACO. This Agreement replaces any Participant or Preferred Provider (“Affiliate”) Agreement between the Parties for Performance Years 2019 through 2022.

WHEREAS, ACO is an accountable care organization that participates in alternative payment programs (“ACO Programs”) with governmental and private payers (collectively referred to as “Payers”) and conducts ACO Activities;

WHEREAS, ACO and Participants and Preferred Providers 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”);

WHEREAS, Participant and Preferred Provider agree to participate in ACO Programs and all Parties are committed to being accountable for the quality, cost and overall care of the patients attributed to the ACO and will, with ACO’s support, implement population health management processes to support that accountability; and

WHEREAS, the Parties agree to share in the financial outcomes from their joint efforts in population health management.

NOW, THEREFORE, the Parties agree as follows:

1.0 DEFINITIONS

The following terms shall have the meanings indicated. In the event an ACO Program Addendum varies from these definitions, the ACO Program Addendum definition will control for that ACO Program.

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- 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 an 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 Preferred Provider 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 ACO Program.
- 1.7 “ACO Program Beneficiary” “Beneficiary” or “Attributed Life” means an individual that receives healthcare benefits from a Payer in an ACO Program and is attributed to ACO in accordance with the terms of an ACO Program Agreement.

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- 1.8 “ACO Provider Portal” means the secure interface between ACO and Participant and Participant’s Providers and Preferred Providers where ACO provides access to policies, procedures and other program information.
- 1.9 “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) care coordination; and (3) clinical data sharing.
- 1.10 “Health Care Services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- 1.11 “NPI” means the National Provider Identifier unique ten-digit identification number required for all licensed health care providers.
- 1.12 “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.
- 1.13 “Participant” means an individual or group of Providers that is: (1) identified by a TIN; (2) included on any list of Participants submitted by ACO to Payers; (3) qualifies to attribute lives in ACO Programs; and (4) that has entered into a Risk Bearing Participant & Preferred Provider Agreement with ACO. Participant may be more particularly defined in each ACO Program.
- 1.14 “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.
- 1.15 “Performance Year” means the twelve (12) month period measured by each ACO Program to determine financial reimbursement.
- 1.16 “Preferred Provider” or “Affiliate” means an individual or an entity that: (1) is identified by a TIN; (2) if required by ACO Payer(s), is included on the list of Preferred Providers submitted by ACO to Payer(s); (3) does not qualify to attribute lives in ACO Programs; and (4) has entered into a Risk Bearing Participant and Preferred Provider Agreement with ACO. Preferred Provider may be more particularly defined in each ACO Program.
- 1.17 “Provider” means a health care practitioner or entity that: (1) meets the terms of participation in ACO Programs; (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 (if required by Payers) submitted by ACO to Payers.

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- 1.18 “Shared Risk” or “Shared Loss” is more particularly defined by each ACO Program, but generally means the portion of Performance Year spending that was greater than expected spending that must be returned to Payer.
- 1.19 “Shared Savings” is more particularly defined by each ACO Program, but generally means the portion of Performance Year spending that was less than the expected spending.
- 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 Preferred Providers 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 Preferred Providers 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 Preferred Provider shall participate in each ACO Program that qualifies for All Payer Model Scale Targets, for which a Program Addendum is provided within the time frames set forth in paragraph 3.1 (“Core ACO Programs”) and that is offered by a Payer for which Participant or Preferred Provider is an enrolled provider and in good standing, by signing an ACO Program Addendum for each such ACO Program. A Participant or Preferred Provider may, with ACO’s approval, choose not to participate in a Core ACO Program if: (1) it shows good cause as determined by the ACO Core Program Exceptions Policy; (2) it demonstrates to the Board’s reasonable satisfaction that the financial risk would jeopardize financial solvency thresholds established by Payer, ACO Program or the ACO; or (3) it demonstrates to the Board’s reasonable satisfaction that the operational demands would materially negatively impact its operations or there is no resource capacity to fully participate in the clinical and quality programs of ACO. Additionally, ACO may offer non-Core ACO Programs which Participant and Preferred Provider may choose not to participate in for any reason. Participants, Providers and Preferred Providers will maintain good standing to provide services with each ACO Program Payer for which it is enrolled 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 or Vermont Medicare ACO Initiative, it may not be in MSSP. Nothing in this Agreement supersedes any of the terms and conditions of Participant’s or Preferred Provider’s enrollment in a Payer’s insurance program unless the Payer’s requirements have been

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waived or modified in the Program Agreement between ACO and Payer. ACO, may, in its discretion, require additional reasonable verification of professional qualifications. Providers who are denied status as Participants or Preferred Providers, those who are not renewed for any reason and those who are terminated from OneCare will receive a written notice explaining the reason for denied status with instruction on how to appeal the decision to ACO, consistent with the ACO's Appeals Policy.

- 2.3 Authority to Bind Employees. Participant and Preferred Provider 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 Programs, 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 Preferred Providers for cause, in accordance with the applicable ACO Program Addendums, Clinical Model or ACO Policies. Participants and Preferred Providers agree to manage their lists of participating Providers with ACO by providing timely notices of changes, as required by Section 5. To the extent that any Provider or employee identified by an NPI linked to Participant's or Preferred Provider's TIN is excluded from an ACO Program, Participant or Preferred Provider will cooperate in de-linking or disassociating that Provider's NPI from the Participant's or Preferred Provider's TIN or ACO Program for purposes of billing applicable Payers.
- 2.5 Grievances and Appeals. Participants and Preferred Providers 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.
- 2.6 Participation in ACO Governance. Participants and Preferred Providers agree to participate in the ACO's governance by participating in the election or appointment of the Participant and Preferred Provider 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

3.1 Payment. Annually, beginning for Performance Year 2020 at least sixty (60) days prior to the Performance Year non-renewal deadline as set forth in Section 4.1.1, ACO will implement a Program of Payment and supporting ACO Policies that will determine the methodology of payment to Participants and Preferred Providers for health care services, supplemental payments through the ACO and risk and sharing arrangements for ACO Programs. The Program of Payment is attached as Exhibits A, A1 and A2 and will be replaced by ACO each Performance Year with supporting ACO Policies at least sixty (60) days prior to the non-renewal deadline, except for PY 2019 in which it will be provided at least thirty (30) days before the non-renewal deadline. Notwithstanding anything to the contrary herein, the Program of Payments will, subject to non-renewal and termination

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rights, be replaced by ACO annually on this schedule and will be effective as an amendment without requiring the Parties' signatures.

The ACO may, notwithstanding anything to the contrary in this Agreement, amend the Program of Payments to add available payments at any time (but not to remove or reduce any payments) which shall be effective as an Amendment without requiring the Parties' signatures. The ACO may amend the Program of Payments consistent with the terms of each ACO Program Addendum which shall control in the event of a conflict with this Agreement.

- 3.2 Supplemental Payments. As part of the Program of Payments, ACO may make supplemental payments to support ACO Activities, such as care coordination, for Participants and Preferred Providers who meet established criteria for those payments as set forth more fully in Exhibit A1. Consistent with Section 3.1, ACO will provide the supplemental payments policy as part of the Program of Payments for each Performance Year. Participants, Preferred Providers and Providers who accept these payments certify that they meet the requirements to receive the payments.
- 3.3 Risk/Savings Methodology. ACO will provide the Shared Risk/Savings Policy, as adopted by the ACO Board of Managers, as part of the Program of Payments in accordance with Section 3.1.

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 Preferred Provider is no longer participating in an ACO Program; or (2) December 31, 2022. In the event that one ACO Program is terminated, but others remain in effect, this Agreement shall continue to be effective as it pertains to the remaining ACO Programs.

4.1.1 Program Year Non-Renewal. As more specifically set forth in each ACO Program Addendum, and consistent with the Core ACO Program requirements set forth in Paragraph 2.2 above, annually Participants and Preferred Providers may elect to terminate this Agreement or non-renew specific ACO Programs effective the first day of the next Performance Year by providing ACO with notice of termination or non-renewal before August 31st of the prior Performance Year (the "non-renewal" or "termination" deadline"). By way of example if a Participant's request to be excluded from a Core ACO Program is refused by the Board, the Participant may terminate the Agreement in its entirety or continue participation in all Core ACO Programs. ACO will, during the Modeling Period (as defined in Exhibit A) provide risk bearing Participants with sufficient financial detail to facilitate an informed decision for participation in ACO Programs including estimates of expected payment and risk to support their participation decisions.

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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 ACO Program Agreement between ACO and a Payer terminates, or in the event Participant or Preferred Provider non-renews an ACO Program Addendum in accordance with paragraph 4.1.1. above, this Agreement shall only terminate with respect to those terminated ACO Programs and all others shall remain in full force and effect. ACO Program obligations for the last Performance Year of participation, such as quality reporting, obligations for Shared Risk and opportunities for Shared Savings will survive termination.

5.0 NOTICES

5.1 Required Notices. In addition to the disclosures that are required in an ACO Program Addendum, Participant and Preferred Provider shall notify ACO and ACO shall notify Participant and Preferred Provider, 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 Preferred Provider with immediate written notice of the termination of ACO's participation in an ACO Program;

5.2.2 Each Party shall provide the other with immediate written notice in the event they or any Provider associated with their TIN 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 Each Party shall provide the other with immediate written notice in the event of investigation or issuance of formal charges by any governmental agency or accrediting agency that could materially impair that Party's ability to perform its obligations under this Agreement;

5.2.4 Each Party shall provide the other with immediate written notice in the event of any lawsuit related to services under this Agreement or that might materially impair the Party's ability to perform its obligations under this Agreement;

5.2.5 Each Party shall provide the other with immediate written notice in the event it receives a written notice of any cancellation, non-renewal or change to any insurance policy required under this Agreement that would affect the coverage required of the party under this Agreement; and

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

5.3 Other Notices.

5.3.1 ACO shall provide Participant and Preferred Provider with thirty (30) business day's written notice prior to making any changes to the terms of ACO Program Addendums, unless the changes are made to comply with an applicable law or regulation, as more fully set out in Section 12.3.

5.3.2 Each Party shall provide the other notice, as soon as reasonably possible but no later than ten (10) days, in the event of a voluntary surrender or termination of any of Participant's, a Provider's, Preferred Provider's or ACO's licenses, certifications, or accreditations;

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

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

6.0 RECORDS

6.1 Beneficiary and ACO Program Records. The Parties 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, quality, 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 HIPAA; and (ii) ACO Program billing, reimbursement, and administrative requirements. For Participants and Preferred Providers, 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

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concurrent or retrospective basis, the medical necessity and appropriateness of care provided.

- 6.2 Financial Records. The Parties 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 Preferred Provider acknowledge that by becoming a Participant or Preferred Provider they are agreeing to participate in an OHCA and further acknowledge that Beneficiary records may be shared with other Participants, Preferred Providers, or ACO Other Entities for ACO Activities. In addition to OHCA sharing, Participant and Preferred Provider shall make the records available to and communicate as appropriate with each Participant, Preferred Provider, 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 Preferred Provider hereby authorizes ACO to release any and all information, records, summaries of records and statistical reports specific to Participant or Preferred Provider, including but not limited to utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Participant's or Preferred Provider's performance of services and professional qualifications to federal or state governmental authority(ies) with jurisdiction, or any of their authorized agents, accreditation agencies, or ACO Program Payers without receiving Participant's or Preferred Provider'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 Preferred Provider shall, consistent with any limitations arising from 42 CFR Part II, 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 coordination services. By way of example and not limitation, ACO expects that it will require clinical data from electronic or paper health records, scheduling data, patient satisfaction survey data, and care coordination data. Participant and Preferred Provider will, consistent with any limitation arising from 42 CFR Part II, 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 Preferred Provider, consistent with any limitation arising from 42 CFR Part II, 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 Program Beneficiaries from Participant's or Preferred Provider's EHR to a third-party data repository designated by

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ACO, or any successor data repository, analytics, or case management system provider (“Data Repository”). Participant and Preferred Provider 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 Preferred Provider, 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 Preferred Provider 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 Data from ACO. ACO will provide Participant and Preferred Provider with data and information to support their participation in ACO Programs. Such data and information will include access to and reports from WorkBench One or any successor platform, the ACO analytics platform for benchmarking and evaluating clinical, quality and financial performance in ACO Programs. Additionally, Participant and Preferred Provider may request data reports at no cost from ACO to evaluate performance. ACO will promptly provide an acknowledgement of the request and work in good faith with Participant or Preferred Provider to accurately and timely provide responsive information.

7.3 Monitoring. ACO and ACO Program Payers may make requests of Preferred Provider under this section. Risk bearing Participants may make requests of ACO under this section. Subject to applicable confidentiality laws and standards of reasonable conduct in monitoring activities, within twenty (20) business days following a written request reasonably identifying the reason for and scope of the monitoring audit, the requesting party shall provide the other or its designees (which may include an independent auditor), access during regular business hours for: (i) inspection and copying of all records maintained by the party subject to the request relating to the ACO Program services, including, but not limited to, medical, financial, quality accounting, administrative and billing records); (ii) access to records to assess the quality of care or investigating grievances and complaints of ACO Program Beneficiaries; (iii) policies and procedures for quality assurance, utilization review, financial policies, fraud and abuse investigation; and (iv) inspection of Participant’s or Preferred Provider’s facilities, policies and procedures for verification of professional qualifications, claims payment verification, and other activities reasonably necessary for the efficient administration of the ACO, and as reasonably necessary for compliance with federal and state law or requirements.

Any monitoring audit costs will be borne by the requesting party.

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

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8.0 COMPLIANCE

- 8.1 ACO Program Rules, Clinical Model and ACO Policies. Participant and Preferred Provider agree to support, comply with, and implement the Clinical Model, the ACO Compliance Program and ACO Policies. The Parties acknowledge that the Clinical Model is an iterative, data driven model developed with the participation of the ACO's network of Providers that will include ACO-wide initiatives as well as HSA specific initiatives and that may vary over the course of this Agreement.

Participant and Preferred Provider shall cooperate with ACO's care coordination protocols, which may include: permitting ACO to conduct telephonic and on-site utilization management and quality assurance activities; and/or requiring Participant or Preferred Provider to coordinate with ACO or other Participant or Preferred Provider hospital's or facility's care coordinators regarding the care of ACO Program Beneficiaries. Participant and Preferred Provider 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 Preferred Provider 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 make new or revised policies available to Participants on the ACO Provider Portal at least thirty (30) days prior to their implementation unless those policies are changed to achieve regulatory or legal compliance for which immediate effectiveness is required. For changes that are not legal or regulatory in nature and that present material administrative burden or material expense to Participants or Preferred Providers, ACO will work collaboratively on the methods and timing for implementation. Changes to ACO Policies supporting the Program of Payment may only be made in accordance with Section 3 of this Agreement.

Participant and Preferred Provider 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 Preferred Provider's policies are consistent or do not conflict with the ACO Program Rules, Clinical Model or ACO Policies, educating Participant's and Preferred Provider's staff and reporting instances of non-compliance.

