



Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
State Innovations Group
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Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative Participation Agreement

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VERMONT MEDICARE ACO INITIATIVE PARTICIPATION AGREEMENT

This participation agreement (“**Agreement**”) is between the CENTERS FOR MEDICARE & MEDICAID SERVICES (“**CMS**”) and OneCare Vermont ACO, LLC, an accountable care organization (“**ACO**”).

CMS is the agency within the U.S. Department of Health and Human Services (“**HHS**”) that is charged with administering the Medicare and Medicaid programs.

The ACO is an entity that has been approved by CMS to operate a Medicare accountable care organization (“**Medicare ACO**”). A Medicare ACO is an entity formed by certain health care providers that accepts financial accountability for the overall quality and cost of medical care furnished to Medicare fee-for-service (“**FFS**”) Beneficiaries aligned to the entity. Typically, the health care providers participating in a Medicare ACO continue to bill Medicare under the traditional FFS system for services rendered to Beneficiaries. However, the Medicare ACO may share in any Medicare savings achieved with respect to the aligned beneficiary population if the Medicare ACO satisfies minimum quality performance standards. The Medicare ACO may also share in any Medicare losses recognized with respect to the aligned beneficiary population. Medicare ACOs participating in a two-sided risk model are liable to CMS for a portion of the Medicare expenditures that exceed a benchmark.

CMS is implementing the Vermont All-Payer ACO Model (“**Model**”) under section 1115A of the Social Security Act (“**Act**”), which authorizes CMS, through its Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program expenditures while maintaining or improving the quality of beneficiaries’ care.

The purpose of the Model is to test whether the health of, and care delivery for, Vermont residents improve and healthcare expenditures for beneficiaries across payers (including Medicare FFS, Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans) decrease if: a) these payers offer Vermont ACOs aligned risk-based arrangements tied to health outcomes and healthcare expenditures; b) the majority of Vermont providers and suppliers participate under such risk-based arrangements; and c) the majority of Vermont residents across payers are aligned to an accountable care organization bound by such arrangements. As part of this Model, the ACO will participate in the Vermont Medicare ACO Initiative (“**Initiative**”), which is the ACO initiative that will be implemented under this Agreement.

CMS executed the Vermont All-Payer Accountable Care Organization Model Agreement (the “**State Agreement**”) with Vermont’s Green Mountain Care Board (“**GMCB**”), the Vermont Agency of Human Services (“**AHS**”), and the Governor of Vermont (collectively the “**State**” or “**Vermont**”), a copy of which has been provided to the ACO. The GMCB is a legislatively created independent healthcare entity whose authority is codified in Title 18, Chapter 220 of the Vermont Statutes Annotated. Its regulatory authority includes payment and delivery system reform oversight, provider rate-setting, health information technology plan approval, workforce plan approval, hospital budget approval, insurer rate approval, certificate of need issuance, and oversight of the state’s all-payer claims database. The Vermont AHS is the Vermont Medicaid Single State Agency that manages Vermont’s Medicaid program through the terms and conditions of Vermont’s demonstration waiver under section 1115 of the Act. The ACO and the

GMCB submitted to CMS a jointly signed letter attesting that the two entities will work together to achieve the goals of the Model, including the Initiative.

The parties therefore agree as follows:

I. Agreement Term

- A. **Effective Date**. This Agreement will become effective when it is signed by both parties. The effective date of this Agreement (the “**Effective Date**”) will be the date this Agreement is signed by the last party to sign it (as indicated by the date associated with that party’s signature).
- B. **Agreement Term**. The term of this Agreement (“**Agreement Term**”) begins on the Effective Date and expires two years after the last day of the Agreement Performance Period.
- C. **Agreement Performance Period**. The period of performance under this Agreement (“**Agreement Performance Period**”) begins on January 1 immediately following the Effective Date (the “**Start Date**”) and ends on December 31, 2022, unless the Agreement is sooner terminated by either party in accordance with Section XVIII.

II. Definitions

“**ACO Activities**” means activities related to promoting accountability for the quality, cost, and overall care for a population of Initiative Beneficiaries, including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; or carrying out any other obligation or duty of the ACO under this Agreement. Examples of these activities include, but are not limited to, providing direct patient care 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, 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 the quality performance standards of this Agreement; evaluating health needs; communicating clinical knowledge and evidence-based medicine; and developing standards for Beneficiary access and communication, including Beneficiary access to medical records.

“**AIPBP**” means the all-inclusive population-based payment Alternative Payment Mechanism in which CMS makes a monthly payment to the ACO reflecting an estimate, based on historical expenditures, of the percentage of total expected Medicare Part A and/or Part B FFS payments for Covered Services furnished to Initiative Beneficiaries by Initiative Participants and Preferred Providers who have agreed to a AIPBP Fee Reduction.

“**AIPBP Fee Reduction**” means the 100% reduction in Medicare FFS payments to selected Initiative Participants and Preferred Providers, who have agreed to receive no payment from Medicare for Covered Services furnished to Initiative Beneficiaries to account for the Monthly AIPBP Payments made by CMS to the ACO under AIPBP.

“**Alternative Payment Mechanism**” means an optional payment mechanism that may be selected by the ACO for a given Performance Year, under which CMS will make interim

payments to the ACO during a Performance Year. For purposes of this Agreement, “Alternative Payment Mechanism” refers to AIPBP.

“**At-Risk Beneficiary**” means a Beneficiary who—

- A. Has a high risk score on the CMS-Hierarchical Condition Category (HCC) risk adjustment model;
- B. Is considered high cost due to having two or more hospitalizations or emergency room visits each year;
- C. Is dually eligible for Medicare and Medicaid;
- D. Has a high utilization pattern;
- E. Has one or more chronic conditions;
- F. Has had a recent diagnosis that is expected to result in increased cost;
- G. Is entitled to Medicaid because of disability;
- H. Is diagnosed with a mental health or substance use disorder; or
- I. Meets such other criteria as specified in writing by CMS.

“**Base Year**” means the calendar year that is two years prior to the relevant Performance Year.

“**Beneficiary**” means an individual who is enrolled in Medicare.

“**Benefit Enhancements**” means the following additional benefits the ACO chooses to make available to Initiative Beneficiaries through Initiative Participants and Preferred Providers in order to support high-value services and allow the ACO to more effectively manage the care of Initiative Beneficiaries: (1) 3-Day SNF Rule Waiver Benefit Enhancement (as described in Section XI.B and Appendix D); (2) Telehealth Expansion Benefit Enhancement (as described in Section XI.C and Appendix E); (3) Post-Discharge Home Visits Benefit Enhancement (as described in Section XI.D and Appendix F); and (4) Care Management Home Visits Benefit Enhancement (as described in Section XI.E and Appendix G).

“**CCN**” means a CMS Certification Number.

“**Covered Services**” means the scope of health care benefits described in sections 1812 and 1832 of the Act for which payment is available under Part A or Part B of Title XVIII of the Act.

“**Days**” means calendar days unless otherwise specified.

“**Descriptive ACO Materials and Activities**” include, but are not limited to, general audience materials such as brochures, advertisements, outreach events, letters to Beneficiaries, web pages published on a web site, mailings, social media, or other activities conducted by or on behalf of the ACO or its Initiative Participants or Preferred Providers, when used to educate, notify, or contact Beneficiaries regarding the Initiative or Vermont All-Payer ACO Model. The following communications are not Descriptive ACO Materials and Activities: communications that do not directly or indirectly reference the Initiative or the Vermont All-Payer ACO Model (for example, information about care coordination generally would not be considered Descriptive ACO Materials and Activities); materials that cover Beneficiary-specific billing and claims issues;

educational information on specific medical conditions; referrals for health care items and services; and any other materials that are excepted from the definition of “marketing” under the HIPAA Privacy Rule (45 CFR Part 160 & Part 164, subparts A & E).

“Initiative Beneficiary” means a Beneficiary who is aligned to the ACO for a given Performance Year using the methodology set forth in Section II of Appendix B and has not subsequently been excluded from the aligned population of the ACO.

“Initiative Participant” means an individual or entity that:

- A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);
- B. Is identified on the Participant List in accordance with Section IV;
- C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
- D. Is not a Preferred Provider;
- E. Is not a Prohibited Participant; and
- F. Pursuant to a written agreement with the ACO, has agreed to participate in the Initiative, to report quality data through the ACO, and to comply with care improvement objectives and Initiative quality performance standards.

“Initiative Professional” means an Initiative Participant who is either:

- A. A physician (as defined in section 1861(r) of the Act); or
- B. One of the following non-physician practitioners:
 1. Physician assistant who satisfies the qualifications set forth at 42 CFR § 410.74(a)(2)(i)-(ii);
 2. Nurse practitioner who satisfies the qualifications set forth at 42 CFR § 410.75(b);
 3. Clinical nurse specialist who satisfies the qualifications set forth at 42 CFR § 410.76(b);
 4. Certified registered nurse anesthetist (as defined at 42 CFR § 410.69(b));
 5. Certified nurse midwife who satisfies the qualifications set forth at 42 CFR § 410.77(a);
 6. Clinical psychologist (as defined at 42 CFR § 410.71(d));
 7. Clinical social worker (as defined at 42 CFR § 410.73(a)); or
 8. Registered dietician or nutrition professional (as defined at 42 CFR § 410.134).

“Legacy TIN or CCN” means a TIN or CCN that an Initiative Participant or Preferred Provider previously used for billing Medicare Parts A and B services but no longer uses to bill for those services, and includes a “sunsetting” Legacy TIN or CCN (a TIN or CCN that is no longer used for billing for Medicare Parts A and B services by any Medicare-enrolled provider or supplier) or

an “active” Legacy TIN or CCN (a TIN or CCN that may be in use by a Medicare-enrolled provider or supplier that is not an Initiative Participant or Preferred Provider).

“**Medically Necessary**” means reasonable and necessary as determined in accordance with section 1862(a) of the Act.

“**Monthly AIPBP Payment**” means the monthly payment made by CMS to the ACO under AIPBP.

“**NPI**” means a national provider identifier.

“**Other Monies Owed**” means a monetary amount owed by either party to this Agreement that represents a reconciliation of payments made by CMS during a Performance Year, including payments made through the Alternative Payment Mechanism, and is neither Shared Savings nor Shared Losses.

“**Participant List**” means the list that identifies each Initiative Participant that is approved by CMS for participation in the Initiative, specifies which Initiative Participants, if any, have agreed to an AIPBP Fee Reduction and designates the Benefit Enhancements, if any, in which each Initiative Participant participates, as updated from time to time in accordance with Section IV of this Agreement.

“**Performance Year**” means a calendar year during the Agreement Performance Period. The first Performance Year begins on the Start Date and ends on December 31 of that calendar year. Subsequent Performance Years are 12 months in duration, beginning on January 1. The final Performance Year begins on January 1, 2022, and ends on December 31, 2022, unless this Agreement is sooner terminated in accordance with Section XVIII.

“**Performance Year Benchmark**” means the target expenditure amount to which actual Medicare Part A and Part B expenditures for items and services furnished to Initiative Beneficiaries during a Performance Year will be compared in order to calculate Shared Losses and Shared Savings as determined by CMS in accordance with Appendix B.

“**Preferred Provider**” means an individual or entity that:

- A. Is a Medicare-enrolled provider (as defined at 42 CFR § 400.202) or supplier (as defined at 42 CFR § 400.202);
- B. Is identified on the Preferred Provider List in accordance with Section IV. ;
- C. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations;
- D. Is not a Initiative Participant;
- E. Is not a Prohibited Participant; and
- F. Has agreed to participate in the Initiative pursuant to a written agreement with the ACO.

“**Preferred Provider List**” means the list that identifies each Preferred Provider that is approved by CMS for participation in the Initiative, specifies which Preferred Providers, if any, have agreed to an AIPBP Fee Reduction, and designates the Benefit Enhancements, if any, in which each Preferred Provider participates, as updated from time to time in accordance with Sections IV.D and IV.E of this Agreement.

“Prohibited Participant” means an individual or entity that is: (1) a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier, (2) an ambulance supplier, (3) a drug or device manufacturer, or (4) excluded or otherwise prohibited from participation in Medicare or Medicaid.

“Risk Arrangement” means the arrangement selected by the ACO that determines the portion of the savings or losses in relation to the Performance Year Benchmark that accrue to the ACO as Shared Savings or Shared Losses.

“Rural ACO” means an accountable care organization that has signed a participation agreement with CMS to participate in this Initiative for which at least 40 percent of the Federal Information Processing Standard (FIPS) codes in its service area are determined to be rural according to the definition of “rural” used by the Health Resources and Services Administration (HRSA) Office of Rural Health Policy. Such definition includes all non-Metropolitan counties, census tracts inside Metropolitan counties with Rural-Urban Commuting Area (RUCA) codes 4-10, and census tracts with RUCA codes 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people per square mile.

“Savings/Losses Cap” means the maximum allowable percentage of the ACO’s Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, as selected by the ACO in accordance with Section X.A.2, and subject to the application of the Risk Arrangement selected by the ACO in accordance with Section X.A.1.

“Shared Losses” means the monetary amount owed to CMS by the ACO in accordance with the applicable Risk Arrangement and Appendix B due to expenditures for Medicare Part A and B items and services furnished to Initiative Beneficiaries in excess of the Performance Year Benchmark.

“Shared Savings” means the monetary amount owed to the ACO by CMS in accordance with the applicable Risk Arrangement and Appendix B due to expenditures for Medicare Part A and B items and services furnished to Initiative Beneficiaries lower than the Performance Year Benchmark.

“TIN” means a federal taxpayer identification number.

“Vermont ACO” means an accountable care organization primarily operating in Vermont that has contracts with any of the following payers: Vermont Medicaid; Vermont Commercial Plans; Vermont Self-insured Plans; or Medicare under the Medicare Shared Savings Program, the Next Generation ACO Model, or the Vermont Medicare ACO Initiative.

“Vermont Commercial Plan” means health insurance plans holding a certificate of authority from Vermont’s Commissioner of Financial Regulation. This term does not include coverage for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage if benefits for health services are secondary or incidental to other insurance benefits. This term includes Medicare Advantage plans, but does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, and other similar benefits.

“**Vermont Medicaid**” means the program of medical assistance benefits under Title XIX of the Act, as modified by Vermont’s demonstration waiver under Section 1115 of the Act, operated by Vermont’s Agency for Human Services to provide health coverage to eligible Vermont residents. This term excludes assistance for Vermont residents who receive pharmacy benefits but no other medical benefits under Vermont’s demonstration waiver or Title XIX of the Act.

“**Vermont Self-insured Plan**” means health plans provided to a Vermont resident by an employer operating in Vermont who is self-insured. This term excludes federal employee health benefit plans, TRICARE and other military coverage, and other employer-based plans for employers operating outside of Vermont.

III. ACO Composition

A. ACO Legal Entity

1. The ACO shall be a legal entity identified by a TIN formed under applicable state, federal, or tribal law, and authorized to conduct business in each state in which it operates for purposes of the following:
 - (a) Receiving and distributing Shared Savings;
 - (b) Repaying Shared Losses or Other Monies Owed to CMS;
 - (c) Establishing, reporting, and ensuring Initiative Participant compliance with health care quality criteria, including quality performance standards; and
 - (d) Fulfilling ACO Activities identified in this Agreement.
2. If the ACO was formed by two or more Initiative Participants, the ACO shall be a legal entity separate from the legal entity of any of its Initiative Participants or Preferred Providers.
3. If the ACO was formed by a single Initiative Participant, the ACO’s legal entity and governing body may be the same as that of the Initiative Participant if the ACO satisfies the requirements of Section III.B.
4. During the term of this Agreement, the ACO shall not participate in the MSSP, Next Generation ACO Model, the independence at home medical practice demonstration program under section 1866E of the Act, another model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings.

B. ACO Governance

1. General

- (a) The ACO shall maintain an identifiable governing body with sole and exclusive authority to execute the functions of the ACO and make final

decisions on behalf of the ACO. The ACO shall have a governing body that satisfies the following criteria:

- i. The governing body has responsibility for oversight and strategic direction of the ACO and is responsible for holding ACO management accountable for the ACO's activities;
 - ii. The governing body is separate and unique to the ACO, except as permitted under Section III.A.3;
 - iii. The governing body has a transparent governing process;
 - iv. When acting as a member of the governing body of the ACO, each governing body member has a fiduciary duty to the ACO, including the duty of loyalty, and shall act consistent with that fiduciary duty; and
 - v. The governing body shall receive regular reports from the designated compliance official of the ACO that satisfies the requirements of Section XVI.A.1.
- (b) The ACO shall provide each member of the governing body with a copy of this Agreement and any amendments hereto.

2. Composition and Control of the Governing Body

- (a) The ACO governing body shall include at least one Beneficiary served by the ACO who:
- i. Does not have a conflict of interest with the ACO;
 - ii. Has no immediate family member with a conflict of interest with the ACO;
 - iii. Is not an Initiative Participant or Preferred Provider; and
 - iv. Does not have a direct or indirect financial relationship with the ACO, an Initiative Participant, or a Preferred Provider, except that such person may be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO.
- (b) The ACO governing body shall include at least one person with training or professional experience in advocating for the rights of consumers (“**Consumer Advocate**”), who may be the same person as the Beneficiary and who:
- i. Does not have a conflict of interest with the ACO;
 - ii. Has no immediate family member with a conflict of interest with the ACO;
 - iii. Is not an Initiative Participant or Preferred Provider; and
 - iv. Does not have a direct or indirect financial relationship with the ACO, an Initiative Participant, or a Preferred Provider, except that such person may

be reasonably compensated by the ACO for his or her duties as a member of the governing body of the ACO.

- (c) The ACO governing body shall not include a Prohibited Participant, or an owner, employee or agent of a Prohibited Participant.
- (d) If Beneficiary and/or Consumer Advocate representation on the ACO governing body is prohibited by state law, the ACO shall notify CMS and request CMS approval of an alternative mechanism to ensure that its policies and procedures reflect consumer and patient perspectives. CMS shall use reasonable efforts to approve or deny the request within 30 days.
- (e) The governing body members may serve in similar or complementary roles or positions for Initiative Participants or Preferred Providers.
- (f) At least 75 percent control of the ACO's governing body shall be held by Initiative Participants and Preferred Providers, or their designated representatives. The Beneficiary and Consumer Advocate required under this Section shall not be included in either the numerator or the denominator when calculating the percent control. The ACO may seek an exception from the 75 percent control requirement by submitting a proposal to CMS describing the current composition of the ACO's governing body and how the ACO will involve Initiative Participants and Preferred Providers in innovative ways in ACO governance. Any exception to the 75 percent control requirement will be at the sole discretion of CMS.

3. Conflict of Interest

The ACO shall have a conflict of interest policy that applies to members of the governing body and satisfies the following criteria:

- (a) Requires each member of the governing body to disclose relevant financial interests;
- (b) Provides a procedure to determine whether a conflict of interest exists and sets forth a process to address any conflicts that arise; and
- (c) Addresses remedial actions for members of the governing body that fail to comply with the policy.

C. **ACO Leadership and Management**

- 1. The ACO's operations shall be managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve the efficiency of processes and outcomes.
- 2. Clinical management and oversight shall be managed by a senior-level medical director who is:
 - (a) An Initiative Participant;

- (b) Physically present on a regular basis at any clinic, office, or other location participating in the ACO; and
- (c) A board-certified physician and licensed in a state in which the ACO operates.

D. ACO Financial Arrangements

1. The ACO shall not condition an Initiative Participant's or Preferred Provider's participation in the Initiative, directly or indirectly, on referrals of items or services provided to Beneficiaries who are not aligned to the ACO.
2. The ACO shall not require that Initiative Beneficiaries be referred only to Initiative Participants or Preferred Providers or to any other provider or supplier. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if an Initiative Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Initiative Beneficiary's best medical interests in the judgment of the referring party.
3. The ACO shall not condition the eligibility of an individual or entity to be an Initiative Participant or Preferred Provider on the individual's or entity's offer or payment of cash or other remuneration to the ACO or any other individual or entity.
4. The ACO, its Initiative Participants, and/or Preferred Providers shall not take any action to limit the ability of an Initiative Participant or Preferred Provider to make decisions in the best interests of the Beneficiary, including the selection of devices, supplies and treatments used in the care of the Beneficiary.
5. The ACO shall notify CMS within 15 days after becoming aware that any Initiative Participant or Preferred Provider 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). If an Initiative Participant or Preferred Provider is under investigation or has been sanctioned but not excluded from Medicare program participation, CMS may take any of the actions set forth in Section XVIII.
6. By the date specified in Section III.D.7, below, the ACO shall have a written agreement with each of the individuals and entities that are approved by CMS to be Initiative Participants or Preferred Providers that complies with the following criteria:
 - (a) The only parties to the agreement are the ACO and the Initiative Participant or Preferred Provider.
 - (b) The agreement requires the Initiative Participant or Preferred Provider to agree to participate in the Initiative, to engage in ACO Activities, to comply with the applicable terms of the Initiative as set forth in this Agreement, and

to comply with all applicable laws and regulations (including, but not limited to, those specified at Section XVI.D). The ACO shall provide each Initiative Participant and Preferred Provider with a copy of this Agreement.

- (c) The agreement expressly sets forth the Initiative Participant's or Preferred Provider's obligation to comply with the applicable terms of this Agreement, including provisions regarding the following: participant exclusivity, quality measure reporting, and continuous care improvement objectives for Initiative Participants and Preferred Providers; Beneficiary freedom of choice; Benefit Enhancements; participation in evaluation, shared learning, monitoring, and oversight activities; the ACO compliance plan; and audit and record retention requirements.
 - (d) The agreement requires the Initiative Participant or Preferred Provider to update its Medicare enrollment information (including the addition and deletion of Initiative Professionals that have reassigned to the Initiative Participant or Preferred Provider their right to Medicare payment) on a timely basis in accordance with Medicare program requirements.
 - (e) The agreement requires the Initiative Participant or Preferred Provider to notify the ACO of any changes to its Medicare enrollment information within 30 days after the change.
 - (f) The agreement requires the Initiative Participant or Preferred Provider to notify the ACO within seven days of becoming 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).
 - (g) The agreement permits the ACO to take remedial action against the Initiative Participant or Preferred Provider (including the imposition of a corrective action plan, denial of incentive payments such as Shared Savings distributions, and termination of the ACO's agreement with the Initiative Participant or Preferred Provider) to address noncompliance with the terms of the Agreement or program integrity issues identified by CMS.
 - (h) The agreement is for a term of at least one year, but permits early termination if CMS requires the ACO to remove the Initiative Participant or Preferred Provider pursuant to Section XVIII.A.1.
 - (i) The agreement requires the Initiative Participant to complete a close-out process upon termination or expiration of the agreement that requires the Initiative Participant to furnish all quality measure reporting data.
7. The ACO shall have fully executed written agreements in place that meet the requirements set forth in Section III.D.6 by the following dates:
- (a) By the Start Date in the case of agreements with individuals and entities that were approved by CMS before the Start Date to be Initiative Participants and Preferred Providers.

- (b) By the date the ACO certifies its Participant List and Proposed Preferred Provider List in accordance with Section IV.E in the case of agreements with individuals and entities approved by CMS to be Initiative Participants and Preferred Providers effective on the first day of the second or any subsequent Performance Year.
 - (c) For agreements with individuals or entities approved by CMS to be Initiative Participants or Preferred Providers effective on a day other than the first day of a Performance Year, by the date the ACO requests the addition of the individual or entity to the Participant List or Preferred Provider List.
- 8. The ACO shall not distribute Shared Savings to any Initiative Participant or Preferred Provider that has been terminated pursuant to Section XVIII.A.1.
 - 9. CMS provides no opinion on the legality of any contractual or financial arrangement that the ACO, an Initiative Participant, or a Preferred Provider has proposed, implemented, or documented. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

IV. Initiative Participants and Preferred Providers

A. General

- 1. Initiative Participants and Preferred Providers will be included on the Participant List or Preferred Provider List only upon the prior written approval of CMS.
- 2. CMS shall maintain the Participant List and Preferred Provider List in a manner that permits the ACO to review the list.
- 3. The ACO shall maintain current and historical Participant Lists and Preferred Provider Lists in accordance with Section XVII.B.
- 4. CMS may periodically monitor the program integrity history of the ACO's Initiative Participants or Preferred Providers. CMS may remove an individual or entity from the Participant List or Preferred Provider List or subject the ACO to additional monitoring pursuant to Section XVIII.A.1, on the basis of the results of a periodic program integrity screening or information obtained regarding an individual's or entity's history of program integrity issues. CMS shall notify the ACO if it chooses to remove an individual or entity from the Participant List or Preferred Provider List, and such notice shall specify the effective date of removal.

B. Initial Participant List

- 1. The parties acknowledge that the ACO submitted to CMS an initial list of proposed Initiative Participants, identified by name, NPI, TIN, Legacy TIN or

CCN (if applicable), and CCN (if applicable), and which identifies the county or counties in which each Initiative Professional has an office location.

