

Draft Vermont All-Payer Accountable Care Organization Model Agreement

SUMMARY

This draft is under legal review by the State of Vermont and the Green Mountain Care Board. Please expect clarifying changes in language as well as technical legal corrections.

Section	Description
Preamble	Overview of the parties and the purpose of the Agreement.
1 — Definitions	This section defines key terms in the agreement.
2 — Agreement Term	The agreement is effective as of the dates that all the parties sign. The model is 6 years long. It begins on January 1, 2017 and ends on December 31, 2022.
3 — Legal Authority	<p>The Centers for Medicare and Medicaid (CMS) has the federal authority to test this type of model. CMS has the authority to waive certain federal laws in a separate waiver document, including fraud and abuse laws that are based on a fee-for-service payment model involving uncoordinated care. Medicaid and Medicare shall remain the same except for the provider payment portions that may be changed under waiver.</p> <p>Vermont has the legal authority to enact payment and provider delivery system reform and has legal authority to enter into this agreement. NOTE: Vermont cannot waive fraud and abuse laws, but these laws are modeled off of federal law, and Vermont will be in compliance with state fraud and abuse laws if it follows federal fraud and abuse laws or waivers thereof.</p> <p>Vermont Medicaid has requested the authority to participate in this agreement under its Global Commitment waiver. Vermont has verbal agreement with the Center for Medicaid and CHIP Services (CMCS) and is waiting for a complete set of draft terms from CMCS.</p>
4 — ACO Scale Targets	This section sets targets for the percentage of people participating in All-Payer ACO programs and for the percentage of people participating in Vermont Medicare ACO programs over the course of the Agreement. The section also indicates which types of programs count for the scale targets and the calculation methodology.
5 — Statewide Health Outcomes and Quality of Care Targets	<p>The population-level health outcomes targets, health care delivery system quality targets, and process milestones are contained in Appendix 1.</p> <p>This section sets out the process for making changes to the Agreement through a corrective action plan if Vermont is not meeting the outcomes and quality targets.</p>
6 — Statewide Financial Targets	<p>The All-Payer Total Cost of Care per Beneficiary Growth Target is set at 3.5% and the Medicare Total Cost of Care per Beneficiary Growth Target is set at .2% under national growth.</p> <p>This section describes these retrospective calculation methods for</p>

	<p>determining performance under this Agreement, including the formulas and adjustments.</p> <p>Lastly, this section sets out the process for making changes to the Agreement through a corrective action plan if Vermont is not meeting the targets.</p>
7 — Vermont Medicare ACO Initiative	Under this Agreement, CMS and Vermont will design and launch a state-specific ACO Initiative on January 1, 2019. Prior to that date, CMS and Vermont will offer Modified Next Generation models under Medicare. This section outlines CMS’ duties and the duties of the GMCB in setting a prospective growth rate.
8 — Payer Differential	<p>This section provides a hold harmless provision for Vermont, if the state chooses to increase Medicaid reimbursement rates to health care providers by excluding these rate increases from the growth target.</p> <p>This section also ensures that Medicaid beneficiaries receive the same access to services under an ACO as other beneficiaries.</p>
9 — One Time Funding	This section and Appendix 2 provide for \$9.5M of funding in 2017 to the State for continuation of Medicare’s participation in: the Blueprint for Health, Services and Supports at Home (SASH), and for ACO infrastructure. This funding is built into the Medicare payments starting in 2018.
10 — Medicaid Behavior Health and Long-Term Services and Supports	<p>By the end of 2019, Vermont will propose a plan for including these services in the All-Payer Financial Target if the Agreement is renewed.</p> <p>Please note that the term “behavior health” is the federal legally defined term. Vermont uses mental health and substance use disorder.</p>
11 — Proposal for Subsequent Agreement	This section provides that Vermont would submit a renewal proposal by December 31, 2021 if the State would like to continue the All-Payer Model.
12 — Medicare Beneficiary Protections	Medicare beneficiaries retain protections afforded to them under federal law.
13 & 14 — Payment Waivers	Specific payment waivers will be negotiated in a separate agreement and may be revoked if Vermont does not comply with this Agreement.
15 — Data Sharing	Vermont and CMS will share data related to this model. Please note that this section will be modified to clarify that only data provided by self-insured employers who elect to participate will be shared; in compliance with ERISA.
16 — Confidentiality	Vermont will protect the confidentiality of Medicare and Medicaid beneficiaries in compliance with federal and state law.
17 — Model Evaluation	CMS and Vermont will both perform evaluations of the All-Payer Model.
18 — CMS Monitoring	CMS may monitor compliance with this Agreement.
19 — Maintenance of Records	The state will maintain records for a set period of time and provide access to the federal government.
20 — Modification	This section provides for an amendment process.
21 — Termination & Correction Action	This section provides for termination of the agreement by either party and also sets forth the process for corrective action if the state is not in compliance with the Agreement.
22 — Review & Dispute Resolution	This section describes the limits on judicial review and the process for dispute resolution.
23 — Severability	This is a technical legal section.

24 — Agency Notification	This section has names and addresses for submitting notices and reports. It will be revised to reflect positions, not solely names of parties.
25 — Entire Agreement 26 — Precedence	These are technical legal sections about interpreting the agreement.
Appendix 1	The quality measures are set forth in detail in this Appendix.
Appendix 2	The parameters for Blueprint and SASH covered services are provided for in this section.

VERMONT ALL-PAYER ACCOUNTABLE CARE ORGANIZATION MODEL AGREEMENT

This Vermont All-Payer Accountable Care Organization (“ACO”) Model Agreement (“Agreement”) is dated _____, 2016, and is between the Centers for Medicare & Medicaid Services (“CMS”) and the Governor of Vermont, the Green Mountain Care Board (“GMCB”), and the Vermont Agency of Human Services (“AHS”) (collectively, “State” or “Vermont”).

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

The GMCB is a legislatively created independent entity responsible for ensuring that changes in Vermont’s health system improve quality while stabilizing costs. The GMCB is an independent body that has broad Vermont healthcare regulatory authority to improve the health of Vermonters and control the rate of growth in healthcare costs. The GMCB’s regulatory authority includes payment and delivery system reform oversight, provider rate-setting, health information technology (“HIT”) plan approval, workforce plan approval, hospital budget approval, insurer rate increase approval, certificate of need issuance, and oversight of the State’s all-payer claims database (“APCD”). The GMCB does not have regulatory authority over self-insured, Medicare Advantage, federal employee, tri-care, or other military coverage plans, though GMCB does exercise regulatory authority over all Vermont acute care hospital revenue regardless of payer.

The Vermont Agency of Human Services is the State’s entity charged with administering Vermont’s Medicaid program.

Through the Vermont All-Payer ACO Model (“Model”), CMS will 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) the aforementioned payers offer Vermont ACOs (ACOs operating primarily in Vermont, defined further below) aligned risk-based arrangements tied to health outcomes and healthcare expenditures; b) the majority of Vermont providers and/or suppliers enter into such risk-based arrangements; and c) the majority of Vermont residents across payers are aligned to an ACO bound by such arrangements. As part of the All-Payer ACO Model, the Vermont ACO will participate in a modified version of the Next Generation ACO Model for Performance Year 1 of the Model and then in the Vermont Medicare ACO Initiative for Performance Years 2 through 5. The Vermont Medicare ACO Initiative shall be initiated under a separately executed Vermont Medicare ACO Initiative Participation Agreement to be effective starting in Performance Year 2.

The success of the Model will be dependent on effective collaboration and partnership between CMS and the State. The parties expect to work closely together throughout the duration of the Model.