- 8.2 Applicable Law. Participant, Preferred Provider 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"), HITECH and Stark. Participant and Preferred Provider shall comply with the provisions set forth in the Business Associate and Qualified Service Organization Agreement, attached hereto as **Exhibit B**. Participant, Preferred Provider, and their Providers also agree to comply with the ACO Policies which are incorporated herein by reference and will be

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made available to Participant and Preferred Provider. Compliance may include Participant, Preferred Provider, and Provider compliance training.

- 8.3 Failure to Comply. Failure to comply with the terms of this Agreement, the applicable ACO Program Addendum or ACO Policies may result in remedial processes and penalties including progressive discipline, reductions of payment, elimination of payments, offsets in payment for amounts owed or termination of this Agreement as to the Participant, Preferred Provider 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 Agreement, attached hereto as **Exhibit B**.

- 9.2 Proprietary Information. The Parties 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 others, 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 Preferred Provider who is not a hospital, 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, Preferred Provider 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, Preferred Provider 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 Preferred Provider will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior

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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 Preferred Provider agree to provide ACO with immediate written notice of any cancellation, non-renewal or change to such policy.

- 10.2 Hospital Insurance. Participant or Preferred Provider 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 or Preferred Provider and all 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 or Preferred Provider 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 or Preferred Provider 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.
- 10.3 ACO Insurance. ACO, at its sole cost and expense, shall procure and maintain such policies of insurance in such amounts as are customarily maintained by ACOs or as required by ACO Programs. This shall include, at a minimum, general liability and property coverage with limits no less than one million dollars (\$1,000,000) per occurrence, two million dollars (\$2,000,000) in annual aggregate.

11.0 INDEMNIFICATION

Unless prohibited by Federal Tort Claim immunity or other law(s), Participant or Preferred Provider, on behalf of itself and its Providers, shall indemnify, defend and hold harmless ACO, its subsidiaries and Preferred Providers 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) as a result of any claim made by a third party 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 Preferred Provider, its subsidiaries and Providers and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the "Participant Party/ies") from and against any and all claims, suits, actions, liabilities, losses, injuries, damages, costs and

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expenses, interest, awards or judgments, incurred by Participant Party/ies (including reasonable attorneys' fees) 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 or 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, 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 shall not be unreasonably withheld or delayed. The obligations 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 and any documents incorporated by reference constitute the entire agreement between the Parties regarding participation in ACO Programs and supersedes any agreements prior its execution. In the event of any conflict between this Agreement and an ACO Program Addendum, the terms of the ACO Program Addendum shall control.
- 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.
- 12.3 Amendments This Agreement may be amended or modified in writing as mutually agreed upon by the Parties, unless otherwise stated herein. ACO may unilaterally modify any provision of this Agreement upon thirty (30) days prior written notice to Participant or Preferred Provider if the amendment is reasonably needed 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, Preferred Provider, Providers, or Payers is intended to create any 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

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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 is 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 emailed or 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 Operations
 Email: ACONetworkOperations@onecarevt.org

Participant/Preferred Provider: 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, .jpeg or other similar attachment shall be treated in all manner and respect 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.

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

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Kevin Stone
Interim Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

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**AMENDMENT #1 TO THE FIRST AMENDED AND RESTATED ONECARE
VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
RISK BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT**

Legal Business Name:

Contractual Address:

TIN:

This Amendment #1 to the First Amended and Restated Risk-Bearing Participant & Preferred Provider Agreement (the “Agreement”) is by and between OneCare Vermont Accountable Care Organization, LLC (“ACO”), a Vermont limited liability company, and Participant or Preferred Provider, a health care provider or organization eligible to participate with ACO as defined in the Agreement, and organized under Vermont or New Hampshire law (each a “Party” and collectively “Parties”) and is effective the date signed by the ACO.

WHEREAS, the Parties wish to Amend the Agreement.

NOW THEREFORE, the Parties agree as follows:

1. The first sentence of Paragraph 2.2. shall be amended to read as follows:

2.2 Qualification to Participate. Participant and Preferred Provider shall participate in each ACO Program that qualifies for All Payer Model Scale Targets, that is designated by the Board as a Core Program and for which a Program Addendum is provided within the time frames set forth in paragraph 3.1 (“Core ACO Programs”) and that is offered by a Payer for which Participant or Preferred Provider is an enrolled provider and in good standing, by signing an ACO Program Addendum for each such ACO Program.

2. The fourth sentence of Paragraph 2.2 shall be amended to read as follows:

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 the Vermont Medicare ACO Initiative, it may not be in MSSP.

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3. Paragraph 4.3 shall be added:

4.3 Bankruptcy. OneCare may terminate this Agreement immediately in the event Participant or Preferred Provider: files a petition commencing a voluntary case against it under the U. S. Bankruptcy Code; makes a general assignment for the benefits of its creditors; becomes insolvent; becomes unable to pay its debts as they become due; files a petition or answer in any proceeding seeking for itself or consenting to, or acquiescing in, any insolvency, receivership, composition, readjustment, liquidation, dissolution, or similar relief under any present or future statute, law, or regulation, or files an answer or other pleading admitting or failing to deny or to contest the material allegations of the petition filed against it in any such proceeding; seeks or consents to, or acquiesces in, the appointment of any trustee, receiver of it or any material part of its property; or has commenced against it any involuntary case under the U. S. Bankruptcy Code, or a proceeding under any receivership, composition, readjustment, liquidation, insolvency, dissolution, or like law or statute, which case or proceeding is not dismissed or vacated within thirty (30) days from commencement. ACO Program obligations for the last Performance Year of participation, such as quality reporting, obligations for Shared Risk and opportunities for Shared Savings will survive termination.

4. Paragraph 8.2.1 shall be added:

8.2.1 In the event that Participant or Preferred Provider reasonably believes that an ACO Policy or procedure is in conflict with one of their legal obligations, by way of example and not limitation a policy in conflict with regulations applicable to Federally Qualified Health Centers, the following process will apply:

- a. Participant or Preferred Provider will immediately notify OneCare by providing written notice specifying the nature of the conflict with reasonable detail in accordance with the notice provisions of this Agreement,
- b. OneCare will suspend application of the ACO Policy or procedure to Participant or Preferred Provider during this resolution process.
- c. OneCare's Chief Operating Officer, or his/her delegee, will gather information about the issues raised by Participant or Preferred Provider and attempt to resolve any conflict.
- d. If the conflict cannot be resolved with the Chief Operating Officer, the Executive Committee may consider the issue and provide advice.
- e. If the conflict remains unresolved, the Participant or Preferred Provider may utilize the Participant Appeals process.
- f. The Parties agree to act diligently and promptly to raise and resolve issues in this process.

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The Agreement is, in all other respects, affirmed and all provisions of the Agreement that are not specifically amended herein shall continue in full force and effect.

IN WITNESS WHEREOF, the Parties have caused this Amendment 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: _____
Kevin Stone
Interim Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

Print Name: _____

Title: _____

Legal Business Name:

TIN:

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Exhibit A
PERFORMANCE YEAR 2020 PROGRAM OF PAYMENT

Definitions

“Dues” or “Deductions from Payment” means the financial contributions to OneCare for administrative funding, population health management and care coordination fees, payment pilots, the Value Based Incentive Fund, and other OneCare board-approved programs that are retained by ACO from a risk bearing Participant’s Gross Fixed Payments.

“Gross Fixed Payments” means the total prospective, fixed payments payable to a risk bearing Participant as calculated for each ACO Program before incorporating the Deductions from Payment.

“Hospital Service Area” or “HSA” means the local health care markets for hospital care that are measured by collections of zip codes whose residents receive most of their hospitalizations from the hospitals in that area. Zip codes are assigned to the hospital area where the greatest proportion of their Medicare residents were hospitalized.

“Initial Attribution” means the attribution to the ACO at the beginning of the Performance Year. Attribution may decline during the course of the Performance Year, due to attrition or other factors, but it may not increase beyond the Initial Attribution level. Payments that are based on Attribution will vary during the course of the Performance Year as Initial Attribution declines.

“Maximum Risk and Sharing Limit” or “MRL” means the limit of the Risk Performance settlement payment exchange between Participant and ACO, either to or from the Participant, that a Participant will be required to assume in an ACO Program for a Performance Year. This is calculated separately for each program and applied in accordance with the Board approved Program Settlement Policy.

“Supplemental Care Coordination Payments” means payments that are made to qualifying Participants and Preferred Providers by OneCare to support care coordination activities that generally do not receive reimbursement from Payers.

“Supplemental Population Health Management Payments” means payments that are made to qualifying Participants or Preferred Providers by OneCare to support population health management activities that generally do not receive reimbursement from Payers.

“Total Cost of Care” or “TCOC” means, generally, the Payer’s financial cost of providing qualifying health care services to ACO’s Attributed Lives for a Performance Year. An Estimated Total Cost of Care is set between ACO and Payers before the Performance Year, and the ACO’s performance is measured by the difference between ACO Program Estimated Total Cost of Care and ACO Program Actual Total Cost of Care (the Payer’s actual cost). Each Program Agreement

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between ACO and a Payer will more particularly describe components of Total Cost of Care for that Program, for example, pharmacy may be excluded from some Programs' calculations of Total Cost of Care.

"Total Cost of Care PMPM Benchmark" means the Estimated Total Cost of Care expressed on a per attributed life per month basis. This is calculated separately for each ACO Program.

"Value Based Incentive Fund" or "VBIF" means funding that is set aside by ACO during the Performance Year to incentivize and reward the network. The funds are reserved by ACO from Risk Participants' prospective payments at levels required by the ACO Program Agreements or as set forth by the Board of Managers. The funds are earned under each ACO Program by meeting set criteria (usually performance on designated quality measures) established in each ACO Program Agreement and unearned funds may be owed to the Payers. Once earned the VBIF will be distributed to the network in accordance with the Board approved Value Based Incentive Fund Policy.

Calculations

Gross Fixed Payments

The Gross Fixed Payments are calculated using the methodology contained in the Board approved Fixed Payment Policy for Program Year 2020. These payments are made monthly to each Participant who accepts a fixed payment, subject to OneCare receiving payment from the corresponding Program payer. By way of example, if the AIPBP payment from Medicare to OneCare is delayed, the Gross Fixed Payment from OneCare to the Participant may be delayed as well. Any delays in payment will be communicated to the affected Participants promptly.

Dues

The Dues are calculated using the methodology contained in the Board approved OneCare Dues Policy for Program Year 2020. These amounts are deducted from the monthly Gross Fixed Payment(s) to the Participant. If the Participant is not accepting fixed payments, or the Program payer cannot make fixed payments, OneCare will invoice the Participant for any Dues amount owed. Payment is due within 30 days of the invoice date for Participant to remain in good standing.

Maximum Risk and Sharing Limit

The Maximum Risk and Sharing Limit is calculated by applying the ACO Program risk corridors and sharing arrangements to each HSA's calculated TCOC for the lives initially attributed. The HSA TCOC is determined by the Board approved HSA Benchmark Policy for Program Year 2020.

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Initial Attribution

The Initial Attribution is calculated by the Payer and reflects the starting number of Attributed Lives to OneCare as a whole. The Attributed Lives are subsequently assigned to Providers or Practices based on their relationships with the Attributed Life for health care services. Attribution will change throughout the year based on continued eligibility of the patients.

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**Performance Year 2020 Program of Payment – Risk Programs
For Newly Contracting and Returning Participants & Preferred Providers (as denoted)**

Examples of ACO Risk Programs include Vermont Medicaid Next Generation ACO Program, Blue Cross Blue Shield of Vermont Next Generation Model ACO Program and Vermont Medicare ACO Initiative.

Provider Type – TIN	Payment
Hospitals	<ul style="list-style-type: none"> • At Financial Risk Quantified in ACO Program Addendums and Maximum Risk Sharing Level Exhibit 1 • All Inclusive Population Based Payment (AIPBP) or equivalent prospective payment where ACO Program allows • If not AIPBP or equivalent, according to Payer’s normal payment methodology • Supplemental Population Health Management payments for Attributed Lives¹ • Potential Supplemental Care Coordination payments for Attributed Lives^{2*} • Shared Risk/Loss Potential³ • Shared Savings Opportunity⁴ • Value Based Incentive Fund Opportunity⁵
Independent Primary Care	<ul style="list-style-type: none"> • NOT at Financial Risk • According to Payer’s normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential Supplemental Care Coordination payments for Attributed Lives* • Value Based Incentive Fund Opportunity

¹ See Exhibit A1.

² See Exhibit A2, Parts 1 and 2.

³ See Exhibit A3.

⁴ See Exhibit A3.

⁵ See Exhibit A4.

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<p>FQHCs</p>	<ul style="list-style-type: none"> • NOT at Financial Risk • According to Payer’s normal payment methodology • Supplemental Population Health Management payments for Attributed Lives • Potential Supplemental Care Coordination payments for Attributed Lives* • Value Based Incentive Fund Opportunity
<p>Independent Specialty Care</p>	<ul style="list-style-type: none"> • NOT at Financial Risk • According to Payer’s normal payment methodology • Value Based Incentive Fund Opportunity
<p>Continuum of Care - Home Health & Hospice - Designated Agencies - Skilled Nursing Facilities</p>	<ul style="list-style-type: none"> • NOT at Financial Risk • According to Payer’s normal payment methodology • Potential Supplemental Care Coordination payments* • Value Based Incentive Fund Opportunity

Potential Supplemental Care Coordination payments for Attributed Lives*

Returning Participants and Preferred Providers

Based on limitations related to the timing of data received from payers, Participants and Preferred Providers who have contracted with OneCare in a Performance Year prior to 2020 will, for the first quarter of Performance Year 2020, receive Supplemental Care Coordination Payments in accordance with the Performance Year 2019 Care Coordination Payment policies and based on the 2019 cohort of Attributed Lives. For the second, third and fourth quarters, the Supplemental Care Coordination Program Payments will be as set forth for Program Year 2020 and based on the 2020 cohort of Attributed Lives. See Exhibit A2.

Newly Contracting Participants and Preferred Providers

Participants and Preferred Providers who are newly contracting with OneCare in Performance Year 2020 will receive estimated Supplemental Care Coordination Payments in the first quarter. These estimated payments will be reconciled in the second quarter, or as soon as practicable after receipt of data from payers.

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**Exhibit A1
2020 Performance Year Supplemental Population Health Management Payments**

The following Population Health Management payments are available to Participants that are, or whose TINs contain, a primary care practice(s).

Payment Descriptions

1. Population Health Management - \$3.25 Per Attributed Life Per Month

OneCare will pay \$3.25 per Attributed Live Per Month (each life that the Participant attributes to a OneCare Program), to each Participant that is, or whose TIN contains, an attributing primary care practice(s) if the practice routinely meet(s) the following criteria. While this is paid on a TIN level, it is measured on the Practice level and each Practice, as reflected on the TIN's roster of providers must meet the following criteria. Participant's signature on this Agreement certifies that each of its practices complies with these requirements.