2. CMS states that it has reviewed the initial list of proposed Initiative Participants and conducted a program integrity screening on the proposed Initiative Participants.
3. CMS states that it has submitted to the ACO an initial list of individuals and entities that it approved to be Initiative Participants. The ACO states that it reviewed this list and made any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Initiative as of the Start Date pursuant to a written agreement. No additions to this list were permitted at that time.
4. The ACO states that it has submitted to CMS, by a date set by CMS, an initial Participant List that the ACO has certified is a true, accurate, and complete list identifying the following: (i) all of the ACO's Initiative Participants approved by CMS to participate in the Initiative as of the Start Date and with whom the ACO will have a fully executed written agreement meeting the requirements in Section III.D.6; (ii) each Initiative Participant, if any, that has agreed to an AIPBP Fee Reduction; and (iii) the specific Benefit Enhancements, if any, in which each Initiative Participant has agreed to participate.
5. The ACO states that no more than 30 days after the Start Date it will furnish a written notice to the executive of each entity through whose TIN an Initiative Participant bills Medicare. The notice must –
 - (a) Include a list identifying by name and NPI each Initiative Participant who is identified on the initial Participant List as billing through the entity's TIN; and
 - (b) Inform the executive that an Initiative Participant's participation in the Initiative may preclude the entire TIN from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.
6. The ACO shall update the initial Participant List in accordance with Section IV.D and IV.E.

C. Initial Preferred Provider List

1. The parties acknowledge that the ACO submitted to CMS an initial list of proposed Preferred Providers identified by name, NPI, TIN, Legacy TIN or CCN (if applicable), and CCN (if applicable). The proposed list also identified which individuals and entities, if any, had agreed to an AIPBP Fee Reduction, and specified the Benefit Enhancements, if any, in which each individual or entity had agreed to participate.
2. CMS states that it will review the list of proposed Preferred Providers and conduct a program integrity screening on the proposed Preferred Providers.

3. Before the Start Date, CMS will submit to the ACO a list of individuals and entities that it has approved to be Preferred Providers. The ACO shall review the list and make any necessary corrections to it, including the removal of any individuals or entities that have not agreed to participate in the Initiative as of the Start Date pursuant to a written agreement. No additions to this list are permitted at this time.
4. Before the Start Date, or at such other time as may be specified by CMS, the ACO shall submit to CMS an initial Preferred Provider List that the ACO has certified is a true, accurate, and complete list identifying the following: (i) all of the ACO's Preferred Providers approved by CMS to participate in the Initiative as of the Start Date, and with whom the ACO will have a fully executed written agreement meeting the requirements in Section III.D.6; (ii) each Preferred Provider, if any, that has agreed to an AIPBP Fee Reduction; and (iii) the specific Benefit Enhancements, if any, in which each Preferred Provider has agreed to participate.
5. The ACO shall update the initial Preferred Provider List in accordance with Section IV.D and IV.E.

D. Updating Lists During a Performance Year

1. Additions to a List

- (a) *Participant List Additions.* The ACO shall not add an Initiative Participant to the Participant List without prior written approval from CMS. If the ACO wishes to add an individual or entity to the Participant List effective on a date other than the first day of a Performance Year (“during a Performance Year”), it shall submit a request to CMS in a form and manner and by a deadline specified by CMS. CMS may accept requests for additions to the Participant List during a Performance Year only under the following circumstances:
 - i. The request for addition is submitted to CMS between January 1 and July 31 of the Performance Year in which the addition would take effect;
 - ii. In the case of a request to add a physician or non-physician practitioner to the Participant List, the ACO certifies that the individual (1) currently bills for items and services he or she furnishes to Beneficiaries under a Medicare billing number assigned to the TIN of an entity that is currently a Initiative Participant, and (2) did not bill for such items and services under the TIN of the same Initiative Participant at the time the ACO submitted its initial Participant List pursuant to Section IV.B, or its most recent Proposed Participant List pursuant to Section IV.E.1, whichever is applicable to the Performance Year in which the addition would take effect;
 - iii. The ACO certifies that it has a fully executed written agreement with the individual or entity it wishes to add to the Participant List and that the agreement meets the requirements of Section III.D.6; and

- iv. The ACO certifies that it has furnished a written notice to each proposed Initiative Participant that is a physician or non-physician practitioner and to the executive of the TIN through which such individual bills Medicare indicating that the ACO has proposed to add such individual to the ACO's Participant List. In the case of a request to add an entity to the Participant List, the ACO certifies that it has furnished a written notice to the executive of each TIN through which such entity bills Medicare indicating that the ACO has proposed to add such entity to the ACO's Participant List. The notice to the TIN must identify by name and NPI each individual or entity who is identified on the request for addition as billing through the TIN.

CMS may reject the request on the basis that the individual or entity fails to satisfy the requirements of paragraph (A) or paragraphs (C) through (F) of the definition of "Initiative Participant," or on the basis of information obtained from a program integrity screening. If CMS approves the request, the individual or entity will be added to the Participant List effective on the date the addition is approved by CMS.

- (b) *Preferred Provider List Additions.* The ACO shall not add an individual or entity to the Preferred Provider List during a Performance Year without prior written approval from CMS. If the ACO wishes to add an individual or entity to the Preferred Provider List during a Performance Year, it shall submit a request to CMS in the form and manner and by a deadline specified by CMS. CMS may accept requests for additions to the Preferred Provider List during a Performance Year only under the following circumstances:
 - i. The request for addition is submitted to CMS between January 1 and September 30 of the Performance Year in which the addition would take effect;
 - ii. The ACO certifies that it has a fully executed written agreement with the individual or entity it wishes to add to the Preferred Provider List and that the agreement meets the requirements of Section III.D.6; and
 - iii. In the case of a request to add an individual or entity to the Preferred Provider List, the ACO certifies that it has furnished a written notice to the executive of the TIN through which such individual or entity bills Medicare indicating that the ACO has proposed to add the individual or entity to the ACO's Preferred Provider List. The notice to the TIN must identify by name and NPI each individual and entity that is identified on the request for addition as billing through the TIN.

CMS may reject the request on the basis that the individual or entity fails to satisfy the requirements of paragraph (A) or paragraphs (C) through (F) of the definition of "Preferred Provider," or on the basis of information obtained from a program integrity screening. If CMS approves the request, the individual or entity will be added to the Preferred Provider List effective on the date the addition is approved by CMS.

2. Removals from a List

In a form and manner specified by CMS, the ACO shall notify CMS no later than 30 days after an individual or entity has ceased to be an Initiative Participant or Preferred Provider and shall include in the notice the date on which the individual or entity ceased to be an Initiative Participant or Preferred Provider. The removal of the individual or entity from the Participant List or Preferred Provider List will be effective on the date the individual or entity ceased to be an Initiative Participant or Preferred Provider. An individual or entity ceases to be an Initiative Participant or Preferred Provider when it is no longer a Medicare-enrolled provider or supplier, when its agreement with the ACO to participate in the Initiative terminates, or when it ceases to bill for items and services furnished to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations.

3. Updating Enrollment Information

The ACO shall ensure that all changes to enrollment information for Initiative Participants and Preferred Providers, including changes to reassignment of the right to receive Medicare payment, are reported to CMS consistent with 42 C.F.R. § 424.516.

E. **Annual Updates to Participant List and Preferred Provider List**

1. Proposed Participant List and Proposed Preferred Provider List

Prior to the end of each Performance Year, unless otherwise instructed by CMS, the ACO shall submit to CMS by a date and in a manner specified by CMS, proposed lists identifying each individual or entity that the ACO expects to participate in the Initiative as an Initiative Participant or Preferred Provider effective at the start of the next Performance Year (“**Proposed Participant List**” and “**Proposed Preferred Provider List**,” respectively). CMS shall specify a submission deadline for the Proposed Participant List that is no later than 165 days before the start of the next Performance Year. CMS shall specify a submission deadline for the Proposed Preferred Provider List that is not later than 45 days before the start of the next Performance Year. The Proposed Participant List must identify each individual or entity by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable), and must identify the county or counties in which each Initiative Professional has an office location. The Proposed Preferred Provider List must identify each individual or entity by name, NPI, TIN, CCN (if applicable), and Legacy TIN or CCN (if applicable), and identify which individuals and entities, if any, have agreed to an AIPBP Fee Reduction, and specify the Benefit Enhancements, if any, in which each individual or entity has agreed to participate. The ACO shall certify that the Proposed Participant List and the Proposed Preferred Provider List are each a true, accurate, and complete list of individuals and entities that have agreed to be

Initiative Participants and Preferred Providers, subject to CMS approval, effective January 1 of the relevant Performance Year.

2. [ACO Notice to Proposed Initiative Participants](#)

At least 7 days prior to submitting its Proposed Participant List to CMS, the ACO shall furnish written notification to each individual or entity the ACO wishes to include on the Proposed Participant List. Such notice shall –

- (a) State that the individual or entity and the relevant TIN through which it bills Medicare will be identified on the Proposed Participant List; and
- (b) State that participation in the Initiative may preclude the individual or entity from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.

3. [ACO Notice to TINs](#)

At least 7 days prior to submitting its Proposed Participant List and Proposed Preferred Provider List to CMS, the ACO shall furnish written notification to the executive of any TIN through which an individual or entity on the Proposed Participant List or Proposed Preferred Provider List bills Medicare. Such notification must:

- (a) Include a list identifying by name and NPI each individual or entity that will be identified on the ACO's Proposed Participant List or Proposed Preferred Provider List as billing through the entity's TIN; and
- (b) Inform the executive of the TIN that an Initiative Participant's participation in the ACO may preclude the entire TIN from participating in the MSSP, another Medicare ACO or other payment model tested or expanded under section 1115A of the Act, or any other Medicare initiative that involves shared savings.

4. [Review, Certification, and Finalization of the Participant List and Preferred Provider List](#)

- (a) With respect to each individual and entity identified on the Proposed Participant List and Proposed Preferred Provider List, CMS shall conduct a program integrity screening, including a review of the individual's or entity's history of Medicare program exclusions, current or prior law enforcement investigations, or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.
- (b) CMS may reject any individual or entity on a Proposed Participant List or a Proposed Preferred Provider List on the basis of the results of this program integrity screening, history of program integrity issues, or:
 - i. for any individual or entity on a Proposed Participant List, if CMS determines that the individual or entity does not satisfy the criteria in

paragraph (A) or paragraphs (C) through (E) of the definition of “Initiative Participant”; or

- ii. for any individual or entity on a Proposed Preferred Provider List, if CMS determines that the individual or entity does not satisfy the criteria in paragraph (A) or paragraphs (C) through (F) of the definition of “Preferred Provider.”
- (c) No later than 115 days before the end of the Performance Year, CMS will send the ACO a list of individuals and entities that CMS has tentatively approved to be Initiative Participants effective at the start of the next Performance Year.
 - (d) No later than 90 days before the end of the Performance Year, the ACO shall, after a review of the list of tentatively approved Initiative Participants, submit a revised Proposed Participant List with any necessary corrections, including the removal of any individuals or entities that have not agreed to participate in the Initiative pursuant to a written agreement with the ACO or that are otherwise ineligible to participate. No additions to the list are permitted at this time. The ACO shall certify that the submitted list is a true, accurate, and complete list of the individuals and entities that have agreed to be Initiative Participants effective January 1 of the relevant Performance Year.
 - (e) No later than 60 days before the end of the Performance Year, CMS will send the ACO a list of individuals and entities that CMS has approved to be Initiative Participants effective at the start of the next Performance Year. The ACO may not request the addition of any individual or entity to this Participant List until after the start of the next Performance Year.
 - (f) No later than 45 days before the end of the Performance Year, the ACO shall submit to CMS a true, accurate, and complete list of Initiative Participants identified on the Participant List referenced in Section IV.E.4(e) and Preferred Providers identified on the Proposed Preferred Provider List referenced in Section IV.E.1 who have agreed to participate in AIPBP Fee Reduction and the Benefit Enhancements, as applicable.
 - (g) No later than 15 days before the end of the Performance Year, CMS will send the ACO a final Participant List identifying all individuals and entities that CMS has approved to be Initiative Participants effective at the start of the next Performance Year (including AIPBP Fee Reduction and Benefit Enhancement information, as applicable) and a final Preferred Provider List identifying all individuals and entities that CMS has approved to be Preferred Providers (including AIPBP Fee Reduction and Benefit Enhancement information, as applicable) effective at the start of the next Performance Year. The ACO shall update such lists in accordance with this Agreement.

F. Non-Duplication and Exclusivity of Participation

1. The ACO and its Initiative Participants may not participate in any other Medicare shared savings initiatives, as described in Appendix A.
2. CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and in the implementing regulations at 42 C.F.R. § 425.114(a) regarding participation in a model tested under section 1115A of the Act that involves shared savings as they apply to Preferred Providers, subject to the conditions and requirements set forth in Appendix A.
3. The ACO and its Initiative Participants and Preferred Providers are bound by the participation overlap provisions set forth in Appendix A.

V. Beneficiary Alignment, Engagement, and Protections

A. Beneficiary Alignment

1. CMS shall, according to the methodology set forth in Appendix B, use an analysis of evaluation and management services furnished by Initiative Professionals to Beneficiaries to align Beneficiaries to the ACO for the purposes of the Initiative. Initiative Beneficiaries are aligned prospectively, prior to the start of the relevant Performance Year.
2. CMS may, in its sole discretion, adjust the alignment of Initiative Beneficiaries to the ACO for a Performance Year due to the addition or removal of an Initiative Participant from the Participant List during the Performance Year pursuant to Section IV.D or Section XVIII.A.

B. [RESERVED]

C. [RESERVED]

D. Beneficiary Notifications

1. In a form and manner and by a date specified by CMS, the ACO shall provide all Initiative Beneficiaries notice in writing that they have been aligned to the ACO for the Performance Year.
2. CMS shall provide the ACO with a template letter, indicating letter content that the ACO shall not change, as well as places in which the ACO may insert its own original content.
3. Pursuant to Section V.E, the ACO shall obtain CMS approval of the final notification letter content, which includes the ACO's own original content, prior to sending letters to Initiative Beneficiaries.

E. Descriptive ACO Materials and Activities

1. The ACO shall not use, and shall prohibit its Initiative Participants and Preferred Providers from using Descriptive ACO Materials or Activities until reviewed and approved by CMS.
2. Descriptive ACO Materials or Activities are deemed approved 10 business days following their submission to CMS if:
 - (a) The ACO certifies in writing its compliance with all the requirements under this Section V.E; and
 - (b) CMS does not disapprove the Descriptive ACO Materials or Activities.
3. CMS may issue written notice of disapproval of Descriptive ACO Materials or Activities at any time, including after the expiration of the 10 day review period.
4. The ACO, Initiative Participants, Preferred Providers, or any other individuals or entities performing functions or services related to ACO Activities, as applicable, must immediately discontinue use of any Descriptive ACO Materials or Activities disapproved by CMS.
5. Any material changes to CMS-approved Descriptive ACO Materials and Activities must be reviewed and approved by CMS before use.
6. The ACO shall retain copies of all written and electronic Descriptive ACO Materials and Activities and appropriate records for all other Descriptive ACO Materials and Activities provided to Beneficiaries in a manner consistent with Section XVII.B.

F. Availability of Services

1. The ACO shall require its Initiative Participants and Preferred Providers to make Medically Necessary Covered Services available to Beneficiaries in accordance with applicable laws, regulations and guidance. Beneficiaries and their assignees retain their right to appeal claims determinations in accordance with 42 CFR Part 405, Subpart I.
2. The ACO and its Initiative Participants and Preferred Providers shall not take any action to avoid treating At-Risk Beneficiaries or to target certain Beneficiaries for services with the purpose of trying to ensure alignment in a future Performance Year.

G. Beneficiary Freedom of Choice

1. Consistent with Section 1802(a) of the Act, neither the ACO nor any Initiative Participant, Preferred Provider, or other individuals or entities performing functions or services related to ACO Activities shall commit any act or omission, nor adopt any policy, that inhibits Beneficiaries from exercising their freedom to obtain health services from providers and suppliers who are not Initiative Participants or Preferred Providers. This prohibition shall not apply to referrals made by employees or contractors who are operating within the scope of their

employment or contractual arrangement with the employer or contracting entity, provided that the employees and contractors remain free to make referrals without restriction or limitation if a Beneficiary expresses a preference for a different provider or supplier, or the referral is not in the Beneficiary's best medical interests in the judgment of the referring party.

2. Notwithstanding the foregoing, the ACO may communicate to Beneficiaries the benefits of receiving care with the ACO. All such communications shall be deemed Descriptive ACO Materials and Activities. CMS may provide the ACO with scripts, talking points or other materials explaining these benefits.

H. Prohibition on Beneficiary Inducements

1. General Prohibition

Except as set forth in Section V.H.2, the ACO, Initiative Participants, Preferred Providers, and other individuals or entities performing functions and services related to ACO Activities are prohibited from providing gifts or other remuneration to Beneficiaries to induce them to receive items or services from the ACO, Initiative Participants, or Preferred Providers, or to induce them to continue to receive items or services from the ACO, Initiative Participants or Preferred Providers.

2. Exception

- (a) Consistent with the provisions of Section V.H.1, and subject to compliance with all other applicable laws and regulations, Initiative Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities may provide in-kind items or services to Beneficiaries if the following conditions are satisfied:
 - i. There is a reasonable connection between the items and services and the medical care of the Beneficiary;
 - ii. The items and services are preventive care items and services or advance a clinical goal for the Beneficiary, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan, or management of a chronic disease or condition; and
 - iii. The in-kind item or service is not a Medicare-covered item or service for the Beneficiary on the date the in-kind item or service is furnished to that Beneficiary. For purposes of this exception, an item or service that could be covered pursuant to a Benefit Enhancement is considered a Medicare-covered item or service, regardless of whether the ACO has selected to participate in such Benefit Enhancement for the Performance Year pursuant to Section X.A.
- (b) For each in-kind item or service provided by an Initiative Participant or Preferred Provider under V.H.2.a, above, the ACO shall maintain records of the following:

- i. The nature of the in-kind item or service;
- ii. The identity of each Beneficiary that received the in-kind item or service;
- iii. The identity of the individual or entity that furnished the in-kind item or service; and
- iv. The date the in-kind item or service was furnished.

I. HIPAA Requirements

1. The ACO acknowledges that it is a covered entity or a business associate, as those terms are defined in 45 CFR § 160.103, of Initiative Participants or Preferred Providers who are covered entities.
2. The ACO shall have all appropriate administrative, technical, and physical safeguards in place before the Start Date to protect the privacy and security of protected health information (“**PHI**”) in accordance with 45 CFR § 164.530(c).
3. The ACO shall maintain the privacy and security of all Initiative-related information that identifies individual Beneficiaries in accordance with the Health Insurance Portability and Accountability Act (“**HIPAA**”) Privacy and Security Rules and all relevant HIPAA Privacy and Security guidance applicable to the use and disclosure of PHI by covered entities, as well as applicable state laws and regulations.

VI. Data Sharing and Reports

A. General

1. Subject to the limitations discussed in this Agreement, and in accordance with applicable law, in advance of each Performance Year 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 the HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet described in Section VI.B.1.
2. The data and reports provided to the ACO under the preceding paragraph will omit individually identifiable data for Initiative 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 Initiative 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 Initiative Participants or Preferred Providers that are HIPAA CEs) would benefit from the receipt of

certain Beneficiary-identifiable claims data on Initiative 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 provided to the ACO by CMS (the “**Worksheet**”). 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 Initiative Participant or Preferred Provider has met all applicable HIPAA requirements for requesting data under 45 CFR § 164.506(c)(4). The ACO and its Initiative 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 the Worksheet.
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 the Worksheet, 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 the Worksheet, 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 Initiative Beneficiaries to promote better care, better health, and lower growth in expenditures. Information derived from the CMS files specified in the Worksheet may be shared and used within the legal confines of the ACO and its Initiative Participants and Preferred Providers in a manner consistent with Section VI.B.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 the Worksheet to anyone who is not a HIPAA CE Initiative Participant or Preferred Provider in a treatment relationship with the subject Initiative Beneficiary(ies); a HIPAA BA of such a CE Initiative Participant or Preferred Provider; the ACO’s BA, where the 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 Initiative Participants or Preferred Providers; or a non-participant HIPAA CE in a treatment relationship with the subject Initiative

Beneficiary(ies). When using or disclosing PHI or personally identifiable information (“**PII**”), obtained from files specified in the Worksheet, 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 the Worksheet.

Subject to the limits specified above and elsewhere in this Agreement and applicable law, the ACO may link individually identifiable information specified in the Worksheet (including directly or indirectly individually identifiable data) or derivative data to other sources of individually-identifiable health information, such as other medical records available to the ACO and its Initiative 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 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 individually identifiable information from the files specified in the Worksheet or any such derivative data files is strictly prohibited. Further, the ACO agrees that the data specified in the Worksheet must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in the Worksheet 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 HHS Office of Inspector General, including at the site of the custodian indicated in the Worksheet, 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 the Worksheet 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 the Worksheet 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 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 the Worksheet 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 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 or except as CMS shall authorize in writing or as otherwise required by law. 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 Initiative Beneficiaries. This aggregate information will not include individually identifiable health information and will incorporate de-identified data from Initiative 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 Performance 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 XIII.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 XIII.C of the Agreement.

D. Beneficiary Rights to Opt Out of Data Sharing

1. The ACO shall provide Initiative 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 an Initiative 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 Initiative 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 Initiative or who have previously declined data sharing under the MSSP, Next Generation ACO Model, or the Pioneer ACO Model.
4. The ACO may affirmatively contact an Initiative Beneficiary who has elected to decline claims data sharing no more than one time in a given Performance Year to provide information regarding data sharing. Such contact includes mailings, phone calls, electronic communications, or other methods of communicating with Initiative Beneficiaries outside of a clinical setting.
5. In the event that an Initiative Professional is terminated from the ACO for any reason, if that departing Initiative Professional is the sole Initiative Professional in the ACO to have submitted claims for a particular Initiative Beneficiary during the 12-month period prior to the effective date of the termination, CMS will administratively opt the Initiative Beneficiary out of all claims data-sharing under this Section VI.D within 30 days of the effective date of the termination, unless—

- (a) The Initiative 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 Initiative Beneficiary has become the patient of another Initiative Professional participating in the ACO.
6. Notwithstanding the foregoing, the ACO shall receive claims data regarding substance use disorder treatment only if the Initiative 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.
7. CMS will administratively opt an Initiative Beneficiary back into claims data sharing if: (a) he or she was administratively opted out of data sharing solely due to the termination of a Initiative Professional from the ACO; (b) he or she is aligned to the ACO for a subsequent Performance Year; and (c) he or she does not affirmatively opt out of data sharing according to this Section VI.D.

E. Beneficiary Substance Use Disorder Data Opt-In

1. The ACO may inform each newly-aligned Initiative 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 Initiative Beneficiary can make this election; and
 - (c) That 1-800-MEDICARE will answer any questions regarding sharing of data regarding utilization of substance use disorder services.
2. An Initiative 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.

VII. Care Improvement Objectives

A. General

1. The ACO shall implement processes and protocols that relate to the following objectives for patient-centered care:
 - (a) Promotion of evidence-based medicine, such as through the establishment and implementation of evidence-based guidelines at the organizational or institutional level. An evidence-based approach would also regularly assess and update such guidelines.
 - (b) Processes to ensure Beneficiary/caregiver engagement, and the use of shared decision making processes by Initiative Participants that take into account Beneficiaries' unique needs, preferences, values, and priorities. Measures for

promoting Beneficiary engagement include, but are not limited to, the use of decision support tools and shared decision making methods with which the Beneficiary can assess the merits of various treatment options in the context of his or her values and convictions. Beneficiary engagement also includes methods for fostering what might be termed "health literacy" in Beneficiaries and their families.

- (c) Coordination of Beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote Beneficiary monitoring, and other enabling technologies).
 - (d) Providing Beneficiaries access to their own medical records and to clinical knowledge so that they may make informed choices about their care.
 - (e) Ensuring individualized care for Beneficiaries, such as through personalized care plans.
 - (f) Routine assessment of Beneficiary and caregiver and/or family experience of care and seek to improve where possible.
 - (g) Providing care that is integrated with the community resources Beneficiaries require.
2. The ACO shall require its Initiative Participants to comply with and implement these designated processes and protocols, and shall institute remedial processes and penalties, as appropriate, for Initiative Participants that fail to comply with or implement a required process or protocol.
 3. The ACO shall make infrastructure and care delivery investments as directed by the GMCB pursuant to section 8.b.iii of the State Agreement. The entirety of the State Agreement is hereby incorporated by reference into this Agreement.

B. Outcomes-Based Contracts with Other Purchasers

1. CMS may require the ACO to report to CMS, in a manner and by a date determined by CMS, information regarding the scope of outcomes-based contracts held by the ACO and/or its Initiative Participants with non-Medicare purchasers. For purposes of this provision, outcomes-based contracts mean contracts that evaluate patient experiences of care, include financial accountability (e.g., shared savings or financial risk) and/or quality performance standards.
2. Notwithstanding other sections of this Agreement, failure to comply with this Section VII.B. may result in CMS imposing appropriate remedial actions under Section XVIII.A. but shall not be cause for CMS to terminate this Agreement.