The parties therefore agree as follows:

1. **Definitions.**

- a. **“Accountable Care Organization” or “ACO”** means an entity, formed by certain health care providers and/or suppliers that accepts financial accountability for the overall quality and cost of medical care furnished to, and health of, beneficiaries aligned to the entity.
- b. **“ACO Benchmark”** means a payer-specific financial target against which the expenditures for healthcare services furnished to an ACO-aligned beneficiary will be assessed. Payer-specific Shared Savings and Shared Losses for an ACO will be determined based on this assessment.
- c. **“All-payer(s)”** means Medicare FFS, Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans.
- d. **“All-payer Total Cost of Care per Beneficiary”** means the expenditures associated with All-payer Financial Target Services provided to Vermont All-payer Beneficiaries for any given year divided by the count of Vermont All-payer Beneficiaries for the same Performance Year.
- e. **“All-payer Total Cost of Care per Beneficiary Growth”** means the growth rate for All-payer Total Cost of Care per Beneficiary as calculated in accordance with section 6.a.
- f. **“All-payer Financial Target Services”** means the Medicare Financial Target Services along with the following categories of services for Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans: acute hospital inpatient and outpatient care, post-acute care, professional services, and durable medical equipment. All-payer Financial Target Services excludes Vermont Commercial Plan, Vermont Self-insured Plan, and Vermont Medicaid dental services; Medicaid Behavioral Health Services; and Medicaid Home and Community-based Services. All-payer Financial Target Services excludes Medicaid Long-Term Institutional Services for PY1-3 but includes Medicaid Long-Term Institutional Services for PY4-5. All-payer Financial Target Services includes services that are provided outside of Vermont.
- g. **“Medicaid Behavioral Health Services”** means mental health and substance use disorder services covered under Vermont Medicaid.
- h. **“Medicaid Home and Community-based Services”** means services captured under Medicaid Long-Term Services and Support that are delivered via home and community-based settings. These exclude Medicaid Long-Term Services and Support delivered via institutional (e.g., nursing home) settings.
- i. **“Medicaid Long-Term Institutional Services”** means services captured under Vermont’s

Medicaid Long-Term Institutional Services that are delivered via institutional settings. These exclude Medicaid Long-Term Services and Support delivered via home and community-based settings.

- j. **“Medicaid Long-Term Services and Support”** means Medicaid reimbursed services delivered via institutional and home and community-based settings that encompass assistance with daily self-care tasks. These include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, and transportation paid for by Vermont Medicaid.
- k. **“Medicare Fee-for-Service (“Medicare FFS”)** means Medicare Part A and Part B, and not Medicare Parts C or D.
- l. **“Medicare Financial Target Services”** means all Medicare Part A and Part B services. Medicare Financial Target Services include services that are provided outside of Vermont. This includes benefit enhancements authorized under the Next Generation ACO Model and the Vermont Medicare ACO Initiative. Medicare Part C and Part D services are excluded.
- m. **“Medicare Advantage United States Per Capita Costs Fee-for-Service Projections (“MA USPCC FFS Projections”)** means projected Medicare FFS per beneficiary expenditure growth published annually by the CMS Office of the Actuary around April in the CMS announcements of Medicare Advantage payment rates.
- n. **“National Medicare Beneficiary”** means a Medicare FFS beneficiary enrolled for benefits under Part A and Part B, but not Part C, who resides in one of the U.S. 50 states or the District of Columbia.
- o. **“National Medicare Total Cost of Care per Beneficiary”** means the expenditures associated with Medicare Financial Target Services provided to National Medicare Beneficiaries for any given Performance Year divided by the count of National Medicare Beneficiaries for the same Performance Year.
- p. **“National Medicare Total Cost of Care per Beneficiary Growth”** means the compounded annualized growth rate for National Medicare Total Cost of Care per Beneficiary.
- q. **“NQF”** means National Quality Forum.
- r. **“Payer Differential”** means the different levels of payments made to providers by Medicare FFS, Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans for similar sets of services. The Payer Differential may be articulated in equivalent manners, such as

different ACO/provider profit margins by payer.

- s. **“Performance Period”** means the six Performance Years this Agreement will be in effect. The Performance Period of this Model will begin on January 1, 2017, and will end at 11:59PM (EST) on December 31, 2022, unless this Agreement is sooner terminated in accordance with Section 21 and in which case the Performance Period concludes on the effective date of termination.
- t. **“Performance Year (“PY”)**” means the 12-month period beginning on January 1 of each year during the Performance Period of this Agreement. The first Performance Year is Performance Year 0 (2017), and the last Performance is Performance Year 5 (2022).
- u. **“Projected National Medicare Total Cost of Care per Beneficiary Growth”** means the growth rate for MA USPCC FFS Projections, as calculated in accordance with section 6.b.i.2.
- v. **“Shared Losses”** means the monetary amount owed to a payer by an ACO as determined by comparing the ACO’s expenditures for aligned beneficiaries against the ACO’s benchmark for that payer.
- w. **“Shared Savings”** means the monetary amount owed to an ACO by a payer as determined by comparing the ACO’s expenditures for aligned beneficiaries against the ACO’s benchmark for that payer.
- x. **“Vermont ACO”** means an ACO primarily operating in Vermont that has contracts with Vermont Medicaid, Vermont Commercial Plans, and/or Vermont Self-insured Plans, and/or has contracts under the Medicare Shared Savings Program or the Next Generation ACO Model.
- y. **“Vermont All-payer Beneficiary”** means a Vermont resident who is also a Vermont Medicare Beneficiary or enrolled in Vermont Medicaid, a Vermont Commercial Plan, or a Vermont Self-Insured Plan.
- z. **“Vermont All-payer Scale Target Beneficiary”** means a Vermont resident who is also a Vermont Medicare Beneficiary or enrolled in Vermont Medicaid, a Vermont Commercial Plan, or a Vermont Self-insured Scale Target Plan.
- aa. **“Vermont Commercial Plan”** means health insurance plans offered on the Vermont health benefits exchange, Medicare Advantage plans covering Vermont residents, and large employer group insurance plans for employers operating in Vermont. This will exclude other employer-based plans for employers operating outside of Vermont.
- bb. **“Vermont Medicaid”** means the program of medical assistance benefits under Title XIX of the Social Security Act, as modified by demonstrations and waivers thereof under Section 1115 of the Social Security Act, operated by the State to provide health coverage to eligible Vermont

residents and to provide other investments consistent with the terms and conditions of that waiver. This excludes assistance for Vermont residents who receive pharmacy benefits but no other medical benefits under Title XIX of the Social Security Act.

- cc. **“Vermont Medicare ACO Initiative” or “Initiative”** is the ACO initiative that will be initiated in Performance Years 2 through 5 of this Model and executed under a Vermont Medicare ACO Initiative Participation Agreement, as described in section 7.
- dd. **“Vermont Medicare ACO Initiative Benchmarks”** means the financial ACO Benchmarks applicable to VMA ACOs and Vermont Modified Next Generation ACOs.
- ee. **“Vermont Medicare Beneficiary”** means a Vermont resident Medicare FFS beneficiary enrolled for benefits under Part A and/or Part B, but not enrolled for benefits under Part C.
- ff. **“Vermont Medicare Total Cost of Care per Beneficiary”** means the expenditures associated with Medicare Financial Target Services provided to Vermont Medicare Beneficiaries for any given Performance Year divided by the count of Vermont Medicare Beneficiaries for the same Performance Year. As described further in section 6.b.i, the Vermont Medicare Beneficiaries included in the calculation of Vermont Medicare Total Cost of Care per Beneficiary will transition over the Performance Period from Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives to all Vermont Medicare Beneficiaries regardless of alignment to Scale Target ACO Initiatives.
- gg. **“Vermont Medicare Total Cost of Care per Beneficiary Growth”** means the growth rate for Vermont Medicare Total Cost of Care per Beneficiary, as calculated in accordance with section 6.b.i.1.
- hh. **“Vermont Modified Next Generation ACO”** means an ACO participating in the Next Generation ACO Model that has the majority of its ACO aligned Medicare beneficiaries residing in Vermont as of the start date of Performance Year 1 of the Vermont All-Payer ACO Model. The Participation Agreement for Vermont Modified Next Generation ACOs will be amended to specify that the GMCB shall have a role in developing the Vermont Medicare ACO Initiative Benchmark.
- ii. **“VMA ACO”** means an ACO participating in the Vermont Medicare ACO Initiative for Performance Years 2 through 5.
- jj. **“Vermont Self-insured Plan”** means health benefits provided to a Vermont resident by an employer operating in Vermont who is self-insured, including the State, to the extent that these entities participate. This excludes federal employee health benefit plans, Tri-care, other military coverage, and other employer-based plans for employers operating outside of Vermont.

kk. **“Vermont Self-insured Scale Target Plan”** means health benefits provided to a Vermont resident by an employer operating in Vermont who is self-insured, including the State, federal government, or the military to the extent that these entities participate. This includes federal employee health benefits plans, Tri-care and other military coverage, but excludes other employer-based plans for employers operating outside of Vermont.

2. Agreement Term.

- a. **Effective Date.** This Agreement will become effective when it is signed by all 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. **Term of Agreement.** The term of this Agreement begins on the Effective Date and concludes at the end of Performance Year 5, or, in the case of early termination of this Agreement by either party in accordance with Section 21, on the effective date of such termination.
- c. The Performance Period of this Model will begin on January 1, 2017, and will end at 11:59PM (EST) on December 31, 2022, unless this Agreement is sooner terminated in accordance with Section 21 and in which case the Performance Period concludes on the effective date of termination.