1. Practice is currently certified by NCQA as a Patient Centered Medical Home (PCMH) or, if not certified, all current <u>PCMH concepts are successfully maintained.</u>
2. Practice conducts patient outreach to ensure patients have had a preventive care visit and/or a disease specific visit with a specialist in the past 12 months (status reports and worklists available via Care Navigator and WorkBench One).
3. Practice accesses and reviews data reports (e.g. patient registry reports, disease-specific panels, ACO quality measure performance) and/or self-service analytics tools to assess current performance, gaps in care, and patient worklists to address these opportunities for improvement.
4. Practice maintains and monitors ACO quality measure performance and uses quality improvement strategies to address gaps in quality measure performance.
5. Practice is actively assessing and improving coding accuracy.

Practices may be asked to provide reasonable documentation to show progress toward or meeting standards.

Participant certifies, on behalf of its practices who accept this payment, that the criteria 1-5 enumerated above are met by the practice. If the practice does not meet the criteria, OneCare may stop and/or seek return of these payments.

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Exhibit A2 – Part 1
Supplemental Care Coordination Payments

First Quarter of Performance Year 2020 for All Participants and Preferred Providers
and Full Performance Year 2020 for Newly Contracted Participants and Preferred Providers Only

General

For the first quarter of 2020, when payer data relating to Attributed Lives for 2020 is not yet available to OneCare, returning Participants and Preferred Providers will continue and be paid for care coordination activities pursuant to this Exhibit A2. These activities will be performed for the 2019 cohort of High and Very High Risk Attributed Lives pursuant to Program Agreements that continue or are renewed for Performance Year 2020.

“High and Very High Risk Patients” means the patient cohort that has been defined in the ACO Program Agreement with a payer or the OneCare Advanced Community Care Coordination Policy. Generally, this is the top 16% of Attributed Lives in an ACO Program determined by risk stratification, but must be determined through the ACO Program Agreement.

For Participants and Preferred Providers who are newly contracting with OneCare in Performance Year 2020, because of limitations in timeliness in accessing data from the payers, OneCare will estimate the expected High and Very High Risk Attributed Lives and make estimated payments in the first quarter. Those newly contracting Participants and Preferred Providers will engage in care coordination activities with a focus on integrating the care model into clinical pathways and building care team relationships across OneCare network participants in support of the complex care coordination program. Once data from payers identifying the 2020 High and Very High Risk Attributed Lives is available, OneCare will reconcile the estimates to actual amounts due and identify those High and Very High Risk Attributed Lives the Participants and Preferred Providers who will engage in the care coordination activities described in this Exhibit A2.

Documentation Requirement

Participant and Preferred Provider eligibility for the OneCare Supplemental Care Coordination Payments described in Exhibit A2 requires the documentation of care coordination activities in OneCare’s Care Navigator software system, or other mutually agreed-upon method of documentation in compliance with the OneCare Clinical Model.

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Payment Descriptions

1. Care Coordination for High/Very High Risk Patients: (1) Primary Care and (2) Community Support - \$15.00 Per Attributed Life Per Month

Paid monthly to a Participant or Preferred Provider that routinely meet the following criteria. For primary care, this is paid at the TIN level, but the criteria are met and measured at the Practice level (sometimes hereinafter "Practice Participants"). Each Participant TIN is responsible for the compliance of all Practice Participants that bill under its TIN. For Preferred Providers, it is paid monthly to Home Health Agencies and Designated Agencies for Mental Health and Substance Abuse that have a qualifying relationship to Attributed Lives within their HSAs based on a proportion of the High and Very High Risk populations they serve.

Practice Participants, Participants and Preferred Providers paid under this model:

- (a) Must comply with the requirements laid out in the table directly below for this payment before the beginning of the Performance Year. Signature on this contract indicates compliance is or will be achieved timely;
- (b) Only those Practice Participant or Preferred Providers that comply with all requirements are eligible for Supplemental Care Coordination payments;
- (c) Practice Participants or Preferred Providers may be asked to provide reasonable documentation to demonstrate meeting these standards.

<p>1. Practice Participant or Preferred Provider has identified one or more employed or community-shared resource staff whose role is to <u>provide care coordination services for its attributed patient panel</u>. Identified care coordination staff will:</p> <ul style="list-style-type: none">a. have each attended at least one <u>care coordination training session</u> in the past 12 months or Practice Participant or Preferred Provider can attest that all care coordination staff will participate in at least one training session in the current Performance Year; andb. <u>utilize Care Navigator</u> or other methods agreed upon with OneCare to create shared care plans and communicate among care team members.
<p>2. Practice Participant or Preferred Provider routinely reviews lists of high/very high-risk patients and <u>conducts outreach to engage patients in care coordination</u> (OneCare estimates a 15% patient engagement rate).</p>
<p>3. Practice Participant or Preferred Provider facilitates <u>regular effective outreach</u> (e.g. 12x/yr for very high risk 4x/yr for high risk, 2x/yr for medium risk) <u>for patients engaged in care coordination</u> as per OneCare's care coordination model and <u>documents this outreach in Care Navigator</u> or in other methods agreed upon with OneCare.</p>

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- | |
|---|
| 4. Practice Participant or Preferred Provider's team-based care model includes <u>defined roles and relationships with continuum of care partners</u> (e.g. primary care, Home Health, Designated Agencies, Skilled Nursing Facilities) and <u>human services organizations</u> (e.g. DCF, nutrition, housing, transportation). |
| 5. Practice Participant or Preferred Provider participates in person-centered <u>shared care planning and care conferences</u> as necessary to facilitate the patient's goals of care. |
| 6. For primary care Practice Participants only, the Practice's team-based care model supports <u>effective transitions of care</u> by providing follow-up calls with patients following emergency department visits within two days and post-hospital discharge in-person visits between 7-14 days depending on acuity. |

2. Patient Activation Payment - One Time Annual Payment of \$150.00 and an additional \$10.00 per Attributed Life Per Month

The Patient Activation Payment consists of two components: (1) a one-time annual payment of \$150 made to the TIN of a Participating Provider who establishes a Lead Care Coordinator relationship and Shared Care Plan with a qualifying Attributed Life; and (2) an additional \$10 per Attributed Life Per Month. The \$10 payment is effective the month the Lead Care Coordinator and Shared Care Plan are designated in OneCare's care coordination software system and paid beginning in the following month. For example, if the designations are made in July, payment is earned as of July and made in August. Only Participants and Preferred Providers who are Primary Care Providers, Home Health Agencies or Designated Agencies for mental health and substance abuse treatment are eligible to receive this payment.

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Exhibit A2 – Part 2
Supplemental Care Coordination Payments

Second, Third and Fourth Quarters of Performance Year 2020 for
All Returning⁶ Participants and Preferred Providers Only

General

For the second, third and fourth quarters of the 2020 Performance Year, when payer data relating to Attributed Lives for 2020 is available to OneCare, returning Participants and Preferred Providers will initiate care coordination activities for the 2020 cohort of High and Very High Risk Attributed Lives and be eligible to receive Supplemental Payments under this Exhibit.

“High and Very High Risk Patients” means the patient cohort that has been defined in the ACO Program Agreement with a payer or the OneCare Advanced Community Care Coordination Policy. Generally, this is the top 16% of Attributed Lives in an ACO Program determined by risk stratification, but must be determined through the ACO Program Agreement.

A “Care Conference” is a meeting of health care professionals who are members of the Care Team of an Attributed Life participating in the OneCare Care Coordination Program where care planning is actively evaluated and conducted and documented in Care Navigator or other mutually agreed to care coordination software.

Documentation Requirement

Participant and Preferred Provider eligibility for the OneCare Supplemental Care Coordination Payments described in Exhibit A2 requires the documentation of care coordination activities in OneCare’s Care Navigator software system, or other mutually agreed-upon method of documentation in compliance with the OneCare Clinical Model.

Eligibility

Only contracted, attributing Primary Care Providers (not specialists), Designated Agencies and Home Health Agencies are eligible for the Supplemental Care Coordination Payments described herein.

⁶ A Returning Participant or Preferred Provider is one who has had a contractual relationship with OneCare prior to Performance Year 2020.

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This model is applicable to all adult Attributed Lives. A separate model for pediatric lives will be provided for implementation in the second quarter of Performance Year 2020.

Participants and Preferred Providers paid under this model:

- (a) Must comply with the requirements laid out in the table directly below for this payment before the beginning of the Performance Year. Signature on this contract indicates compliance is or will be achieved timely;
- (b) Only those Participants or Preferred Providers that comply with all requirements are eligible for Supplemental Care Coordination payments;
- (c) Participants or Preferred Providers may be asked to provide reasonable documentation to demonstrate meeting these standards.

<p>1. Participant or Preferred Provider has identified one or more employed or community-shared resource staff whose role is to <u>provide care coordination services for its attributed patient panel</u>. Identified care coordination staff will:</p> <ul style="list-style-type: none">a. have each attended at least one <u>care coordination training session</u> in the past 12 months or Participant or Preferred Provider can attest that all care coordination staff will participate in at least one training session in the current Performance Year; andb. <u>utilize Care Navigator</u> or other methods agreed upon with OneCare to create shared care plans and communicate among care team members.
<p>2. Participant or Preferred Provider routinely reviews lists of high/very high-risk patients and <u>conducts outreach to engage patients in care coordination</u> (OneCare estimates practice(s) will achieve a 15% patient engagement rate).</p>
<p>3. Participant or Preferred Provider facilitates <u>regular effective outreach</u> (e.g. 12x/yr for very high risk 4x/yr for high risk, 2x/yr for medium risk) <u>for patients engaged in care coordination</u> as per OneCare's care coordination model and <u>documents this outreach in Care Navigator</u> or in other methods agreed upon with OneCare.</p>
<p>4. Participant or Preferred Provider's team-based care model includes <u>defined roles and relationships with continuum of care partners</u> (e.g. primary care, home health, designated agencies, skilled nursing facilities) and <u>human services organizations</u> (e.g. DCF, nutrition, housing, transportation).</p>
<p>5. Participant or Preferred Provider participates in person-centered <u>shared care planning and care conferences</u> as necessary to facilitate the patient's goals of care.</p>
<p>6. As applicable, Primary Care Practice's team-based care model supports <u>effective transitions of care</u> by providing follow-up calls with patients following emergency department visits within two days and post-hospital discharge in-person visits between 7-14 days depending on acuity.</p>

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Payment Descriptions

1. Lead Care Coordinator - \$80.00 per adult Attributed Life Per Month

Paid monthly to the TIN of an eligible Participant or Preferred Provider that establishes a Lead Care Coordinator relationship and Shared Care Plan (as described in the four quadrant Care Coordination Model) with the adult Attributed Life and documents these events in Care Navigator or other mutually agreed upon care coordination software. The \$80 per adult Attributed Life Per Month is effective the month the Lead Care Coordinator and Shared Care Plan are designated in Care Navigator or other mutually agreed upon care coordination software and is paid beginning the following month. For example, if the designations are made in July, payment is earned as of July and made in August.

2. Care Team - \$60.00 per adult Attributed Life Per Month

Paid monthly to the TIN of an eligible OneCare Participant or Preferred Provider who participates in the Care Team (as described in the four quadrant Care Coordination Model) as reflected in Care Navigator or other mutually agreed upon care coordination software, with the adult Attributed Life. The \$60 per adult Attributed Life Per Month is effective the month the Care Team member and Shared Care Plan are designated in Care Navigator or other mutually agreed upon care coordination software and paid beginning the following month. In the instance that multiple Care Team members are from the same primary care TIN, representatives from at least one other organization must participate on the Care Team for the TIN to be eligible for a second Care Team payment.

3. Care Conference: Lead Care Coordinator - \$300.00 per adult Attributed Life Per Year

Paid once per year to the TIN of an eligible Participant or Preferred Provider who establishes a Lead Care Coordinator relationship and completes a qualifying Care Conference with the adult Attributed Life. The \$300.00 per adult Attributed Life Per Year is paid in the month following documentation of the Care Conference in Care Navigator or other mutually agreed upon care coordination software.

3. Care Conference: Care Team - \$150.00 per adult Attributed Life Per Year

Paid once per year to the TIN of an eligible Participant or Preferred Provider who participates in the Care Team and completes a Care Conference with the adult Attributed Life. The \$150.00 per adult Attributed Life Per Year is paid in the month following documentation of the

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qualifying Care Conference in Care Navigator or other mutually agreed upon care coordination software.

Review/Oversight by OneCare

This Model is supported by predicted rates of patient engagement in care coordination and will be monitored for outliers. If 20% or more of a Participant's or Practice Participant's High or Very High Risk Attributed Lives, as identified by OneCare, are actively Care Managed, OneCare may initiate a quality assurance review. Participants and Preferred Providers assigned to that Health Service Area may be required to participate in that review. The quality assurance review may result in corrective action, which may include a corrective action plan or other remedies such as repayment.

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Exhibit A3

2020 Performance Year Program Settlement Policy

1) General Policy

- a) Participant hospitals function as the Risk Bearing Entity (RBE) and bear the risk of losses or receive savings for the cost of care for the attributed lives in their Healthcare Service Area (HSA).
 - i) Any lives that attribute to OneCare but cannot be assigned to a Primary Care Provider (PCP) will be assigned to an HSA using the preponderance of care within the current Performance Year as the basis. If no services were delivered in the current Performance Year, historical claims will be substituted as the data source for assignment.
- b) Once finalized with the plan, all figures within the final program settlement will control and be the reference point for all subsequent allocations of payments due to and from RBEs.
- c) The settlement process has two components: (1) Risk Performance (performance against the spending benchmark or expected spending) and; (2) Other Monies Owed for reconciling activity (ex. AIPBP/FPP reconciliations, reinsurance cost). The Risk Performance component is subject to Maximum Risk Limit (MRL) constraints while Other Monies Owed is not.
- d) Risk Performance amounts and MRL constraints will be calculated separately for each Program.
- e) Final settlement calculations will be approved by the Finance Committee and/or Board of Managers.

2) Risk Performance Calculations

- a) Each HSA's individual performance will be calculated by subtracting the actual spending from the benchmark(s) supplied to each RBE to determine the Gross Risk Performance amount. The actual spending will be calculated using the applicable OneCare Program Agreement methodology and applying any modifications specified in OneCare policies for the lives attributed or assigned to the HSA.
 - i) If the Program operates an unreconciled fixed payment (ex. Medicaid), the value for the home hospital cost of care will be the actual fixed payment amount and the value for the non-home hospital cost of care delivered by a participating hospital on fixed payment(s) will be the fee-for-service (FFS) equivalent value.
 - ii) If the Program operates a reconciled fixed payment (ex. Medicare), the cost of care for all services delivered under the reconciled fixed payment will be the FFS equivalent value.
 - iii) Any actual spending that OneCare cannot specifically tie to an Attributed Life (ex. due to data restrictions) will be allocated across HSAs using a fair basis.
 - iv) Any pooling of specific populations of Attributed Lives as described in

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the HSA Benchmark Policy will be calculated in alignment with the terms of the HSA Benchmark Policy.