VIII. ACO Quality Performance

A. Quality Scores

1. As described in Appendix B, the ACO's Performance Year Benchmark will be determined using a quality score of 100% and adjusted during financial settlement to reflect the ACO's total quality score for the Performance Year. Prior to the start of each Performance Year, CMS shall notify the ACO of the methodology for adjusting the ACO's Performance Year Benchmark based on the ACO's total quality score for that Performance Year.
2. CMS shall use the ACO's performance on each of the quality measures described in Section VIII.B to calculate the ACO's total quality score according to a methodology determined by CMS. Prior to the start of each Performance Year, CMS shall notify the ACO of the methodology for calculating performance for each quality measure and the methodology for calculating the ACO's total quality score for that Performance Year.

B. Quality Measures

CMS shall assess quality performance using the quality measures set forth in Appendix K and the quality measure data reported by the ACO. CMS may amend Appendix K without the consent of the ACO prior to the beginning of a Performance Year to change the quality measures to be used for the Performance Year, including to make changes to the status of such measures as pay for reporting or pay for performance. CMS shall notify the ACO of any change in the measures applicable for a Performance Year prior to the beginning of the Performance Year in which such measures take effect.

C. Quality Measure Reporting

1. Except as set forth in Section VIII.C.2, the ACO shall completely and accurately report quality measures for each Performance Year and shall require its Initiative Participants to cooperate in quality measure reporting. Complete reporting means that the ACO meets all of the reporting requirements including timely reporting the requested data for all measures.
2. The ACO shall not report quality measures data on behalf of its Initiative Participants for a Performance Year if the ACO terminates this Agreement pursuant to Section XVIII.D.3, and the termination is effective no later than 30 days after February 28 of that Performance Year.
3. CMS shall use the following sources for quality reporting:
 - (a) ACO reporting of results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other patient experience surveys;
 - (b) Medicare claims submitted for items and services furnished to Initiative Beneficiaries; and
 - (c) Any other relevant data shared between the ACO and CMS pursuant to this Agreement.

4. For each Performance Year, the ACO is responsible for procuring a CMS-approved vendor to conduct the CAHPS or other patient experience surveys. The ACO is responsible for paying for the surveys and for ensuring that the survey results are transmitted to CMS by a date and in a manner established by CMS.

IX. Use of Certified EHR Technology

As of the Start Date, the ACO and its Initiative Participants shall use Certified Electronic Health Record Technology (“CEHRT”), as such term is defined under 42 C.F.R. § 414.1305, in a manner sufficient to meet the applicable requirements of 42 C.F.R. § 414.1415(a)(1)(i), including any amendments thereto.

X. ACO Selections and Approval

A. ACO Selections

For each Performance Year, in a manner and by one or more deadlines determined by CMS, the ACO shall submit to CMS its selections for the following:

1. The ACO’s selected Risk Arrangement from the alternatives described in Appendix B;
2. The ACO’s selected Savings/Losses Cap, between 5.0% and 15.0%;
3. The ACO’s selection whether to participate in the Alternative Payment Mechanism; and
4. The Benefit Enhancements if any, that the ACO selects to offer through its Initiative Participants and Preferred Providers.

B. Risk Arrangement and Savings/Losses Cap Approval

The ACO’s Risk Arrangement and Savings/Losses Cap selection for a Performance Year shall be deemed approved unless rejected in writing by CMS within 30 days after submission.

C. Alternative Payment Mechanism Approval

1. The parties acknowledge that the ACO’s selection of AIPBP as an Alternative Payment Mechanism for Performance Year 1 (CY 2019) pursuant to Section X.A. was deemed approved by CMS.
2. For Performance Year 2 (CY2020) and each subsequent Performance Year, if the ACO selects to participate in the Alternative Payment Mechanism for such Performance Year, CMS shall send the ACO written notice of approval or rejection of the Alternative Payment Mechanism selection within 15 days after the ACO’s submission of its Alternative Payment Mechanism selection. In the event that CMS does not send such written notice within 15 days after the ACO’s submission of its selection, the ACO’s selection shall be deemed approved. CMS shall assess the ACO’s Alternative Payment Mechanism

selection according to Section XIII and the eligibility criteria set forth in Appendix J.

XI. Benefit Enhancements

A. General

1. The ACO may select to provide one or more Benefit Enhancements for a Performance Year. The ACO shall submit to CMS, in a form and manner and by a date specified by CMS, a plan for implementing each Benefit Enhancement selected under Section X by the ACO (“**Implementation Plan**”) the first time that Benefit Enhancement is selected under Section X by the ACO, in advance of any Performance Year during which a material amendment to a Benefit Enhancement previously selected under Section X will take effect, and at such other times specified by CMS.
2. If the ACO selects to provide one or more Benefit Enhancements for a Performance Year, the ACO’s Initiative Participants and Preferred Providers, as indicated on the relevant Participant List and Preferred Provider List under Section IV, may submit claims for services furnished pursuant to such Benefit Enhancement(s) as described in this Section during the Performance Year for which the ACO selected to provide the Benefit Enhancement. Appendices D, E, F, and G shall apply to this Agreement only if the ACO selected under Section X to provide the relevant Benefit Enhancement for the given Performance Year.
3. CMS may require the ACO to report data on the use of Benefit Enhancements to CMS. Such data shall be reported in a form and in a manner and by a date to be determined by CMS.
4. If CMS determines that the ACO’s implementation of one or more Benefit Enhancements does not satisfy the applicable requirements of this Agreement, including the appendices hereto, or is likely to result in program abuse, CMS may reject the ACO’s selection to provide one or more Benefit Enhancements or may reject (or require the amendment of) the ACO’s Implementation Plan. If CMS rejects an Implementation Plan for a Benefit Enhancement, the ACO shall not implement the Benefit Enhancement.

B. 3-Day SNF Rule Waiver Benefit Enhancement

1. Appendix D shall apply to this Agreement for any Performance Year for which the ACO has selected the 3-Day SNF Rule Waiver Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the 3-Day SNF Rule Waiver Benefit Enhancement.
2. The ACO shall require that, in order to be eligible to submit claims for services furnished to Initiative Beneficiaries pursuant to the 3-Day SNF Rule Waiver Benefit Enhancement, an entity must be:

- (a) A Initiative Participant or Preferred Provider; and
 - (b) A skilled-nursing facility (“SNF”) or a hospital or critical access hospital that has swing-bed approval for Medicare post-hospital extended care services (“**Swing-Bed Hospital**”); and
 - (c) Designated on the Participant List or Preferred Provider List submitted in accordance with Section IV of the Agreement as participating in the 3-Day SNF Rule Waiver Benefit Enhancement; and
 - (d) Approved by CMS according to the criteria described in this Section XI.B.2 and Appendix D.
3. If CMS notifies the ACO that a SNF or Swing-Bed Hospital has not been approved for participation in the 3-Day SNF Rule Waiver Benefit Enhancement under this Section XI.B, but the provider is otherwise eligible to be an Initiative Participant or Preferred Provider, the ACO may either remove the provider from the Participant List or Preferred Provider List, or amend the relevant list to reflect that the provider will not participate in the 3-Day SNF Rule Waiver Benefit Enhancement. The ACO shall amend the relevant list no later than 30 days after the date of the notice from CMS.

C. Telehealth Expansion Benefit Enhancement

- 1. Appendix E shall apply to this Agreement for any Performance Year for which the ACO has selected the Telehealth Expansion Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the Telehealth Expansion Benefit Enhancement.
- 2. In order to be eligible to bill for telehealth services furnished pursuant to the Telehealth Expansion Benefit Enhancement, an individual must be:
 - (a) A physician or non-physician practitioner listed at 42 C.F.R. § 410.78(b)(2) who is an Initiative Participant or Preferred Provider; and
 - (b) Authorized under relevant Medicare rules and applicable state law to bill for telehealth services; and
 - (c) Designated on the Participant List or Preferred Provider List submitted in accordance with Section IV of the Agreement as participating in the Telehealth Expansion Benefit Enhancement; and
 - (d) Approved by CMS according to the criteria described in this Section XI.C.2 and Appendix E.
- 3. If CMS notifies the ACO that a physician or non-physician practitioner who is an Initiative Participant or Preferred Provider has not been approved for participation in the Telehealth Expansion Benefit Enhancement under this Section XI.C, but the individual is otherwise eligible to be an Initiative Participant or Preferred Provider, the ACO may either remove the individual from the Participant List or Preferred Provider List, or amend the relevant list to reflect that the individual will not participate in the Telehealth Expansion Benefit Enhancement. The ACO

shall amend the relevant list no later than 30 days after the date of the notice from CMS.

4. In order to be eligible to bill for teledermatology or teleophthalmology furnished using asynchronous store and forward technologies, as that term is defined under section 42 C.F.R. § 410.78(a)(1), pursuant to the Telehealth Expansion Benefit Enhancement an individual must be:
 - (a) Approved to bill for telehealth services pursuant to the Telehealth Expansion Benefit Enhancement under Section XI.C.2(d); and
 - (b) A physician; and
 - (c) Enrolled in Medicare with a Medicare physician specialty of dermatologist (C7) or ophthalmologist (C18).
5. The ACO shall ensure that Initiative Participants and Preferred Providers do not substitute telehealth services for in-person services when in-person services are more clinically appropriate.
6. The ACO shall ensure that Initiative Participants and Preferred Providers only furnish Medically Necessary telehealth services and do not use telehealth services to prevent or deter a Beneficiary from seeking or receiving in-person care when such care is Medically Necessary.

D. Post-Discharge Home Visits Benefit Enhancement

1. Appendix F shall apply to this Agreement for any Performance Year for which the ACO has selected the Post-Discharge Home Visits Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the Post-Discharge Home Visits Benefit Enhancement.
2. In order to be eligible to submit claims for post-discharge home visits furnished pursuant to the Post-Discharge Home Visits Benefit Enhancement, the supervising physician or other practitioner must be:
 - (a) A physician or non-physician practitioner who is an Initiative Participant or Preferred Provider; and
 - (b) Eligible under Medicare rules to submit claims for “incident to” services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and
 - (c) Designated on the Initiative Participant List or Preferred Provider List submitted in accordance with Section IV of the Agreement as participating in the Post-Discharge Home Visits Benefit Enhancement.
3. The individual performing services under this Benefit Enhancement must be “auxiliary personnel” as defined at 42 CFR § 410.26(a)(1).
4. The ACO shall ensure that post-discharge home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

E. Care Management Home Visits Benefit Enhancement

1. Appendix G shall apply to this Agreement for any Performance Year for which the ACO has selected the Care Management Home Visits Benefit Enhancement under Section X.A.4, and for which the ACO has submitted an Implementation Plan under Section XI.A.1 for the Care Management Home Visits Benefit Enhancement.
2. In order to be eligible to submit claims for care management home visits furnished pursuant to the Care Management Home Visits Benefit Enhancement, the supervising physician or other practitioner must be:
 - (a) A physician or non-physician practitioner who is a Initiative Participant or Preferred Provider; and
 - (b) Eligible under Medicare rules to submit claims for “incident to” services as defined in Chapter 15, Section 60 of the Medicare Benefit Policy Manual; and
 - (c) Designated on the Initiative Participant List or Preferred Provider List submitted in accordance with Section IV of the Agreement as participating in the Care Management Home Visits Benefit Enhancement.
3. The individual performing services under this Benefit Enhancement must be “auxiliary personnel” as defined at 42 CFR § 410.26(a)(1).
4. The ACO shall ensure that care management home visits are not used to prevent or deter a Beneficiary from seeking or receiving other Medically Necessary care.

F. Requirements for Termination of Benefit Enhancements

1. The ACO must obtain CMS consent before voluntarily discontinuing any Benefit Enhancement during a Performance Year.
2. In the event that during a Performance Year a Benefit Enhancement will cease to be in effect with respect to the ACO or any Initiative Participant or Preferred Provider pursuant to Section XVIII, the effective date of such termination shall be the date specified by CMS in the notice to the ACO.
 - (a) Within 30 days after the effective date of termination, the ACO shall send notice in writing to the affected Beneficiaries and/or Initiative Beneficiaries. Such notification shall state that following a date that is 90 days after the effective date of termination or the end of the Performance Year, whichever is sooner, services furnished under the Benefit Enhancement will no longer be covered by Medicare and the Beneficiary may be responsible for the payment of such services.
 - (b) CMS shall cease coverage of claims for a terminated Benefit Enhancement 90 days after the effective date of such termination.

3. In the event that the ACO selects to discontinue a Benefit Enhancement for a subsequent Performance Year through the selection process under Section X of this Agreement, the ACO shall notify all its Initiative Participants and Preferred Providers no later than 30 days prior to the start of that Performance Year.

G. Termination of Benefit Enhancements upon Termination

If this Agreement is terminated by either party prior to the end of a Performance Year, CMS shall terminate the ACO's Benefit Enhancements on the effective date of the termination and the ACO shall notify Initiative Beneficiaries and Beneficiaries who are currently receiving services pursuant to a Benefit Enhancement and may notify other Beneficiaries in accordance with Section XVIII.E.

XII. ACO Benchmark

A. Prospective Benchmark

1. For each Performance Year, the GMCB will submit to CMS for CMS's review and approval the ACO's Performance Year Benchmark, and CMS shall determine whether to approve the ACO's Performance Year Benchmark for that Performance Year as set forth in Appendix B.
2. Prior to the start of each Performance Year, CMS shall provide the ACO with a report ("**Performance Year Benchmark Report**") consisting of the ACO's CMS-approved Performance Year Benchmark.
3. On a quarterly basis during each Performance Year, CMS shall provide the ACO with a financial report ("**Quarterly Financial Report**"). The Quarterly Financial Report may include adjustments to the Performance Year Benchmark resulting from updated information regarding any factors that affect the Performance Year Benchmark calculation.

B. Performance Year Benchmark Adjustments

1. CMS may, at CMS's sole discretion, retroactively modify a CMS-approved Performance Year Benchmark if CMS determines that exogenous factors, such as a natural disaster, epidemiological event, legislative change, and/or other similarly unforeseen circumstance during the relevant Performance Year renders the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for assessing the expected level of spending between the Base Year and Performance Year.
2. Any retroactive modification to the Performance Year Benchmark made by CMS will be pursuant to Section XII.B.1.
3. CMS will notify the ACO of any adjustments to the Performance Year Benchmark made pursuant to this Section XII.B.
4. In order to accommodate an adjustment made pursuant to this Section XII.B, CMS may at its sole discretion delay settlement under Section XIII.C of this Agreement for the affected Performance Year for no more than 60 days.

5. Except for calculations made as part of a settlement reopening conducted pursuant to Section XIII.C.4, CMS may not adjust the Performance Year Benchmark under this Section XII.B after the issuance of the settlement report as described in Section XIII.C for the relevant Performance Year.

XIII. Payment

A. General

For each Performance Year, CMS shall pay the ACO in accordance with (i) the Alternative Payment Mechanism, if any, approved or deemed approved by CMS under Section X.C; (ii) the Risk Arrangement and Savings/Losses Cap deemed approved by CMS under Section X.B; (iii) Appendix B; (iv) Section XII; and (v) this Section XIII.

B. Alternative Payment Mechanism

1. General

- (a) CMS shall approve or reject the ACO's selection to participate in the Alternative Payment Mechanism for a Performance Year in accordance with Section X.C and Appendix J.
- (b) By the deadline specified by CMS, the ACO shall submit to CMS a financial disclosure statement demonstrating sufficient financial reserves to repay Other Monies Owed incurred as a result of participation in the Alternative Payment Mechanism.

2. All-Inclusive Population-Based Payments (AIPBP)

- (a) If the ACO wishes to participate in AIPBP for a Performance Year, it must select AIPBP as the Alternative Payment Mechanism in accordance with Section I.A of Appendix J. CMS shall review and respond to the ACO's selection in accordance with Sections I.A and I.B of Appendix J.
- (b) Unless CMS rejects or later terminates the ACO's selection to participate in AIPBP, CMS shall make Monthly AIPBP Payments to the ACO in accordance with the methodology in Appendix J. Each party shall comply with the terms of Appendix J that are applicable to that party.
- (c) As part of settlement for a Performance Year under Section XIII.C, CMS shall calculate the difference between the total Monthly AIPBP Payments that CMS paid to the ACO during the Performance Year and the total amount of AIPBP Fee Reductions. Such calculations shall be made in accordance with Appendix J. Any difference would constitute Other Monies Owed and may be subject to collection in accordance with Appendix J and Section XIII.C of this Agreement. CMS will conduct a second AIPBP reconciliation in accordance

with Appendix J, which may result in Other Monies Owed to or by the ACO in accordance with Section XIII.C.5.

C. Settlement

1. General

- (a) Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses, the amount of Other Monies Owed by CMS or the ACO, and the net amount owed by either CMS or the ACO. CMS shall calculate Shared Savings, Shared Losses, and Other Monies Owed according to the methodology in Appendix B, Appendix D, Appendix E, Appendix F, Appendix G, and Appendix J.
- (b) CMS shall make reasonable efforts to issue the settlement report for each Performance Year no later than 240 days after the end of the Performance Year.
- (c) Any amounts determined to be owed as a result of a settlement or revised settlement upon reopening shall be paid in accordance with Section XIII.C.5.

2. Error Notice

- (a) A settlement report will be deemed final 30 days after the date it is issued, unless the ACO submits to CMS written notice of an error in the mathematical calculations in the settlement report within 30 days after the settlement report is issued (“**Timely Error Notice**”).
- (b) Upon receipt of a Timely Error Notice, CMS shall review the calculations in question and any mathematical issues raised by the ACO in its written notice.
- (c) If CMS issues a written determination that the settlement report is correct, the settlement report is final on the date the written determination is issued.
- (d) If CMS issues a revised settlement report, the revised settlement report is final on the date it is issued.
- (e) There shall be no further administrative or judicial review of the settlement report or a revised settlement report.

3. Deferred Settlement

- (a) The ACO may elect, in a manner and by a date specified by CMS, to defer settlement for a period not to exceed 180 days (“**Deferred Settlement**”).
- (b) As a condition of Deferred Settlement, CMS may require the ACO to increase the amount of its financial guarantee under Section XIII.D in an amount and by a date determined by CMS.

4. Settlement Reopening

- (a) For a given Performance Year, for a period of one year following issuance of the settlement report for that Performance Year, or until issuance of the settlement report for the subsequent Performance Year, whichever comes earlier, CMS reserves the right to reopen the settlement report in order to include payments or recoupments specified in Appendix B and Appendix J that were not included in the initial settlement, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO.
- (b) CMS reserves the right, for a period of six years following the end of the term or termination of this Agreement, to reopen a final settlement report in order to recalculate the amounts owed, issue a revised settlement report, and make or demand payment of any additional amounts owed to or by the ACO if, as a result of later inspection, evaluation, investigation, or audit, it is determined that the amount due to the ACO by CMS or due to CMS by the ACO has been calculated in error due to CMS data source file errors, computational errors, or other similar CMS technical errors.
- (c) The parties shall pay any amounts determined to be owed as a result of a reopening under this Section XIII.C.4 in accordance with Section XVIII.C.5.
- (d) CMS may reopen and revise a settlement report at any time in the event of fraud or similar fault by the ACO, an Initiative Participant or Preferred Provider.

5. Payment of Amounts Owed

- (a) If CMS owes the ACO Shared Savings or Other Monies Owed as a result of a final settlement or revised settlement upon reopening, CMS shall pay the ACO in full within 30 days after the date on which the relevant settlement report is deemed final, except that CMS shall not make any payment of Shared Savings if this Agreement is terminated by CMS pursuant to Section XVIII, and CMS may reduce amounts owed to the ACO under this Agreement by amounts owed by the ACO under this Agreement or any other CMS program or initiative.
- (b) If the ACO owes CMS Shared Losses or Other Monies Owed as a result of a final settlement, or revised settlement upon reopening, the ACO shall pay CMS in full within 30 days after the relevant settlement report is deemed final.
- (c) If CMS does not timely receive payment in full, the remaining amount owed will be considered a delinquent debt subject to the provisions of Section XIII.E.

D. Financial Guarantee

- 1. The ACO must have the ability to repay all Shared Losses and Other Monies Owed for which it may be liable under the terms of this Agreement and shall

provide a financial guarantee for each Performance Year in accordance with the terms set forth in Appendix H.

2. The ACO shall submit such documentation of such financial guarantee for the first Performance Year to CMS by a date determined by CMS, and thereafter in accordance with Appendix H.
3. Any changes made to a financial guarantee must be approved in advance by CMS.
4. Nothing in this Agreement or its Appendices shall be construed to limit the ACO's liability to pay any Shared Losses or Other Monies Owed in excess of the amount of the financial guarantee.

E. Delinquent Debt

1. If CMS does not receive payment in full by the date payment is due, CMS shall pursue payment under the financial guarantee required under Section XIII.D. and may withhold payments otherwise owed to the ACO under this Agreement or any other CMS program or initiative.
2. If the ACO fails to pay the amounts due CMS in full within 30 days after the date of a demand letter or settlement report, CMS shall assess simple interest on the unpaid balance at the rate applicable to other Medicare debts under 45 CFR § 30.18 and 42 CFR § 405.378. Interest shall be calculated in 30-day periods and shall be assessed for each 30-day period that payment is not made in full.
3. CMS and the U.S. Department of the Treasury may use any applicable debt collection tools available to collect the total amount owed by the ACO.

XIV. Participation in Evaluation, Shared Learning Activities, and Site Visits

A. Evaluation Requirement

1. General

- (a) The ACO shall participate and cooperate in any independent evaluation activities conducted by CMS and/or its designees aimed at assessing the impact of the Initiative and the Vermont All-Payer ACO Model on the goals of better health, better health care, and lower Medicare per capita costs for Initiative Beneficiaries. The ACO shall require its Initiative Participants and Preferred Providers to participate and cooperate in any such independent evaluation activities conducted by CMS and/or its designees.
- (b) The ACO shall ensure that it has written agreements and/or legal relationships with any individuals and entities performing functions and services related to ACO Activities, that are necessary to ensure CMS or its designees can carry out evaluation activities.

2. Primary Data

In its evaluation activities, CMS may collect qualitative and quantitative data from the following sources:

- (a) Site visits;
- (b) Interviews with Beneficiaries and their caregivers;
- (c) Focus groups of Beneficiaries and their caregivers;
- (d) Interviews with ACO, Initiative Participant and Preferred Provider staff;
- (e) Focus groups with ACO, Initiative Participant and Preferred Provider staff;
- (f) Direct observation of Beneficiary interactions with Initiative Participant and Preferred Provider staff, care management meetings among Initiative Participant and Preferred Provider staff, and other activities related to the ACO's participation in the Initiative; and
- (g) Surveys.

3. Secondary Data

In its evaluation activities, CMS may use data or information submitted by the ACO as well as claims submitted to CMS for items and services furnished to Beneficiaries. This data may include, but is not limited to:

- (a) Survey data from CAHPS surveys;
- (b) Clinical data such as lab values;
- (c) Medical records; and
- (d) ACO Implementation Plans.

B. Shared Learning Activities

1. The ACO shall participate in CMS-sponsored learning activities designed to strengthen results and share learning that emerges from participation in the Model.
2. The ACO shall participate in periodic conference calls, site visits, and virtual or in-person meetings, and actively share resources, tools and ideas as prescribed by CMS.

C. Site Visits

1. The ACO shall cooperate in periodic site visits by CMS and/or its designees in order to facilitate evaluation, shared learning activities, or the fulfilment of the terms of this Agreement.
2. CMS shall schedule site visits with the ACO no fewer than 15 days in advance. To the extent practicable, CMS will attempt to accommodate the ACO's request for particular dates in scheduling site visits. However, the ACO may not request a date that is more than 60 days after the date of the initial site visit notice from CMS.

3. The ACO shall ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during site visits.
4. Notwithstanding the foregoing, CMS may perform unannounced site visits at the office of any Initiative Participant or Preferred Provider at any time to investigate concerns about the health or safety of Beneficiaries or other program integrity issues.
5. Nothing in this Agreement shall be construed to limit or otherwise prevent CMS from performing site visits permitted by applicable law or regulations.

D. Rights in Data and Intellectual Property

1. CMS may use any data obtained pursuant to the Initiative and the Vermont All-Payer ACO Model to evaluate the Model and to disseminate quantitative results and successful care management techniques, to other providers and suppliers and to the public. Data to be disseminated may include results of patient experience of care and quality of life surveys as well as measures based upon claims and medical records. The ACO will be permitted to comment on evaluation reports for factual accuracy but may not edit conclusions or control the dissemination of reports.
2. Notwithstanding any other provision in this Agreement, all proprietary trade secret information and technology of the ACO or its Initiative Participants and Preferred Providers is and shall remain the sole property of the ACO, the Initiative Participant, or Preferred Provider and, except as required by federal law, shall not be released by CMS without express written consent. The regulation at 48 CFR § 52.227-14, "Rights in Data-General" is hereby incorporated by reference into this Agreement. CMS does not acquire by license or otherwise, whether express or implied, any intellectual property right or other rights to the ACO's, Initiative Participants', or Preferred Providers' proprietary information or technology.
3. The ACO acknowledges that it has submitted to CMS a form identifying specific examples of what it considers proprietary and confidential information currently contained in its program that should not be publicly disclosed. This form is attached as Appendix I.