3. Legal Authority

- a. **CMS Legal Authority.**
 - i. **General Authority to Test Model.** Section 1115A(b) of the Social Security Act (the “Act”) authorizes the Center for Medicare and Medicaid Innovation (“Innovation Center”) to test innovative payment and service delivery models that are expected to reduce Medicare, Medicaid, or Children’s Health Insurance Program (“CHIP”) expenditures while maintaining or improving the quality of care for beneficiaries.
 - ii. **Financial and Payment Model Authorities.** Section 1115A(b)(2) of the Act requires the Secretary to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute provides a non-exhaustive list of examples of models that the Secretary may select including, “[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.”

- iii. **Waiver Authority.** Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services (“Secretary”) may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in 1115A(b). For this model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the SSA. Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Agreement, all individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Model. Any such waiver would apply solely to the Model and could differ in scope or design from waivers granted for other programs or models. The Secretary has no authority to waive state fraud and abuse laws that may be implicated by the testing of this Model. The State shall ensure that all individuals and entities participating in this Model comply with state fraud and abuse laws or issue waivers of any applicable state laws.
- iv. **Medicare Authority.** The Medicare portions of the Model shall operate according to existing Medicare law, regulation, and sub-regulatory guidance, and are subject to existing requirements for financial and program integrity, except to the extent these requirements are waived or modified in separately issued documentation.
- v. **Medicaid Authority.** The Medicaid elements of the Model shall operate according to existing Medicaid law, regulation and sub-regulatory guidance, including but not limited to all requirements of Vermont’s Medicaid demonstration project under section 1115 of the Social Security Act.
- b. **Vermont Legal Authority.** The State represents and warrants that it has the legal authority under Titles 8, 18, and 33 of Vermont Statutes Annotated to implement methodologies for payment reforms, set rates for providers and/or suppliers and require payers to comply with those rates, waive certain state fraud and abuse laws that are implicated by the testing of this Model and perform the regulatory functions consistent with this Agreement. The State further represents and warrants that it has the legal authority to enter into this Agreement and shall bind by law or contract by January 1, 2018, Vermont ACO(s), Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans to comply with the applicable terms and conditions of this Agreement and all submissions related to the Model required pursuant to this Agreement.
- c. **Vermont Medicaid Authority.** By January 1, 2018, the State shall secure approval from CMS under section 1115(a) of the Social Security Act authorizing Vermont’s state Medicaid agency

to operate Vermont Medicaid, including Medicaid payment methodologies, to meet the requirements of this Agreement. Vermont must maintain such approval for the duration of the Model. This Agreement does not limit or modify any rules and regulations or processes applicable to such approvals. Additionally, this Agreement does not abrogate the designation of the AHS as the single State agency as required by 42 C.F.R. § 431.10 or alter AHS’s sole authority to set rates for Vermont Medicaid.

4. ACO Scale Targets.

- a. **Percentage of Vermont Beneficiaries Aligned to an ACO.** Vermont shall ensure that the percentage of Vermont Medicare Beneficiaries and the percentage of Vermont All-payer Scale Target Beneficiaries aligned to a Scale Target ACO Initiative, as defined in section 4.b, meet or exceed the following percentages for each Performance Year (“ACO Scale Targets”):

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

- b. **Scale Target ACO Initiatives.** A Scale Target ACO Initiative is an ACO arrangement offered by Vermont Medicaid, Vermont Commercial Plans, Vermont Self-insured Scale Target Plans, and/or Medicare FFS (e.g., Vermont Medicare ACO Initiative, Vermont Modified Next Generation ACO Model, Medicare Shared Savings Program) to a Vermont ACO that incorporates, at a minimum, the following:
- i. The Vermont ACO has available the possibility of Shared Savings if the Vermont ACO achieves goals related to quality of care and/or utilization;
 - ii. The Vermont ACO’s portion, as a percentage of the ACO’s expenditures less than the ACO’s benchmark, of Shared Savings is, at minimum 30 percent, and if it is also at risk for Shared Losses, the Vermont ACO’s portion, as a percentage of the ACO’s expenditures in excess of the ACO’s benchmark, of Shared Losses for which it is responsible to the payer is, at minimum, 30 percent;
 - iii. Services comparable to, but not limited to, the All-payer Financial Target Services and their associated expenditures are included for determination of the ACO’s Shared Losses and Shared Savings; and
 - iv. The ACO Benchmark is tied to the quality of care it delivers and/or the health of its aligned beneficiaries.
- c. **Calculation Methodology.** The percentage of Vermont All-payer Scale Target Beneficiaries and Vermont Medicare Beneficiaries aligned to a Scale Target ACO Initiative will be calculated as follows:

- i. **Vermont All-Payer Scale Target Beneficiaries:** the denominator will be the number of Vermont All-payer Scale Target Beneficiaries. The numerator will include any Vermont All-payer Scale Target Beneficiary who is aligned to a Scale Target ACO Initiative.
 - ii. **Vermont Medicare Beneficiaries:** the denominator will be the number of Vermont Medicare Beneficiaries. The numerator will include any Vermont Medicare Beneficiary who is aligned to a Scale Target ACO Initiative.
- d. AHS shall ensure that Vermont Medicaid offers a Scale Target ACO Initiative to Vermont ACOs. The State intends for Vermont Medicaid to be a reliable payer within the Model. The State intends that payments paid by Vermont Medicaid to Vermont ACOs be set for a calendar year to allow predictability for both the Vermont ACOs and the GMCB's Vermont ACO regulations. Furthermore, AHS and Vermont Medicaid intend to work collaboratively with the GMCB within its ACO regulatory process under the direction of the Governor's Director of Health Care Reform.
- e. Vermont shall encourage Vermont Commercial Plans and Vermont Self-insured Scale Target Plans to offer Scale Target ACO Initiatives to Vermont ACOs.
- f. Vermont shall ensure that Scale Target ACO Initiatives offered by Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans reasonably align in their design (e.g., beneficiary alignment methodology, ACO quality measures, payment mechanisms, risk arrangements, and services included for determination of the ACO's Shared Losses and Shared Savings as described in section 4.b.iii) with the Vermont Medicare ACO Initiative in Performance Years 2 through 5 and with the Vermont Modified Next Generation ACO in Performance Year 1. CMS and Vermont shall work together to make modifications to the Vermont Medicare ACO Initiative in order to facilitate greater design alignment
- g. CMS shall explore potential opportunities with federal employee health benefits plans and military health plans to offer Scale Target ACO Initiatives to Vermont ACOs to support the achievement of the ACO Scale Targets and ACO design alignment.
- h. Vermont shall encourage providers and/or suppliers operating in Vermont participate in Vermont ACOs to achieve the ACO Scale Targets as specified in sections 4.a, 4.b, and 4.c.
- i. **Annual ACO Scale Targets and Alignment Report.**
 - i. In accordance with section 4.f, Vermont shall submit to CMS, for CMS approval, by June 30th during the year after the conclusion of each Performance Year , excluding Performance Year 0, an assessment describing how the Scale Target ACO Initiatives' designs compare against each other on key design dimensions such as services included

for determination of the ACO's Shared Losses and Shared Savings as described in section 4.b.iii., risk arrangement, payment mechanism, quality measures, and beneficiary alignment. The assessment must also describe how the Scale Target ACO Initiatives designs across all payers are aligned, how they are different, justification for differences that will remain, and a plan to bridge differences that will not remain. CMS has the sole discretion to approve or disapprove the State's assessment. If CMS disapproves the State's assessments, it may qualify as a triggering event and a corrective action plan ("CAP") may be initiated as described in Section 21.

- ii. In accordance with sections 4.a through 4.c, Vermont shall submit to CMS, for CMS approval, by June 30th during the year after the conclusion of each Performance Year (excluding Performance Year 0), the State's performance on the ACO Scale Targets described in sections 4.a, 4.b, and 4.c.
- j. **Consequences for Not Achieving ACO Scale Targets.** If the State fails to achieve the ACO Scale Targets described in sections 4.a, 4.b, and 4.c for two consecutive Performance Years (excluding Performance Year 0), the State shall submit, for CMS approval, a CAP. The State's CAP submission shall be in accordance with the requirements set forth in section 21, and shall include methodology on how the State will improve its performance against the ACO Scale Targets.