- v) Any high cost case truncation will be applied to the actual spending in a similar manner used to set the HSA benchmarks in the HSA Benchmark Policy. The aggregate amount over the truncation point will be spread to all HSAs using a fair basis.
 - vi) Factors that cannot be specifically assigned to an HSA such as sequestration, quality score adjustment, or other plan-dictated factors incorporated to the program settlement will be spread across HSAs using fair basis.
 - vii) Any remaining balance necessary to reconcile to the program Risk Performance amounts will be allocated across HSAs using a fair basis.
- b) The Gross Risk Performance amount will be limited to the calculated MRL using the methodology and amounts contained in the RBE's OneCare Contract for each program to determine the Adjusted Risk Performance amount.
- i) If the Gross Risk Performance amount is in excess of the MRL on either the savings side or the loss side, the Risk Performance amount will be replaced by the MRL value with the sign (+/-) matching the sign of the Gross Risk Performance amount.
 - ii) After limiting all RBEs to their own MRLs (if applicable), there may be a remaining balance not yet allocated to RBEs. Any proceeds from reinsurance or third-party risk protections will be applied to this remaining balance.
 - iii) Any remaining balance after step ii above will be allocated to all RBEs that have not met their MRLs in the direction (+/-) corresponding to the remaining balance using the eligible RBEs' MRLs as the basis.
 - (1) If spreading the remaining balance results in an RBE exceeding its MRL, that RBE will only receive the share that results in it meeting its MRL. If there is remaining balance, the amount will be allocated to all RBEs that have not yet met their MRLs in the direction (+/-) corresponding to the remaining balance. The eligible RBEs' MRLs is used as the basis for this allocation. This process will be done iteratively until there is no remaining balance and no RBE is in excess of its MRL.
- c) The Adjusted Risk Performance amount, combined with any benefit or detriment experienced under an unreconciled fixed payment, will be the reported Program Performance.

3) Other Monies Owed

- a) In the event that there are Other Monies Owed, which can be either to or from each RBE, the amounts will be added to the Adjusted Risk Performance amounts when determining the amount of final settlement between the RBE and OneCare.
- b) For Programs with unreconciled fixed payments:
 - i) Hospital Participants: The component of each hospital's fixed payment that is designated for care delivered to patients attributed or assigned to a

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different HSA will be reconciled to the FFS equivalent value. This can result in an amount owed to the hospital or from the hospital.

- ii) Non-Hospital Participants (ex. Comprehensive Payment Reform (CPR) practices): There will be no reconciliation of the fixed payments.
 - iii) The plans may impose corrections to fixed payments made to OneCare due to factors such as the timing of information or changes in patient classification. These reconciling amounts will be applied to each hospital in alignment with the specific correction being made. If the correction cannot be attributed to any specific hospital(s), the amount will be allocated across hospitals using a fair basis.
- c) For Programs with reconciled fixed payments:
- i) Hospital Participants: The fixed payment paid to the hospital will be reconciled in full to the FFS equivalent value. This can result in an amount owed to the hospital or from the hospital.
 - ii) Non-Hospital Participants: There will be no reconciliation of the fixed payments. Any balance owed to or from the plan will be assigned to the hospital in the HSA(s) of the non-hospital participant(s).
- d) If in the OneCare budget process the Board of Managers approves the use of final settlement to fund Programs and/or operations/administration, the total cost of the initiative(s) will be spread across RBEs using a fair basis.

4) Cash Exchange

- a) Once settlement calculation have been approved by the Board on either an interim or final basis, all RBEs owing money to OneCare will have thirty (30) days to submit payment to OneCare from the date of demand. This can be either through check or deduction from ongoing payments being made to the RBE.
 - i) OneCare reserves the right to deduct the amount owed from ongoing payments to ensure OneCare is able to meet its obligations to the plan(s).
- b) All RBEs owed money from OneCare will receive payments within thirty (30) days of final approval, but contingent upon OneCare receiving payment from the plan and/or other network RBEs.

5) Ongoing Review

- a) Some Program Agreements allow for review of the results well after the final settlement has concluded. In the event that a plan initiates this subsequent review, the results will be brought to the Finance Committee and Board of Managers for review and a decision in regard to the best way to manage the circumstance. The Board's actions may supersede any/all methodologies outlined in this policy.

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Exhibit A4
Value Based Incentive Fund

The Value Based Incentive Fund (“VBIF”) will be paid according the Board approved Value Based Incentive Fund Policy for Performance Year 2020.

ACO will accumulate funds as negotiated in each ACO Program Agreement to VBIF to reward designated Participants and Preferred Providers who meet quality goals in each ACO Program.

Distributions will be calculated separately for each ACO Program after the close of the Program Year after the Total cost of Care calculations have been fully reconciled and quality measure performance is reported to ACO by the Payer. Participants and Preferred Providers may only receive VBIF funding for ACO Programs in which they participate, and only if they remain in good standing at the time of distribution.

The fund will be distributed by a methodology established by the Board and consistent with ACO strategy, 70% to attributing primary care providers based on attribution, of which 10% will be reserved for practices that exceed the network average on primary care engagement by payer. Of the remaining 30%, 10% will be distributed to a quality improvement investment(s) approved by the Board of Managers; and 20% to the remainder of the network who qualify based on proportion of Total Cost of Care spend during the Performance Year. VBIF payments shall be of a minimum \$100.

EXHIBIT B

BUSINESS ASSOCIATE AND QUALIFIED SERVICE ORGANIZATION AGREEMENT

This Business Associate & Qualified Service Organization Agreement (the “BAA”) is incorporated into the First Amended and Restated Risk-Bearing Participant & Preferred Provider Agreement (the “Agreement”) entered into by and between **OneCare Vermont Accountable Care Organization, LLC** (“Business Associate”) and (“Covered Entity”).

RECITALS

Covered Entity and Business Associate are parties to the Agreement pursuant to which Business Associate provides certain services to Covered Entity and, in connection with those services, Covered Entity discloses to Business Associate or permits disclosure to Business Associate certain Protected Health Information (“PHI”) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and Title XIII, The Health Information Technology for Economic and Clinical Health Act (“HITECH”), of the American Recovery and Reinvestment Act (“ARRA”) and may also be subject to 42 USC § 290dd-2 and 42 CFR Part 2.

Under the terms of the Agreement and for purposes of sharing PHI for population health management purposes, Business Associate and Covered Entity have also agreed to participate in an Organized Health Care Arrangement (“OHCA”) as that term is defined under HIPAA and the Agreement.

The parties desire to comply with the requirements set forth in the Privacy and Security Regulations and HITECH concerning the privacy of PHI.

The purpose of this Addendum is to comply with the requirements of the Privacy Rule, the Security Rule, HITECH and, if applicable, 42 CFR Part 2 including but not limited to the Business Associate Requirements at 45 C.F.R. Section 164.504(e) and the Qualified Service Organization provisions at 42 CFR Sections 2.11 and 2.12(c)(4).

Therefore, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

SECTION I – DEFINITIONS

- 1.1 **Definitions.** Unless otherwise provided in this BAA, capitalized terms shall have the same meaning as set forth in the HIPAA regulations, 45 C.F.R. Sections 160 and 164, and HITECH and its related regulations or under 42 CFR Section 2.11.

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SECTION II – OBLIGATIONS OF BUSINESS ASSOCIATE

- 2.2 Use/Disclosure of PHI. In connection with its use and disclosure of PHI, Business Associate agrees that it shall use and/or disclose PHI only as permitted or required by this BAA or as otherwise required by law.
- 2.1 Safeguards for Protection of PHI. Business Associate agrees to use reasonable and appropriate safeguards to prevent the use or disclosure of PHI other than as provided in this BAA.
- 2.2 Compliance with HITECH Act and Regulations. Business Associate will comply with the requirements of HITECH, codified at 42 U.S.C. §§ 17921-17954, which are applicable to Business Associate, and will comply with all regulations issued by the Department of Health and Human Services to implement these referenced statutes, as of the date by which Business Associate is required to comply with such referenced statutes and HHS regulations.
- 2.3 General Reporting. Business Associate shall report to Covered Entity any use or disclosure of PHI which is not provided for by this BAA of which Business Associate becomes aware.
- 2.4 Reporting of Breaches of Unsecured Protected Health Information. Business Associate will report in writing to Covered Entity’s Privacy Officer any Breach of Unsecured PHI, as defined in the Breach Notification Regulations, within ten (10) business days of the date Business Associate learns of the incident giving rise to the Breach. Business Associate will provide such information to Covered Entity as required in the Breach Notification Regulations. Business Associate will reimburse Covered Entity for any reasonable expenses Covered Entity incurs in notifying Individuals of a Breach caused by Business Associate or Business Associate’s subcontractors or agents, and for reasonable expenses Covered Entity incurs in mitigating harm to those Individuals. Business Associate also will defend, hold harmless and indemnify Covered Entity and its employees, agents, officers, directors, members, contractors, and subsidiary and affiliate entities, from and against any claims, losses, damages, liabilities, costs, expenses, penalties or obligations (including attorneys’ fees) which Covered Entity may incur due to a Breach caused by Business Associate or Business Associate’s subcontractors or agents.
- 2.5 Mitigation. Business Associate shall make reasonable efforts to mitigate, to the greatest extent possible, any harmful effects arising from any improper use and/or disclosure of PHI.
- 2.6 Subcontractors. Business Associate shall ensure that any agents, including any ACO Other Entities or subcontractors, to whom it provides PHI, shall agree to the same restrictions and conditions that apply to Business Associate with respect to PHI.

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- 2.7 Access by Individuals. Business Associate shall allow individuals who are the subject of the PHI to inspect and copy their PHI in the possession of Business Associate if Covered Entity does not also maintain such information.
- 2.8 Access by Department of Health and Human Services. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services for purposes of determining Covered Entity's compliance with the HIPAA privacy regulations.
- 2.9 Access by Covered Entity. Upon reasonable notice, Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI available to Covered Entity for purposes of determining Business Associate's compliance with the terms of this Agreement and Business Associate's compliance with HIPAA and HITECH.
- 2.10 Accountings of Disclosures. If Business Associate discloses any PHI, Business Associate shall make available to Covered Entity the information necessary for Covered Entity to provide an Accounting of Disclosures to any Individual who requests such an Accounting, or, in the alternative, Business Associate shall provide an Accounting of Disclosures directly to the requesting Individual, if requested by Covered Entity.
- 2.11 Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to Covered Entity's obligations under the Privacy Rule.

SECTION III – PERMITTED USES AND DISCLOSURES

- 3.1 General. Except as otherwise limited in this BAA, Business Associate may use or disclose PHI to perform ACO Activities or on behalf of, Covered Entity as specified in the Agreement and allowed by an OHCA, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.

SECTION IV – OBLIGATIONS OF COVERED ENTITY

- 4.1 Notice of Privacy Practices. Covered Entity has included and will continue to include, in the Covered Entity Notice of Privacy Practices information advising Individuals that Covered Entity may disclose their PHI to Business Associates.
- 4.1 Consents/Authorizations. Covered Entity has obtained and will continue to obtain, from Individuals, consents, authorizations and other permissions that may be required by the Privacy Rule or applicable state laws and/or regulations prior to furnishing Business Associate PHI pertaining to Individuals.

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- 4.2 Restrictions. Covered Entity will promptly notify Business Associate in writing of any restrictions on the use and disclosure of PHI about Individuals that Covered Entity has agreed to that may affect Business Associate's ability to perform its obligations under the Agreement or this BAA.
- 4.3 Revocation of Authorization. Covered Entity shall promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to use or disclose PHI, if such changes or revocation may affect Business Associate's ability to perform its obligations under the Agreement or this BAA.

SECTION V – SECURITY

- 5.1 Compliance with Security Rule. Business Associate agrees to implement the Security Rule (security standards as set out in 45 C.F.R. parts 160, 162 and 164), Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic PHI that Business Associate creates, receives, maintains, or transmits on behalf of the Covered Entity.
- 5.2 Reporting. Business Associate agrees to report to Covered Entity any security incident of which it becomes aware.
- 5.3 Agents Compliance with Business Associate Addendum. Business Associate agrees to ensure that any agent, including a subcontractor or ACO Other Entity, to whom it provides PHI received from, or created or received by, Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information.
- 5.4 Agents Compliance with Security Rule. Business Associate will ensure that any agent, including a subcontractor or ACO Other Entity, to whom it provides electronic PHI agrees to implement the Security Rule, Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic PHI.
- 5.5 Records Availability. Business Associate agrees to make its policies, procedures, and documentation relating to the safeguards described herein available to the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Security Rule.

SECTION VI – TERM & TERMINATION

- 6.1 Term and Termination. This BAA shall be effective as of effective date of the Agreement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity. The parties acknowledge and agree

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that the terms and conditions stipulated in this BAA shall apply to any future written or oral agreements between Covered Entity and Business Associate which require the disclosure of PHI, whether or not this BAA is incorporated by reference into future agreements executed between the parties. This BAA shall terminate in accordance with the termination provisions in the Agreement.

- 6.2 Effect of Termination. Upon termination of the Agreement, for any reason, Business Associate shall, if feasible, return or destroy all PHI that Business Associate still maintains in any form and shall not retain any copies of such PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the PHI and shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible. Notwithstanding the foregoing, Covered Entity acknowledges that Business Associate receives some PHI, with Covered Entity's consent, from third-party payers that may not be able to be returned or destroyed on behalf of Covered Entity. In the event Business Associate must maintain PHI after termination it will continue to protect such PHI in accordance with HIPAA for the time that it possesses the PHI. Nothing in this BAA shall prohibit the Business Associate from de-identifying PHI, in accordance with HIPAA, and using such de-identified information for ACO Activities during the term of or after the Agreement has terminated.

SECTION VII – QUALIFIED SERVICE ORGANIZATION PROVISIONS

- 7.1 Applicability. This Section shall only apply in the event that Business Associate is also considered a Qualified Services Organization, as defined in 42 CFR § 2.11, because the Covered Entity or Covered Entity Affiliate is subject to 42 CFR Part 2 (“Part 2 Program”).
- 7.2 Limits on Use and Disclosure. Where Business Associate acts as a Qualified Services Organization it agrees to the following limits on use and disclosure:
- a. Business Associate shall only access Part 2 Program information to the extent needed by it to provide the services described in this Agreement.
 - a. Business Associate agrees not to use or further disclose any Part 2 Program information other than as specified in this Agreement.
 - b. Business Associate acknowledges that in receiving, storing, processing, or otherwise using any PHI from a Part 2 Program, it is fully bound by the provisions of the federal regulations governing confidentiality of alcohol and drug abuse treatment records, 42 CFR Part 2.
 - c. Business Associate undertakes to resist in judicial proceedings any effort to obtain access to PHI pertaining to Part 2 Program patients other than as expressly

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provided for in 42 CFR Part 2, and Business Associate shall notify Covered Entity in such case.