XV. Public Reporting and Release of Information

A. ACO Public Reporting and Transparency

The ACO shall report the following information on a publicly accessible website maintained by the ACO. CMS may publish some or all of this information on the CMS website.

1. Organizational information including all of the following:
 - (a) Name and location of the ACO;

- (b) Primary contact information for the ACO;
 - (c) Identification of all Initiative Participants and Preferred Providers;
 - (d) Identification of all joint ventures between or among the ACO and any of its Initiative Participants and Preferred Providers;
 - (e) Identification of the ACO's key clinical and administrative leaders and the name of any company by which they are employed; and
 - (f) Identification of members of the ACO's governing body and the name of any entity by which they are employed.
- 2. Shared Savings and Shared Losses information, including:
 - (a) The amount of any Shared Savings or Shared Losses for any Performance Year;
 - (b) The proportion of Shared Savings invested in infrastructure, redesigned care processes, and other resources necessary to improve outcomes and reduce Medicare costs for Beneficiaries; and
 - (c) The proportion of Shared Savings distributed to Initiative Participants and Preferred Providers.
 - 3. The ACO's performance on the quality measures described in Appendix K.

B. ACO Release of Information

- 1. The ACO, its Initiative Participants, and its Preferred Providers shall obtain prior approval from CMS during the term of this Agreement and for 1 year thereafter for the publication or release of any press release, external report or statistical/analytical material that materially and substantially references the ACO's participation in the Initiative or the ACO's financial arrangement with CMS. External reports and statistical/analytical material may include, but are not limited to, papers, articles, professional publications, speeches, and testimony.
- 2. All external reports and statistical/analytical material that are subject to this Section XV.B must include the following statement on the first page: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

XVI. Compliance and Oversight

A. ACO Compliance Plan

- 1. The ACO shall have a compliance plan that includes at least the following elements:
 - (a) A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body;

- (b) Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance;
 - (c) A method for employees or contractors of the ACO, its Initiative Participants and Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to anonymously report suspected problems related to the ACO to the compliance official;
 - (d) Compliance training for the ACO and its Initiative Participants and Preferred Providers;
 - (e) A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.
2. The ACO's compliance plan must be in compliance with all applicable laws and regulations and be updated periodically to reflect changes in those laws and regulations.

B. CMS Monitoring and Oversight Activities

1. CMS shall conduct monitoring activities to evaluate compliance by the ACO, its Initiative Participants, and its Preferred Providers with the terms of this Agreement. Such monitoring activities may include, without limitation:
- (a) Interviews with any individual or entity participating in ACO Activities, including members of the ACO leadership and management, Initiative Participants, and Preferred Providers;
 - (b) Interviews with Beneficiaries and their caregivers;
 - (c) Audits of charts, medical records, Implementation Plans, and other data from the ACO, its Initiative Participants, and its Preferred Providers;
 - (d) Site visits to the ACO and its Initiative Participants and Preferred Providers; and
 - (e) Documentation requests sent to the ACO, its Initiative Participants, and/or its Preferred Providers, including surveys and questionnaires.
2. In conducting monitoring and oversight activities, CMS or its designees may use any relevant data or information including, without limitation, all Medicare claims submitted for items or services furnished to Beneficiaries.
3. CMS shall, to the extent practicable and as soon as practicable, provide the ACO with a comprehensive schedule of planned comprehensive annual audits related to compliance with this Agreement.
- (a) Such schedule does not preclude the ability of CMS to conduct more limited, targeted or ad hoc audits as necessary.
 - (b) CMS may alter such schedule without the consent of the ACO. CMS shall notify the ACO within 15 days of altering such schedule.

C. ACO Compliance with Monitoring and Oversight Activities

The ACO shall cooperate with, and the ACO shall require its Initiative Participants, its Preferred Providers and other individuals and entities performing functions and services related to ACO Activities to cooperate with all CMS monitoring and oversight requests and activities.

D. Compliance with Laws

1. Agreement to Comply

- (a) The ACO shall comply with, and shall require all Initiative Participants, Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to comply with the applicable terms of this Agreement and all applicable statutes regulations, and guidance, including without limitation: (a) federal criminal laws; (b) the False Claims Act (31 U.S.C. § 3729 et seq.); (c) the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the civil monetary penalties law (42 U.S.C. § 1320a-7a); and (e) the physician self-referral law (42 U.S.C. § 1395nn).
- (b) This Agreement does not waive any obligation of the ACO or the ACO's Initiative Participants or Preferred Providers to comply with the terms of any other CMS contract, agreement, model, or demonstration.

2. State Recognition

During all Performance Years of this Agreement, the ACO shall be in compliance with applicable state licensure requirements in each state in which it operates regarding risk-bearing entities unless it has provided a written attestation to CMS that it is exempt from such state laws. If the ACO is exempt from such laws, it shall submit a certification to CMS no later than 60 days after the Start Date or after the date on which it becomes exempt from any such laws.

3. Reservation of Rights

- (a) Nothing contained in this Agreement or in the application process for the Initiative is intended or can be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of Inspector General, or CMS of any right to institute any proceeding or action for violations of any statutes, rules or regulations administered by the government, or to prevent or limit the rights of the government to obtain relief under any other federal statutes or regulations, or on account of any violation of this Agreement or any other provision of law. This Agreement cannot be construed to bind any government agency except CMS and this Agreement binds CMS only to the extent provided herein.
- (b) The failure by CMS to require performance of any provision of this Agreement does not affect CMS's right to require performance at any time thereafter, nor does a waiver of any breach or default of this Agreement

constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

4. Office of Inspector General of the Department of Health and Human Services (OIG) Authority

None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the ACO or its Initiative Participants and Preferred Providers.

5. Other Government Authority

None of the provisions of this Agreement limit or restrict any other government authority that is permitted by law to audit, evaluate, investigate, or inspect the ACO or its Initiative Participants and Preferred Providers.

E. Certification of Data and Information

1. With respect to data and information generated or submitted to CMS by the ACO, Initiative Participants, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities, the ACO shall ensure that an individual with the authority to legally bind the individual or entity submitting such data or information certifies the accuracy, completeness, and truthfulness of that data and information to the best of his or her knowledge, information, and belief. Such certifications are a condition of receiving Shared Savings and Other Monies Owed.
2. At the end of each Performance Year, an individual with the legal authority to bind the ACO must certify to the best of his or her knowledge, information, and belief:
 - (a) That the ACO, its Initiative Participants, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities are in compliance with program requirements; and
 - (b) The accuracy, completeness, and truthfulness of all data and information that are generated or submitted by the ACO, Initiative Participants, Preferred Providers, or other individuals or entities performing functions or services related to ACO Activities, including any quality data or other information or data relied upon by CMS in determining the ACO's eligibility for, and the amount of Shared Savings, or the amount of Shared Losses or Other Monies Owed.

XVII. Audits and Record Retention

A. Right to Audit and Correction

The ACO agrees, and must require all of its Initiative Participants and its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities to agree, that the government, including CMS, HHS, and the

Comptroller General or their designees, has the right to audit, inspect, investigate, and evaluate any books, contracts, records, documents and other evidence of the ACO and its Initiative Participants, its Preferred Providers, and other individuals or entities performing functions or services related to ACO Activities that pertain to the following:

1. The ACO's compliance with the terms of this Agreement, including provisions that require the ACO to impose duties or requirements on Initiative Participants or Preferred Providers;
2. Whether Initiative Participants and Preferred Providers complied with the duties and requirements imposed on them by the ACO pursuant to the terms of this Agreement;
3. The quality of the services performed under this Agreement;
4. The ACO's right to, and distribution of, Shared Savings; and
5. The ability of the ACO to bear the risk of potential losses and the obligation and ability of the ACO to repay any Shared Losses or Other Monies Owed to CMS.

B. Maintenance of Records

The ACO agrees, and must require all Initiative Participants, Preferred Providers, and individuals and entities performing functions or services related to ACO Activities to agree, to the following:

1. To maintain and give the government, including CMS, HHS, and the Comptroller General or their designees, access to all books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the following: the ACO's compliance with the terms of this Agreement, including provisions that require the ACO to impose duties or requirements on Initiative Participants or Preferred Providers; whether Initiative Participants or Preferred Providers complied with the duties and requirements imposed on them by the ACO pursuant to the terms of this Agreement; the quality of services furnished under this Agreement; the ACO's right to, and distribution of, Shared Savings; and the ability of the ACO to bear the risk of potential losses and the obligation and ability of the ACO to repay any Shared Losses or Other Monies Owed to CMS.
2. To maintain such books, contracts, records, documents, and other evidence for a period of 10 years from the expiration or termination of this Agreement or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless:
 - (a) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the ACO at least 30 calendar days before the normal disposition date; or
 - (b) There has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its Initiative Participants, Preferred Providers, or other

individuals or entities performing functions or services related to ACO Activities, in which case the records shall be maintained for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

XVIII. Remedial Action and Termination

A. Remedial Action

1. If CMS determines that any provision of this Agreement may have been violated, CMS may take one or more of the following actions:
 - (a) Notify the ACO and, if appropriate, the Initiative Participant, and/or Preferred Provider of the violation;
 - (b) Require the ACO to provide additional information to CMS or its designees;
 - (c) Conduct on-site visits, interview Beneficiaries, or take other actions to gather information;
 - (d) Place the ACO on a monitoring and/or auditing plan developed by CMS;
 - (e) Require the ACO to remove an Initiative Participant or Preferred Provider from the Participant List or Preferred Provider List and to terminate its agreement, immediately or within a timeframe specified by CMS, with such Initiative Participant or Preferred Provider with respect to this Initiative;
 - (f) Require the ACO to terminate its relationship with any other individual or entity performing functions or services related to ACO Activities;
 - (g) Prohibit the ACO from distributing Shared Savings to an Initiative Participant or Preferred Provider;
 - (h) Request a corrective action plan (“CAP”) from the ACO that is acceptable to CMS, in which case, the following requirements apply:
 - i. The ACO shall submit a CAP for CMS approval by a deadline established by CMS; and
 - ii. The CAP must address what actions the ACO will take (or will require any Initiative Participant, Preferred Provider or other individual or entity performing functions or services related to ACO Activities to take) within a specified time period to ensure that all deficiencies will be corrected and that the ACO will be in compliance with the terms of this Agreement;
 - (i) Amend this Agreement without the consent of the ACO to provide that any or all waivers of existing law made pursuant to section 1115A(d)(1) of the Act will be inapplicable;
 - (j) Amend this Agreement without the consent of the ACO to deny the use of the Alternative Payment Mechanism by the ACO or any Initiative Participant or Preferred Provider and to require that the ACO terminate any agreements effectuating the Alternative Payment Mechanism by a date determined by

CMS, in which case, the ACO (and any Initiative Participant or Preferred Provider, if applicable) shall be paid under normal FFS following the effective date determined by CMS, and Other Monies Owed will be calculated and paid in accordance with Section XIII.C;

- (k) Discontinue the provision of data sharing and reports to the ACO under Section VI;
 - (l) Amend this Agreement without the consent of the ACO to deny the use of one or more Benefit Enhancements by the ACO or any Initiative Participant or Preferred Provider and to require that the ACO terminate any agreements effectuating such Benefit Enhancements by a date determined by CMS.
2. CMS may impose additional remedial actions or terminate this Agreement pursuant to Section XVIII.B if CMS determines that remedial actions were insufficient to correct noncompliance with the terms of this Agreement.
 3. CMS may require the ACO to remove an Initiative Participant or Preferred Provider from the ACO's Participant List or Preferred Provider List and terminate its written agreement with the removed Initiative Participant or Preferred Provider if CMS determines that the Initiative Participant or Preferred Provider:
 - (a) Has failed to comply with any Medicare program requirement, rule, or regulation;
 - (b) Has failed to comply with the ACO's CAP, the monitoring and/or auditing plan developed by CMS for the ACO, or other remedial action imposed by CMS; or
 - (c) Has taken any action that threatens the health or safety of a Beneficiary or other patient.

B. Termination of Agreement by CMS

CMS may immediately or with advance notice terminate this Agreement if:

1. CMS determines that the Agency no longer has the funds to support the Model;
2. CMS modifies or terminates the Model pursuant to Section 1115A(b)(3)(B) of the Act;
3. CMS determines that the ACO:
 - (a) Has failed to comply with any term of this Agreement or any other Medicare program requirement, rule, or regulation;
 - (b) Has failed to comply with a monitoring and/or auditing plan;
 - (c) Has failed to submit, obtain approval for, implement or fully comply with the terms of a CAP;
 - (d) Has failed to demonstrate improved performance following any remedial action;

- (e) Has taken any action that threatens the health or safety of a Beneficiary or other patient;
 - (f) Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Initiative or Model;
 - (g) Is subject to sanctions or other actions of an accrediting organization or a federal, state or local government agency;
 - (h) Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action; or
 - (i) Assigns or purports to assign any of the rights or obligations under this Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS.
4. CMS determines that one or more of the ACO's Initiative Participants or Preferred Providers has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the Initiative or Model; or
 5. The State Agreement is terminated by any party to the State Agreement.

C. Termination of Agreement by ACO

The ACO may terminate this Agreement prior to the end of a Performance Year upon advance written notice to CMS. Such notice must specify the effective date of the termination, which date may be no sooner than 30 days following the date of notice.

D. Financial Settlement upon Termination

1. [RESERVED]
2. If this Agreement is terminated by CMS under Section XVIII.B, CMS shall not make any payments of Shared Savings to the ACO, and the ACO shall remain liable for any Shared Losses, for the Performance Year in which termination becomes effective.
3. If the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C prior to the end of a Performance Year by providing notice to CMS on or before February 28 of that Performance Year, with an effective date no later than 30 days after the date of that notice, no annual settlement will be conducted for such Performance Year in accordance with Section XIII.C.1, and the ACO shall neither be eligible to receive Shared Savings nor liable for Shared Losses for such Performance Year. If the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C prior to the end of a Performance Year with an effective date greater than 30 days after February 28 but prior to the end of that Performance

Year, the ACO shall not be eligible to receive Shared Savings but shall remain liable for Shared Losses for such Performance Year. If the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C with an effective date at the end of that Performance Year, CMS shall conduct settlement for the Performance Year in which the ACO voluntarily terminates this Agreement pursuant to Section XVIII.C.

4. Upon the termination or expiration of this Agreement, the ACO shall immediately pay all Other Monies Owed to CMS and shall remain liable for any amounts included in a settlement report issued for any Performance Year in accordance with Section XIII.C.5.

E. Notifications to Participants, Preferred Providers, and Beneficiaries upon Termination

1. If this Agreement is terminated under Sections XVIII.B or XVIII.C, the ACO shall provide written notice of the termination to all Initiative Participants and Preferred Providers. The ACO shall also post a notice of the termination on its ACO website. The ACO shall deliver such written notice in a manner determined by CMS and no later than 30 days before the effective date of termination unless a later date is specified by CMS. The ACO shall include in such notices any content specified by CMS, including information regarding data destruction and the discontinuation of Benefit Enhancements, as applicable.
2. The ACO shall provide written notice of the termination to Initiative Beneficiaries and Beneficiaries who are currently receiving services pursuant to a Benefit Enhancement and may provide written notice of the termination to other Beneficiaries. The ACO shall deliver such notices in a manner determined by CMS and no later than 30 days before the effective date of termination unless a later date is specified by CMS. The ACO shall include in such notices any content specified by CMS, including information regarding the discontinuation of Benefit Enhancements, as applicable. Any notice to Initiative Beneficiaries is subject to review and approval by CMS under Section V.E, as “Descriptive ACO Materials and Activities.”

XIX. Limitation on Review and Dispute Resolution

A. Limitations on Review

There is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

1. The selection of organizations, sites, or participants to test models selected for testing or expansion under Section 1115A of the Act, including the decision by CMS to terminate this Agreement or to require the termination of any individual’s or entity’s status as an Initiative Participant or Preferred Provider;
2. The elements, parameters, scope, and duration of such models for testing or dissemination;

3. Determinations regarding budget neutrality under Section 1115A(b)(3);
4. The termination or modification of the design and implementation of a model under Section 1115A(b)(3)(B);
5. Determinations about expansion of the duration and scope of a model under Section 1115A(c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection (c);
6. The selection of quality performance standards by CMS;
7. The assessment of the quality of care furnished by the ACO by CMS;
8. The alignment of Beneficiaries to the ACO by CMS; and
9. A final settlement report issued pursuant to Section XIII.C, including without limitation the determination or approval by CMS of—
 - (a) the historical Base Year expenditure;
 - (b) the Performance Year Benchmark;
 - (c) the ACO’s Performance Year expenditures;
 - (d) the ACO’s eligibility for Shared Savings or liability for Shared Losses or Other Monies Owed; and
 - (e) the amount of such Shared Savings, Shared Losses, and/or Other Monies Owed.

B. Dispute Resolution

1. Right to Reconsideration

The ACO may request reconsideration of a determination made by CMS pursuant to this Agreement only if such reconsideration is not precluded by Section 1115A(d)(2) of the Act or this Agreement.

- (a) Such a request for reconsideration by the ACO must satisfy the following criteria:
 - i. The request must be submitted to a designee of CMS (“**Reconsideration Official**”) who—
 - A. Is authorized to receive such requests; and
 - B. Did not participate in the determination that is the subject of the reconsideration request.
 - ii. The request must contain a detailed, written explanation of the basis for the dispute, including supporting documentation.
 - iii. The request must be made within 30 days of the date of the determination for which reconsideration is being requested via email to CMS at the address specified in Section XX.A or such other address as may be specified by CMS.

- (b) Requests that do not meet the requirements of Section XIX.B.1(a) will be denied by the Reconsideration Official.
 - (c) Within 10 business days of receiving a request for reconsideration, the Reconsideration Official will send to the ACO and to CMS a written acknowledgement of receipt of the reconsideration request. Such an acknowledgement will set forth:
 - i. The review procedures; and
 - ii. A schedule that permits each party to submit only one written position paper, including any supporting documentation, for consideration by the Reconsideration Official in support of the party's position. The submission of any additional papers or supporting documentation will be at the sole discretion of the Reconsideration Official.
2. [Standards for reconsideration.](#)
- (a) The parties shall proceed diligently with the performance of this Agreement during the course of any dispute arising under the Agreement.
 - (b) The reconsideration will consist of a review of documentation that is submitted timely and in accordance with the standards specified by the Reconsideration Official.
 - (c) The burden of proof is on the ACO to demonstrate to the Reconsideration Official with clear and convincing evidence that the determination is inconsistent with the terms of the Agreement.
3. [Reconsideration determination.](#)
- (a) The reconsideration determination will be based only upon:
 - i. Position papers and supporting documentation that are timely submitted to the Reconsideration Official and meet the standards for submission under Section XIX.B.1(a); and
 - ii. Documents and data that were timely submitted to CMS in the required format before the agency made the determination that is the subject of the reconsideration request.
 - (b) The Reconsideration Official will issue to CMS and to the ACO a written notification of the reconsideration determination. Absent unusual circumstances, such written notification will be issued within 60 days of receipt of timely filed position papers and supporting documentation.
 - (c) Effect of the Reconsideration Determination
 - i. The determination of the Reconsideration Official is final and binding.
 - ii. The reconsideration review process under this Agreement shall not be construed to negate, diminish, or otherwise alter the applicability of existing laws, rules, and regulations or determinations made by other government agencies.

XX. Miscellaneous

A. Agency Notifications and Submission of Reports

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this Agreement shall be submitted to the parties at the addresses set forth below.

CMS: Vermont Medicare ACO Initiative, Vermont All-Payer ACO Model
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: WB-03-23
Baltimore, MD 21244
Email: VermontAllPayerACOModel@cms.hhs.gov

ACO: OneCare Vermont, ACO
356 Mountain View Drive
Suite 301
Colchester, VT 05446

B. Notice of Bankruptcy

In the event the ACO enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the ACO agrees to furnish, by certified mail, written notification of the bankruptcy to CMS. This notification shall be furnished within 5 calendar days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the court in which the bankruptcy petition was filed, and a listing of government contracts, project agreements, contract officers, and project officers for all government contracts and project agreements against which final payment has not been made. This obligation remains in effect until final payment by the ACO under this Agreement has been made.

C. Severability

In the event that any one or more of the provisions of this Agreement is, for any reason, held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Agreement, and this Agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been included in the Agreement, unless the deletion of such provision or provisions would result in such a material change to the Agreement so as to cause continued participation under the terms of the Agreement to be unreasonable.

D. Entire Agreement; Amendment

This Agreement, including all Appendices, constitutes the entire agreement between the parties. The parties may amend this Agreement or any Appendix hereto at any time by mutual written agreement; provided, however, that CMS may amend this Agreement or any Appendix hereto without the consent of the ACO as specified in this Agreement or Appendix, or for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, accreditation standards or licensing guidelines or rules. To the extent practicable, CMS shall provide the ACO with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

E. Survival

Expiration or termination of this Agreement by any party shall not affect the rights and obligations of the parties accrued prior to the effective date of the expiration or termination of this Agreement, except as provided in this Agreement. The rights and duties under the following sections of this Agreement shall also survive termination of this Agreement and apply thereafter:

1. Section XVII (Audits and Record Retention);
2. Section VI.B (Data Sharing and Reports);
3. Section VIII.C (Quality Measure Reporting);
4. Section XVI (Compliance and Oversight);
5. Section XIV.A (Evaluation Requirement);
6. Section XVI.E (Certification of Data and Information);
7. Section XVIII (Payment);
8. Section XVIII.D, E (Financial Settlement upon Termination; Notifications to Participants, Preferred Providers, and Beneficiaries upon Termination);
9. Section XX.B (Notice of Bankruptcy);
10. Section XX.H (Prohibition on Assignment);
11. Section XX.G (Change in Control); and
12. Appendix B (Initiative Beneficiary Alignment and Benchmarking Methods)

Provisions of this Agreement that survive the expiration or termination of this Agreement, as specified in this Section XX.E may be amended after the effective date of the expiration or termination of this Agreement with the mutual consent of the parties as necessary to achieve the purpose of the Initiative.

F. Precedence

If any provision of this Agreement conflicts with a provision of any document incorporated herein by reference, the provision of this Agreement shall prevail.

G. Change of ACO Name

If the ACO changes its name, the ACO shall forward to CMS a copy of the document effecting the name change, authenticated by the appropriate state official, and the parties shall execute an agreement reflecting the change of the ACO's name.

H. Prohibition on Assignment

Except with the prior written consent of CMS, the ACO shall not transfer, including by merger (whether the ACO is the surviving or disappearing entity), consolidation, dissolution, or otherwise: (1) any discretion granted it under this Agreement; (2) any right that it has to satisfy a condition under this Agreement; (3) any remedy that it has under this Agreement; or (4) any obligation imposed on it under this Agreement. The ACO shall provide CMS 90 days advance written notice of any such proposed transfer. This obligation remains in effect until the expiration or termination of this Agreement and final payment by the ACO under this Agreement has been made. CMS may condition its consent to such transfer on full or partial reconciliation of Shared Losses and Other Monies Owed. Any purported transfer in violation of this Section is voidable at the discretion of CMS.

I. Change in Control

CMS may terminate this Agreement or require immediate reconciliation and payment of Shared Losses and Other Monies Owed if the ACO undergoes a Change in Control. For purposes of this paragraph, a "Change in Control" shall mean: (1) the acquisition by any "person" (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Securities Exchange Act of 1934), directly or indirectly, of voting securities of the ACO representing more than 50% of the ACO's outstanding voting securities or rights to acquire such securities; (2) upon any sale, lease, exchange or other transfer (in one transaction or a series of transactions) of all or substantially all of the assets of the ACO; or (3) a plan of liquidation of the ACO or an agreement for the sale or liquidation of the ACO is approved and completed. The ACO shall provide CMS 90 days advance written notice of a Change in Control. This obligation remains in effect until the expiration or termination of this Agreement and final payment by the ACO under this Agreement has been made.

J. Certification

The ACO executive signing this Agreement certifies to the best of his or her knowledge, information, and belief that the information submitted to CMS and contained in this Agreement (inclusive of Appendices), is accurate, complete, and truthful, and that he or she is authorized by the ACO to execute this Agreement and to legally bind the ACO on whose behalf he or she is executing this Agreement to its terms and conditions.

K. Execution in Counterpart

This Agreement and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. In the event that any signature is delivered by

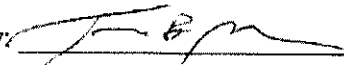
facsimile transmission or by e-mail delivery of a “.pdf” format data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or “.pdf” signature page were an original thereof.

[SIGNATURE PAGE FOLLOWS]

Each party is signing this Agreement on the date stated opposite that party's signature. If a party signs but fails to date a signature, the date that the other party receives the signing party's signature will be deemed to be the date that the signing party signed this Agreement.