5. Statewide Health Outcomes and Quality of Care Targets.

- a. Vermont shall achieve the population-level health outcomes targets, healthcare delivery system quality targets, and process milestones as described in Appendix 1.
- b. **Consequences for not achieving population-level health outcomes targets.** If CMS determines that the State is not on track to achieve at least four of the six (note: each of the three chronic conditions targets will be considered separately) of the population-level health targets, as described in **Appendix 1.a.i through Appendix 1.a.iv**, CMS may initiate the following remedies:
 - i. CMS may provide a warning notice to the State in accordance with section 21 that the State is not on track to achieve a population-level health outcomes target, indicating the relevant target(s).
 - ii. Within ninety days of receipt of the warning notice, Vermont shall submit to CMS, for CMS approval, a written response. CMS will review the State's response within 90 calendar days and will either accept the response as sufficient or require the State to submit a Corrective Action Plan (CAP). The State's CAP submission shall be in accordance with the requirements set forth in section 21, and shall include methodology on how the State will improve its performance against the population-level health outcomes target(s) for which the State is not on track to achieve the target. The State's plan to improve its performance against the population-level health outcomes target(s)

may include, but is not limited to, increasing the State and/or Vermont ACO's investments into community-based resources and/or increasing the Vermont Medicare ACO Initiative Benchmark's weight given to ACO quality performance.

- c. **Consequences for not achieving healthcare delivery system quality targets.** If CMS determines that the State is not on track to achieve at least four of the seven healthcare delivery system quality targets, as described in [Appendix 1.b.i through Appendix 1.b.vii](#), CMS may initiate the following remedies:
- i. CMS will provide a warning notice to the State in accordance with section 21 that the State is not on track to achieve a healthcare delivery system quality target, indicating the relevant target(s).
 - ii. Within ninety days of receipt of the warning notice, Vermont shall submit to CMS, for CMS approval, a written response. CMS will review the State's response within 90 calendar days and will either accept the response as sufficient or require the State to submit a Corrective Action Plan (CAP). The State's CAP submission shall be in accordance with the requirements set forth in section 21, and shall include methodology on how the State will improve its performance against the healthcare delivery system quality target(s) for which the State is not on track to achieve the target. The State's plan to improve its performance against the population-level health outcomes target(s) may include, but is not limited to, increasing the State and/or Vermont ACO's investments into community-based resources and/or increasing the Vermont Medicare ACO Initiative Benchmark's weight given to ACO quality performance.
 - iii. If after implementation of the corrective action plan, per the start date in the corrective action plan, for one year the State is still not on track to achieve at least two-thirds of the healthcare delivery system quality targets, or if the Innovation Center rejects the CAP, CMS may take the following actions:
 - 1) Determine the quality measures and targets to which the Vermont Medicare ACO Initiative Benchmark is tied.
 - 2) Determine the percentage of the Vermont Medicare ACO Initiative Benchmark that is tied to quality for Medicare FFS beneficiaries aligned to the VMA ACO or Modified Next Generation ACO.
- d. **Consequences for not achieving process milestones.** If CMS determines that the State is not on track to achieve at least five of the seven process milestones, as described in [Appendix 1.c.i through Appendix 1.c.vii](#), CMS may initiate the following remedies:
- i. CMS may provide a warning notice to the State in accordance with section 21 that the State is not on track to achieve a process milestone, indicating the relevant process milestone(s).

- ii. Within ninety days of receipt of the warning notice, Vermont shall submit to CMS, for CMS approval, a written response. CMS will review the State's response within 90 calendar days and will either accept the response as sufficient or require the State to submit a Corrective Action Plan (CAP). The State's CAP submission shall be in accordance with the requirements set forth in section 21, and shall include methodology on how the State will improve its performance against the process milestone(s) for which the State is not on track to achieve.
- e. **Annual Health Outcomes and Quality of Care Report.** The State shall submit to CMS, for CMS approval, on or before September 30th following each Performance Year, excluding Performance Year 0, a report on the State's efforts to achieve the Statewide Health Outcomes and Quality of Care Targets. At a minimum, the State shall describe the following in the Annual Report:
 - i. Vermont's progress on achieving statewide health outcomes and quality of care targets set forth in Appendix 1;
 - ii. How the State holds Scale Target ACO Initiatives accountable to quality of care and/or the health of its aligned beneficiaries (section 4.b.iv);
 - iii. How the State holds its ACO accountable to allocate funding for and invests in community health services to achieve the statewide health outcomes and quality of care targets.
- f. **Collaboration with Public Health.** The State shall submit by June 30th of Performance Year 3 a plan signed by Vermont's Department of Health, the Green Mountain Care Board, and the Vermont ACOs that provides an accountability framework to the public health system to ensure that any Vermont ACO funding allocated to community health services is being used towards achieving the Statewide Health Outcomes and Quality Targets.
- g. **Potential additional Healthcare Delivery System Quality Target measure.** Vermont and CMS shall develop by December 31, 2017, a measure to monitor Medicaid patient caseload for specialist and non-specialist physicians. CMS and Vermont may choose by the end of Performance Year 2 to add this measure and an associated target as an additional Healthcare Delivery System Quality Target.

6. Statewide Financial Targets.

- a. **All-payer Total Cost of Care per Beneficiary Growth Target.** Vermont shall limit All-payer Total Cost of Care per Beneficiary Growth to 3.5 percent (the "*All-payer Total Cost of Care per Beneficiary Growth Target*").
 - i. **Calculation Method.** All-payer Total Cost of Care per Beneficiary Growth will be calculated in aggregate as a compounded annualized growth rate of All-payer Total Cost of Care per Beneficiary across Performance Years 1-5 of this Model, using 2017 as a

baseline. All-payer Total Cost of Care (TCOC) per Beneficiary for any given Performance Year will incorporate the count of all Vermont All-payer Beneficiaries and expenditures associated with All-payer Financial Target Services for all Vermont All-payer Beneficiaries. Vermont’s performance on the All-payer Total Cost of Care per Beneficiary Growth Target will be calculated by the following formula:

$$\left(\frac{\left(\frac{\text{Vermont all-payer TCOC}_{2022}}{\text{Vermont all-payer beneficiaries}_{2022}} \right)}{\left(\frac{\text{Vermont all-payer TCOC}_{2017}}{\text{Vermont all-payer beneficiaries}_{2017}} \right)} \right)^{\frac{1}{5}} - 1 \leq 0.035$$

- b. **Medicare Total Cost of Care per Beneficiary Growth Target.** Vermont shall limit Vermont Medicare Total Cost of Care per Beneficiary Growth to at least 0.2 percentage points less than Projected National Medicare Total Cost of Care per Beneficiary Growth (the “*Medicare Total Cost of Care per Beneficiary Growth Target*”).

i. **Calculation Methodology.**

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

For Performance Years 1 and 2, the Vermont Medicare Total Cost of Care per Beneficiary will include only Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives. Vermont Medicare Total Cost of Care per Beneficiary Growth for Performance Years 1-2 will be calculated by comparing (a) Vermont Medicare Total Cost of Care per Beneficiary for Vermont Medicare Beneficiaries who are aligned to Scale Target ACO Initiatives in the same Performance Year (referenced as “Vermont ACO-aligned Medicare beneficiaries” in the below formulas) and (b) the Medicare Total Cost of Care per Beneficiary for Vermont Medicare Beneficiaries who would have been aligned to the Scale Target ACO Initiative in the year prior to the Performance Year given the same alignment methodology and providers who participated in the Vermont ACO (referenced as “Vermont ACO comparison Medicare beneficiaries” in the below formula).

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

If in Performance Year 3 Vermont achieves at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries, then for Performance Year 3 the Vermont Medicare Total Cost of Care per Beneficiary will include all

Vermont Medicare Beneficiaries, and Vermont Medicare Total Cost of Care per Beneficiary Growth will be calculated in a similar manner as for Performance Years 4-5. If in Performance Year 3 Vermont does not achieve at least 65 percent in ACO Scale Target performance for Vermont Medicare Beneficiaries, then for Performance Year 3 the Vermont Medicare Total Cost of Care per Beneficiary will include only Vermont Medicare Beneficiaries aligned to a Medicare FFS ACO initiative, and Vermont Medicare Total Cost of Care per Beneficiary Growth will be calculated in a similar manner as for Performance Years 1-2.