SECTION VIII – MISCELLANEOUS

- 8.1 Amendment. This BAA shall be deemed to amend automatically, by force of law and without further act of the parties, if necessary to bring the Agreement into compliance with any changes in HIPAA, HITECH or any related regulations that are made after the date of execution of this Agreement.
- 8.2 Interpretation. Any ambiguity in this BAA shall be resolved in a manner that brings the BAA into compliance with the then most current version of HIPAA and the HIPAA privacy regulations.
- 8.3 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any other person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

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ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL
ACO PROGRAM ADDENDUM

THIS BLUE CROSS BLUE SHIELD OF VERMONT (“BCBSVT”) NEXT GENERATION MODEL ACO PROGRAM ADDENDUM (“ACO Program Addendum”) is attached to and made part of the First Amended and Restated Risk Bearing Participant and Preferred Provider Agreement (“Agreement”) in place between ACO and Participant or Preferred Provider (collectively, the “Parties”). To the extent any terms of this ACO Program Addendum conflict with terms of the Agreement, the applicable terms of this ACO Program Addendum shall control.

BACKGROUND

ACO has entered into an agreement with BCBSVT through which the ACO will participate in an alternative payment and population health management program with BCBSVT (the “Program”), as described in the BCBSVT Next Generation Program Agreement (“Program Agreement”) available on the ACO Provider Portal and incorporated by reference into this ACO Program Addendum. ACO, Participant and Preferred Provider agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 BCBSVT NEXT GENERATION ACO PROGRAM PARTICIPATION

- 1.1 Participation. Participant and Preferred Provider agree to participate in the Program, to engage in ACO Activities, to comply with the applicable terms of the Program as set forth in the BCBSVT Next Generation Participation Agreement and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the provisions of the BCBSVT Next Generation Participation Agreement relating to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Preferred Providers; (4) voluntary attribution; (5) Beneficiary/Member freedom of choice; (6) participation in evaluation, shared learning, monitoring and oversight activities; (7) the ACO Compliance Plan; (8) continuity of benefits; (9) ACO Policies; and (10) audit and record retention requirements. Participant and Preferred Provider further agree that as part of their participation in the Program and their BCBSVT provider agreements they will not terminate a Beneficiary for any cause related to his/her health status or his/her need for medical services that result in utilization risk of the Participant or Preferred Provider.
- 1.2 Updating Information. Participant and Preferred Provider are each required to update its BCBSVT enrollment information (including the addition and deletion of Providers, identified at the NPI level, that have reassigned to the Participant or Preferred Provider

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their right to BCBSVT payment) on a timely basis in accordance with BCBSVT requirements.

- 1.3 Authority to Bind. Participant warrants that it has the authority to and does bind itself and its employees, including each Provider with an NPI number billing under its TIN who is included on the BCBSVT Next Generation Participant List, to the Agreement and this Program Addendum. Preferred Provider warrants that it has the authority to and does bind itself and its employees, including each Provider with an NPI number whose services are billed under Preferred Provider's TIN, to the Agreement and this Program Addendum.
- 1.4 Providers in Good Standing with BCBSVT. Participant and Preferred Provider will each, for itself and for each Provider associated with and billing individually or collectively under its TIN, maintain a current BCBSVT provider agreement in good standing and to be duly licensed and remain in good standing with the appropriate state licensing board.
- 1.5 Contracting Exclusivity. Subject to the Program exclusivity requirements, ACO will not prohibit a Participant, Preferred Provider or provider from contracting with other state or commercial contractors.
- 1.6 Required Notices. Participants and Preferred Providers will provide ACO with the following notices:
 - 1.6.1 All relevant information about any changes to BCBSVT enrollment information, within thirty (30) days after the change.
 - 1.6.2 All pertinent information about any investigation or sanction by the government, BCBSVT or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of billing privileges) that could materially impact the ability to perform under this Program Addendum immediately upon becoming aware of the triggering event.
- 1.7 Exclusivity. The exclusivity of the ACO Participants and ACO Preferred Providers is based on BCBSVT Next Generation Program exclusivity requirements. ACO Participants or ACO Preferred Provider Participants that are themselves, or who include within their TIN, Providers who are "Primary Care Providers", as defined by the BCBSVT Next Generation Program Agreement, may not participate in any other BCBSVT Next Generation participating ACO while a party to this Program Addendum. By way of examples, an individual Primary Care Provider who bills primary care services under an individual TIN must be exclusive to a single ACO. An individual Primary Care Provider who assigns billing or collection to a group practice with a separate TIN must be exclusive to the same ACO and the ACO Participant that contains the Primary Care Provider must also be exclusive to the same ACO. If an ACO Participant and the associated Providers who assign billings to the ACO Participant do not contain Primary Care Providers, the ACO Participant and the non-Primary Care Providers are not required to be exclusive.

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2.0 PAYMENT

2.1 Form of Payment. Preferred Provider will be paid according to the BCBSVT normal payment methodology. Annually, before the Performance Year termination or non-renewal deadline, as set forth in the Agreement, ACO will develop and provide Participants and Preferred Providers with a Program of Payment. Participation in ACO may result in a change to the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, BCBSVT, 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 BCBSVT. The Board of Managers reserves the right to amend or alter the Program of Payment at any time as a result of material changes in ACO's circumstances, such as BCBSVT changing its financial commitments to ACO mid-Performance Year or a regulatory directive to make changes.

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

2.2 Payment in Full. Participant and Preferred Provider will collect applicable copayments, coinsurance and/or deductibles from Beneficiaries/Members in accordance with their BCBSVT 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.

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- 2.3 Claims Submission. Participants and Preferred Providers will submit claims to BCBSVT in accordance with timely filing rules and in accordance with BCBSVTs 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 services included in the Program will be based on the allowed claims incurred for each Exchange-offered product in a manner consistent with ACO strategy and approved by the Board of Managers Exclusions include claims allowable under separate benefit riders.
- 2.5 Beneficiary Appeals and/or Grievances. Beneficiaries/Members retain their rights to appeal claims determinations in accordance with the terms of their benefit policies and Participant and Preferred Provider remain bound by the terms of their BCBSVT provider agreements as to Beneficiary/Member grievances and appeals.
- 2.6 Shared Savings. Shared Savings, if earned, will be distributed according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.
- 2.7 Shared Losses. Losses, if incurred, will be paid by ACO and Participants according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

- 3.1 Term. The term of this Program Addendum shall commence on the Effective Date and shall run through the last date of the last Performance Year for the Program, or December 31, 2020. Thereafter, this Agreement may be extended as agreed by the Parties.
- 3.2 Remedial Action.
- a. ACO may take remedial action against the Participant or Preferred Provider including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, elimination of payments, offset of payments, denied access to ACO data systems, and termination of the ACO's Participant Agreement or this Program Addendum with the Participant or Preferred Provider to address material noncompliance with the terms of the Program or program integrity issues identified by ACO, the Green Mountain Care Board or BCBSVT.
 - b. Participant or Preferred Provider with a dispute relating to ACO's performance of its obligations under this Agreement may appeal through the ACO Appeals Policy, if applicable, or initiate a dispute under the dispute resolution process of the applicable Program Agreement. Participant or Preferred Provider may not appeal or dispute any

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matter that ACO may not appeal or dispute under the BCBSVT Next Generation Program Agreement.

- 3.3 Termination. This Program Addendum will automatically terminate if the Participation Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in BCBSVT, for any reason. This Program Addendum will terminate prior to the end of Term, if BCBSVT requires the ACO to remove the Next Generation Participant from the approved list of providers.
- a. Participant or Preferred Provider may terminate this Program Addendum, consistent with the Agreement's provisions relating to Core ACO Programs, for any Performance Year, if after receiving the initial Program of Payment and preliminary Maximum Risk and Sharing Limit, it does not wish to remain in this ACO Program. To terminate under this provision, Participant must provide written notice to ACO on or before August 31st of the year before the Performance Year commences (should BCBSVT provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by ACO Program). By way of example, if a Participant wishes to terminate effective for Performance Year 2020, and ACO does not extend the deadline, notice must be given by August 31, 2019. Should Participant or Preferred Provider terminate or non-renew for any Performance Year, it will have no financial obligation to ACO for the Performance Year as to which it terminated or non-renewed, but must comply with Section 3.4.
 - 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 BCBSVT, it determines not to participate in the ACO Program and provides that notice to BCBSVT 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 Preferred Provider agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries/Members, to ACO and to BCBSVT. Moreover, Participant, Preferred Provider and ACO will be required to meet all financial obligations for the Performance Year when notice is given, including Shared Losses and Savings.

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

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Kevin Stone
Interim Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

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2019 Vermont Medicare ACO Initiative Addendum

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM

THIS VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM (“ACO Program Addendum”) is attached and made part of the First Amended and Restated Risk Bearing Participant and Preferred Provider Agreement (“the Agreement”) in place between ACO and Participant or Preferred Provider (collectively the “Parties”). To the extent any terms of this ACO Program Addendum conflict with terms of the Agreement, the applicable terms of this ACO Program Addendum or the ACO Program rules applicable to the Participant or Preferred Provider, shall control.

BACKGROUND

ACO has entered into the Vermont Medicare ACO Initiative Program Agreement with the Centers for Medicare and Medicaid Services (“CMS”) and the Green Mountain Care Board (“GMCB”) through which the ACO will participate in the Vermont Medicare ACO Initiative (the “Program”), an alternative payment and population health management program. The Vermont Medicare ACO Initiative succeeds the Medicare Next Generation Model. The Vermont Medicare ACO Initiative Program Agreement will be available on the ACO Provider Portal and is incorporated by reference into this ACO Program Addendum. ACO, Participant and Preferred Provider agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 VERMONT MEDICARE ACO INITIATIVE PROGRAM PARTICIPATION

1.1 Participation. Participant and Preferred Provider agree to participate in the Program, to engage in ACO Activities, to comply with the applicable terms of the Program as set forth in the Vermont Medicare ACO Initiative Agreement and to comply with all applicable laws and regulations. This compliance includes but is not limited to, compliance with the provisions in the Vermont Medicare ACO Initiative Agreement relating to the following: (1) Participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Preferred Providers; (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; (10) ACO Policies; and (11) audit and record retention requirements.

1.2 Updating Information. Participant and Preferred Provider are each required to update its Medicare enrollment information (including the addition and deletion of Providers, identified at the NPI level, that have reassigned to the Participant or Preferred Provider

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2019 Vermont Medicare ACO Initiative Addendum

their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.

- 1.3 Authority to Bind. Participant warrants that it has the authority to and does bind itself and employees, including each Provider with an NPI number billing under its TIN who is included on the Vermont Medicare ACO Initiative Participant List, to the Agreement and this Program Addendum. Preferred Provider warrants that it has the authority to and does bind itself and employees, including each Provider with an NPI number whose services are billed under Preferred Provider's TIN, to the Agreement and this Program Addendum.
- 1.4 Providers in Good Standing with Vermont and Medicare. Participant and Preferred Provider will each, for itself and for each Provider associated with and billing individually or collectively under its TIN, maintain a current Medicare provider agreement in good standing and be duly licensed and remain in good standing with the appropriate state licensing board.
- 1.5 Patient Record Requests. Participant and Preferred Provider 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. Participant and Preferred Provider 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 pertinent information about any investigation or sanction by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicare billing privileges) that could materially impact the ability to perform under this Program Addendum, immediately upon becoming aware of the triggering event.
- 1.7 Exclusivity. Participants whose TIN includes NPIs of a "Primary Care Practitioner" who bills "Qualified Evaluation and Management" services (as both terms are defined by the Vermont Medicare ACO Initiative Agreement) may not participate in more than one Medicare Alternative Payment Model or with any other accountable care organization in which they attribute or align Medicare lives. Nothing in this paragraph shall be interpreted to preclude a Participant or Preferred Provider whose TIN does not include NPIs of Primary Care Practitioners, from participation 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.

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2019 Vermont Medicare ACO Initiative Addendum

2.0 PAYMENT

2.1 Form of Payment. Preferred Providers will be paid according to Medicare's normal payment methodology. Annually, before the Performance Year termination or non-renewal deadline as set forth in the Agreement, ACO will develop and provide Participants and Preferred Providers with a Program of Payment. 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 the Program of Payment at any time as a result of material changes in ACO's circumstances, such as nonpayment by Medicare, Medicare revoking All Inclusive Population Health Payments or a regulatory directive to make changes.

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

2.2 Payment in Full. Participant and Preferred Provider will collect applicable copayments, coinsurance and/or deductibles from Beneficiaries in accordance with their Medicare benefits 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. Participant and Preferred Provider 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 may receive reimbursement from ACO, as outlined in this Section 2.0.

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2019 Vermont Medicare ACO Initiative Addendum

- 2.4 Beneficiary Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with 42 C.F.R. § 405, Subpart I. Participant and Preferred Provider will direct all appeals and/or grievances or payment disputes, related to this Program, to ACO and ACO will manage them in accordance with an ACO Appeals Policy that complies with Program requirements. Participant and Preferred Provider will continue to cooperate with CMS in the resolution of an Attributed Beneficiary’s appeal or grievance.
- 2.5 Shared Savings. Shared Savings if earned will be distributed according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant’s Maximum Risk and Sharing Limit.
- 2.6 Shared Losses. Losses, if incurred, will be paid by ACO and Participants according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant’s Maximum Risk and Sharing Limit.

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, 2022. Thereafter, this Agreement may be extended for additional one (1) year terms, as agreed by the Parties.
- 3.2 Remedial Action.
- a. ACO may take remedial action against a Participant or Preferred Provider (including, but not limited to, imposition of a corrective action plan (“CAP”), reduction of payments, elimination of payments, offset of payments, denied access to ACO data systems, and termination of the Agreement or this Program Addendum with the Participant or Preferred Provider) to address material noncompliance with the terms of the Program or program integrity issues identified by ACO, the Green Mountain Care Board or CMS.
 - b. Participant or Preferred Provider with a dispute relating to ACO’s performance of its obligations under this Agreement may appeal through the ACO Appeals Policy, if applicable, or initiate a dispute under the dispute resolution process of the applicable Program Agreement. Participant or Preferred Provider may not appeal or dispute any matter that ACO may not appeal or dispute under the Vermont Medicare Initiative ACO Program Agreement.
- 3.3 Termination. This Program Addendum will automatically terminate if the Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in Medicare, for any reason. This Program Addendum will terminate prior to the end of the

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2019 Vermont Medicare ACO Initiative Addendum

Term if CMMI or the Green Mountain Care Board requires the ACO to remove the Participant or Preferred Provider from the approved list of providers.

- a. Participant may non-renew this Program Addendum for any Performance Year, if it does not wish to participate after receiving the Program of Payment, by providing written notice to ACO on or before August 31st of the year before the Performance Year commences (should Payer 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 August 31, 2018. Should Participant or Preferred Provider terminate or non-renew for any Performance Year, it will have no financial obligation to ACO for the Performance Year as to which it terminated or non-renewed, but must comply with Section 3.4.
- b. ACO may terminate this ACO Program Addendum if, after evaluating the network of participants and the final financial terms for the ACO Program, it determines not to participate in the ACO Program and provides that notice to Payer in accordance with its 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, ACO, Participant and Preferred Provider agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries, to ACO. Moreover, a Participant, Preferred Provider and ACO will be required to meet all financial obligations for any Performance Year in which it participated in ACO for any period of time, even if not the full Performance Year, including Shared Losses and Savings.