ACO:

Date: 12/21/18

By: 

Todd B. Moore

Name of authorized signatory

CEO

Title

CMS:

Date: DEC 27 2018

By: 

Amy Bassano

Name of authorized signatory

Deputy Director, CMME

Title

Appendices

- Appendix A: Non-Duplication Waiver and Participant Exclusivity
- Appendix B: Initiative Beneficiary Alignment and Benchmarking Methods
- Appendix C: [RESERVED]
- Appendix D: Benefit Enhancement - 3-Day SNF Rule Waiver
- Appendix E: Benefit Enhancement - Telehealth Expansion
- Appendix F: Benefit Enhancement - Post-Discharge Home Visits
- Appendix G: Benefit Enhancement - Care Management Home Visits
- Appendix H: Financial Guarantees - Requirements and Guidance
- Appendix I: ACO Proprietary Information
- Appendix J: Alternative Payment Mechanism - All-Inclusive Population-Based Payment
- Appendix K: Quality Measures

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Appendix A - Non-Duplication Waiver and Participant Overlap

I. Waiver

In order to support the ACO's ability to enter into agreements with Medicare-enrolled providers and suppliers to participate as Preferred Providers, and thus enable the ACO to better care for its Initiative Beneficiaries in an environment where increasing numbers of providers and suppliers are participating in ACOs under the Medicare Shared Savings Program and in other Medicare shared savings initiatives, CMS waives the non-duplication requirements under section 1899(b)(4)(A) of the Act and 42 C.F.R. § 425.114(a) as they apply to Preferred Providers, subject to the requirements set forth in this Appendix A.

II. ACO Overlap

- A. The ACO may not simultaneously participate in any other Medicare shared savings initiatives (e.g., MSSP, Next Generation ACO (NGACO) Model, Comprehensive ESRD Care (CEC) Initiative).
- B. If the ACO is otherwise eligible, the ACO may participate in other Medicare demonstrations or models. CMS may issue guidance or work directly with the ACO in determining how participation in certain demonstrations or models can be combined with participation in the Vermont Medicare ACO Initiative as part of the Vermont All-Payer ACO Model.

III. Initiative Participant and Preferred Provider Overlap

- A. Pursuant to section 1899(b)(4)(A) of the Act, an Initiative Participant may not also be an ACO participant, ACO provider/supplier and/or ACO professional in an accountable care organization in the MSSP.
- B. An Initiative Professional who is a Primary Care Specialist as defined in Appendix B of this Agreement may not: (a) be identified as an Initiative Participant by a different accountable care organization in this Initiative; (b) be an ACO participant, ACO provider/supplier or ACO professional in the MSSP; or (c) participate in another Medicare shared savings initiative, except as expressly permitted by CMS.
- C. An Initiative Participant who is a Non-Primary Care Specialist as defined in Appendix B of this Agreement may be an Initiative Participant in another accountable care organization in this Initiative, or serve in an equivalent role in any other shared savings initiative in which such non-primary care specialists are not required to be exclusive to one participating entity.

D. A Preferred Provider may serve in the following roles provided all other applicable requirements are met:

1. Preferred Provider for one or more other accountable care organizations participating in this Initiative;
2. Subject to Section III.B of this Appendix, an Initiative Participant in one or more other accountable care organizations participating in this Initiative;
3. Pursuant to the waiver in Section I of this Appendix, an ACO participant, ACO provider/supplier, and/or ACO professional in an accountable care organization in the MSSP; and/or
4. Role similar in function to an Initiative Participant in another shared savings initiative.

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Appendix B - Beneficiary Alignment and Benchmarking Methods

This Appendix describes the methodologies for Beneficiary alignment conducted pursuant to Section V of this Agreement, the Performance Year Benchmark calculated pursuant to Section XII of this Agreement, and financial settlement of Shared Savings and Shared Losses conducted pursuant to Section XIII.C of this Agreement.

I. Definitions

“**ACO Service Area**” means all counties in which Initiative Professionals who are Primary Care Specialists have office locations and the adjacent counties. The counties in which Initiative Professionals have office locations will be referred to as the “core” service area. The counties adjacent to the “core” service area may be referred to as the “extended” service area. As required under Sections IV.B.1 and IVE.1 of the Agreement, the ACO is responsible for identifying the counties in which its Initiative Professionals have office locations, i.e., the “core” service area.

“**Aligned Beneficiary**” means a Beneficiary aligned to the ACO for a Performance Year pursuant to Section V.A of this Agreement and Section II of this Appendix B.

“**Alignment-Eligible Beneficiary**” means a Beneficiary who, for a Base Year or a Performance Year, as applicable:

- Is covered under Part A in every month of the Base Year or the Performance Year, as applicable;
- Has no months of coverage under only Part A;
- Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
- Has no months in which Medicare was the secondary payer; and
- Was a resident of the United States in every month of the Base Year or the Performance Year, as applicable.

“**Base Year Alignment Period**” means the 2-year period ending six months prior to the first day of the Base Year for which Beneficiary alignment is being performed.

“**Base Year Beneficiary**” means an Alignment-Eligible Beneficiary who is aligned to the ACO for a given Base Year using the methodology set forth in Section II of this Appendix B.

“**Entitlement Category**” means one of the following two entitlement categories of Beneficiaries:

- 1) Aged and Disabled (A/D) Beneficiaries (Beneficiaries eligible for Medicare by age or disability) who are not End-Stage Renal Disease (ESRD) Beneficiaries (“**A/D Beneficiaries**”); or
- 2) ESRD Beneficiaries (Beneficiaries eligible for Medicare on the basis of an ESRD diagnosis) (“**ESRD Beneficiaries**”).¹

“**Performance Year Alignment Period**” means the 2-year period ending six months prior to the first day of the Performance Year for which Beneficiary alignment is being performed.

“**Primary Care Specialist**” means a physician or non-physician practitioner (NPP) whose principal specialty is listed in Table 1.3 of this Appendix B.

“**Non-Primary Care Specialist**” means a physician or NPP whose principal specialty is listed in Table 1.4 of this Appendix B.

“**QEM Services**” means Qualified Evaluation & Management (QEM) services identified by the Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1.2 of this Appendix B.

II. Beneficiary Alignment Methodology

A. General

Beneficiaries are aligned to the ACO for each Performance Year on the basis of each Beneficiary’s receipt of QEM Services from an Initiative Professional during the Performance Year Alignment Period using the alignment algorithm described in Section II.C of this Appendix. Beneficiaries are similarly aligned to the ACO for each Base Year on the basis of each Beneficiary’s receipt of QEM Services from an Initiative Professional during the Base Year Alignment Period using the alignment algorithm described in Section II.C of this Appendix.

B. Alignment Years

The Performance Year Alignment Period and the Base Year Alignment Period each consist of two alignment years (each an “**Alignment Year**”). The first such Alignment Year is the 12-month period ending 18 months prior to the start of the Performance Year or Base Year, as applicable. The second such Alignment Year is the 12-month period ending 6 months prior to the start of the Performance Year or Base Year, as applicable.

¹ ESRD status in a month is determined based on Medicare enrollment/eligibility files not dialysis claims. A Beneficiary’s experience accrues to the ESRD Entitlement Category if, during a month, the Beneficiary was receiving maintenance dialysis for kidney failure or was in the 3-month period starting in the month when a kidney transplant was performed.

In this Appendix B, an Alignment Year is identified by the calendar year in which the Alignment Year ends. For example, Alignment Year 2019 (AY2019) is the 12-month period ending in June 2019. Table 1.1 of this Appendix B specifies the period covered by each Base Year and each Performance Year, and their corresponding Alignment Years.

C. Alignment Algorithm

Alignment of a Beneficiary is determined by comparing, for the Performance Year Alignment Period or the Base Year Alignment Period, as applicable:

1. The weighted allowable charge for all QEM Services that the Beneficiary received from an Initiative Professional included on the Participant List for the relevant Performance Year; and
2. The weighted allowable charge for all QEM Services that the Beneficiary received from a provider or supplier not included on the Participant List for the relevant Performance Year.

Alignment is determined for Performance Year 2019 using the initial Participant List described in Section IV.B.4 of the Agreement for Performance Year 2019 and, for each subsequent Performance Year, the final Participant List described in Section IV.E.4(g) of the Agreement for the applicable Performance Year. As set forth in Section V.A.2 of the Agreement, CMS may, in its sole discretion, adjust the alignment of Initiative Beneficiaries to the ACO for a Performance Year due to the addition or removal of an Initiative Participant from the Participant List during the Performance Year pursuant to Section IV.D or Section XVIII.A of the Agreement.

To determine the weighted allowable charge, the allowable charge on every paid claim for QEM Services received by a Beneficiary during the two Alignment Years that comprise the Base Year Alignment Period or the Performance Year Alignment Period, as applicable, will be weighted as follows:

1. The allowable charge for QEM Services provided during the first (i.e., earlier) of the two Alignment Years will be weighted by a factor of $\frac{1}{3}$.
2. The allowable charge for QEM Services provided during the second (i.e., later or more recent) of the two Alignment Years will be weighted by a factor of $\frac{2}{3}$.

Only those claims for QEM Services that are identified as being furnished by Primary Care Specialists or, if applicable, Non-Primary Care Specialists will be used in Beneficiary alignment determinations. Specifically:

1. Beneficiary Alignment based on QEM Services furnished by Primary Care Specialists
If 10% or more of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Primary Care Specialists.

2. Beneficiary Alignment based on QEM Services furnished by Non-Primary Care Specialists

If less than 10% of the weighted allowable charges are for QEM Services furnished by Primary Care Specialists, then Beneficiary alignment is based on the weighted allowable charges for QEM Services furnished by Non-Primary Care Specialists.

A Beneficiary is aligned to the ACO for a Performance Year if the Beneficiary received the plurality of QEM Services during the applicable Performance Year Alignment Period from an Initiative Professional included on the Participant List for that Performance Year.

A Beneficiary is aligned to the ACO for a Base Year if the Beneficiary received the plurality of QEM Services during the applicable Base Year Alignment Period from an Initiative Professional included on the Participant List for the relevant Performance Year.

In the case of a tie in the dollar amount of the weighted allowable charges for QEM Services furnished to a Beneficiary by two or more providers or suppliers, the Beneficiary will be aligned to the provider or supplier from whom the Beneficiary most recently obtained a QEM Service.

D. Initiative Beneficiary Population

Alignment-eligibility of Aligned Beneficiaries will be determined each quarter of a Performance Year based on whether an Aligned Beneficiary satisfies the definition of an Alignment-Eligible Beneficiary for each month of the applicable quarter. During the quarterly identification of Alignment-Eligible Beneficiaries, CMS will also identify Aligned Beneficiaries who have died during the applicable quarter.

For purposes of the financial settlement of Shared Savings and Shared Losses, as described in Section IV.C of this Appendix, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

III. Performance Year Benchmark Methodology

A. Overview

The Performance Year Benchmark is set prospectively for each Performance Year prior to the start of the Performance Year, as described below. The Performance Year Benchmark is determined using included Base Year expenditures for each of the two Entitlement Categories,

subject to certain exclusions, and subject to the application of a trend factor and adjustments for quality performance. As stated in Section XII.B of the Agreement, a Performance Year Benchmark may be retroactively modified if CMS determines that exogenous factors during the relevant Performance Year render the data used in calculating the Performance Year Benchmark inaccurate or inappropriate for purposes of assessing the expected level of spending between the Base Year and Performance Year.

B. Role of the Green Mountain Care Board

The GMCB will prospectively develop the Performance Year Benchmark for the ACO in accordance with the standards set forth in the State Agreement and this Appendix B. Prior to the start of the Performance Year for which the Performance Year Benchmark will apply, the GMCB will submit to CMS for approval the proposed Performance Year Benchmark for the ACO. CMS will assess the Performance Year Benchmark to ensure consistency with the standards set forth in the State Agreement and will decide, in its sole discretion, whether to approve or disapprove the Performance Year Benchmark submitted by the GMCB. If CMS disapproves the GMCB's submission for the Performance Year Benchmark, CMS will work with the GMCB to revise the submission to be consistent with the standards set forth in the State Agreement and this Appendix B. Prior to the start of each Performance Year, GMCB will provide the ACO with the CMS-approved Performance Year Benchmark and CMS will provide the ACO with a Performance Year Benchmark Report (as defined in Section XII.A.2 of this Agreement) setting forth the calculation of the ACO's CMS-approved Performance Year Benchmark.

C. Performance Year Benchmark Components

The ACO's Performance Year Benchmark is determined using the Base Year Expenditures for each of the two Entitlement Categories, subject to the application of a trend factor. The total Base Year Expenditure is the sum of the following two amounts:

1. The trended Base Year expenditure for A/D Beneficiaries who are Base Year Beneficiaries, multiplied by the person-months accrued to the A/D Entitlement Category by Base Year Beneficiaries during the Base Year; and
2. The trended Base Year expenditure for ESRD Beneficiaries who are Base Year Beneficiaries, multiplied by the person-months accrued to the ESRD Entitlement Category by Base Year Beneficiaries during the Base Year.

This can be expressed as a per-Beneficiary per-month expenditure by dividing the total Base Year expenditure by the total number of person-months accrued during the Base Year by Base Year Beneficiaries. For a Base Year Beneficiary who dies during a Base Year, this calculation includes person-months and expenditures only for those months of the Base Year that the Base Year Beneficiary was alive. At the time of financial settlement, this amount is then subject to an adjustment based on the ACO's quality performance. The three components of the Performance Year Benchmark calculation are discussed in more detail below.

1. Included and Excluded Base Year Expenditures for Base Year Beneficiaries.

For purposes of calculating the Performance Year Benchmark, the expenditure incurred by a Base Year Beneficiary is the sum of all Medicare claims paid to providers and suppliers:

1. For services covered by Medicare Parts A and/or B;
2. With a date of service during the Base Year; and
3. That are paid within 3 months of the close of the Base Year. The paid date for a claim is the date the claim is loaded into the Integrated Data Repository (IDR).

Indirect Medical Education (IME) and the empirically justified Medicare Disproportionate Share Hospital (DSH) payments are included expenditures for purposes of the calculation of the Performance Year Benchmark.

The following claims are excluded from expenditures for purposes of calculating the Performance Year Benchmark:

1. Payments for services provided to identifiable beneficiaries that are made outside the standard Part A and Part B claims systems; and
2. Uncompensated Care (UCC) payments.

2. Trend factor applied to the Base Year expenditures for Base Year Beneficiaries

The trend factor is the projected growth rate applied to the Base Year expenditures for Base Year Beneficiaries to account for expected increases in per-Beneficiary expenditures for the upcoming Performance Year.

The Medicare FFS United States Per-Capita Cost (USPCC) projection will be used to calculate the trend factor for purposes of calculating the Performance Year Benchmark. Though historical USPCC projections are continuously updated (e.g., 2018-2019 USPCC projection is updated using the April 2019 projection release), USPCC projection calculations used to calculate each Performance Year Benchmark under this Agreement will not be retroactively updated.

For example, for the Performance Year 2019 Performance Year Benchmark, the trend factor will be calculated by dividing the USPCC Parts A&B current estimate for CY2019 by the USPCC Parts A&B current estimate for CY2018. For the Performance Year 2020 Performance Year Benchmark, the trend factor will similarly be calculated by dividing the Parts A&B current estimate for CY2020 by the Parts A&B current estimate for CY2019.

3. Quality Measures and Quality Score

Appendix K of this Agreement describes quality measures used to assess quality performance. The prospective Performance Year Benchmark will be calculated based on a preliminary quality score of 100%, to be adjusted during financial settlement to reflect the ACO's actual quality performance.

During financial settlement, CMS will apply a downward adjustment to the ACO's Performance Year Benchmark in an amount of up to 0.5% of the Performance Year expenditure calculated in accordance with Section IV of this Appendix B, depending on the ACO's actual quality performance. The amount of any downward adjustment will be based on the ACO's actual quality score for the Performance Year, with a higher quality score resulting in a smaller downward adjustment. If the ACO receives an actual quality score of 100%, the ACO will not receive a downward adjustment to its Performance Year Benchmark.

IV. Financial Settlement

A. Overview

Following the end of each Performance Year, and at such other times as may be required under this Agreement, CMS will issue a financial settlement report to the ACO setting forth the amount of any Shared Savings or Shared Losses, the amount of Other Monies Owed by CMS or the ACO, and the net amount owed by either CMS or the ACO. The methodology used for purposes of the financial settlement of Shared Savings and Shared Losses is described below.

B. Initiative Beneficiaries for Financial Settlement

As described in Section I.E of this Appendix, for purposes of the financial settlement of Shared Savings and Shared Losses, CMS includes only the following:

1. for Aligned Beneficiaries who were Alignment-Eligible Beneficiaries for each month of the Performance Year, person-months and expenditures for the full Performance Year; and
2. for Aligned Beneficiaries who died during the Performance Year but were Alignment-Eligible Beneficiaries for each month of the Performance Year prior to death, person-months and expenditures for each month they were alive during the Performance Year.

For purposes of financial settlement of Shared Savings and Shared Losses, Beneficiaries will also be excluded from the population of Initiative Beneficiaries retroactive to the start of the Performance Year if, during the Performance Year, at least 50% of QEM Services received by

the Beneficiary were furnished by providers or suppliers practicing outside the ACO Service Area.

C. Performance Year Expenditures

For purposes of conducting financial settlement pursuant to Section VIII.C of the Agreement, expenditures will be calculated separately for each of the two Entitlement Categories: ESRD Beneficiaries and A/D Beneficiaries. CMS will apply the same inclusions and exclusions in determining the Performance Year expenditures as those described in Section III.C of this Appendix with respect to determining the Base Year expenditures for purposes of the calculation of the Performance Year Benchmark, except that only Medicare claims with a date of service during the Performance Year and that are paid within 3 months of the close of the Performance Year will be included.

The total Performance Year expenditure is the sum of the following two amounts:

1. The Performance Year expenditure for A/D Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the A/D Entitlement Category by Initiative Beneficiaries during the Performance Year; and
2. The Performance Year expenditure for ESRD Beneficiaries who are Initiative Beneficiaries multiplied by the person-months accrued to the ESRD Entitlement Category by Initiative Beneficiaries during the Performance Year.

This can be expressed as a per-Beneficiary per-month expenditure by dividing the total Performance Year expenditure by the total number of person-months accrued during the Performance Year by Initiative Beneficiaries.²

D. Savings/Losses Amount

The ACO's aggregate gross savings or losses will be determined by subtracting the Performance Year expenditure calculated in accordance with Section IV.C of this Appendix from the ACO's Performance Year Benchmark calculated in accordance with Section III of this Appendix.

The Risk Arrangement selected by the ACO in accordance with Section X.A of the Agreement will determine the portion of the aggregate gross savings or losses in relation to the Performance Year Benchmark that accrue to the ACO as Shared Savings or Shared Losses. The Initiative offers two Risk Arrangements:

1. Risk Arrangement A: 80% Shared Savings/Shared Losses, ACO selects a Savings/Losses Cap between 5%-15%.

² The combined benchmark is, therefore, simply the person-month weighted average of the Aged/Disabled and ESRD PBPM benchmarks.

2. Risk Arrangement B: 100% Shared Savings/Shared Losses, ACO selects a Savings/Losses Cap between 5%-15%.

The Savings/Losses Cap is the maximum allowable percentage of the ACO’s Performance Year Benchmark that will be paid to the ACO as Shared Savings or owed by the ACO as Shared Losses, subject to the application of the Risk Arrangement selected by the ACO. For example, if the ACO selects a 5% Savings/Losses Cap and a 100% Risk Arrangement, the ACO would only share in savings up to 5% of its Performance Year Benchmark, even if it achieved savings equal to 6% of that Performance Year Benchmark. In instances in which aggregate gross ACO savings/losses exceed the Savings/Losses Cap selected by the ACO, the Savings/Losses Cap is first applied to determine the maximum allowable savings/losses, and the Risk Arrangement is then applied to that maximum allowable savings/loss amount. For example, if the ACO selects a 5% Savings/Losses Cap and a 80% Risk Arrangement, the ACO would share in savings/losses up to 4% [80% of the 5% maximum allowable savings/losses] of its Performance Year Benchmark.

Budget sequestration will apply to the calculation of Shared Savings, but will not apply to the calculation of Shared Losses. For example, if the budget sequestration rate is 2%, the amount of Shared Savings owed to the ACO would be 98% of any savings calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above, but the amount of Shared Losses owed by the ACO would be 100% of any losses calculated after application of the Savings/Losses Cap and the Risk Arrangement as described above.

V. Tables

Table 1.1 - Period Covered by Each Base Year and Performance Year and Corresponding Alignment Years

Period	Period covered¹	Corresponding Alignment Years (AYs)
Base Year (CY two years prior to the Performance Year)	<u>PY2019</u> Base Year: 01/01/2017 – 12/31/2017	AY1: 07/01/2014 – 06/30/2015 (AY2015) AY2: 07/01/2015 – 06/30/2016 (AY2016)
	<u>PY2020</u> Base Year: 01/01/2018 – 12/31/2018	AY1: 07/01/2015 – 06/30/2016 (AY2016) AY2: 07/01/2016 – 06/30/2017 (AY2017)

	<u>PY2021</u> Base Year: 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)
	<u>PY2022</u> Base Year: 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)
Performance Year (Current CY)	<u>PY2019</u> 01/01/2019 – 12/31/2019	AY1: 07/01/2016 – 06/30/2017 (AY2017) AY2: 07/01/2017 – 06/30/2018 (AY2018)
	<u>PY2020</u> 01/01/2020 – 12/31/2020	AY1: 07/01/2017 – 06/30/2018 (AY2018) AY2: 07/01/2018 – 06/30/2019 (AY2019)
	<u>PY2021</u> 01/01/2021 – 12/31/2021	AY1: 07/01/2018 – 06/30/2019 (AY2019) AY2: 07/01/2019 – 06/30/2020 (AY2020)
	<u>PY2022</u> 01/01/2022 – 12/31/2022	AY1: 07/01/2019 – 06/30/2020 (AY2020) AY2: 07/01/2020 – 06/30/2021 (AY2021)

¹ The period covered is the calendar year for which the expenditures will be calculated for purposes of setting the Performance Year Benchmark or determining Shared Savings or Shared Losses.

Table 1.2 – Qualified Evaluation & Management Services

Office or Other Outpatient Services	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive

Office or Other Outpatient Services	
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief
99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Transitional Care Management Services	
99495	Communication (14 days of discharge)
99496	Communication (7 days of discharge)
Chronic Care Management Services	
99490	Comprehensive care plan establishment/implementations/revision/monitoring
Wellness Visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

Table 1.3 - Specialty codes used to identify Primary Care Specialists

Code ¹	Specialty
1	General Practice

8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
89	Clinical nurse specialist
97	Physician Assistant

¹ The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at:
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

Table 1.4 - Specialty codes used to identify Non-Primary Care Specialists

Code¹	Specialty
6	Cardiology
12	Osteopathic manipulative medicine
13	Neurology
16	Obstetrics/gynecology
23	Sports medicine
25	Physical medicine and rehabilitation
26	Psychiatry
27	Geriatric psychiatry
29	Pulmonology
39	Nephrology
46	Endocrinology
70	Multispecialty clinic or group practice
79	Addiction medicine
82	Hematology
83	Hematology/oncology

84	Preventative medicine
90	Medical oncology
98	Gynecological/oncology
86	Neuropsychiatry

¹ The Medicare Specialty Code. A cross-walk between Medicare Specialty Codes and the Healthcare Provider Taxonomy is published on the CMS website at:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf>

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Appendix D - 3-Day SNF Rule Waiver Benefit Enhancement

I. Election of the 3-Day SNF Rule Waiver Benefit Enhancement

If the ACO wishes to offer the 3-Day SNF Rule Waiver Benefit Enhancement during a Performance Year, the ACO must–

- A. Timely submit to CMS its selection of the 3-Day SNF Rule Waiver Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement for the 3-Day SNF Rule Waiver Benefit Enhancement; and
- B. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Initiative Participants that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement.

II. Waiver

CMS waives the requirement in section 1861(i) of the Social Security Act for a three-day inpatient hospital stay prior to the provision of otherwise covered Medicare post-hospital extended care services (“**SNF Services**”) furnished under the terms and conditions set forth in this Appendix (“**3-Day SNF Rule Waiver Benefit Enhancement**”).

III. Eligible SNFs

- A. For purposes of this waiver, an “**Eligible SNF**” is a SNF or a Swing-Bed Hospital that is an Initiative Participant or Preferred Provider that has (i) entered into a written agreement with the ACO to provide SNF Services in accordance with the SNF 3-Day Rule Waiver Benefit Enhancement under Section II of this Appendix; (ii) been identified by the ACO as having agreed to participate in the 3-Day SNF Rule Waiver Benefit Enhancement in accordance with Section I.B of this Appendix; and (iii) been approved by CMS to participate under the 3-Day SNF Rule Waiver Benefit Enhancement following a review of the qualifications of the SNF or Swing Bed Hospital to accept admissions without a prior inpatient hospital stay (“**Direct SNF Admissions**”) and admissions after an inpatient stay of fewer than three days.
- B. CMS review and approval of a SNF or Swing Bed Hospital to provide services in accordance with the 3-Day SNF Rule Waiver Benefit Enhancement includes consideration of the program integrity history of the SNF or Swing Bed Hospital and any

other factors that CMS determines may affect the qualifications of the SNF or Swing Bed Hospital to provide SNF Services under the terms and conditions of the 3-Day SNF Rule Waiver Benefit Enhancement. Additionally, at the time of CMS review and approval of a SNF to participate under the 3-Day SNF Rule Waiver Benefit Enhancement, the SNF must have an overall rating of three or more stars under the CMS 5-Star Quality Rating System in seven of the previous twelve months, as reported on the Nursing Home Compare website.