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

Vermont Total Cost of Care per Beneficiary Growth:

$$\left(\frac{\left(\frac{\text{Vermont Medicare TCOC}_{2018}}{\text{Vermont ACO – aligned Medicare beneficiaries}_{2018}} \right)}{\left(\frac{\text{Vermont Medicare TCOC}_{2017}}{\text{Vermont ACO comparison Medicare beneficiaries}_{2017}} \right)} * \frac{\left(\frac{\text{Vermont Medicare TCOC}_{2019}}{\text{Vermont ACO – aligned Medicare beneficiaries}_{2019}} \right)}{\left(\frac{\text{Vermont Medicare TCOC}_{2018}}{\text{Vermont ACO comparison Medicare beneficiaries}_{2018}} \right)} * \frac{\left(\frac{\text{Vermont Medicare TCOC}_{2020}}{\text{Vermont Medicare beneficiaries}_{2020}} \right)}{\left(\frac{\text{Vermont Medicare TCOC}_{2019}}{\text{Vermont Medicare beneficiaries}_{2019}} \right)} * \frac{\left(\frac{\text{Vermont Medicare TCOC}_{2021}}{\text{Vermont Medicare beneficiaries}_{2021}} \right)}{\left(\frac{\text{Vermont Medicare TCOC}_{2020}}{\text{Vermont Medicare beneficiaries}_{2020}} \right)} * \frac{\left(\frac{\text{Vermont Medicare TCOC}_{2022}}{\text{Vermont Medicare beneficiaries}_{2022}} \right)}{\left(\frac{\text{Vermont Medicare TCOC}_{2021}}{\text{Vermont Medicare beneficiaries}_{2021}} \right)} \right)^{\frac{1}{5}} - 1$$

2. **Calculating Projected National Medicare Total Cost of Care per Beneficiary Growth.** The Projected National Medicare Total Cost of Care per Beneficiary Growth for any given Performance Year will be determined based on the MA USPPC FFS Projections published in the year prior to the Performance Year. Projected National Medicare Total Cost of Care per Beneficiary Growth will be calculated as a compounded annualized growth rate in aggregate across Performance Years 1-5 of this Model, using 2017 as a baseline and summarized by the following formula.

Projected National Medicare Total Cost of Care per Beneficiary Growth:

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

3. **Calculating Vermont’s performance on the Medicare Total Cost of Care per Beneficiary Growth Target.** Vermont’s performance on the Medicare Total Cost of Care per Beneficiary Growth Target will be calculated as a difference between Vermont Medicare Total Cost of Care per Beneficiary Growth and Projected National Medicare Total Cost of Care per Beneficiary Growth. Vermont’s performance on the Medicare Total Cost of Care per Beneficiary Growth Target will be calculated by the formulas in this section, except as adjusted in Sections 6.b.ii, 6.b.iii, 6.b.iv, and 6.c of this Agreement.

Medicare Total Cost of Care per Beneficiary Growth Target performance:

Projected National Medicare Growth – Vermont Medicare Growth ≥ 0.002

- ii. **Age Band Adjustment.** Vermont Medicare Total Cost of Care per Beneficiary Growth calculations will be adjusted for age differences between Vermont Medicare Beneficiaries and National Medicare Beneficiaries. This age adjustment will be performed by calculating Vermont Medicare Total Cost of Care per Beneficiary Growth separately for the following age bands, and weighting the age bands according to the age distribution of National Medicare Beneficiaries: under 65, 65-74, 75-84, over 85.
- iii. **Aged and Disabled and ESRD Adjustment.** The MA USPCC FFS Projections provide for separate projections for Medicare FFS beneficiaries with and without end-stage renal disease (ESRD). The Projected National Medicare Growth calculations will be based on a blend of the ESRD and non-ESRD MA USPCC FFS Projections according to the relative proportions of Vermont Medicare Beneficiaries who have, and do not have, ESRD.
- iv. **Projected National Medicare Total Cost of Care per Beneficiary Growth Target Floor for Performance Year 1.** If the Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1, calculated as a growth rate using 2017 as a baseline, is less than 3.7 percent but greater than or equal to 2.7 percent, then 3.7 percent will be used as the Projected National Medicare Total Cost of Care per Beneficiary Growth between 2017 and Performance Year 1 for purposes of calculating Vermont’s performance on the Medicare Total Cost of Care per Beneficiary Growth Target. In such a case, the following formula will be used to calculate Projected National Medicare Total Cost of Care per Beneficiary Growth, except as adjusted in sections 6.b.ii, 6.b.iii, and 6.c of this Agreement:

Projected National Medicare Total Cost of Care per Beneficiary Growth:

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

If the Projected National Medicare Total Cost of Care per Beneficiary Growth in Performance Year 1, calculated as a growth rate using 2017 as a baseline, is less than 2.7 percent, then for purposes of calculating Vermont’s performance on the Medicare Total Cost of Care Growth Target, the Projected National Medicare Total Cost of Care per Beneficiary Growth between 2017 and Performance Year 1 will be calculated as 1.2 percentage points above the MA USPCC FFS Projections for the same time period. In such a case, the following formula will be used to calculate Projected National Medicare Total Cost of Care per Beneficiary Growth, except as adjusted in sections 6.b.ii, 6.b.iii, and 6.c of this Agreement:

Projected National Medicare Total Cost of Care per Beneficiary Growth:

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

If the Projected National Medicare Total Cost of Care per Beneficiary Growth in Performance Year 1, calculated as a growth rate using 2017 as a baseline, is equal to or greater than 3.5 percent, then the Medicare Total Cost of Care per Beneficiary Growth Target shall be 0.1 percentage points less than the Projected National Medicare Total Cost of Care per Beneficiary Growth. That is, Vermont shall limit the Vermont Medicare Total Cost of Care per Beneficiary Growth to at least 0.1 percentage points less than the Projected National Medicare Total Cost of Care per Beneficiary Growth. In such a case, the following formula will be used to calculate Vermont’s performance on the Medicare Total Cost of Care per Beneficiary Growth Target, except as adjusted in sections 6.b.ii, 6.b.iii, and 6.c of this Agreement:

Medicare Total Cost of Care per Beneficiary Growth Target performance:

$$\text{Projected National Medicare Growth} - \text{Vermont Medicare Growth} \geq 0.001$$

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

- i. **Payments Made under the Medicare Program and Medicare Demonstrations or Models.** CMS may adjust the Vermont Medicare Total Cost of Care per Beneficiary Growth calculation as necessary to avoid duplicative accounting for, and payment of, amounts made to or received by providers in the State that are participating in any existing or future Medicare program, demonstration or model, including but not limited to those that involve Shared Savings or incentive payments.
 1. **ACO Shared Savings and Shared Losses Adjustment.** The Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth calculations will be adjusted to incorporate any Shared Losses or Shared Savings for any Vermont ACOs participating in a Medicare FFS ACO initiative (e.g., Vermont Medicare ACO Initiative, Vermont Modified Next Generation ACO Model, and Medicare Shared Savings Program). Such Shared Losses would be considered as reductions in expenditures and such Shared Savings as additional expenditures for purposes of calculating the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth.
- ii. **Medicare payments made under the Multipayer Advanced Primary Care Practice demonstration.** CMS will include in the Vermont Medicare Total Cost of Care per Beneficiary Growth and All-payer Total Cost of Care per Beneficiary Growth calculations \$7.5M, approximately the sum of Medicare payments made to Vermont providers in 2016 as part of the Multipayer Advanced Primary Care Practice demonstration, during the baseline year of 2017.
- iii. The All-Payer Total Cost of Care per Beneficiary Growth Target calculations shall be adjusted to exclude growth attributable to efforts by Vermont to increase Vermont Medicaid reimbursement rates to levels more comparable to Medicare FFS reimbursement rates, as more fully described in and subject to the reporting provisions of section 8.
- iv. Starting in Performance Year 3, CMS and/or Vermont may request modifications to the Projected National Medicare Total Cost of Care per Beneficiary Growth calculation if the MA USPPC FFS Projections differ by at least 1 percentage point from National Medicare per Beneficiary Total Cost of Care Growth as calculated over the Performance Years that have concluded. Any such modifications would need to be intended to reduce the difference between Projected National Medicare Total Cost of Care per Beneficiary Growth and National Medicare per Beneficiary Total Cost of Care Growth. Any such adjustment will be dependent on mutual agreement of both CMS and the State.
- v. **Exogenous Factors.** Vermont may submit, in writing to CMS, a request that exogenous factor(s) (e.g., changes in Medicare law and regulation or Vermont-localized health or

economic shocks) be taken into consideration when assessing performance on the All-payer and/or Medicare Total Cost of Care per Beneficiary Growth Targets. Vermont shall explain the impact of such factors on the Model, including any recommendations as to how CMS should adjust the Model to reflect these exogenous factors. Any such adjustment will be at the sole discretion of CMS.