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2019 Vermont Medicare ACO Initiative Addendum

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: _____
Kevin Stone
Interim Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

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Amendment #1 to the Vermont Medicare
ACO Initiative Program Addendum
Regulatory Amendment

This Amendment #1 to the Vermont Medicare ACO Initiative Program Addendum (“Addendum”) is by and between OneCare Vermont Accountable Care Organization, LLC (“ACO”), a Vermont limited liability company, and Participant or Preferred Provider, a health care provider or organization eligible to participate with ACO and organized under Vermont or New Hampshire law (each a “Party” and collectively “Parties”) and is effective thirty (30) days from July 2, 2019.

Whereas, the Agreement and Addendum may be amended by ACO for regulatory compliance without the signature of Participant or Preferred Provider; and

Whereas, The Vermont All Payer ACO Model Vermont Medicare Initiative Participation Agreement between ACO and CMS requires certain terms be included in the ACO’s contracts with Participants and Preferred Providers;

NOW THEREFORE, the Addendum is amended as follows:

The following provisions are added:

4.0 REGULATORY TERMS

4.1 ACO will reimburse Participant for all Covered Services that Medicare would otherwise have paid for, but for the AIPBP Fee Reduction, no later than thirty (30) days after receiving notice of the processed claim, from CMS on its weekly report to ACO.

4.2 Participant shall make all Medically Necessary Covered Services available to Medicare Attributed Lives in accordance with all applicable laws and regulations.

4.3 ACO shall not require prior authorization for services furnished to Medicare Attributed Lives.

4.4 Neither Participant, Preferred Provider nor ACO will interfere in any way with a Medicare Attributed Life’s freedom of choice to receive care and supplies from any Medicare provider, regardless of participation in the ACO.

4.5 Participant shall maintain records regarding the AIPBP payment arrangement, for ten (10) years from termination of the Agreement, to provide those records upon request by the government and to otherwise meet the requirements of Section XVII.B. of the Vermont All-Payer ACO Model Vermont Medicare ACO Initiative Participation Agreement.

4.6 Participant or Preferred Provider will notify ACO within seven (7) days of become aware that it is under investigation or has been 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).

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4.7 ACO will not distribute shared savings to any Participant or Preferred Provider who has been terminated by CMS in accordance with Section XVIII.A.1 of the Vermont All Payer ACO Model Vermont Medicare ACO Initiative Participation Agreement.

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2019 Medicaid Addendum

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

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

BACKGROUND

ACO has entered into an agreement with DVHA through which the ACO will participate in the Vermont Medicaid Next Generation Model (the “Program”), an alternative payment and population health management program with Medicaid, as described in Vermont Medicaid Next Generation Participation Agreement that will be available on the ACO Provider Portal and is incorporated by reference into this ACO Program Addendum. ACO, Participant and Preferred Provider agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 MEDICAID NEXT GENERATION ACO PROGRAM PARTICIPATION

- 1.1 Participation. Participant and Preferred Provider agree to participate in the Program, to engage in ACO Activities, to comply with the applicable terms of the Program as set forth in the Vermont Medicaid Next Generation Participation Agreement between ACO and DVHA and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the 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 Preferred Providers; (4) voluntary attribution; (5) Beneficiary freedom of choice; (6) benefit enhancements; (7) participation in evaluation, shared learning, monitoring and oversight activities; (8) the ACO Compliance Plan; (9) continuity of benefits; (10) ACO Policies and (11) audit and record retention requirements. Participant and Preferred Provider further agree that as part of their participation in the Program and their Vermont Medicaid provider agreements that they will not terminate a patient for any cause related to his/her health status or his/her need for medical services that result

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2019 Medicaid Addendum

in utilization risk for the Participant or Preferred Provider.

- 1.2 Updating Information. Participant and Preferred Provider are each required to update its Medicaid enrollment information (including the addition and deletion of Providers, identified at the NPI level, that have reassigned to the Participant or Preferred Provider their right to Medicaid payment) on a timely basis in accordance with Medicaid program requirements.
- 1.3 Authority to Bind. Participant warrants that it has the authority to and does bind itself and its employees, including each Provider with an NPI number billing under its TIN who is included on the Vermont Medicaid Next Generation Participant List to the Agreement and this Program Addendum. Preferred Provider warrants that it has the authority to and does bind itself and its employees, including each Provider with an NPI number whose services are billed under the Preferred Provider's TIN, to the terms of the Agreement and this Program Addendum.
- 1.4 Providers in Good Standing with Vermont and Medicaid. Participant and Preferred Provider will each, for itself and for each Provider associated with and billing individually or collectively under its TIN, maintain a current DVHA General Provider Agreement in good standing and be duly licensed and remain in good standing with the appropriate state licensing board.
- 1.5 Contracting Exclusivity. Subject to the Program exclusivity requirements, ACO will not prohibit a Participant, Preferred Provider or Provider from contracting with other state contractors.
- 1.6 Patient Record Requests. Participants and Preferred Providers will provide a Beneficiary with a copy of his/her medical records at no charge upon request by the Beneficiary, and facilitate the transfer of Beneficiary's medical record to another provider at Beneficiary's request.
- 1.7 Required Notices. Participants and Preferred Providers will provide ACO with the following notices:
 - 1.7.1 All relevant information about any changes to Medicaid enrollment information, within thirty (30) days after the change.
 - 1.7.2 All pertinent information about any investigation or sanction by the government or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicaid billing privileges) that could materially impact the ability to perform under this Program Addendum immediately upon becoming aware of the triggering event.

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1.8 Exclusivity. Participants whose TIN includes NPIs of a “Primary Care Practitioner” who bills “Qualified Evaluation and Management Services” (as both terms are defined by the Vermont Medicaid Next Generation Participation Agreement) may not participate in more than one Medicaid Next Generation Model Program, or any other Medicaid ACO-based payment reform program or with any other accountable care organization in which they attribute or align lives. Nothing in this paragraph shall be interpreted to preclude a Participant, whose TIN does not include NPIs of Primary Care Practitioners, from membership in more than one accountable care organization participating in the 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. Preferred Provider will be paid according to Medicaid’s normal payment methodology. Annually, before the Performance Year termination or non-renewal deadline, as set forth in the Agreement, ACO will develop and provide Participants and Preferred Providers with a Program of Payment. Participation in ACO may result in a change to the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, Medicaid, a combination of the two, or ACO’s delegate. All payment methodologies and formulas will be made pursuant to a Program of Payment approved by the Board of Managers after receiving the necessary Program financial information from DVHA. The Board of Managers reserves the right to amend or alter the Program of Payment at any time as a result of material changes in ACO’s circumstances, such as DVHA changing its financial commitments to ACO mid-Performance Year or a regulatory directive to make changes.

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

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- 2.2 Payment in Full. Participant and Preferred Provider will collect applicable copayments, coinsurance and/or deductibles from Beneficiaries in accordance with their Medicaid benefits which are not affected by this ACO Program and agree to accept any applicable copayment, coinsurance and/or deductible together with the payments provided for under this Agreement as full reimbursement for services rendered.
- 2.3 Claims Submission. Participants and Preferred Providers will submit claims to DVHA in accordance with timely filing rules and in accordance with DVHA's applicable policies, but will receive reimbursement for services within the Program, as outlined in this Section 2.0.
- 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.

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- 2.5 Beneficiary Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with the terms of the DVHA Member Handbook and Participant and Preferred Provider remain bound by the terms of the DVHA General Provider Agreement as to Beneficiary grievances and appeals. Participant and Preferred Provider will direct all appeals and/or grievances or payment disputes related to this Program to ACO and ACO will manage them in accordance with an ACO Appeals Policy that complies with Program requirements. The appeals policy includes a written initial appeal and a second level of appeal with the opportunity to be heard in person. Participant and Preferred Provider will continue to cooperate with DVHA in the resolution of Beneficiary grievances and disputes.
- 2.6 Shared Savings. Shared Savings, if earned, will be distributed according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.
- 2.7 Shared Losses. Losses, if incurred, will be paid by ACO and Participants according to the Performance Year Shared Risk and Savings Policy as set forth in the Agreement and each Participant's Maximum Risk and Sharing Limit.

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, 2022. Thereafter, this Agreement may be extended for additional one (1) year terms, as agreed by the Parties.
- 3.2 Remedial Action.
- a. ACO may take remedial action against the Participant or Preferred Provider including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, elimination of payments, offset of payments, denied access to ACO data systems, and termination of the ACO's Participant Agreement or this Program Addendum with the Participant or Preferred Provider to address material noncompliance with the terms of the Program or program integrity issues identified by ACO, the Green Mountain Care Board or DVHA.
 - b. Participant or Preferred Provider with a dispute relating to ACO's performance of its obligations under this Agreement may appeal through the ACO Appeals Policy, if applicable, or initiate a dispute under the dispute resolution clause of the applicable Program Agreement. Participant or Preferred Provider may not appeal or dispute any matter that ACO may not appeal or dispute under the Vermont Medicaid Next Generation Program Agreement.

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2019 Medicaid Addendum

- 3.3 Termination. This Program Addendum will automatically terminate if the Agreement terminates or if the Participant or Preferred Provider becomes ineligible to participate in Vermont Medicaid, for any reason. This Program Addendum will terminate prior to the end of the Term if DVHA requires the ACO to remove the Next Generation Participant from the approved list of providers.
- a. Participant or Preferred Provider may terminate this Program Addendum, consistent with the Agreement's provisions relating to Core ACO Programs, for any Performance Year, if after receiving the initial Program of Payment and preliminary Maximum Risk and Sharing Limit, it does not wish to remain in this ACO Program. To terminate under this provision, Participant or Preferred Provider must provide written notice to ACO on or before August 31st of the year before the Performance Year commences (should DVHA provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by the ACO Program). By way of example, if a Participant wishes to terminate effective Performance Year 2019, and ACO does not extend the deadline, notice must be given by August 31, 2018. Should Participant or Preferred Provider terminate or non-renew for any Performance Year, it will have no financial obligation to ACO for the Performance Year as to which it terminated or non-renewed but must comply with Section 3.4.
 - 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, non-renewed or expires, ACO, Participant and Preferred Provider agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries, to ACO and to DVHA's fiscal agent. Moreover, Participant, Preferred Provider and ACO will be required to meet all financial obligations for any Performance Year in which it participated in ACO for any period of time, even if not the full Performance Year, including Shared Losses and Savings.

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2019 Medicaid Addendum

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: _____
Kevin Stone
Interim Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

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

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**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL
ACO PROGRAM ADDENDUM**

EXHIBIT 1 – PERFORMANCE YEAR 2020

This EXHIBIT 1, to the BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL ACO PROGRAM ADDENDUM (“ACO Program Addendum”) between [Legal Business Name] and OneCare Vermont Accountable Care Organization, LLC is attached to and a part of the Parties’ Agreement.

Whereby, in accordance with Section 2.1 of the ACO Program Addendum, the following preliminary model of payment is hereby incorporated into and made a part of the Agreement;

Whereby, the Parties acknowledge that these calculations are based on a programmatic prospective attribution model, and that adjustments may be made during the Program Year based on the terms of the Fixed Payment Policy for factors such as changes in attribution and changes in shadow claims; and

Whereby, the Parties acknowledge that this payment model is subject to final financial information and the rights reserved to OneCare in the Agreement and ACO Program Addendum:

Single Cohort	
Home Hospital Spend PMPM	\$0.00
Other Hospital Spend PMPM	\$0.00
Fee-for-Service PMPM	\$0.00
Total Benchmark PMPM	\$0.00
Initial Attribution ¹	0
Estimated Spend ²	\$0
Maximum Risk Limit (MRL) - 4% Risk Corridor ³	\$0

(1) Attribution is subject to change based on the methodology contained within each Plan Agreement. Final member months of attribution will be used in final settlement calculations.

(2) Total estimated spend for lives attributed to the HSA calculated by multiplying the Total Benchmark PMPM x Attribution x 12 Months

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(3) This amount will be recalculated in the same manner using actual member months of attribution at the time of settlement.

ONE CARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: [Exemplar – No Signature Required] Date: _____
Authorized Signature

PARTICIPANT

By: [Exemplar – No Signature Required] Date: _____
Authorized Signature

Print Name: _____ Title: _____

Legal Business Name: _____ TIN: _____

EXEMPLAR

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**ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
VERMONT MEDICARE ACO INITIATIVE
PROGRAM ADDENDUM**

EXHIBIT 1 – PERFORMANCE YEAR 2020

This EXHIBIT 1, to the VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM (“ACO Program Addendum”) between [Legal Business Name] and OneCare Vermont Accountable Care Organization, LLC is attached to and a part of the Parties’ Agreement.

Whereby, in accordance with Section 2.1 of the ACO Program Addendum, the following preliminary model of payment is hereby incorporated into and made a part of the Agreement;

Whereby, the Parties acknowledge that these calculations are based on a programmatic prospective attribution model, and that adjustments may be made during the Program Year based on the terms of the Fixed Payment Policy for factors such as changes in attribution and changes in shadow claims; and

Whereby, the Parties acknowledge that this payment model is subject to final financial information and the rights reserved to OneCare in the Agreement and ACO Program Addendum:

ESRD	
Total Benchmark PMPM ¹	\$0.00
Initial Attribution ²	0
Estimated Spend ³	\$0
Non-ESRD	
Home Hospital Spend PMPM	\$0.00
Other Hospital Spend PMPM	\$0.00
Fee-for-Service PMPM	\$0.00
Total Benchmark PMPM	\$0.00
Initial Attribution ²	0
Estimated Spend ³	\$0

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Other Components	
Amount Obligated as Advanced Shared Savings ⁴	\$0
Prior Year Performance Carryforward ⁵	\$0
Estimated Spend	\$0
Maximum Risk Limit (MRL) - 5% Risk Corridor⁶	\$0

- (1) This is the ACO-level benchmark. While the spend for this population is subject to Aggregate ACO Pooling per the HSA Benchmark Policy, this amount is used for determining each HSA's Maximum Risk/Reward.
- (2) Attribution is subject to change based on the methodology contained within each Plan Agreement. Final member months of attribution will be used in final settlement calculations.
- (3) Total estimated spend for lives attributed to the HSA calculated by multiplying the Total Benchmark PMPM x Attribution x 12 Months.
- (4) Component of the benchmark that in whole or in part is received as advanced shared savings and used to fund the Blueprint programs as approved in the OneCare budget. This is a fixed amount (not PMPM based) and spread by attribution.
- (5) Allocation of additional remaining shared savings from the prior performance year assigned according to the terms of the HSA Benchmark Policy. This is a fixed amount (not PMPM based) and is subject to change based on the final 2019 Medicare program settlement.
- (6) Calculated by applying the program risk corridor and sharing terms to the combined Estimated Spend amounts. This amount will be recalculated in the same manner using actual member months of attribution at the time of settlement.

ONE CARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: [Exemplar – No Signature Required] Date: _____
Authorized Signature

PARTICIPANT

By: [Exemplar – No Signature Required] Date: _____
Authorized Signature

Print Name: _____ Title: _____

Legal Business Name: _____ TIN: _____

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

EXHIBIT 1 – PERFORMANCE YEAR 2020

This EXHIBIT 1, to the DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM (“ACO Program Addendum”) between [Legal Business Name] and OneCare Vermont Accountable Care Organization, LLC is attached to and a part of the Parties’ Agreement.