- C. Eligibility of SNFs and Swing Bed Hospitals to provide services under this 3-Day SNF Rule Waiver Benefit Enhancement will be reassessed by CMS annually, prior to the start of each Performance Year.
- D. The ACO shall maintain and provide to its Initiative Participants and Preferred Providers an accurate and complete list of Eligible SNFs and shall furnish updated lists as necessary to reflect any changes in SNF or Swing Bed Hospital eligibility. The ACO shall also furnish these lists to an Initiative Beneficiary, upon request.
- E. The ACO must provide written notification to CMS within 10 days of any changes to its list of Eligible SNFs. Within 10 days following the removal of any Eligible SNF from the list of Eligible SNFs, the ACO must also provide written notification to the SNF or Swing-Bed Hospital that it has been removed from the list and that it no longer qualifies to use this 3-Day SNF Rule Waiver Benefit Enhancement.
- F. The ACO shall provide a copy of this Appendix D to each Eligible SNF to which Beneficiaries are referred by Initiative Participants and Preferred Providers.

IV. Beneficiary Eligibility Requirements

- A. To be eligible to receive services covered under the terms of the waiver under Section II of this Appendix the Beneficiary must be:
 - 1. An Initiative Beneficiary at the time of admission to an Eligible SNF under this waiver or within the grace period under Section V of this Appendix; and
 - 2. Not residing in a SNF or long-term care facility at the time of admission to an Eligible SNF under this waiver. For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities.
- B. A Direct SNF Admission will be covered under the terms of the waiver under Section II of this Appendix only if, at the time of admission, in addition to meeting the eligibility requirements under section IV.A of this Appendix D, the Beneficiary:
 - 1. Is medically stable;
 - 2. Has confirmed diagnoses;
 - 3. Has been evaluated by a physician or other practitioner licensed to perform the evaluation within three days prior to admission to the Eligible SNF;
 - 4. Does not require inpatient hospital evaluation or treatment; and

5. Has a skilled nursing or rehabilitation need that is identified by the evaluating physician or other practitioner and cannot be provided as an outpatient.
- C. A SNF or Swing Bed Hospital admission will be covered under the terms of the waiver under Section II of this Appendix for a Beneficiary who is discharged to an Eligible SNF after fewer than three days of inpatient hospitalization only if, at the time of admission, the Beneficiary:
1. Is medically stable;
 2. Has confirmed diagnoses;
 3. Does not require further inpatient hospital evaluation or treatment; and
 4. Has a skilled nursing or rehabilitation need that has been identified by a physician or other practitioner during the inpatient hospitalization and that cannot be provided on an outpatient basis.

V. Grace Period for Excluded Beneficiaries

In the case of a Beneficiary who was aligned to the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO during the Performance Year, CMS shall make payment for SNF Services furnished by an Eligible SNF to such Beneficiary without a prior 3-day inpatient hospitalization under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as if the Beneficiary were still an Initiative Beneficiary aligned to the ACO, provided that admission to the Eligible SNF occurs within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

VI. SNF Services Provided to Non-Eligible Beneficiaries

If an Eligible SNF provides SNF Services under this 3-Day SNF Rule Waiver Benefit Enhancement to a Beneficiary who does not meet the Beneficiary Eligibility Requirements in Section IV of this Appendix, the following rules shall apply:

- A. CMS shall make no payment to the Eligible SNF for such services;
- B. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services;
- C. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Responsibility for Denied Claims

- A. If a claim for any SNF Services furnished to a Beneficiary by an Eligible SNF is denied as a result of a CMS error and the Eligible SNF did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such SNF Services under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as though the coverage denial had not occurred.

- B. If a claim for any SNF Services furnished to a Beneficiary by an Eligible SNF is denied for any reason other than a CMS error and CMS determines that that the Eligible SNF did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
 - 1. CMS shall, notwithstanding such determination, pay for such SNF Services under the terms of the 3-Day SNF Rule Waiver Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
 - 2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services; and
 - 3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for SNF Services furnished to a Beneficiary by an Eligible SNF is denied and the Eligible SNF knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
 - 1. CMS shall not make payment to the Eligible SNF for such services;
 - 2. The ACO shall ensure that the Eligible SNF that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services; and
 - 3. The ACO shall ensure that the Eligible SNF that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- D. If an Initiative Participant or Preferred Provider that is not an Eligible SNF submits a claim for SNF Services under this 3-Day SNF Rule Waiver Benefit Enhancement for which CMS only would have made payment if the Initiative Participant or Preferred Provider was an Eligible SNF participating in the 3-Day SNF Rule Waiver Benefit Enhancement at the time of service:
 - 1. CMS shall not make payment to the Initiative Participant or Preferred Provider for such services;
 - 2. The ACO shall ensure that the Initiative Participant or Preferred Provider that provided the SNF Services does not charge the Beneficiary for the expenses incurred for such services; and
 - 3. The ACO shall ensure that the Initiative Participant or Preferred Provider that provided the SNF Services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VIII. Compliance and Enforcement

- A. CMS may revoke its approval of an Initiative Participant or Preferred Provider to participate as an Eligible SNF under the 3-Day SNF Rule Waiver Benefit Enhancement at any time if the Initiative Participant or Preferred Provider's continued participation in

this 3-Day SNF Rule Waiver Benefit Enhancement might compromise the integrity of the Initiative.

- B. The ACO must have appropriate procedures in place to ensure that Initiative Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.
- C. The ACO shall submit quarterly reports to CMS, in a manner to be determined by CMS, regarding its use of the 3-Day SNF Rule Waiver Benefit Enhancement. The ACO shall provide CMS with supplemental information upon request regarding its use of the 3-Day SNF Rule Waiver Benefit Enhancement.
- D. CMS will monitor the ACO's use of the 3-Day SNF Rule Waiver Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.
- E. In accordance with Section XVIII of the Agreement, CMS may terminate or suspend the waiver under Section II of this Appendix or take other remedial action, as appropriate, if the ACO or any of its Initiative Participants or Preferred Providers fails to comply with the terms and conditions of the 3-Day SNF Rule Waiver Benefit Enhancement.

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Appendix E - Telehealth Expansion Benefit Enhancement

I. Election of the Telehealth Expansion Benefit Enhancement

If the ACO wishes to offer the Telehealth Expansion Benefit Enhancement during a Performance Year, the ACO must –

- A. Timely submit to CMS its election of the Telehealth Expansion Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement for the Telehealth Expansion Benefit Enhancement; and

- B. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Initiative Participants that have agreed to participate in the Telehealth Expansion Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Telehealth Expansion Benefit Enhancement.

II. Waiver

- A. Waivers of Originating Site Requirements: CMS waives the following requirements with respect to otherwise covered telehealth services furnished by an Eligible Telehealth Provider (as that term is defined in Section III.A of this Appendix) in accordance with the terms and conditions set forth in this Appendix:
 - 1. Waiver of Originating Site Requirements: CMS waives the requirements in Section 1834(m)(4)(C) of the Act and 42 C.F.R. § 410.78(b)(3)–(4) with respect to telehealth services furnished in accordance with this Appendix.
 - 2. Waiver of Originating Site Requirement in the Eligible Telehealth Individual Provision: CMS waives the requirement in Section 1834(m)(4)(B) of the Act that telehealth services be “furnished at an originating site” when the services are furnished in accordance with this Appendix.
 - 3. Waiver of Originating Site Facility Fee Provision: CMS waives the requirement in Section 1834(m)(2)(B) of the Act and 42 C.F.R. § 414.65(b) with respect to telehealth services furnished to a Beneficiary at his/her home or place of residence when furnished in accordance with this Appendix.

- B. Waiver of Interactive Telecommunications System Requirement: CMS waives the following requirements with respect to otherwise covered teledermatology and teleophthalmology services furnished by an Eligible Asynchronous Telehealth Provider (as that term is defined in Section III.B. of this Appendix) using asynchronous store and

forward technologies, in accordance with the terms and conditions set forth in this Appendix:

1. Waiver of Originating Site Requirements: CMS waives the requirement in Section 1834(m)(4)(C)(i) of the Act regarding the location of the originating site and the requirements of 42 C.F.R. § 410.78(b)(4) with respect to covered teledermatology and teleophthalmology furnished using asynchronous store and forward technologies in accordance with this Appendix.
 2. Waiver of Interactive Telecommunications System Requirement: CMS waives the requirement under Section 1834(m)(1) of the Act and 42 C.F.R. § 410.78(b) that telehealth services be furnished via an “interactive telecommunication system,” as that term is defined under 42 C.F.R. § 410.78(a)(3), when such services are furnished in accordance with this Appendix.
- C. The waivers described in Section II.A and II.B of this Appendix are collectively referred to as the “**Telehealth Expansion Benefit Enhancement**”.

III. Eligible Telehealth Providers and Eligible Asynchronous Telehealth Providers

- A. For purposes of this Telehealth Expansion Benefit Enhancement, an “**Eligible Telehealth Provider**” is an Initiative Participant or Preferred Provider who meets the requirements under Section XI.C.2 of the Agreement.
- B. For the purposes of this Telehealth Expansion Benefit Enhancement, an “**Eligible Asynchronous Telehealth Provider**” is an Initiative Participant or Preferred Provider who meets the requirements under Section XI.C.4 of the Agreement.
- C. CMS review and approval of an Initiative Participant or a Preferred Provider to provide services in accordance with the Telehealth Expansion Benefit Enhancement under Section II of this Appendix includes consideration of the program integrity history of the Initiative Participant or Preferred Provider and any other factors that CMS determines may affect the qualifications of the Initiative Participant or Preferred Provider to provide telehealth services under the terms of the Telehealth Expansion Benefit Enhancement.

IV. Eligibility Requirements

- A. In order for telehealth services to be eligible for reimbursement under the terms of the waivers under Section II.A of this Appendix, the Beneficiary must be:
 1. An Initiative Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
 2. Located at an originating site that is either:
 - a. One of the sites listed in section 1834(m)(4)(C)(ii) of the Act; or
 - b. The Beneficiary’s home or place of residence.
- B. In order for telehealth services to be eligible for reimbursement under the terms of the waiver under Section II.B of this Appendix, the Beneficiary must be:

1. An Initiative Beneficiary at the time the telehealth services are furnished or within the grace period under Section V of this Appendix; and
 2. Located at an originating site that is one of the sites listed in Section 1834(m)(4)(C)(ii) of the Act.
- C. Claims for telehealth services furnished under the terms of the waiver under Section II.A of this Appendix for which the originating site is a Beneficiary's home or place of residence will be denied unless submitted using one of the HCPCS codes G9481-G9489.
- D. Claims for asynchronous teledermatology and teleophthalmology services furnished under the terms of the waiver under Section II.B of this Appendix will be denied unless submitted using one of the HCPCS codes G9868-G9870.
- E. In the event that technical issues with telecommunications equipment required for telehealth services cause an inability to appropriately furnish such telehealth services, the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider shall not submit a claim for such telehealth services.
- F. All telehealth services must be furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining requirements of Section 1834(m) of the Act and 42 C.F.R. §§ 410.78 and 414.65.
- G. An Eligible Telehealth Provider or an Eligible Asynchronous Telehealth Provider shall not furnish telehealth services in lieu of in person services or encourage, coerce, or otherwise influence a Beneficiary to seek or receive telehealth services in lieu of in person services when the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knows or should know in person services are medically necessary.

V. Grace Period for Excluded Beneficiaries

In the case of a Beneficiary who had been aligned with the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO during the Performance Year, CMS shall make payment for telehealth services furnished to such Beneficiary under the terms of the Telehealth Expansion Benefit Enhancement as if the Beneficiary were still an Initiative Beneficiary aligned to the ACO, provided that the telehealth services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section IV of this Appendix are met.

VI. Responsibility for Denied Claims

- A. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider under the Telehealth Expansion Benefit Enhancement is denied as a result of a CMS error and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred.

- B. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider is denied for any reason other than a CMS error and CMS determines that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall, notwithstanding such denial, pay for such telehealth services under the terms of the Telehealth Expansion Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
 2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for any telehealth services furnished by an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall not make payment to the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider for such services;
 2. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- D. If an Initiative Participant or Preferred Provider that is not an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider submits claims for telehealth services for which CMS only would have made payment if the Initiative Participant or Preferred Provider was an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider participating in this Telehealth Expansion Benefit Enhancement at the time of service:
1. CMS shall not make payment to the Initiative Participant or Preferred Provider for such services;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider that provided the telehealth services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Initiative Participant or Preferred Provider that provided the telehealth services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

VII. Compliance and Enforcement

- A. CMS may reject the ACO's designation of an Initiative Participant or Preferred Provider as an Eligible Telehealth Provider or Eligible Asynchronous Telehealth Provider at any time if the Initiative Participant or Preferred Provider's participation in this Telehealth Expansion Benefit Enhancement might compromise the integrity of the Initiative .
- B. The ACO must have appropriate procedures in place to ensure that Initiative Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.
- C. [RESERVED]
- D. CMS will monitor the ACO's use of the Telehealth Expansion Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of the Benefit Enhancement.
- E. In accordance with Section XVIII of this Agreement, CMS may terminate or suspend one or more of the waivers under Section II of this Appendix or take other remedial action if the ACO or any of its Initiative Participants or Preferred Providers fails to comply with the terms and conditions of the Telehealth Expansion Benefit Enhancement.

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Appendix F - Post-Discharge Home Visits Benefit Enhancement

This Post-Discharge Home Visits Benefit Enhancement increases the availability to Beneficiaries of in-home care following discharge from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility by altering the supervision level for “incident to” services to allow personnel under a physician’s general supervision (instead of direct supervision) to make home visits under certain conditions.

I. Post-Discharge Home Visits Benefit Enhancement Election

If the ACO wishes to offer the Post-Discharge Home Visits Benefit Enhancement during a Performance Year, the ACO must –

- A. Timely submit to CMS its selection of the Post-Discharge Home Visits Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement for the Post-Discharge Home Visits Benefit Enhancement; and
- B. Timely submit in accordance with Section IV of this Agreement a true, accurate and complete list of Initiative Participants that have agreed to participate in the Post-Discharge Home Visits Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Post-Discharge Home Visits Benefit Enhancement.

II. Waiver and Terms

CMS waives the requirement in 42 C.F.R. § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) (“incident to” services) must be furnished under the direct supervision of the physician (or other practitioner)¹, provided that such services are furnished as follows and in accordance with all other terms and conditions set forth in this Appendix (“**Post-Discharge Home Visits Benefit Enhancement**”):

- A. The services are furnished to a Beneficiary who either does not qualify for Medicare coverage of home health services under 42 C.F.R. § 409.42 or who qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 § 60.4; and
- B. The services are furnished in the Beneficiary’s home after the Beneficiary has been discharged from an acute inpatient hospital, inpatient psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility; and

¹ For additional guidance on “incident to” billing, the ACO may refer to the Medicare Benefit Policy Manual, Chapter 15 § 60, found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>, excepting the references therein to direct supervision.

- C. The services are furnished by “auxiliary personnel,” as defined in 42 C.F.R. § 410.26(a)(1), under the general supervision, as defined in 42 C.F.R. § 410.32(b)(3)(i), of an Initiative Participant or Preferred Provider identified on the ACO’s Participant List or Preferred Provider List submitted in accordance with Section IV of this Agreement as participating in the Post-Discharge Home Visits Benefit Enhancement under the terms of this Appendix who is a physician or other practitioner and meets the requirements under Section XI.D.2 of the Agreement; and
- D. The claims for such services are submitted by the supervising Initiative Participant or Preferred Provider who satisfies the criteria outlined in Section XI.D.2 of the Agreement; and
- E. The services are furnished not more than nine times in the first ninety (90) days following discharge; and
- F. The provision of such services must be documented and records maintained by the ACO in accordance with Section XVII.B. of the Agreement; and
- G. The nine services described in Section II.E. of this Appendix cannot be accumulated across multiple discharges: if the Beneficiary is readmitted within ninety (90) days of the initial discharge, following the subsequent discharge the Beneficiary may receive only the nine services described in Section II.E. above in connection with the most recent discharge; and
- H. The claims for services furnished under the terms of the Post-Discharge Home Visits Benefit Enhancement must be submitted using one of the HCPCS codes G0064-G0075; and
- I. The services are furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b); and
- J. The Beneficiary must be an Initiative Beneficiary at the time the services are furnished or within the grace period under Section III of this Appendix.

CMS also waives the direct supervision requirement in 42 C.F.R. § 410.26(b)(5) under such other circumstances as provided in this Appendix.

III. Grace Period for Excluded Beneficiaries

In the case of a Beneficiary who had been aligned with the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO during the Performance Year, CMS shall make payment for the post-discharge home visits services furnished to such a Beneficiary under the terms of the Post-Discharge Home Visits Benefit Enhancement as if the Beneficiary were still aligned to the ACO, provided that the post-discharge home visits services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section II of this Appendix are met.

IV. Responsibility for Denied Claims

- A. If a claim for any post-discharge home visits services furnished by an Initiative Participant or Preferred Provider who has been identified as participating in the Post-Discharge Home Visits Benefit Enhancement pursuant to Section IV of the Agreement is denied as a result of a CMS error and the Initiative Participant or Preferred Provider did

not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such services under the terms of the Post-Discharge Home Visits Benefit Enhancement as though the coverage denial had not occurred.

- B. If a claim for any post-discharge home visits services furnished by an Initiative Participant or Preferred Provider who has been identified as participating in the Post-Discharge Home Visits Benefit Enhancement pursuant to Section IV of the Agreement is denied for any reason other than a CMS error and the Initiative Participant or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall, notwithstanding such denial, pay for such post-discharge home visits services under the terms of the Post-Discharge Home Visits Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the post-discharge home visits services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the post-discharge home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for any post-discharge home visits services furnished by an Initiative Participant or Preferred Provider who has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Initiative Participant or Preferred Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall not make payment to the Initiative Participant or Preferred Provider for such services;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the post-discharge home visits services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the post-discharge home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

- D. If an Initiative Participant or Preferred Provider who has not been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement furnishes post-discharge home visits services for which CMS only would have made payment if the Initiative Participant or Preferred Provider had been identified as participating in this Benefit Enhancement at the time of service:
1. CMS shall make no payment to the Initiative Participant or Preferred Provider for such services;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the post-discharge home visits services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the post-discharge home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

V. Compliance and Enforcement

- A. The ACO shall ensure, through its agreement with each Initiative Participant and Preferred Provider who will be participating in the Post-Discharge Home Visits Benefit Enhancement, that the Initiative Participant or Preferred Provider shall require all auxiliary personnel to comply with the terms of this Agreement and Appendix.
- B. CMS may remove an Initiative Participant or Preferred Provider from the list of Initiative Participants or Preferred Providers who may participate in this Post-Discharge Home Visits Benefit Enhancement at any time if the Initiative Participant or Preferred Provider's participation in this Post-Discharge Home Visits Benefits Enhancement might compromise the integrity of the Initiative.
- C. The ACO must have appropriate procedures in place to ensure that Initiative Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.
- D. [RESERVED]
- E. CMS will monitor the ACO's use of the Post-Discharge Home Visits Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.
- F. In accordance with Section XVIII of this Agreement, CMS may terminate or suspend this Benefit Enhancement or take other remedial action if the ACO or any of its Initiative Participants or Preferred Providers fails to comply with the terms and conditions of the Post-Discharge Home Visits Benefit Enhancement.

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Appendix G - Care Management Home Visits Benefit Enhancement

This Care Management Home Visits Benefit Enhancement increases the availability of in-home care to Beneficiaries determined by the ACO to be at risk of hospitalization and for whom an Initiative Participant or Preferred Provider has initiated a care treatment plan by altering the supervision level for “incident to” services to allow personnel under a physician’s general supervision (instead of direct supervision) to make home visits under certain conditions.

I. Care Management Home Visits Benefit Enhancement Election

If the ACO wishes to offer the Care Management Home Visits Benefit Enhancement during a Performance Year, the ACO must –

- A. Timely submit to CMS its selection of the Care Management Home Visits Benefit Enhancement in accordance with Section X.A of this Agreement and an Implementation Plan in accordance with Section XI of this Agreement for the Care Management Home Visits Benefit Enhancement; and
- B. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Initiative Participants that have agreed to participate in the Care Management Home Visits Benefit Enhancement and a true, accurate, and complete list of Preferred Providers that have agreed to participate in the Care Management Home Visits Benefit Enhancement.

II. Waiver and Terms

CMS waives the requirement in 42 CFR § 410.26(b)(5) that services and supplies furnished incident to the service of a physician (or other practitioner) (“incident to” services) must be furnished under the direct supervision of the physician (or other practitioner)¹, provided that such services are furnished as follows and in accordance with all other terms and conditions set forth in this Appendix G (“**Care Management Home Visits Benefit Enhancement**”):

- A. The services are furnished to a Beneficiary who is determined to be at risk of hospitalization, for whom an Initiative Participant or Preferred Provider has initiated a care treatment plan, who is not eligible for the Post-Discharge Home Visits Benefit Enhancement, and either does not qualify for Medicare coverage of home health services under 42 CFR § 409.42 or qualifies for Medicare coverage of home health services on the sole basis of living in a medically underserved area, as described in Medicare Benefit Policy Manual, Chapter 15 § 60.4; and
- B. The services are furnished in the Beneficiary’s home by “auxiliary personnel,” as defined in 42 CFR § 410.26(a)(1), under the general supervision, as defined in 42 CFR § 410.32(b)(3)(i), of an Initiative Participant or Preferred Provider identified on the ACO’s

¹ For additional guidance on “incident to” billing, the ACO may refer to the Medicare Benefit Policy Manual, Chapter 15 § 60, found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>, excepting the references therein to direct supervision.

- Participant List or Preferred Provider List submitted in accordance with Section IV of this Agreement as participating in the Care Management Home Visits Benefit Enhancement under the terms of this Appendix G who is a physician or other practitioner and meets the requirements under Section XI.E.2 of the Agreement; and
- C. The claims for such services are submitted by the supervising Initiative Participant or Preferred Provider who satisfies the criteria outlined in Section XI.E.2 of the Agreement; and
 - D. The services are furnished not more than two times within ninety (90) days of the Beneficiary seeing an Initiative Participant or Preferred Provider who has initiated a care management plan, except that a Beneficiary may receive one additional care management home visit within this 90-day period if the Beneficiary first has an in-office visit with an Initiative Participant or Preferred Provider where a service identified by an Evaluation and Management code is furnished; and
 - E. No additional care management home visits services beyond those described in Section II.D of this Appendix are furnished to the Beneficiary until the completion of the 90-day period described in Section II.D, after which time additional care management home visits services are furnished to the Beneficiary only in accordance with the terms and conditions of this Appendix; and
 - F. The provision of services under the Care Management Home Visits Benefit Enhancement must be documented in records maintained by the ACO in accordance with Section XVII.B of the Agreement; and
 - G. The claims for services furnished under the terms of the Care Management Home Visits Benefit Enhancement must be submitted using one of the HCPCS codes G0076-G0087; and
 - H. The services are furnished in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining provisions of 42 CFR § 410.26(b); and
 - I. The Beneficiary must be an Initiative Beneficiary at the time the services are furnished or within the grace period under Section III of this Appendix.

CMS also waives the direct supervision requirement in 42 CFR § 410.26(b)(5) under such other circumstances as provided in this Appendix.

III. Grace Period for Excluded Beneficiaries

In the case of a Beneficiary who had been aligned with the ACO at the start of the applicable Performance Year but who is later excluded from alignment to the ACO during the Performance Year, CMS shall make payment for the care management home visits services furnished to such a Beneficiary under the terms of the Care Management Home Visits Benefit Enhancement as if the Beneficiary were still aligned to the ACO, provided that the care management home visits services were furnished within 90 days following the date of the alignment exclusion and all requirements under Section II of this Appendix are met.