- d. **Consequences for not achieving Financial Targets.** If during the Performance Period Vermont is not on track to achieve the All-payer and/or Medicare Total Cost of Care per Beneficiary Growth Targets, as described in section 6.d.i and 6.d.ii, respectively, the State shall submit, for CMS approval, a CAP 30 days after receipt of written notice from CMS. The State's CAP submission shall be in accordance with the requirements set forth in section 21, and shall include methodology on how the State will improve its performance against the financial target(s). If CMS does not approve the CAP, or if the included corrective actions over one year from the implementation date of the CAP failed to place the State back on track for its performance against the financial targets, CMS shall directly set the Vermont Medicare ACO Initiative Benchmarks.
- i. Beginning in Performance Year 2, CMS shall determine that the State is not on track to meet the All-payer Total Cost of Care per Beneficiary Growth Target if the cumulative All-payer Total Cost of Care per Beneficiary Growth, measured as a compounded annualized growth rate across Performance Years 1 through the latest Performance Year to conclude, is greater than 4.3 percent. The All-payer Total Cost of Care per Beneficiary Growth will be adjusted as described in section 6.c.
 - ii. Beginning in Performance Year 2, CMS shall determine that the State is not on track to meet the Medicare Total Cost of Care per Beneficiary Growth Target if the cumulative Vermont Medicare Total Cost of Care per Beneficiary Growth exceeds 0.1 percentage point above the cumulative Projected National Medicare Total Cost of Care per Beneficiary Growth. The cumulative Vermont Medicare Total Cost of Care per Beneficiary Growth and Projected National Medicare Total Cost of Care per Beneficiary Growth would be measured as compounded annualized growth rates across Performance Year 1 through the latest Performance Year to conclude. The Vermont Medicare Total Cost of Care per Beneficiary Growth and Projected National Medicare Total Cost of Care per Beneficiary Growth calculations will be adjusted as described in sections 6.b.ii, 6.b.iii, 6.b.iv, and 6.c.
- e. **Request for modifications to Medicare and All-payer Financial Target Services.** Vermont may request modifications to the definitions of Medicare Financial Target Services and All-payer Financial Target Services, subject to CMS approval, by proposing an amendment to the Model Agreement at least 6 months before the beginning of the Performance Year during which proposed modifications would be applicable.

- f. **Quarterly Financial Report.** The State shall submit to CMS on a quarterly basis, a report on the State's performance on the All-payer Total Cost of Care per Beneficiary Growth Target. Each Performance Year's All-payer Total Cost of Care per Beneficiary Growth performance results shall be finalized by June 30th of the following year.
7. **Vermont Medicare ACO Initiative (Initiative).** CMS, in collaboration with Vermont, shall design and launch the Vermont Medicare ACO Initiative to begin on January 1, 2019, and its performance period will align with Performance Years 2 through 5 of this Agreement. CMS shall require Vermont ACOs participating in the Initiative (VMA ACOs) to accept beneficiary alignment methodology, ACO quality measures, payment mechanisms, and risk arrangements for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the ACO. Vermont may propose modifications to the Initiative to better align the Initiative with ACO programs operated by Vermont Medicaid, Vermont Commercial Plans, and Vermont Self-insured Plans. CMS may accept such proposals at its sole discretion.
- a. **CMS Duties.**
- i. CMS, in collaboration with Vermont, will determine the parameters and requirements of the Initiative, including governance, beneficiary alignment methodology, payment mechanisms, risk arrangements, and benefit enhancements. CMS may exercise its authority to set the Vermont Medicare ACO Initiative Benchmarks as articulated in Sections 5.c and 6.d of this Agreement.
 - ii. For Performance Year 1 of the Model, CMS shall provide Vermont Modified Next Generation ACOs participation agreements that are based on the Next Generation ACO Model participation agreements but are amended to reflect GMCB's duty to set the Vermont Medicare ACO Initiative Benchmark, except as described in section 5.c and 6.d of this Agreement.
 - iii. For Performance Years 2 through 5 of the Model, CMS shall provide VMA ACOs separate Vermont Medicare ACO Initiative participation agreements that are based on the amended participation agreements offered to the Vermont Modified Next Generation ACOs in Performance Year 1. The Vermont Medicare ACO Initiative participation agreements may include additional modifications developed in collaboration with the State to support greater alignment across Scale Target ACO Programs, per Section 4.f.
 - iv. CMS shall include as part of the Vermont Medicare ACO Initiative benefit enhancements that are also included in the Next Generation ACO Model: Telehealth, Post-discharge home visits, and 3-day SNF Rule waivers.
 - v. CMS shall work with the GMCB throughout the year prior to each Performance Year to analyze and understand data to inform how Vermont Medicare ACO Initiative Benchmarks are set for Vermont Modified Next Generation ACOs and VMA ACOs.

b. **GMCB Duties.**

- i. In order for a Vermont ACO to be eligible to participate in the Vermont Medicare ACO Initiative or be eligible to become a Vermont Modified Next Generation ACO, GMCB must submit to CMS a letter jointly signed by GMCB and the Vermont ACO attesting that the two entities will work together to achieve the ACO Scale Targets, Statewide Financial Targets, and Statewide Health Outcomes and Quality of Care Targets of the Vermont All-payer ACO Model. GMCB and the Vermont ACO shall submit the letter in a manner and by a deadline determined by CMS.
- ii. Except as described in sections 5.c and 6.d of this Agreement, the GMCB shall develop the Vermont Medicare ACO Initiative Benchmarks for each VMA ACO in accordance with the terms of this agreement.
 1. The benchmarking methodology shall be consistent with the following principles:
 - a. Incentivize high quality and efficient care and improvement in health for aligned beneficiaries;
 - b. If for Performance Year 1 the Projected National Medicare Total Cost of Care per Beneficiary Growth is calculated to be less than 3.7 percent (as discussed in section 6.b.iii), have the growth rates for Vermont Medicare ACO Initiative Benchmarks for Performance Year 1 come in at most 3.5 percent. If for Performance Year 1 the Projected National Medicare Total Cost of Care per Beneficiary Growth is calculated to be greater than or equal to 3.7 percent, have the growth rates for Vermont Medicare ACO Initiative Benchmarks come in at least 0.1 percentage points below the Projected National Medicare Total Cost of Care per Beneficiary Growth for Performance Year 1.
 - c. For Performance Years 2-5 have the Vermont Medicare ACO Initiative Benchmarks either
 - i. Be such that the growth rates for Vermont Medicare ACO Initiative Benchmarks come in at least 0.2 percentage points (or 0.1 percentage points if, as discussed in section 6.b.iii, the Projected National Medicare Total Cost of Care per Beneficiary Growth for PY1 is calculated to be is less than 3.7 percent) below the Projected National Medicare Total Cost of Care per Beneficiary Growth for the Performance Year during which the Vermont Medicare ACO Initiative Benchmark would be applicable, or
 - ii. Be such that the compounded annualized growth rates for Vermont Medicare ACO Initiative Benchmarks over PY1 through the Performance Year in question come in at less than 0.1 percentage points above the compounded annualized growth rate for the Projected National Medicare Total Cost of Care per Beneficiary Growth over the same period of time;

- d. Apply the growth rates in (b) and (c) to the best estimate available on Medicare FFS expenditures incurred during the year prior to the Performance Year in question for the Medicare FFS beneficiaries who are aligned to the Vermont Modified Next Generation ACO for PY1 and VMA ACO for PY2-PY5, respectively.
 - e. Enable achievement of the Financial Targets described above in section 6;
 - f. Incorporate ACO quality performance into the benchmark;
 - g. Place a percentage of benchmarks at risk due to ACO quality performance that at minimum meets the percentage tied to ACO quality scores for ACOs participating in the Next Generation ACO Model;
 - h. Mitigate adverse patient selection, or any behavior to increase the alignment of healthier beneficiaries while avoiding more medically complex beneficiaries;
 - i. Provide benchmarks to the ACO prospectively; and
 - j. Set separate benchmarks for Medicare FFS Aged and Disabled beneficiaries and ESRD beneficiaries.
2. The GMCB shall submit to CMS for approval the Vermont Medicare ACO Initiative Benchmarks for each VMA ACO at least 30 days prior to the beginning of each Performance Year for which the benchmarks would be applicable. CMS will assess the benchmarks to ensure consistency with standards articulated in section 7.b.ii.1 and will make a decision within 10 days of GMCB's submission on whether to approve the Vermont Medicare ACO Initiative Benchmarks.
- iii. For Performance Year 1 of the Model, before the Initiative begins, Vermont shall develop the Vermont Medicare ACO Initiative Benchmarks for each Vermont Modified Next Generation ACO in the same manner as the requirements, exceptions, and standards articulated in Sections 5.c, 6.d, and 7.b.ii of this Agreement.
 - iv. To the extent it has the authority, the GMCB may direct a VMA ACO and a Vermont Modified Next Generation ACO, to make specific infrastructure and care delivery investments.
 - v. GMCB shall obtain waivers of all state fraud and abuse laws necessary to implement the Model and the Initiative.
 - vi. The GMCB shall work with CMS throughout the year prior to each Performance Year to analyze and understand data to inform how Vermont Medicare ACO Initiative Benchmarks are set for Vermont Modified Next Generation ACOs and VMA ACOs.
- c. CMS and Vermont intend to explore any potential modifications to the Vermont Medicare ACO Initiative that may be necessary such that the Initiative be considered an Advanced Alternative Payment Model under the Quality Payment Program, pending final rulemaking.