Whereby, in accordance with Section 2.1 of the ACO Program Addendum, the following preliminary model of payment is hereby incorporated into and made a part of the Agreement;

Whereby, the Parties acknowledge that these calculations are based on a programmatic prospective attribution model, and that adjustments may be made during the Program Year based on the terms of the Fixed Payment Policy for factors such as changes in attribution and changes in shadow claims; and

Whereby, the Parties acknowledge that this payment model is subject to final financial information and the rights reserved to OneCare in the Agreement and ACO Program Addendum:

Aged Blind Disabled	
Total Benchmark PMPM ¹	\$0.00
Initial Attribution ²	0
Estimated Spend ³	\$0
Consolidated Adult	
Home Hospital Spend PMPM	\$0.00
Other Hospital Spend PMPM	\$0.00
Fee-for-Service PMPM	\$0.00
Total Benchmark PMPM	\$0.00
Initial Attribution ²	0
Estimated Spend ³	\$0

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Consolidated Child	
Home Hospital Spend PMPM	\$0.00
Other Hospital Spend PMPM	\$0.00
Fee-for-Service PMPM	\$0.00
Total Benchmark PMPM	\$0.00
Initial Attribution ²	0
Estimated Spend ³	\$0
Maximum Risk Limit (MRL) - 4% Risk Corridor ⁴	\$0

(1) This is the ACO-level benchmark. While the spend for this population is subject to Aggregate ACO Pooling per the HSA Benchmark Policy, this amount is used for determining each HSA's Maximum Risk/Reward.

(2) Attribution is subject to change based on the methodology contained within each Plan Agreement. Final member months of attribution will be used in final settlement calculations.

(3) Total estimated spend for lives attributed to the HSA calculated by multiplying the Total Benchmark PMPM x Attribution x 12 Months

(4) This amount will be recalculated in the same manner using actual member months of attribution at the time of settlement.

ONE CARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: [Exemplar – No Signature Required] Date: _____
Authorized Signature

PARTICIPANT

By: [Exemplar – No Signature Required] Date: _____
Authorized Signature

Print Name: _____ Title: _____

Legal Business Name: _____ TIN: _____

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AMENDMENT #2

TO THE FIRST AMENDED AND RESTATED ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC RISK BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT TOGETHER WITH: (1) the VERMONT MEDICARE ACO INITIATIVE PROGRAM ADDENDUM; (2) the DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDENDUM AND (3) the BLUE CROSS BLUE SHIELD OF VERMONT NEXT GENERATION MODEL ACO PROGRAM ADDENDUM

COMPREHENSIVE PAYMENT REFORM PROGRAM INDEPENDENT PRIMARY CARE FULL CAPITATION MODEL

Legal Business Name:

Contractual Address:

TIN:

WHEREAS, Participant is an independent Primary Care Provider and a party to the above agreements with OneCare to participate in three Next Generation Model Programs: (1) Medicare, (2) Medicaid and (3) Blue Cross Blue Shield of Vermont; and

WHEREAS, Participant has elected to be compensated under the Performance Year 2020 Independent Primary Care Comprehensive Payment Reform Program (“CPR Program”) for all three Core Next Generation Model Programs for Performance Year 2020; and

WHEREAS, Participant authorizes OneCare to submit the “Vermont All-Payer ACO Model: All-Inclusive Population-Based Payments Fee Reduction Agreement” to CMS in furtherance of its payment for services under the CPR Program.

NOW THEREFORE, Participant agrees:

1. That it will accept a payer-blended, risk-adjusted capitation payment model for Attributed Lives in the Medicare, Medicaid and Blue Cross Blue Shield of Vermont Next Generation ACO programs, rather than payment by ACO Program Payers’ normal payment methodologies. The payments will have two parts: (1) a fixed payment based on the fee-for-service (FFS) equivalent and \$3.25 PMPM Population Health Management payment and (2) a variable earned payment for care coordination engagement and care delivery outcomes and will be set forth in a policy to be approved by the Board of Managers and incorporated herein.

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2. That it will participate in meetings with other practices participating in the CPR Program at OneCare on a quarterly basis.
3. That it will take all reasonable steps to operationalize the CPR Program.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____
Victoria Loner
Chief Executive Officer

Date: _____

PARTICIPANT

By: _____
Authorized Signature

Date: _____

Print Name: _____

Title: _____

Legal Business Name:

TIN:

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**AMENDMENT #1 TO THE FIRST AMENDED AND RESTATED ONECARE
VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
RISK BEARING PARTICIPANT & PREFERRED PROVIDER AGREEMENT**

Legal Business Name:

Contractual Address:

E-mail: healthcarecontracting@uvmhealth.org

TIN:

This Amendment #1 to the First Amended and Restated Risk-Bearing Participant & Preferred Provider Agreement (the “Agreement”) is by and between OneCare Vermont Accountable Care Organization, LLC (“ACO”), a Vermont limited liability company, and Participant or Preferred Provider, a health care provider or organization eligible to participate with ACO as defined in the Agreement, and organized under Vermont or New Hampshire law (each a “Party” and collectively “Parties”) and is effective the date signed by the ACO.

WHEREAS, the Parties wish to Amend the Agreement.

NOW THEREFORE, the Parties agree as follows:

1. The first sentence of Paragraph 2.2. shall be amended to read as follows:

2.2 Qualification to Participate. Participant and Preferred Provider shall participate in each ACO Program that qualifies for All Payer Model Scale Targets, that is designated by the Board as a Core Program and for which a Program Addendum is provided within the time frames set forth in paragraph 3.1 (“Core ACO Programs”) and that is offered by a Payer for which Participant or Preferred Provider is an enrolled provider and in good standing, by signing an ACO Program Addendum for each such ACO Program.

2. The fourth sentence of Paragraph 2.2 shall be amended to read as follows:

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 the Vermont Medicare ACO Initiative, it may not be in MSSP.

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3. The third sentence of Section 4.1.1 shall be amended to read as follows:

ACO will, during the Modeling Period (defined as the time period in advance of the beginning of a Performance Year, during which ACO will provide its best estimates of the expected attribution, payments and risk that will be finalized after the beginning of the Performance Year) provide risk bearing Participants with sufficient financial detail to facilitate an informed decision for participation in ACO Programs including estimates of expected payment and risk to support their participation decisions. During the Modeling Period ACO uses its best judgment as to expected ACO Program terms, attribution, and risk corridors based on all available data that it continues to update ACO-wide models and Participant specific data during this period.

4. Paragraph 4.3 shall be added:

4.3 Bankruptcy. OneCare may terminate this Agreement immediately in the event Participant or Preferred Provider: files a petition commencing a voluntary case against it under the U. S. Bankruptcy Code; makes a general assignment for the benefits of its creditors; becomes insolvent; becomes unable to pay its debts as they become due; files a petition or answer in any proceeding seeking for itself or consenting to, or acquiescing in, any insolvency, receivership, composition, readjustment, liquidation, dissolution, or similar relief under any present or future statute, law, or regulation, or files an answer or other pleading admitting or failing to deny or to contest the material allegations of the petition filed against it in any such proceeding; seeks or consents to, or acquiesces in, the appointment of any trustee, receiver of it or any material part of its property; or has commenced against it any involuntary case under the U. S. Bankruptcy Code, or a proceeding under any receivership, composition, readjustment, liquidation, insolvency, dissolution, or like law or statute, which case or proceeding is not dismissed or vacated within thirty (30) days from commencement. ACO Program obligations for the last Performance Year of participation, such as quality reporting, obligations for Shared Risk and opportunities for Shared Savings will survive termination.

5. Paragraph 8.2.1 shall be added:

8.2.1 In the event that Participant or Preferred Provider reasonably believes that an ACO Policy or procedure is in conflict with one of their legal obligations, by way of example and not limitation a policy in conflict with regulations applicable to Federally Qualified Health Centers, the following process will apply:

- a. Participant or Preferred Provider will immediately notify OneCare by providing written notice specifying the nature of the conflict with reasonable detail in accordance with the notice provisions of this Agreement,
- b. OneCare will suspend application of the ACO Policy or procedure to Participant or Preferred Provider during this resolution process.

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- c. OneCare's Chief Operating Officer, or his/her delegee, will gather information about the issues raised by Participant or Preferred Provider and attempt to resolve any conflict.
- d. If the conflict cannot be resolved with the Chief Operating Officer, the Executive Committee may consider the issue and provide advice.
- e. If the conflict remains unresolved, the Participant or Preferred Provider may utilize the Participant Appeals process.
- f. The Parties agree to act diligently and promptly to raise and resolve issues in this process.

The Agreement is, in all other respects, affirmed and all provisions of the Agreement that are not specifically amended herein shall continue in full force and effect.

IN WITNESS WHEREOF, the Parties have caused this Amendment 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: _____
Kevin Stone
Interim Chief Executive Officer

PARTICIPANT/PREFERRED PROVIDER

By: _____ Date: _____
Authorized Signature

Print Name: _____

Title: _____

Legal Business Name:

TIN:

COLLABORATION AGREEMENT

BETWEEN

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC (“ACO”)

AND

<xcd_contract_desc>

This Collaboration Agreement (the “Agreement”) is made as of the date it has been signed by OneCare Vermont Accountable Care Organization, LLC’s Chief Executive Officer, and indicated on the signature page of the agreement (the “Effective Date”), by and between **OneCare Vermont Accountable Care Organization, LLC (“ACO”)**, organized under the laws of the State of Vermont, and **<xcd_contract_desc>** (“Collaborator”), with the tax identification number (“TIN”) listed on the signature page hereto (collectively, the “Parties” and each, individually a “Party”).

WHEREAS, ACO is participating in the All Payer Model, including Medicare NextGeneration, Medicaid NextGeneration and Commercial NextGeneration Blue Cross programs and may participate in other value based payment arrangements (collectively, the “Programs”);

WHEREAS, Collaborator is an entity that provides for, arranges for or manages health care services and/or social support services in the ACO service area or otherwise supports the activities and goals of the ACO and desires to engage in functions or services with the ACO related to ACO activities;

WHEREAS, ACO and Collaborator are committed to improving the quality, cost and overall care of individuals attributed under the Programs and while Collaborator will not attribute individual lives to ACO, it desires to assist ACO to successfully meet its goals of better health, better healthcare, and reduced healthcare cost growth; and

WHEREAS, the sharing of de-identified data relating to quality and utilization is a necessary part of the Parties’ ability to meet the goals of this Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 COLLABORATOR SERVICES

1.1 Collaborator shall support and assist ACO and ACO related activities which includes, but is not limited to: participating in Community Collaborative Committees; assisting ACO in a collaborative fashion to accomplish its triple aim; supporting and assisting with care coordination; supporting and assisting in the development, maintenance and implementation of the Clinical Model; supporting and assisting with applicable ACO case

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management protocols and ACO Policies and Procedures; and supporting or assisting with other mutually defined goals.

- 1.2 Collaborator shall comply with all applicable laws, regulations and payment program requirements that are applicable to its services. This includes, but is not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, HIPAA, Stark and anti-discrimination. The provisions of this Section 1.2 shall survive termination of this Agreement for any reason.
- 1.3 Collaborator shall hold confidential all confidential and proprietary information and all Data provided to or shared with it by ACO during the performance of this Agreement and will comply with the terms of the Business Associate Agreement attached hereto as **Exhibit 1**, the Data Use Agreement Addendum attached hereto as **Exhibit 2** (originally applicable to MSSP & VMSSP data, and now applicable to Medicare and Medicaid NextGen data as required in those program agreements), and ACO's Data Use Policies and Procedures. Collaborator may not disseminate or share any Data with any person or entity other than ACO employees; ACO Participants and/or ACO Affiliate Participants in the ACO Program from which the Data originated. The terms of this Section 1.3 shall survive termination of this Agreement for any reason.
- 1.4 Collaborator may not create or distribute any marketing or other materials that reference ACO, or Collaborator's participation in any ACO Program without ACO's express, written consent.
- 1.5 Collaborator acknowledges that CMS, DHHS, the Comptroller General, the federal government or its designees, DVHA or GMCB have the right under various ACO Programs to monitor, investigate, audit, inspect or evaluate any books, contracts, records, documents or other evidence of services or functions related to ACO Programs. Collaborator agrees to cooperate and assist those parties and ACO in connection with any such activity, including allowing reasonable access to records and facilities to regulators with authority.
- 1.6 Collaborator agrees to maintain for ten (10) years from the final date of this Agreement all books, contracts, records, documents or other evidence of the performance of services or functions related to ACO activities. If there is a termination, dispute or allegation of fraud or similar fault against the Collaborator, Collaborator agrees to maintain such materials for an additional six (6) years (or sixteen (16) years total).

2.0 TERM & TERMINATION

- 2.1 The term of this Agreement shall commence on the Effective Date and shall continue in effect until one Party gives notice of intention to terminate no less than ninety (90) days before the effective date of termination.

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3.0 GENERAL PROVISIONS

- 3.1 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, Attachments and Riders upon thirty (30) days prior written notice to Collaborator, or immediately upon receipt by Collaborator if such modification is made to comply with federal or state laws or other regulatory bodies.
- 3.2 Independent Contractor Relationship. None of the provisions of this Agreement between or among ACO, Collaborator, or Payors create a relationship other than that of independent entities contracting solely for the purposes of effecting the provisions of this Agreement.
- 3.3 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.
- 3.4 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:

OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301
Colchester, VT 05446
Attn: Director of Contracting

Collaborator
<send_full_address>
Attention: _____

- 3.5 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 and shall be effective when OneCare Vermont has executed its counterpart. Any signature delivered by facsimile machine, or by .pdf, .tif, .gif, .peg or other similar attachment shall be treated in all manner 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.
- 3.6 Applicable Law. This Agreement, together with all of the respective rights of the parties hereto, shall be governed by and construed and enforced in accordance with the laws of the State of Vermont.

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

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____
Todd B. Moore
Chief Executive Officer

Effective Date: _____

<xcd_contract_desc>

By: _____
Authorized Signature

Print Name: _____

TIN: <xcd_tin>

Date: _____

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EXHIBIT 1

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Addendum (the “Addendum”) is entered into by and between **OneCare Vermont Accountable Care Organization, LLC** (“ACO”) and Collaborator (“Business Associate”).

RECITALS

ACO and Business Associate are parties to this Collaboration Agreement (the “Agreement”) pursuant to which Business Associate provides certain services to ACO and, in connection with those services, ACO discloses to Business Associate certain Protected Health Information (“PHI”) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and Title XIII, The Health Information Technology for Economic and Clinical Health Act (“HITECH”), of the American Recovery and Reinvestment Act (“ARRA”).

The parties desire to comply with the requirements set forth in the Privacy and Security Regulations and HITECH concerning the privacy of PHI.

The purpose of this Addendum is to comply with the requirements of the Privacy Rule, the Security Rule, HITECH and, if applicable, 42 CFR Part 2 including but not limited to the Business Associate Requirements at 45 C.F.R. Section 164.504(e).