IV. Responsibility for Denied Claims

- A. If a claim for any care management home visits services furnished by an Initiative Participant or Preferred Provider who has been identified as participating in the Care Management Home Visits Benefit Enhancement pursuant to Section IV of the Agreement is denied as a result of a CMS error and the Initiative Participant or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that the claim would be denied, payment shall, notwithstanding such denial, be made by CMS for such services under the terms of the Care Management Home Visits Benefit Enhancement as though the coverage denial had not occurred.
- B. If a claim for any care management home visits services furnished by an Initiative Participant or Preferred Provider who has been identified as participating in the Care Management Home Visits Benefit Enhancement pursuant to Section IV of the Agreement is denied for any reason other than a CMS error and the Initiative Participant or Preferred Provider did not know, and could not reasonably have been expected to know, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall, notwithstanding such denial, pay for such care management home visits services under the terms of the Care Management Home Visits Benefit Enhancement as though the coverage denial had not occurred, but CMS will recoup these payments from the ACO. The ACO shall owe CMS the amount of any such payments, payable as Other Monies Owed for that Performance Year;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the care management home visits services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the care management home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- C. If a claim for any care management home visits services furnished by an Initiative Participant or Preferred Provider who has been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement is denied and the Initiative Participant or Preferred Provider knew, or reasonably could be expected to have known, as determined by CMS, that payment would not be made for such items or services under Part A or Part B of Title XVIII:
1. CMS shall not make payment to the Initiative Participant or Preferred Provider for such services;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the care management home visits services does not charge the Beneficiary for the expenses incurred for such services; and

3. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the care management home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.
- D. If an Initiative Participant or Preferred Provider who has not been identified as participating in this Benefit Enhancement pursuant to Section IV of the Agreement furnishes care management home visits services for which CMS only would have made payment if the Initiative Participant or Preferred Provider had been identified as participating in this Benefit Enhancement at the time of service:
1. CMS shall make no payment to the Initiative Participant or Preferred Provider for such services;
 2. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the care management home visits services does not charge the Beneficiary for the expenses incurred for such services; and
 3. The ACO shall ensure that the Initiative Participant or Preferred Provider who furnished the care management home visits services returns to the Beneficiary any monies collected from the Beneficiary related to such services.

V. Compliance and Enforcement

- A. The ACO shall ensure, through its agreement with each Initiative Participant and Preferred Provider who will be participating in the Care Management Home Visits Benefit Enhancement, that the Initiative Participant or Preferred Provider shall require all auxiliary personnel to comply with the terms of this Agreement and Appendix.
- B. CMS may remove an Initiative Participant or Preferred Provider from the list of Initiative Participants or Preferred Providers who may participate in this Care Management Home Visits Benefit Enhancement at any time if the Initiative Participant or Preferred Provider's participation in this Care Management Home Visits Benefit Enhancement might compromise the integrity of the Initiative.
- C. The ACO must have appropriate procedures in place to ensure that Initiative Participants and Preferred Providers have access to the most up-to-date information regarding Beneficiary alignment to the ACO.
- D. [RESERVED]
- E. CMS will monitor the ACO's use of the Care Management Home Visits Benefit Enhancement to ensure that services furnished under the Benefit Enhancement are medically appropriate and consistent with the terms of this Benefit Enhancement.

- F. In accordance with Section XVIII of this Agreement, CMS may terminate or suspend this Benefit Enhancement or take other remedial action if the ACO or any of its Initiative Participants or Preferred Providers fails to comply with the terms and conditions of the Care Management Home Visits Benefit Enhancement.

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Appendix H - Financial Guarantee

This Appendix provides requirements regarding the ACO's financial guarantee for repayment of amounts owed to CMS as Shared Losses and/or Other Monies Owed, as required under Section XIII.D of this Agreement.

1. Form of Financial Guarantee

- 1.1. The financial guarantee must be in one or more of the following forms:
 - (a) Funds placed in escrow;
 - (b) A line of credit as evidenced by a letter of credit upon which CMS may draw;
 - (c) Surety bond.
- 1.2. CMS may reject any financial guarantee that does not comply with the terms of this Appendix H.
- 1.3. Consistent with Section XIII.D.3 of the Agreement, any changes made to a financial guarantee must be approved in advance by CMS.

2. Amount of the Financial Guarantee

- 2.1. For each Performance Year during which the ACO participates in the Initiative, the ACO shall obtain a financial guarantee in an amount to be specified by CMS in the annual written notice furnished to the ACO under paragraph 2.2 of this Appendix H.
- 2.2. CMS shall provide written notice to the ACO prior to the start of each Performance Year, of the amount that must be funded by the financial guarantee for the applicable Performance Year, which will be equal to two percent of the ACO's estimated total Medicare Parts A and B fee-for-service expenditures for Initiative Beneficiaries for the Performance Year. The amount is based on the ACO's Performance Year Benchmark and will be calculated by CMS.
- 2.3. The ACO shall submit to CMS written documentation of the form and amount of its financial guarantee for the Performance Year for CMS review within 60 days of the date of the written notice furnished to the ACO under paragraph 2.2 of this Appendix H.

3. Duration of the Financial Guarantee

- 3.1. Except as set forth in paragraph 3.2, the financial guarantee for each Performance Year must remain in effect (or the amount funded for a Performance Year in a financial guarantee that funds multiple Performance Years must remain available to CMS) until the earliest of the following:
 - (a) The ACO has fully repaid CMS any Shared Losses and Other Monies Owed for the Performance Year;
 - (b) CMS has exhausted the amount funded by the financial guarantee for the Performance Year and CMS determines that the ACO does not need to replenish the financial guarantee in accordance with paragraph 3.3; or
 - (c) CMS determines that the ACO does not owe any Shared Losses or Other Monies Owed under this Initiative for the Performance Year.

- 3.2. The ACO shall maintain its financial guarantee until the earlier of the following with respect to the final Performance Year:
 - (a) The date on which the settlement report for the final Performance Year, including any second AIPBP reconciliation for the final Performance Year, is deemed final, if such settlement report indicates that the ACO does not owe any Shared Losses or Other Monies Owed for any Performance Year; or
 - (b) The date on which the ACO makes payment in full for all Shared Losses or Other Monies Owed for any Performance Year.
- 3.3. If any portion of the financial guarantee is used to repay Shared Losses or Other Monies Owed to CMS for a Performance Year and the financial guarantee for the Performance Year must remain in effect in accordance with paragraph 3.1 or the financial guarantee funds multiple Performance Years, the ACO must, within 90 days of the date that CMS draws on the financial guarantee: (1) replenish the amount of its financial guarantee or establish another financial guarantee to ensure it maintains coverage equal to the amount required under paragraph 2.1; and (2) submit to CMS documentation demonstrating that it has complied with this provision.

4. Other requirements

- 4.1. **Beneficiary/Obligee:** The ACO shall designate CMS as the sole beneficiary or obligee of the financial guarantee. CMS's address is 7500 Security Boulevard, Baltimore, MD 21244.
- 4.2. **Condition for calling funds:** The financial guarantee should indicate that the ACO is obligated to repay money it owes to CMS as a result of participation in the Vermont Medicare ACO Initiative, citing the Vermont Medicare ACO Initiative Participation Agreement.

Example:

The ACO is obligated to repay money it owes to CMS under the Vermont Medicare ACO Initiative, as required by the Vermont Medicare ACO Initiative Participation Agreement. The amount of Shared Losses and/or Other Monies Owed will be noted in a demand letter to the ACO from CMS.
- 4.3. **Demand letter:** The financial guarantee must allow for payment to CMS in response to a demand letter from CMS.
- 4.4. **Account fees:** Account fees or other fees associated with establishing, maintaining, or cancelling a financial guarantee are the responsibility of the ACO and must not be paid out of the principal for the financial guarantee.

5. Requirements for specific financial guarantee mechanisms

5.1. Funds placed in Escrow

CMS and U.S. Bank National Association (“U.S. Bank”) have a standard escrow account agreement available for use between U.S. Bank, CMS, and third parties, where CMS is the recipient of funds held in escrow if payment is due to CMS. The ACO should contact the Vermont Medicare ACO Initiative to open a U.S. Bank escrow account.

If the ACO wants to establish an escrow account at a different institution, CMS must approve the escrow agreement and the instructions for disbursement of the assets. Generally, CMS will accept an escrow agreement with a different institution under the following conditions:

- (a) The funds are invested in Treasury-backed securities or a money market fund;
- (b) The instructions for disbursement of the assets are consistent with CMS' standard escrow instructions (see Escrow Instructions of Depositor in Exhibit A);
- (c) The costs, fees, and expenses associated with the escrow account, including any legal expenses incurred by the escrow agent or the ACO, are not borne by CMS and such costs are not charged to principal;
- (d) The principal cannot be encumbered for any purpose other than repaying Shared Losses and/or Other Monies Owed by the ACO to CMS;
- (e) CMS is not required to indemnify any person or entity against any loss, claim, damages, liabilities, or expenses, including the costs of litigation arising from the escrow agreement or the subject of the agreement;
- (f) CMS will receive advance notice of early termination of the escrow account and any change in the amount of funds held in escrow.

5.2. Letter of Credit

- (a) CMS will generally accept a Letter of Credit under the following conditions:
 - i. The letter of credit is irrevocable;
 - ii. CMS is designated as the sole beneficiary;
 - iii. The appropriate credit amount is specified;
 - iv. The terms allow an authorized official of CMS to draw on the letter of credit upon submission to the issuing bank of the following items: (a) a certification that "The amount of the drawing under this credit represents funds due to CMS from [ACO Name] under the Vermont Medicare ACO Initiative and which have remained unpaid for at least 30 days"; and (b) a copy of the appropriate written notice to the ACO of the amount owed; and
 - v. The letter must show that CMS will receive advance notice if there is any change in the amount of credit.
- (b) **Auto renewal clauses:** ACO must not use clauses providing for the automatic renewal of an irrevocable standby letter of credit to establish the required term. The ACO may, however, use these clauses to automatically renew the letter of credit for a period of time beyond the required term. If the ACO uses an auto renewal clause, it should state that the lender will notify CMS and the ACO at least 90 days in advance if electing not to renew.
- (c) **Sanctioned entity clauses:** The bank issuing the letter of credit must omit these clauses entirely, or, if included, exclude entities sanctioned by a federal health care program or by any federal agency.

5.3. Surety Bond

- (a) **Surety Companies:** The surety bond should be issued from a company included on the U.S. Department of Treasury's Listing of Certified (Surety Bond) Companies (https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm).
- (b) **Surety Bond Terms:** The bond must contain:
 - i. A statement that the surety is liable for assessments that occur during the term of the bond;

- ii. The surety's name, street address or post office box number, city, state, and zip code;
and
- iii. A statement naming the ACO as the Principal, CMS as the Obligee, and the surety
(and its heirs, executors, administrators, successors and assignees, jointly and
severally) as surety.

Exhibit A

Escrow Instructions of Depositor

- 1) Immediately upon deposit, all monies (“Assets”) held in the Account shall be invested by Agent in Treasury-backed securities. Upon deposit and at such other times as may be requested by Recipient, Agent shall notify Recipient of the date and amount of each deposit and other Account transaction.
- 2) Agent shall dispose of the Assets only upon written instruction from an authorized representative of Recipient. Such written instructions shall:
 - a) Identify the amount, if any, of Shared Losses and/or Other Monies Owed incurred by the Depositor for the relevant Performance Year, as determined by CMS and set forth in a final settlement report, as revised if applicable, issued by CMS pursuant to Section XIII.C of the Vermont Medicare ACO Initiative Participation Agreement.
 - b) Identify the amount of such Shared Losses and/or Other Monies Owed that Depositor has failed to pay (the “Debt”) within 30 days of the date of the settlement report.
 - c) Instruct Agent to convert the Assets to cash and pay the amount of the Debt to Recipient. If the Assets will be zero after delivering the amount of the Debt to Recipient, Agent shall notify Recipient, and Recipient shall provide further instructions, in consultation with Depositor, for the replenishment of assets or closure of the Account.
 - d) In the event of the expiration or termination of the Depositor’s Vermont Medicare ACO Initiative Participation Agreement or other circumstances requiring closure of the Account, the Depositor will notify the Agent and instruct Agent to convert the Assets to cash and dispose of them as follows:
 - i) If the Debt is zero, Agent shall return the full cash value of the Assets to Depositor, less Agent’s unpaid fees, costs and expenses.
 - ii) If the cash value of the Assets is less than or equal to the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the full cash value of the Assets.
 - iii) If the cash value of the Assets exceeds the amount of the Debt, Agent shall deliver to Recipient payment by check or wire transfer in the amount of the Debt and shall return the remaining Assets to Depositor, less Agent’s unpaid fees, costs and expenses.
- 3) Upon disposition of the Assets as specified in paragraph 2(d), Agent shall close the Account and the Escrow Agreement shall terminate.
- 4) Unless otherwise specified by written notice of the Parties, the following persons are authorized to provide instructions from Depositor or Recipient, as the case may be, to Agent, consistent with the terms of this Agreement:

Depositor

Name: _____

Specimen Signature

Title: _____

Recipient

Name: _____

Specimen Signature

Title: _____

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Appendix I - ACO Proprietary and Confidential Information

The following are specific examples, without limitation, of what the ACO considers proprietary and confidential information currently contained in its program that should not be publicly disclosed:

- 1)
- 2)
- 3)

In accordance with Section XV.D of the Agreement, this information shall remain the sole property of the ACO and, except as required by federal law, shall not be released by CMS without the express written consent of the ACO.

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**Appendix J - Alternative Payment Mechanism – All-Inclusive Population-Based Payments
(AIPBP)**

I. AIPBP Election

- A. To participate in AIPBP, the ACO must, by a time and in a manner specified by CMS, --
 - 2. Timely submit to CMS its selection of AIPBP as the Alternative Payment Mechanism for a Performance Year in accordance with Section X.A of this Agreement;
 - 3. Timely submit in accordance with Section IV of this Agreement a true, accurate, and complete list of Initiative Participants that have agreed to participate in AIPBP and a true, accurate, and complete list of Preferred Providers that have agreed to participate in AIPBP;
 - 4. Timely submit a fully executed “Vermont Medicare ACO Initiative: All-Inclusive Population-Based Payments Fee Reduction Agreement” (described in Section II.J of this Appendix) for each Initiative Participant and Preferred Provider that is identified as participating in AIPBP, as set forth on the lists submitted in accordance with Section I.A.2 of this Appendix;
 - 5. Timely submit by a date and in a manner specified by CMS a certification that the ACO has satisfied the notice and education requirement under Section II.B of this Appendix; and
 - 6. Timely submit by a date and in a manner specified by CMS a certification that the ACO has the necessary infrastructure to be able to pay its AIPBP-participating Initiative Participants and Preferred Providers promptly in accordance with Section III.G of this Appendix.
- A. CMS may reject the ACO’s selection to participate in AIPBP for a Performance Year if:
 - 1. CMS has identified any noncompliance with the terms of this Agreement, regardless of whether the ACO resolves the noncompliant activity;
 - 2. CMS has taken any remedial actions against the ACO in connection with its participation in another CMS initiative involving Medicare ACOs during either of the ACO’s last two performance years in that initiative;
 - 3. CMS determines on the basis of a program integrity screening or other information that the ACO’s participation in AIPBP might compromise the integrity of the Initiative;
 - 4. The ACO’s selection to participate in AIPBP is for the ACO’s first Performance Year participating in the Initiative and the ACO has not participated in any CMS initiative involving Medicare ACOs prior to its participation in the Initiative; or
 - 5. The ACO has failed to timely submit the documentation and certifications described in Section I.A of this Appendix
- B. CMS may prohibit the ACO from having an AIPBP Payment Arrangement (as defined in Section III of this Appendix) with an Initiative Participant or Preferred Provider if:

1. The conduct of the Initiative Participant or Preferred Provider has caused CMS to impose remedial action pursuant to Section XVIII of this Agreement or to impose a sanction under any CMS administrative authority; or
 2. CMS determines on the basis of a program integrity screening or other information that the Initiative Participant's or Preferred Provider's participation in AIPBP might compromise the integrity of the Initiative.
- C. If CMS rejects or later terminates the ACO's selection to participate in AIPBP for a Performance Year (in accordance with Section X.C or Section XVIII.A of this Agreement, respectively), payments to the ACO's Initiative Participants and Preferred Providers will default to traditional FFS for the Performance Year or the remainder of the Performance Year, as applicable.

II. AIPBP Fee Reduction

- A. [RESERVED]
- B. If the ACO has selected to participate in AIPBP for a Performance Year in accordance with Section I.A of this Appendix, the ACO shall, by a date specified by CMS, notify and educate all Initiative Participants and Preferred Providers about the ACO's intended participation in AIPBP and the associated AIPBP Fee Reduction. Providing a copy of the Vermont Medicare ACO Initiative: All-Inclusive Population-Based Payments Fee Reduction Agreement does not constitute notification and education for purposes of this requirement. If the ACO's selection to participate in AIPBP for a Performance Year is rejected or later terminated, the ACO shall notify all Initiative Participants and Preferred Providers that it is not participating in AIPBP for that Performance Year or the remainder of that Performance Year, as applicable.
- C. An Initiative Participant or Preferred Provider may participate in AIPBP for a Performance Year only if the Initiative Participant or Preferred Provider was included on the ACO's Participant List or Preferred Provider List, respectively, at the start of that Performance Year. Initiative Participants and Preferred Providers who were added to the ACO's Participant List or Preferred Provider List during a Performance Year may participate in AIPBP in a subsequent Performance Year only if they are included on the ACO's Participant List or Preferred Provider List at the start of the subsequent Performance Year.
- D. Not all Initiative Participants and Preferred Providers must agree to participate in AIPBP for the ACO to participate in AIPBP.
- E. Not all Initiative Participants and Preferred Providers billing under a TIN must agree to participate in AIPBP for other Initiative Participants and Preferred Providers billing under the same TIN to participate in AIPBP.
- F. CMS will reduce FFS payments on claims for services furnished to Initiative Beneficiaries by 100% only for those Initiative Participants and Preferred Providers that have consented to receive the AIPBP Fee Reduction pursuant to Section II.J of this Appendix and with whom the ACO is not prohibited under Section I.C of this Appendix from having an AIPBP Payment Arrangement.

- G. A hospital paid under the Inpatient Prospective Payment System that is an Initiative Participant or Preferred Provider that has agreed to receive the AIPBP Fee Reduction will continue to receive IME, DSH, inpatient outlier, and inpatient new technology add-on payments calculated in accordance with the applicable statutory and regulatory provisions.
- H. For certain types of institutional providers, such as Method II CAHs and FQHCs, that are Initiative Participants or Preferred Providers and are participating in AIPBP, CMS will reduce by 100% all FFS payments for services furnished to Initiative Beneficiaries that are billed under that institution's CCN and organizational NPI regardless of whether the individual NPIs rendering the service are Initiative Participants or Preferred Providers.
- I. CMS will not reduce FFS payments on claims for services furnished to Initiative Beneficiaries who elect to decline data sharing or for claims for services related to the diagnosis and treatment of substance use disorder furnished to Initiative Beneficiaries.
- J. Written Confirmation of Consent
 1. The ACO shall obtain written confirmation that each AIPBP-participating Initiative Participant and Preferred Provider has consented to receive the AIPBP Fee Reduction. Such written confirmation of consent must be in the form of a completed Vermont Medicare ACO Initiative: All-Inclusive Population-Based Payments Fee Reduction Agreement signed by an individual legally authorized to act for the entity through whose TIN the Initiative Participant or Preferred Provider bills Medicare.
 2. As part of the written confirmation of consent, the individual legally authorized to act for the entity through whose TIN the Initiative Participant or Preferred Provider bills Medicare must verify the accuracy of the list of Initiative Participants and Preferred Providers billing under that TIN that have affirmatively consented to receiving the AIPBP Fee Reduction.
 3. An Initiative Participant's or Preferred Provider's consent to receive the AIPBP Fee Reduction must apply for the full Performance Year and must be renewed annually in order for the Initiative Participant or Preferred Provider to continue to participate in AIPBP.
 4. Consent to participate in AIPBP by an Initiative Participant or Preferred Provider must be voluntary and must not be contingent on or related to receipt of referrals from the ACO, its Initiative Participants, or Preferred Providers.

III. AIPBP Payment Arrangements

- A. The ACO shall have a written payment arrangement with each AIPBP-participating Initiative Participant or Preferred Provider that establishes how the ACO will make payments to the AIPBP-participating Initiative Participant or Preferred Provider for Covered Services that are subject to the AIPBP Fee Reduction (“**AIPBP Payment Arrangement**”).
- B. In establishing the terms of any AIPBP Payment Arrangement, neither party gives or receives remuneration in return for or to induce business other than business covered by the AIPBP Payment Arrangement.

- C. The payments made by the ACO under an AIPBP Payment Arrangement may not be made knowingly to induce the AIPBP-participating Initiative Participant or Preferred Provider to reduce or limit Medically Necessary items or services to Beneficiaries.
- D. All payments made by the ACO for Covered Services under an AIPBP Payment Arrangement must be monetary payments that have been negotiated in good faith and are consistent with fair market value (which may be more or less than the Medicare payment amount for a given Medicare-reimbursable service).
- E. The ACO shall maintain, in accordance with Section XVII.B of the Agreement, records of all payments made or received pursuant to each AIPBP Payment Arrangement.
- F. The AIPBP Payment Arrangement must:
 - 1. Require the ACO to reimburse Initiative Participants and Preferred Providers for all Covered Services that Medicare would have otherwise paid for, but for the AIPBP Fee Reduction.
 - 2. Require the ACO to pay for Covered Services furnished by AIPBP-participating Initiative Participants and Preferred Providers no later than 30 days after receiving notice of the processed claim, as indicated on a weekly report from CMS to the ACO.
 - 3. Require the Initiative Participant or Preferred Provider to make Medically Necessary Covered Services available to Initiative Beneficiaries in accordance with all applicable laws and regulations.
 - 4. Prohibit the ACO from requiring prior authorization for services furnished to Initiative Beneficiaries.
 - 5. Prohibit the ACO and the Initiative Participant or Preferred Provider from interfering with an Initiative Beneficiary's freedom to receive Covered Services from the Medicare-enrolled provider or supplier of his or her choice, regardless of whether the provider or supplier is participating in AIPBP or with the ACO.
 - 6. Require the Initiative Participant or Preferred Provider to maintain records regarding the AIPBP Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section XVII.B of the Agreement.
 - 7. Require the Initiative Participant or Preferred Provider to provide the government with access to records regarding the AIPBP Payment Arrangement (including records of any payments made or received under the arrangement) in accordance with Section XVII.A of the Agreement.
- G. The ACO shall ensure that it has and will maintain the capability and funds to reimburse AIPBP-participating Initiative Participants and Preferred Providers for all Covered Services that they furnish, and that it will promptly make such payments in accordance with Section III.F.2 of this Appendix.
- H. The ACO shall, on a schedule and in a manner determined by CMS, report to CMS an accounting of the AIPBP payments received by the ACO from CMS and the payments made by the ACO to Initiative Participants and Preferred Providers.

IV. Beneficiary Disputes

- A. CMS will process all claims submitted by AIPBP-participating Initiative Participants and Preferred Providers, and assess coverage for such services and any Beneficiary liability using the same standards that apply under traditional Medicare fee-for-service.
- B. All disputes brought by Beneficiaries regarding denied claims will be adjudicated under the claims appeals process at 42 C.F.R. Part 405, subpart I.

V. Provider Payment Dispute Resolution

The ACO must establish procedures under which AIPBP-participating Initiative Participants and Preferred Providers may request reconsideration by the ACO of a payment determination. The procedures for requesting reconsideration must be included in the written AIPBP Payment Arrangement between the ACO and the AIPBP-participating Initiative Participant or Preferred Provider required under Section III.A of this Appendix.

VI. Calculation of the All-Inclusive Population-Based Payment

A. Overview

- 1. CMS shall calculate the Monthly AIPBP Payment in accordance with Section VI.B of this Appendix.
- 2. CMS will make a Monthly AIPBP Payment to the ACO for each month that the ACO participates in AIPBP during the Performance Year.
- 3. CMS shall not make any Monthly AIPBP Payments to the ACO after the effective date of the termination of this Agreement.
- 4. CMS shall not make any Monthly AIPBP Payments after the effective date of CMS' termination (in accordance with Section XVIII.A of this Agreement) of the ACO's selection to participate in AIPBP.

B. AIPBP Payment Calculation

1. Calibration Year FFS Expenditures Used to Estimate the Reduction in FFS Payments

To estimate the reduction in FFS payments to AIPBP-participating Initiative Participants and Preferred Providers for Part A and Part B services furnished to Initiative Beneficiaries during the applicable Performance Year, CMS will use the aggregate Part A and Part B payments made for services furnished to the applicable population of Beneficiaries (described in Section VI.B.2 of this Appendix) by all AIPBP-participating Initiative Participants and Preferred Providers during a calibration year. The calibration year is defined as claims paid and incurred January 1 through September 30 four years prior to the start of the Performance Year. For example, for Performance Year 1 (CY2019), the calibration year runs from January 1, 2014 through September 30, 2018.

2. Beneficiary Population Used to Estimate the Reduction in FFS Payments

To estimate the reduction in FFS payments to AIPBP-participating Initiative Participants and Preferred Providers for Performance Year 1 and subsequent Performance Years, CMS will use the population of Beneficiaries aligned to the ACO under the terms of this Agreement as of July 1 of the prior Performance Year for the upcoming Performance

Year. This population includes Beneficiaries who may be excluded from alignment to the ACO after July 1 of the applicable year because they did not meet alignment-eligibility requirements during every month of the applicable year.

3. Calculation of Total AIPBP Payment and Monthly AIPBP Payment

The total amount of AIPBP payments to the ACO for a Performance Year is equal to:

- i. The aggregate Part A and Part B payments made for services furnished by all AIPBP-participating Initiative Participants and Preferred Providers during the calibration year to the applicable population of Beneficiaries determined in accordance with Section VI.B.2 of this Appendix;
- ii. Multiplied by the ratio of the estimated number of Initiative Beneficiaries for the Performance Year to the number of Beneficiaries in the applicable population of Beneficiaries determined in accordance with Section VI.B.2 of this Appendix; and
- iii. Multiplied by 0.98 (i.e., reduced by 2%) if budget sequestration is in effect for the Performance Year.