8. Payer Differential.

- a. Vermont shall submit to CMS no later than 90 days after the start of each Performance Year,

beginning in Performance Year 2, the percent increase in ACO Benchmarks by payer for Vermont ACOs. Vermont shall provide CMS an explanation for any differences in ACO Benchmark percentage increases between payers and the impact such differences may have on the Payer Differential as it affects Vermont ACOs.

- b. Vermont shall submit to CMS by the end of Performance Year 2 an assessment of the Payer Differential as it affects Vermont ACOs. This assessment may include, but is not limited to, payment rates and ACO profit margins by payer.
- c. Vermont shall submit to CMS by the end of Performance Year 3 a report on options to narrow the Payer Differential between payers during and after the Performance Period.
- d. CMS shall make adjustments to the All-payer Total Cost of Care per Beneficiary Growth Target Calculation, as necessary and as specified in this sub-section, to recognize that that cumulative All-payer Financial Target Services growth may be attributable to efforts by Vermont to increase Medicaid reimbursement rates to levels more comparable to Medicare reimbursement rates. In calculating Vermont Medicaid spending towards the All Payer Total Cost of Care per Beneficiary Growth target, CMS will adjust Vermont growth to exclude growth attributable to such efforts. The State may submit, in writing, a request that changes in payments to Medicaid providers be taken into consideration when assessing performance on the financial targets. Vermont must explain the impact of such factors on financial target services and recommend how CMS should adjust the growth target calculation to reflect these factors.
- e. The purpose of this subsection is to ensure Medicaid beneficiaries have equal access to ACO network providers as those with Medicare or commercial coverage. This subsection is not intended to modify the services covered by a payer nor to limit access to providers of services that are not covered by all payers. A Vermont ACO shall not interfere with patients' choice of their own health care providers under their health plan, regardless of whether a provider is participating in the ACO.
 - i. Vermont ACOs shall have a single network of providers, regardless of payer, for All-payer Financial Target Services. If a healthcare payer has covered services that are excluded by other payers, the Vermont ACO may have a broader network of providers for that payer to ensure beneficiaries have full access to covered services.
 - ii. If any Vermont ACO does not have a single network of providers for common covered services regardless of payer by the beginning of Performance Year 2, then the State shall ensure that at least 90% of all providers in the Vermont ACO's network accept Vermont Medicaid beneficiaries.
 - iii. If neither of the network access tests set forth in sections 8.e.i and 8.e.ii are satisfied, Vermont shall submit to CMS, for CMS approval, a CAP within 180 days from the date that such a determination is made. The State's CAP submission shall be in accordance with the requirements set forth in section 21 and shall include options for either restoring a single network of providers for Vermont ACOs or meeting the access goal set forth above. Options shall include the effect of increasing Medicaid rates to reduce the Payer Differential as a means of improving access.

9. **One-time Funding.** CMS shall provide Vermont with one-time funding of \$9.5M in 2017 to fund care

coordination, connections to community-based resources, and practice transformation for Medicare FFS beneficiaries in support of the Model. Any such funding shall be executed under a separate agreement and will incorporate terms described in Appendix 2.

10. **Medicaid Behavioral Health and Long-Term Services and Supports.** Vermont shall define, by the end of Performance Year 3, a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with the All-payer Financial Target Services, which shall include a plan and strategy for including Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the State’s delivery system reform efforts and supporting the inclusion of such Medicaid services in the definition of All-payer Financial Target Services for a subsequent agreement, as described in Section 11.
11. **Proposal for Subsequent Agreement.** By December 31 of Performance Year 4, Vermont may submit to CMS a proposal for a subsequent model spanning 5 performance years and detailing operations to be effective 2023 through 2027. CMS reserves the right at its sole discretion to accept, reject, or put forth a revised proposal. Vermont reserves the right at its sole discretion to accept or reject any such revised proposal. The proposal, if submitted by Vermont, shall include, at minimum, the following:
 - a. A Medicare total cost of care per beneficiary growth target that is similar to the one described in section 6;
 - b. An all-payer total cost of care per beneficiary growth target that is similar to the one described in section 6, but that also includes expenditures related to Medicaid Behavioral Health Services and the Home and Community-based Services; and
 - c. Statewide health outcomes and quality of care targets that are similar in scope to the ones described in section 5.
12. **Medicare Beneficiary Protections.** Vermont and CMS shall ensure that Medicare FFS beneficiaries’ access to care and services and providers and/or suppliers will not be limited under the Model. Specifically, Vermont and CMS shall ensure that Vermont Medicare Beneficiaries will: (1) retain full freedom of choice of providers and suppliers, as well as all rights and beneficiary protections of Medicare, and (2) retain coverage of the same care and services provided under Medicare FFS. Vermont Medicare Beneficiaries will not experience any reductions in benefits or covered services under this Agreement.
13. **Request for Payment Waivers.** The State may suggest, and the Secretary may consider, additional waivers of Medicare payment policies, as may be necessary solely for purposes of carrying out this Model. In particular, the State may suggest a Medicare payment waiver in the future to implement a discount on Medicare fee-for-service payments to Vermont providers and/or suppliers not participating in an ACO. The State may request additional Medicare payment waivers, along with the rationale for the amendment. CMS may grant these waivers at its sole discretion. Such waivers, if any, would be set forth in separately issued documentation specific to this Agreement and/or pursued through CMS rulemaking

as necessary. Any such waiver would apply solely to this Model and could differ in scope from waivers granted in other CMS models.

14. **Revocation of Payment Waivers.** The Secretary reserves the right to withdraw any payment policy waivers issued by the Secretary at a future date for the sole purpose of carrying out this Agreement, or as applicable, to terminate the Agreement, pursuant to the procedures set forth in in Section 21 of this Agreement, if Vermont does not comply with the conditions associated with the applicable waivers as set forth in the Agreement.

15. **Data Sharing.**

a. **State of Vermont Data Sharing.** As described in sections 4, 5, and 6, the State shall supply CMS reports and information on a regular basis to support CMS’s monitoring and evaluation of the Model and retain such documentation in accordance with section 19. In addition, Vermont shall provide CMS with Vermont Medicaid claims data, Vermont Commercial Plan claims data and Vermont Self-insured Plan claims data on at most an annual basis to support CMS’s monitoring and evaluation of the Model. Vermont may provide these claims data from a combination of sources, including its all-payer claims database (“APCD”), the Vermont ACOs, Vermont Medicaid, Vermont Commercial Plans, and/or Vermont Self-insured Plans.

CMS also may use these reports, information, and data to conduct analyses and may publish, and potentially co-publish with Vermont, the data and analyses in de-identified form. All information will be provided to CMS in a manner consistent with all applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (“HIPAA”).

- i. The State shall ensure that for each Performance Year the State’s APCD captures claims data from Vermont Commercial Plans and Vermont Self-insured Plans such that it represents claims data for at least 80 percent of Vermont residents with health insurance provided under a Vermont Commercial Plans or Vermont Self-insured Plans. If the State cannot ensure such a condition, Vermont and CMS shall work together to secure within 180 days after such a determination is made separate arrangements with said payers to capture claims data for at least 80 percent of Vermont residents with health insurance provided under a Vermont Commercial Plans or Vermont Self-insured Plans.
- b. **CMS Data Sharing.** Over the Performance Period of the Model, CMS is willing to accept requests from the GMCB for Medicare data necessary to achieve the purposes of the Model. This Medicare data may include individually identifiable Medicare eligibility status and demographic information of all Medicare FFS beneficiaries residing in Vermont, and claim and claim line data for services furnished by Medicare-enrolled providers and suppliers to Medicare FFS beneficiaries residing in Vermont. Additional reports may be provided upon request that include

the following: utilization, expenditures, quality of care, Medicare FFS eligibility type, VMA ACO alignment, and performance summary comparisons to other states. All such requests for individually-identifiable health information must clearly state the HIPAA basis for requested disclosure (e.g., for research purposes under 45 C.F.R. § 164.512(i), to enable GMCB to analyze healthcare utilization, quality, expenditures, and system performance under the Vermont All-payer ACO Model). CMS will make best efforts to approve, deny, or request additional information regarding data requests within a reasonable amount of time. All information will be provided consistent with all applicable laws and regulations, including HIPAA and the Part 2 regulations governing the use of information regarding diagnosis and treatment for substance abuse. Appropriate privacy and security protections will be required for any data disclosed under this Model.

- c. **Public Disclosure of Provider Performance Data.** CMS will share with the State in de-identified form the data necessary to determine provider performance on the Statewide Health Outcomes and Quality of Care Targets and Medicare Total Cost of Care per Beneficiary Growth Target in sections 5 and 6, respectively, of this Agreement. Vermont may publicly disclose, with consent from CMS, provider-specific performance for purposes of provider accountability for the quality of care delivered under the Model.