Therefore, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

SECTION I – DEFINITIONS

- 1.1 **Definitions.** Unless otherwise provided in this Agreement, capitalized terms shall have the same meaning as set forth in the HIPAA regulations, 45 C.F.R. Sections 160 and 164, and HITECH and its related regulations or under 42 CFR Section 2.11.

SECTION II – OBLIGATIONS OF BUSINESS ASSOCIATE

- 2.1 **Use/Disclosure of PHI.** In connection with its use and disclosure of PHI, Business Associate agrees that it shall use and/or disclose PHI only as permitted or required by this Addendum or as otherwise required by law.
- 2.2 **Safeguards for Protection of PHI.** Business Associate agrees to use reasonable and appropriate safeguards to prevent the use or disclosure of PHI other than as provided in this Addendum.
- 2.3 **Compliance with HITECH Act and Regulations.** Business Associate will comply with the requirements of HITECH, codified at 42 U.S.C. §§ 17921-17954, which are applicable to Business Associate, and will comply with all regulations issued by the Department of Health and Human Services to implement these referenced statutes, as of

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the date by which Business Associate is required to comply with such referenced statutes and HHS regulations.

- 2.4 General Reporting. Business Associate shall report to ACO any use or disclosure of PHI which is not provided for by this Agreement of which Business Associate becomes aware.
- 2.5 Reporting of Breaches of Unsecured Protected Health Information. Business Associate will report in writing to ACO's Privacy Officer any breach of unsecured PHI, as defined in the breach notification regulations, within ten (10) business days of the date Business Associate learns of the incident giving rise to the breach. Business Associate will provide such information to ACO as required in the regulations. Business Associate will reimburse ACO for any reasonable expenses ACO incurs in notifying individuals of a breach caused by Business Associate or Business Associate's subcontractors or agents, and for reasonable expenses ACO incurs in mitigating harm to those Individuals. Business Associate also will defend, hold harmless and indemnify ACO and its employees, agents, officers, directors, members, contractors, and subsidiary and affiliate entities, from and against any claims, losses, damages, liabilities, costs, expenses, penalties or obligations (including attorneys' fees) which ACO may incur due to a breach caused by Business Associate or Business Associate's subcontractors or agents.
- 2.6 Mitigation. Business Associate shall make reasonable efforts to mitigate, to the greatest extent possible, any harmful effects arising from any improper use and/or disclosure of PHI.
- 2.7 Subcontractors. Business Associate shall ensure that any agents, including any subcontractor, to whom it provides PHI, shall agree to the same restrictions and conditions that apply to Business Associate with respect to PHI.
- 2.8 Access by Individuals. Business Associate shall allow individuals who are the subject of the PHI to inspect and copy their PHI in the possession of Business Associate if ACO does not also maintain such information.
- 2.9 Access by Department of Health and Human Services. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services for purposes of determining ACO's compliance with the HIPAA privacy regulations.
- 2.10 Access by ACO. Upon reasonable notice, Business Associate shall make its internal practices, book, and records relating to the use and disclosure of PHI available to ACO for purposes of determining Business Associate's compliance with the terms of this Agreement and Business Associate's compliance with HIPAA and HITECH.
- 2.11 Accountings of Disclosures. If Business Associate discloses any PHI, Business Associate shall make available to ACO the information necessary for ACO to provide an accounting of disclosures to any individual who requests such an Accounting, or, in the

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alternative, Business Associate shall provide an accounting of disclosures directly to the requesting individual, if requested by ACO.

- 2.12 Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI in a designated record set that ACO directs or agrees to pursuant to ACO's obligations under the Privacy Rule.

SECTION III – PERMITTED USES AND DISCLOSURES

- 2.1 General. Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, ACO as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by ACO.

SECTION IV – SECURITY

- 4.1 Compliance with Security Rule. Business Associate agrees to implement the Security Rule (security standards as set out in 45 C.F.R. parts 160, 162 and 164), Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the electronic PHI that Business Associate creates, receives, maintains, or transmits on behalf of the Covered Entity.
- 4.2 Reporting. Business Associate agrees to report to Covered Entity any security incident of which it becomes aware.
- 4.3 Agents Compliance with Business Associate Addendum. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PH I received from, or created or received by, Business Associate on behalf of ACO agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information.
- 4.4 Agents Compliance with Security Rule. Business Associate will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement the Security Rule, Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI.
- 4.5 Records Availability. Business Associate agrees to make its policies, procedures, and documentation relating to the safeguards described herein available to the Secretary, for purposes of the Secretary determining ACO's compliance with the Security Rule.

SECTION V – TERM & TERMINATION

- 5.1 Term and Termination. This Addendum shall be effective as of effective date of the Agreement and shall terminate when all of the PHI provided by ACO to Business Associate, or created or received by Business Associate on behalf of ACO, is destroyed or returned to ACO. The parties acknowledge and agree that the terms and conditions

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stipulated in this Agreement shall apply to any future written or oral agreements between ACO and Business Associate which require the disclosure of PHI, whether or not this Agreement is incorporated by reference into future agreements executed between the parties. This Agreement shall terminate in accordance with the termination provisions in the Agreement.

- 5.2 Effect of Termination. Upon termination of the Agreement, for any reason, Business Associate shall, if feasible, return or destroy all PHI that Business Associate still maintains in any form and shall not retain any copies of such PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the PHI and shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

SECTION VI – MISCELLANEOUS

- 6.1 Amendment. This Addendum shall be deemed to amend automatically, by force of law and without further act of the parties, if necessary to bring the Agreement into compliance with any changes in HIPAA, HITECH or any related regulations that are made after the date of execution of this Agreement.
- 6.2 Interpretation. Any ambiguity in this Addendum shall be resolved in a manner that brings the Addendum into compliance with the then most current version of HIPAA and the HIPAA privacy regulations.
- 6.3 No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any other person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

EXHIBIT 2

DATA USE AGREEMENT

A. General

1. Subject to the limitations discussed in this Agreement, and in accordance with applicable law, in advance of the Start Date and at any other time deemed necessary by CMS, CMS will offer the ACO an opportunity to request certain data and reports, which are described in Sections VI.B, VI.C, and Appendix D of this Agreement.
2. The data and reports provided to the ACO under the preceding paragraph will omit individually identifiable data for Next Generation Beneficiaries who have opted out of data sharing with the ACO, as described in Section VI.D. of this Agreement. The data and reports provided to the ACO will also omit substance use disorder data for any Next Generation Beneficiaries who have not opted into substance use disorder data sharing, as described in Section VI.E. of this Agreement.

**B. Provision of Certain
Claims Data**

1. CMS believes that the care coordination and quality improvement work of the ACO (that is acting on its own behalf as a HIPAA covered entity (“CE”) or who is a business associate (“BA”) acting on behalf of its Next Generation Participants or Preferred Providers that are HIPAA CEs) would benefit from the receipt of certain beneficiary-identifiable claims data on Next Generation Beneficiaries. CMS will therefore offer to the ACO an opportunity to request specific beneficiary-identifiable claims data by completing the HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet (Appendix D). All requests for beneficiary-identifiable claims data will be granted or denied at CMS’ sole discretion based on CMS’ available resources, the limitations in this Agreement, and applicable law.
2. In offering this beneficiary-identifiable claims data, CMS does not represent that the ACO or any Next Generation Participant or Preferred Provider has met all applicable HIPAA requirements for requesting data under 45 CFR § 164.506(c)(4). The ACO and its Next Generation Participants and Preferred Providers should consult with their own counsel to make those determinations prior to requesting this data from CMS.
3. The beneficiary-identifiable claims data available is the data described in Appendix D.
4. The parties mutually agree that, except for data covered by Section VI.B.13 below, CMS retains all ownership rights to the data files referred to in Appendix D, and the ACO does not obtain any right, title, or interest in any of the data furnished by CMS.
5. The ACO represents, and in furnishing the data files specified in Appendix D

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CMS relies upon such representation, that such data files will be used solely for the purposes described in this Agreement. The ACO agrees not to disclose, use or reuse the data except as specified in this Agreement or except as CMS shall authorize in writing or as otherwise required by law. The ACO further agrees not to sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement.

6. The ACO intends to use the requested information as a tool to deliver seamless, coordinated care for Next Generation Beneficiaries to promote better care, better health, and lower growth in expenditures. Information derived from the CMS files specified in Appendix D may be shared and used within the legal confines of the ACO and its Next Generation Participants and Preferred Providers in a manner consistent with paragraph 7 below to enable the ACO to improve care integration and be a patient-centered organization.

7. The ACO may reuse original or derivative data without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation, but shall not disseminate individually identifiable original or derived information from the files specified in Appendix D to anyone who is not a HIPAA CE Next Generation Participant or Preferred Provider in a treatment relationship with the subject Next Generation Beneficiary(ies); a HIPAA BA of such a CE Next Generation Participant or Preferred Provider; the ACO's BA, where that ACO is itself a HIPAA CE; the ACO's sub-BA, which is hired by the ACO to carry out work on behalf of the CE Next Generation Participants or Preferred Providers; or a non-participant HIPAA CE in a treatment relationship with the subject Next Generation Beneficiary(ies). When using or disclosing PHI or personally identifiable information ("PII"), obtained from files specified in Appendix D, the ACO must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. The ACO shall further limit its disclosure of such information to the types of disclosures that CMS itself would be permitted make under the "routine uses" in the applicable systems of records listed in Appendix D.

Subject to the limits specified above and elsewhere in this Agreement and applicable law, the ACO may link individually identifiable information specified in Appendix D (including directly or indirectly identifiable data) or derivative data to other sources of individually-identifiable health information, such as other medical records available to the ACO and its Next Generation Participants or Preferred Providers. The ACO may disseminate such data that has been linked to other sources of individually identifiable health information provided such data has been de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b).

8. The ACO agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that

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is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I--Responsibilities for Protecting and Managing Federal Information Resources (https://www.whitehouse.gov/omb/circulars_default) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (<http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf>); and, NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (<http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf>). The ACO acknowledges that the use of unsecured telecommunications, including the Internet, to transmit directly or indirectly identifiable information from the files specified in Appendix D or any such derivative data files is strictly prohibited. Further, the ACO agrees that the data specified in Appendix D must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in Appendix D other than as provided in this Agreement without written approval from CMS, unless such movement, transmission or disclosure is required by a law.

9. The ACO agrees to grant access to the data and/or the facility(ies) in which the data is maintained to the authorized representatives of CMS or DHHS Office of the Inspector General, including at the site of the custodian indicated in Appendix D, for the purpose of inspecting to confirm compliance with the terms of this Agreement.
10. The ACO agrees that any use of CMS data in the creation of any document concerning the purpose specified in this section and Appendix D must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer beneficiaries may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.
11. The ACO agrees to report any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2850 or by email notification at cms_it_service_desk@cms.hhs.gov within one hour. Furthermore, the ACO agrees to cooperate fully in any federal incident security process that results from such improper use or disclosure.
12. The parties mutually agree that the individual named in Appendix D is designated as Custodian of the CMS data files on behalf of the ACO and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, and for the establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use or disclosure. Furthermore, such Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in this Agreement as a condition of receiving such data. The ACO agrees to notify CMS

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within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

13. Data disclosed to the ACO pursuant to Appendix D may be retained by the ACO until the conclusion or termination of this Agreement. The ACO is permitted to retain any individually identifiable health information from such data files or derivative data files after the conclusion or termination of the Agreement if the ACO is a HIPAA CE, and the data has been incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom the ACO provides such data in the course of carrying out the Model initiative may also retain such data if the recipient entity is a HIPAA CE or BA and the data is incorporated into the subject Beneficiaries' medical records that are part of a designated record set under HIPAA. The ACO shall destroy all other data and send written certification of the destruction of the data files and/or any derivative data files to CMS within 30 days following the conclusion or termination of the Agreement. Except for disclosures for treatment purposes, the ACO shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph. These retention provisions survive the conclusion or termination of the Agreement.

C. De-Identified Reports

CMS will provide the following reports to the ACO, which will be de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b):

1. Monthly Financial Reports

These reports will include monthly and year-to-date information on total Medicare expenditures and expenditures for selected categories of services for Next Generation Beneficiaries. This aggregate information will not include individually identifiable health information and will incorporate de-identified data from Next Generation Beneficiaries who have opted out of data sharing.

2. Quarterly Benchmark Reports

CMS will provide quarterly benchmark reports (“**BRs**”) to the ACO to monitor ACO financial performance throughout the year. The BRs will not contain individually identifiable data. The design and data source used to generate the BRs is also used for the final year-end settlement report, as described in Section XIV.C. In the event that data contained in the BRs conflicts with data provided from any other source, the data in the BRs will control with respect to settlement under Section XIV.B of the Agreement.

D. Beneficiary Rights to Opt Out of Data Sharing

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1. The ACO shall provide Next Generation Beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences via 1-800-MEDICARE. Such communications shall note that, even if a Next Generation Beneficiary has elected to decline claims data sharing, CMS may still engage in certain limited data sharing for quality improvement purposes.
2. The ACO shall allow Next Generation Beneficiaries to reverse a data sharing preference at any time by calling 1-800-MEDICARE.
3. CMS will maintain the data sharing preferences of Beneficiaries who elect to decline data sharing in this Model or who have previously declined data sharing under the MSSP or the Pioneer ACO Model.
4. The ACO may affirmatively contact a Next Generation Beneficiary who has elected to decline claims data sharing no more than one time in the Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Next Generation Beneficiaries outside of a clinical setting.
5. In the event that a Next Generation Professional is terminated from the ACO for any reason, if that departing Next Generation Professional is the sole Next Generation Professional in the ACO to have submitted claims for a particular Next Generation Beneficiary during the 12-month period prior to the effective date of the termination, CMS will administratively opt the Next Generation Beneficiary out of all claims data-sharing under this Section VI within 30 days of the effective date of the termination, unless—
 - (a) The Next Generation Beneficiary affirmatively consents to continued data sharing of such claims with the ACO through an authorization that meets the requirements under 45 CFR § 164.508(b); or
 - (b) The Next Generation Beneficiary has become the patient of another Next Generation Professional participating in the ACO.
6. Notwithstanding the foregoing, an ACO shall receive claims data regarding substance use disorder treatment only if the Next Generation Beneficiary has not elected to decline data sharing or otherwise been opted out of data sharing and has also submitted a CMS-approved form pursuant to Section VI.E of this Agreement.

E. Beneficiary Substance Use Disorder Data Opt-In

1. The ACO may inform each newly-aligned Next Generation Beneficiary, in compliance with applicable law:
 - (a) That he or she may elect to allow the ACO to receive beneficiary-identifiable data regarding his or her utilization of substance use disorder services;
 - (b) Of the mechanism by which the Next Generation Beneficiary can make

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 this election; and

- (c) That 1-800-Medicare will answer any questions regarding sharing of data regarding utilization of substance use disorder services.
2. A Next Generation Beneficiary may opt in to substance use disorder data sharing only by submitting a CMS-approved substance use disorder opt in form to the ACO. The ACO shall promptly send the opt-in form to CMS