The resulting amount is then divided by 12 to determine the “**Monthly AIPBP Payment.**”

C. AIPBP Payment Recalculation

1. Except as provided for in this Section VI.C of this Appendix, CMS will not recalculate the total amount of the AIPBP payment or the Monthly AIPBP Payment calculated under Section VI.B.3 of this Appendix during the applicable Performance Year.
2. CMS will review actual AIPBP Fee Reductions during the Performance Year. If during a Performance Year, data shows that the total Monthly AIPBP Payments received are at least 10% greater or at least 10% less than the total actual amount of AIPBP Fee Reductions taken, CMS may recalculate and revise the total amount of the AIPBP payment for the Performance Year and the amount of the Monthly AIPBP Payment calculated under Section VI.B.3 of this Appendix based on Performance Year data. Such revised amount may be adjusted to account for overpayment or underpayment of Monthly AIPBP Payments during the Performance Year. CMS will provide a report of the recalculated amounts to the ACO.

VII. Reconciliation of the Total Monthly AIPBP Payments

- A. Following each Performance Year the ACO participates in AIPBP, CMS will reconcile total Monthly AIPBP Payments with total amount of AIPBP Fee Reductions for such Performance Year by calculating the difference between the total amount of Monthly AIPBP Payments CMS paid to the ACO during the Performance Year and the total AIPBP Fee Reductions taken by CMS during the Performance Year. Any difference will constitute Other Monies Owed and may be subject to collection after settlement under Section XIV.C of this Agreement.

- B. The AIPBP Fee Reductions do not affect the calculation of Shared Savings or Shared Losses, which will continue to be based on the amount of the FFS payments that would have been made in the absence of the AIPBP Fee Reduction. The reconciliation of total Monthly AIPBP Payments and the total AIPBP Fee Reductions does not affect and is not affected by the ACO's selected Risk Arrangement or selected Savings/Losses Cap.
- C. CMS will include any Other Monies Owed, including Other Monies Owed due to the reconciliation of the total Monthly AIPBP Payments, on the settlement report issued under Section XVIII.C.1 of this Agreement, such that the settlement report will set forth the amount of Shared Savings or Shared Losses, the amount of Other Monies Owed by either CMS or the ACO, as well as the net amount owed by either CMS or the ACO.
- D. [RESERVED]
- E. [RESERVED]
- F. In the event that the ACO elects to terminate this Agreement pursuant to Section XVIII.C of the Agreement prior to the end of a Performance Year in which the ACO participates in AIPBP by providing notice to CMS on or before February 28 of that Performance Year with effect no later than 30 days from that notice, there will be no annual financial settlement for that Performance Year in accordance with Section XIII.C.1 of the Agreement, CMS will reconcile total onthly AIPBP Payments as part of a settlement reopening for a prior Performance Year, and the ACO must pay any Other Monies Owed to CMS in accordance with Section XIII.C.5 of the Agreement.
- G. CMS will include in the reconciliation of total Monthly AIPBP Payments any AIPBP Fee Reductions for services furnished to Beneficiaries who were aligned to the ACO at the time the services were furnished but were later excluded from the aligned population during the Performance Year because they did not meet alignment-eligibility requirements.
- H. Adjusted Settlement
 - 1. For each Performance Year in which the ACO participates in AIPBP, CMS shall conduct a second AIPBP reconciliation one year after the original AIPBP reconciliation at the same time that CMS issues the settlement report for the subsequent Performance Year.
 - 2. If, as a result of the second reconciliation of total Monthly AIPBP Payments, CMS determines that:
 - a. The total AIPBP Fee Reductions taken by CMS during the Performance Year exceed the total Monthly AIPBP Payments made to the ACO during the Performance Year, as reconciled during the initial reconciliation of total Monthly AIPBP Payments for the applicable Performance Year under Section VII.A of this Appendix, the difference will be deemed Other Monies Owed by CMS and included on the next settlement report;
 - b. The total Monthly AIPBP Payments made to the ACO during the Performance Year, as reconciled during the initial reconciliation of total Monthly AIPBP Payments for the applicable Performance Year under Section VII.A of this Appendix, exceeds the total AIPBP Fee Reductions during the Performance

Year, the difference will be deemed Other Monies Owed by the ACO and included on the next settlement report.

3. In the case of the final Performance Year of the Agreement Performance Period:
 - a. CMS will make reasonable efforts to conduct the second reconciliation of total Monthly AIPBP Payments within 12 months after the initial reconciliation of total Monthly AIPBP Payments described in Section VII.A of this Appendix;
 - b. CMS will issue an adjusted settlement report to the ACO setting forth the results of the second reconciliation of total Monthly AIPBP Payments and identifying any Other Monies Owed by the ACO to CMS, or by CMS to the ACO, as a result of this second reconciliation of total Monthly AIPBP Payments.
 - c. Any amounts owed by the ACO to CMS, or by CMS to the ACO, as a result of this second reconciliation of total Monthly AIPBP Payments will be payable in accordance with Section XIII.C of the Agreement.

**Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative**

Appendix K - Quality Measures

The following quality measures are the measures for use in establishing quality performance standards beginning with the first Performance Year of the Initiative (CY2019).

	ACO Measure #	Measure Title	Method of Data Submission	Pay for Performance Status R—Reporting; P—Performance
Access to Care	ACO – 1	CAHPS: Getting Timely Care, Appointments, and Information	Survey	P
	ACO – 2	CAHPS: How Well Your Providers Communicate	Survey	P
	ACO – 3	CAHPS: Patients' Rating of Provider	Survey	P
	ACO – 4	CAHPS: Access to Specialists	Survey	P
	ACO – 5	CAHPS: Health Promotion and Education	Survey	P
	ACO – 6	CAHPS: Shared Decision Making	Survey	P
	ACO – 7	CAHPS: Health Status/Functional Status	Survey	R
	ACO – 34	CAHPS: Stewardship of Patient Resources	Survey	R
Reduce Deaths Due to Drug Overdose and Suicide	ACO – 18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	CMS Web Interface	P
	VT – 1*	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims	R
	VT – 2*	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims	R
Reduce Prevalence of Chronic Disease for COPD, Hypertension, Diabetes	ACO - 27	Diabetes Hemoglobin (HbA1c) Poor Control (>9%)	CMS Web Interface	P
	ACO - 28	Hypertension: Controlling High Blood Pressure	CMS Web Interface	P
	ACO - 38	Risk-Standardized, Acute Admission Rate for Patients with Multiple Chronic Conditions	CMS Web Interface	P
	ACO – 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	P
Care Coordination/Patient Safety	ACO – 8	Risk-Standardized, All Condition Readmission	Claims	P
Preventive Health	ACO – 14	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	P
	ACO – 19	Colorectal Cancer Screening	CMS Web Interface	P

*These measures are not included in the [2019 Physician Fee Schedule final rule](#).

**Vermont All-Payer ACO Model
Vermont Medicare ACO Initiative**

HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet

I. 2019 Performance Year HIPAA-Covered Disclosure Request Attestation

The ACO requests the CMS data listed in the Data Specification Worksheet below for the 2019 Performance Year and makes the following assertions regarding its ability to meet the HIPAA requirements for receiving such data:

The ACO is (select one):

- A HIPAA Covered Entity (CE) as defined in 45 CFR § 160.103.
- The business associate (BA) of a HIPAA CE as defined in 45 CFR § 160.103.
- Neither a HIPAA CE nor a BA of a HIPAA CE.

The ACO is seeking protected health information (PHI), as defined in 45 CFR § 160.103 (select one):

- For its own use.
- On behalf of a CE for which the ACO is a BA.
- Other: Please attach a description of the intended purpose (e.g., for “research” purposes, for “public health” purposes, etc.).

The ACO requests :

- For the Medicare beneficiaries that have been aligned to the ACO under the Vermont Medicare ACO Initiative using the methodology described in the Vermont Medicare ACO Initiative Participation Agreement: (i) three years [2016-2018] of historical data files consisting of the data elements identified in the Data Specification Worksheet for Initiative Beneficiaries; and (ii) monthly claims data files for all Initiative Beneficiaries for the data elements identified in the Data Specification Worksheet, from the following CMS data files:

File	System of Record
HIGLAS - Payment Data	N/A
NLR - Meaningful Use Data	NCH (71 FR 67137 / 11/20/2006)
RAS - Risk Adjustment Data	IDR (71 FR 74915 / 12/13/2006)
CAHPS - Beneficiary Survey Data	IDR (71 FR 74915 / 12/13/2006)
GPRO - Quality Measurement Data	NCH (71 FR 67137 / 11/20/2006)
NPICS - NPI Crosswalk	NPS (63 FR 40297 / 7/28/1998)
PECOS - Provider Enrollment Data	PECOS (71 FR 60536/ 10/13/2006)
CME - Beneficiary Enrollment Data	EDB (73 FR 10249 / 2/26/2008)
IDR - Parts A, B, and D Claims	IDR (71 FR 74915 / 12/13/2006)

Other: Please attach a detailed description of the data requested.

The ACO intends to use the requested data to carry out (select one):

- "Health care operations" that fall within the first and second paragraphs of the definition of that phrase under the HIPAA Privacy Rule (45 CFR § 164.501).
- Other: Please attach a description of the intended purpose (e.g., for "research" purposes, for "public health" purposes, etc.).

The data requested is (select one):

- The "minimum necessary" (as defined at 45 CFR § 164.502) to carry out the health care operations activities described above.
- Other: Please attach a description of how (if applicable) the data requested exceeds what is needed to carry out the work described above.

This HIPAA-Covered Disclosure Request Attestation supersedes all such prior attestations made by the ACO to CMS at any time during its participation in the Vermont All-Payer ACO Model.

The ACO's data custodian for the requested data is: Sara Barry
 (name)
802-847-0932
 (phone number)

By: 

Date: 12/21/10

Todd B. Moore
 Name of authorized signatory
CEO
 Title

II. Data Specification Worksheet

Data Element Source	Data Element	Data Element Description
Part A Claims	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim

	40=Outpatient claim
	50=Hospice claim
	60=Inpatient claim
	61=Inpatient "Full-Encounter" claim
Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
Claim Bill Facility Type Code	<p>The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are:</p> <p>1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved</p>
Claim Bill Facility Type Code	<p>The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are:</p> <p>1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved</p>
Claim Bill Classification Code	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital).
Principal Diagnosis Code	The International Classification of Diseases (ICD)-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
Admitting Diagnosis Code	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted.
Claim Medicare Non Payment Reason Code	Indicates the reason payment on an institutional claim is denied.
Claim Payment Amount	Amount that Medicare paid on the claim.
Claim NCH Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer.
Federal Information Processing Standards FIPS State Code	Identifies the state where the facility providing services is located.
Beneficiary Patient Status Code	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death).
Diagnosis Related Group Code	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes.
Claim Outpatient Service Type Code	<p>Indicates the type and priority of outpatient service. Claim Outpatient Service Type Codes are:</p> <p>0=Blank 1=Emergency</p>

		2=Urgent
		3=Elective
		5-8=Reserved
		9=Unknown
Facility Provider NPI Number		Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
Operating Provider NPI Number		Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.
Attending Provider NPI Number		Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.
Other Provider NPI Number		Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
Claim Adjustment Type Code		Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)
Claim Effective Date		Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.
Claim IDR Load Date		When the claim was loaded into the IDR.
Beneficiary Equitable BIC HICN Number		This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
Claim Admission Type Code		Indicates the type and priority of inpatient services.
		Claim Admission Type Codes are:
		0=Blank
		1=Emergency
		2=Urgent
		3=Elective
		4=Newborn
		5=Trauma Center
		6-8=Reserved
	9=Unknown	
Claim Admission Source Code		Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Find Admission Source Codes here: http://www.resdac.org/cms-data/variables/Claim-Source-Inpatient-Admission-Code
Claim Bill Frequency Code		The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided). Find Claim Frequency Codes here: http://www.resdac.org/cms-data/variables/Claim-Frequency-Code .
Claim Query Code		Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator).
		Claim Query Codes are:
		0=Credit adjustment
		1=Interim bill
		2=HHA benefits exhausted
		3=Final bill
	4=Discharge notice	
	5=Debit adjustment	
Beneficiary Surrogate Key		A IDR assigned surrogate key used to uniquely identify a beneficiary
ACO Identifier		The unique identifier of an ACO
Calendar Century Year Month Number		The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
Meta Process Date		The date the CCLF process loaded the historical record in the table
Part A Claims Revenue Center Details	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line

	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
	60=Inpatient claim	
	61=Inpatient "Full-Encounter" claim	
	Claim Line From Date	The date the service associated with the line item began.
	Claim Line Thru Date	The date the service associated with the line item ended.
	Product Revenue Center Code	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).
	Claim Line Institutional Revenue Center Date	The date that applies to the service associated with the Revenue Center code.
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Procedure Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
10=HHA claim		
	20=Non swing bed SNF claim	

		30=Swing bed SNF claim
		40=Outpatient claim
		50=Hospice claim
		60=Inpatient claim
		61=Inpatient "Full-Encounter" claim
	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Procedure Code	The ICD-9/10 code that indicates the procedure performed during the period covered by the claim.
	Procedure Performed Date	The date the indicated procedure was performed.
	Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.
	Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part A Diagnosis Codes	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Value Sequence Number	An arbitrary sequential number that uniquely identifies a procedure code record within the claim.
	Claim Product Type Code	Codes classifying the diagnosis category:
		E=Accident diagnosis code
		1=First diagnosis E code
		D=Other diagnosis codes
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
		10=HHA claim
		20=Non swing bed SNF claim
		30=Swing bed SNF claim
		40=Outpatient claim
50=Hospice claim		
60=Inpatient claim		
	61=Inpatient "Full-Encounter" claim	
Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's illness or disability.	
Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level. For example, if a beneficiary's spouse becomes widowed, the HICN will change, but the Beneficiary Equitable BIC HICN will not. This groups the pre- and post-widow status HICNs together. Note that the ONLY use of this field is to link together claims that all represent the same event, using the natural key.	
Provider OSCAR Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.	
Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
	Also known as "Statement Covers From Date."	
Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.	
Claim Present on Admission Indicator	Indicates whether a patient had the condition listed on the claim line at the time of admission to the facility. Find Present-on-Admission values here:	

	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
	ACO Identifier	The unique identifier of an ACO	
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.	
	Meta Process Date	The date the CCLF process loaded the historical record in the table	
Part B Physicians	Current Claim Unique Identifier	A unique identification number assigned to the claim.	
	Claim Line Number	A sequential number that identifies a specific claim line	
	Beneficiary HIC Number	A beneficiary identifier.	
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.	
		Claim type codes are:	
		10=HHA claim	
		20=Non swing bed SNF claim	
		30=Swing bed SNF claim	
		40=Outpatient claim	
		61=Inpatient "Full-Encounter" claim	
	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
	Provider Type Code	Identifies the type of Provider Identifier.	
	Rendering Provider FIPS State Code	Identifies the state that the provider providing the service is located in.	
	Claim Rendering Federal Provider Specialty Code	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item.	
	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.	
	Claim Line From Date	The date the service associated with the line item began.	
	Claim Line Thru Date	The date the service associated with the line item ended.	
	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.	
	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.	
	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code.	
Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.		
Claim Provider Tax Number	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.		
Rendering Provider NPI Number	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.		
Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.		
Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.		
Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)		
Claim Effective Date	Date the claim was processed and added to the NCH.		

	Claim IDR Load Date	When the claim was loaded into the IDR.
	Claim Control Number	A unique number assigned to a claim by the Medicare carrier.
	Beneficiary Equitable BIC HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.
	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.
	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
	Claim Disposition Code	Information regarding payment actions on the claim.
		Claim Disposition Codes are:
		01=Debit accepted
		02=Debit accepted (automatic adjustment)
		03=Cancel accepted
	Claim Diagnosis First Code	The first of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Second Code	The second of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Third Code	The third of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Fourth Code	The fourth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Fifth Code	The fifth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Sixth Code	The sixth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Seventh Code	The seventh of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Claim Diagnosis Eighth Code	The eighth of eight allowable ICD-9/10 diagnosis codes identifying the beneficiary’s illness or disability.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Part B DMEs	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Claim Line Number	A sequential number that identifies a specific claim line
	Beneficiary HIC Number	A beneficiary identifier.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
		Claim type codes are:
10=HHA claim		
20=Non swing bed SNF claim		
	30=Swing bed SNF claim	
	40=Outpatient claim	

	50=Hospice claim	
	60=Inpatient claim	
	61=Inpatient "Full-Encounter" claim	
Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.	
Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.	
Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.	
Claim Place of Service Code	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual.	
Claim Line From Date	The date the service associated with the line item began.	
Claim Line Thru Date	The date the service associated with the line item ended.	
HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.	
Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.	
Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer.	
Pay to Provider NPI Number	A number that identifies the provider billing for the indicated service on the claim line. Each provider is assigned its own unique NPI.	
Ordering Provider NPI Number	A number that identifies the provider ordering the indicated service on the claim line. Each provider is assigned its own unique NPI.	
Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied. Find Carrier Payment Denial Codes here:	
Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.	
Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)	
Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.	
Claim IDR Load Date	When the claim was loaded into the IDR.	
Claim Control Number	A unique number assigned to a claim by the Medicare carrier.	
Beneficiary Equitable BIC HICN Number	This number is an "umbrella" HICN that groups certain HICNs together at the beneficiary level.	
Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.	
Claim Disposition Code	Information regarding payment actions on the claim.	
	Claim Disposition Codes are:	
	01=Debit accepted	
	02=Debit accepted (automatic adjustment)	
	03=Cancel accepted	
Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
ACO Identifier	The unique identifier of an ACO	
Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'.	
Meta Process Date	The date the CCLF process loaded the historical record in the table	
Part D	Current Claim Unique Identifier	A unique identification number assigned to the claim.
	Beneficiary HIC Number	A beneficiary identifier.
	NDC Code	A universal unique product identifier for human drugs.
	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.

	<p>Claim type codes are:</p> <p>10=HHA claim</p> <p>20=Non swing bed SNF claim</p> <p>30=Swing bed SNF claim</p> <p>40=Outpatient claim</p> <p>50=Hospice claim</p> <p>60=Inpatient claim</p> <p>61=Inpatient "Full-Encounter" claim</p>
Claim Line From Date	The date the service associated with the line item began.
Provider Service Identifier Qualifier Code	<p>Indicates the type of number used to identify the pharmacy providing the services:</p> <p>01= NPI Number</p> <p>06=Unique Physician Identification Number (UPIN)</p> <p>07=National Council for Prescription Drug Programs (NCPDP) Number</p> <p>08=State License Number</p> <p>11=TIN</p> <p>99=Other mandatory for Standard Data Format</p>
Claim Service Provider Generic ID Number	The number associated with the indicated code in the Provider Service Identification Qualifier Code field.
Claim Dispensing Status Code	<p>Indicates the status of prescription fulfillment.</p> <p>Dispensing Codes are:</p> <p>P=Partially filled</p> <p>C=Completely filled</p>
Claim Dispense as Written DAW Product Selection Code	<p>Indicates the prescriber's instructions regarding generic substitution or how those instructions were followed.</p> <p>DAW Product Selection Codes are:</p> <p>0=No product selection indicated</p> <p>1=Substitution not allowed by prescriber</p> <p>2=Substitution allowed – Patient requested that brand be dispensed</p> <p>3=Substitution allowed – Pharmacist selected product dispensed</p> <p>4=Substitution allowed – Generic not in stock</p> <p>5=Substitution allowed – Brand drug dispensed as generic</p> <p>6=Override</p> <p>7=Substitution not allowed – Brand drug mandated by law</p> <p>8=Substitution allowed – Generic drug not available in marketplace</p> <p>9=Other</p>
Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
Claim Line Days' Supply Quantity	The number of days the supply of medication dispensed by the pharmacy will cover.
Provider Prescribing ID Qualifier Code	<p>The number of days the supply of medication dispensed by the pharmacy will cover.</p> <p>Indicates the type of number used to identify the prescribing provider:</p> <p>01= NPI Number</p> <p>06= UPIN</p> <p>07= NCPDP Number</p> <p>08=State License Number</p> <p>11=TIN</p> <p>99=Other mandatory for Standard Data Format</p>
Claim Prescribing Provider Generic ID Number	The number associated with the indicated code in the Provider Prescribing Service Identification Qualifier Code field.
Claim Line Beneficiary Payment Amount	The dollar amount paid by the beneficiary that is not reimbursed by a third party (e.g., copayments, coinsurance, deductible or other patient pay amounts).
Claim Adjustment Type Code	Claim adjustment types (Original, Adjustment, Deleted, Resubmitted, etc.)

	Claim Effective Date	Date the claim was processed and added to the NCH. Also referred to as the NCH Weekly Processing Date.	
	Claim IDR Load Date	When the claim was loaded into the IDR.	
	Claim Line Prescription Service Reference Number	Identifies a prescription dispensed by a particular service provider on a particular service date.	
	Claim Line Prescription Fill Number	Assigned to the current dispensed supply by the pharmacy. It designates the sequential order of the original fill or subsequent refills of a prescription.	
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary	
	ACO Identifier	The unique identifier of an ACO	
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.	
	Meta Process Date	The date the CCLF process loaded the historical record in the table	
Beneficiary Demographics	Beneficiary HICN Number	This number is an “umbrella” HICN that groups certain HICNs together at the beneficiary level.	
	Beneficiary FIPS State Code	Identifies the state where the beneficiary receiving services resides.	
	Beneficiary FIPS County Code	Identifies the county where the beneficiary receiving services resides.	
	Beneficiary ZIP Code	The beneficiary’s ZIP code as indicated in their Medicare enrollment record.	
	Beneficiary Date of Birth	The month, day, and year of the beneficiary’s birth.	
	Beneficiary Sex Code	The beneficiary’s sex:	
		1=Male	
		2=Female	
	Beneficiary Race Code	0=Unknown	
		The beneficiary's race:	
		0=Unknown	
		1=White	
		2=Black	
		3=Other	
	Beneficiary Age	4=Asian	
5=Hispanic			
6=North American Native			
The beneficiary’s current age, as calculated by subtracting the beneficiary’s date of birth from the current date.			
Beneficiary Medicare Status Code	Indicates the reason for a beneficiary's entitlement to Medicare benefits as of a particular date, broken down by the following categories: Old Age & Survivors Insurance (OASI), Disabled, and End Stage Renal Disease (ESRD), and by appropriate combinations of these categories:		
	10=Aged without ESRD		
	11=Aged with ESRD		
	20=Disabled without ESRD		
	21=Disabled with ESRD		
31=ESRD only			
Beneficiary Dual Status Code	Identifies the most recent entitlement status of beneficiaries eligible for a program(s) in addition to Medicare (e.g., Medicaid).		
Beneficiary Death Date	The month, day, and year of a beneficiary’s death.		
Date beneficiary enrolled in Hospice	The date the beneficiary enrolled in Hospice.		
Date beneficiary ended Hospice	The date the beneficiary is-enrolled in hospice.		
Beneficiary First Name	The first name of the beneficiary.		

	Beneficiary Middle Name	The middle name of the beneficiary.
	Beneficiary Last Name	The last name of the beneficiary.
	Beneficiary Original Entitlement Reason Code	Original Reason for the beneficiary's entitlement to Medicare Benefits.
		Values are:
		0 Beneficiary insured due to age (OASI);
		1 Beneficiary insured due to disability;
		2 Beneficiary insured due to End Stage; Renal Disease (ESRD);
		3 Beneficiary insured due to disability and current ESRD.
		4. None of the above
	Beneficiary Entitlement Buy In Indicator	Indicates for each month of the Denominator reference year, the entitlement of the beneficiary to Medicare Part A, Medicare Part B, or Medicare Parts A and B both, as well as whether or not the beneficiary's state of residence was liable and paid for the beneficiary's Medicare Part B monthly premiums.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Beneficiary XREF	Current HIC Number	A beneficiary identifier.
	Previous HIC Number	The HICN that appears in this field is the beneficiary's previous HICN.
	Previous HICN Effective Date	The date the previous HICN became active.
	Previous HICN Obsolete Date	The date the previous HICN ceased to be active.
	Beneficiary Railroad Board Number	The external (to Medicare) HICN for beneficiaries that are RRB members.
	Beneficiary Surrogate Key	A IDR assigned surrogate key used to uniquely identify a beneficiary
	ACO Identifier	The unique identifier of an ACO
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
Summary Statistics	ACO Identifier	The unique identifier of an ACO
	File Type	The CCLF File Type
	Calendar Century Year Month Number	The year and calendar month number combination in the format 'YYYYMM'. e.g. 200701, 200702, etc.
	Meta Process Date	The date the CCLF process loaded the historical record in the table
	File Description	The description of the CCLF File
	Total Records Count	The total number of records in the file
	Record Length	The length of the record for the file
	File Name	The name the CCLF extract file that was sent to be swept by the EFT process