16. **Confidentiality.** The State shall develop procedures to protect the confidentiality of all information that identifies individual Medicare and Medicaid beneficiaries in accordance with all applicable laws.

17. **Model Evaluation.**

- a. **CMS Evaluation.** CMS shall evaluate the Model in accordance with Section 1115A(b)(4) of the Act. CMS and the State agree that the State or its agents shall cooperate with CMS and/or its contractor(s) and provide all data needed to monitor and evaluate the Model in accordance with applicable law. Such data may include, but would not be limited to, individually identifiable health information that is needed to carry out CMS' evaluation and monitoring of this Model. The State shall ensure the production of such data through statutory or regulatory mandates on those holding the required data, or through alternative legal arrangements. The State must ensure that all written agreements and/or legal relationships have been secured with any relevant entities (e.g. Vermont Commercial Plans and Vermont Self-insured Plans) as well as with institutional review boards that are necessary to ensure CMS or its designee(s) can access individual-level, identifiable data and to carry out monitoring and evaluation activities.. CMS shall have the authority to share all Model data, documents, and other information with its designees for evaluation, monitoring, oversight, and other purposes, in accordance with applicable law. CMS shall have the authority to use any data obtained pursuant to the Model to publically disseminate quantitative and qualitative results, in accordance with applicable law.
- b. **Vermont Evaluation.** The State shall submit to CMS the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the Quarterly

Financial Report, as described in sections 4, 5, and 6, respectively, of the Agreement. Additionally, as described in section 15.a, Vermont shall provide CMS Vermont Medicaid claims data, and Vermont Commercial Plans claims data, and Vermont Self-insured Plan claims data to support CMS's monitoring and evaluation of the Model. The State must make available to CMS and CMS' contractors, for validation and oversight purposes, the State's datasets and methodologies used for this evaluation, including, as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under the Model Agreement.

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

- a. Such monitoring activities may include, without limitation:
 - i. Interviews with any members of the State involved in operating the Vermont Medicare All-payer ACO Model;
 - ii. Interviews with beneficiaries and their caregivers;
 - iii. Interviews with Vermont ACOs;
 - iv. Audits of the Annual ACO Scale Targets and Alignment Report, the Annual Health Outcomes and Quality of Care Report, and the Quarterly Financial Report;
 - v. Audits of regulatory approach, implementation plans, and other data from the State;
 - vi. Site visits to the State and Vermont ACOs; and
 - vii. Documentation requests sent to the State and to Vermont ACOs.
- b. CMS shall, to the extent practicable and as soon as practicable, provide the State with a comprehensive schedule of planned comprehensive annual audits related to compliance with this Agreement.
 - i. Such schedule does not preclude the ability of CMS to conduct more limited, targeted or ad hoc audits as necessary.
 - ii. CMS may alter such schedule without the consent of the State. CMS shall notify the State within 15 days of altering such schedule.
- c. The State shall cooperate, and ensure that all Vermont ACOs cooperate with all CMS monitoring and oversight requests and activities.

19. Maintenance of Records. In accordance with applicable law, the State shall maintain, and require Vermont ACOs to maintain, and give the Government, including CMS, DHHS, the Department of Justice, the Government Accountability Office, and other federal agencies or their designees access to all books, contracts, records, documents, software systems, and other information (including data related to calculations required under the Model Agreement, Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements) sufficient to enable the audit, evaluation, inspection, or investigation of the States' and/or Vermont ACO's

compliance with the requirements of this Agreement. The State shall maintain and require Vermont ACOs to maintain such books, contracts, records, documents, and other information for a period of 10 years after the final date of the Performance Period 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 State 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 State or the Vermont ACOs or other individuals or entities performing functions or services related to the Model, 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.

20. **Modification.** The Parties may amend the Model Agreement, including any appendix to the Model Agreement, at any time by mutual written consent. CMS may amend the Model Agreement for good cause shown or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS shall include with any proposed amendment an explanation of the reasons for the proposed amendment. To the extent practicable, CMS shall provide the State with 30 calendar days advance written notice of the effective date of such amendment, which notice shall specify the amendment's effective date. If State law precludes application of the amendment to the Model Agreement, the Parties will promptly seek modification of the amendment. If modification of the amendment is impracticable or consensus cannot be reached, the Secretary or the State may terminate the Model and/or Waivers under the Termination section of the Model Agreement.

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

- a. **Warning Notice and Corrective Action Plan (CAP).** If CMS determines that a Triggering Event has occurred, CMS will provide written notice to the State that it is not meeting a requirement of the Agreement ("Warning Notice") with an explanation and data supporting its determination. CMS shall provide the State with the Warning Notice no later than six (6) months following the end of the applicable Performance Year for any Triggering Event. Unless otherwise noted in this Agreement, within 90 calendar days of receipt of the Warning Notice, the State will submit a written response to CMS. CMS will review the State's response within 90 calendar days and will either accept the response as sufficient or require the State to submit a CAP. If CMS requires the State to submit a CAP, the State shall do so within 30 calendar days of CMS notice that the State response is not sufficient. In its CAP, the State shall address all actions the State and/or Vermont ACO will take to correct any deficiencies and remain in compliance with the Agreement. The CAP may include, but is not limited to, new safeguards or programmatic features. CMS will review and approve the CAP within 30 calendar days or

specified under a Warning Notice, CMS may take control over setting benchmarks for a Vermont Medicare ACO, including how benchmarks are tied to quality performance.

e. **Termination of the Agreement.**

- i. **Termination by the Secretary.** If the Secretary determines, in its sole discretion, that the State has not successfully implemented a required CAP or complied with an alternative CMS-provided corrective action in the time period specified under a Warning Notice, the Secretary may immediately terminate this Agreement.
 - ii. **Termination by the State.** The State may terminate this Agreement at any time for any reason upon 180 calendar days written advance notice to CMS.
 - iii. **Survival.** Termination of this Agreement by either Party shall not affect the rights and obligations of the Parties accrued prior to the effective date of the termination or expiration of this Agreement, except as provided in this Agreement. The rights and duties under the following sections of this Agreement shall survive termination of this Agreement and apply thereafter:
 - a. Section 15 (Data Sharing)
 - b. Section 17 (Vermont Evaluation)
 - c. Section 18 (CMS Monitoring of Model)
 - d. Section 19 (Maintenance of Records)
- f. **Termination under Section 1115A(b)(3)(B).** The Secretary may terminate this Agreement immediately if she makes findings under Section 1115A(b)(3)(B) of the Act requiring the termination of the Model.
- g. **Federal Government Enforcement.**

- i. Nothing contained in this Agreement is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of the Inspector General (OIG), or CMS of any right to institute any proceeding or action against defendants for violations of any statutes, rules or regulations administered by the federal government, or to prevent or limit the rights of the federal 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.
- ii. This Agreement shall not be construed to bind any federal government agency except

CMS, and this Agreement binds CMS only to the extent provided herein. The failure by CMS to require performance of any provision shall not affect CMS's right to require performance at any time thereafter, nor shall 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. None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the State, hospitals or providers and/or suppliers in the state of Vermont, or individuals or entities performing functions or services related to activities under this Agreement.

- iii. CMS provides no opinion on the legality of any contractual or financial arrangement that a Vermont ACO 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 a 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.

22. Limitations 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:
 - i. The selection of states, organizations, sites, or participants in the Model and Initiative, including the decision by CMS to terminate this agreement or to require the termination of any individual's or entity's status in the Model or Initiative;
 - ii. The elements, parameters, scope, and duration of the Model and the Initiative;
 - iii. The termination or modification of the design and implementation of the Model and/or Initiative under subsection 1115A(b)(3)(B); and
 - iv. Determinations about expansion of the duration and scope of the Model under subsection 1115A(c), including the determination that the Model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.
- b. **Dispute Resolution**
 - i. The parties agree to the following procedures for any dispute that is not subject to preclusion of administrative or judicial review as set forth in **section 21** of this agreement. The State shall notify CMS of any such dispute in writing within 30 days of the date on which the State becomes aware, or should have become aware, of the act giving rise to the dispute. This written notification must provide a detailed explanation of the basis for the dispute and supporting documentation.

- ii. If the parties cannot resolve any such dispute within 30 days after CMS receives written notice of the dispute, then the Participant shall submit within 30 subsequent days an informal hearing request to a CMS hearing officer, or a CMS designee, including the detailed explanation of the basis for the dispute and supporting documentation.
- iii. After receiving the Participant's informal hearing request, the CMS hearing officer shall issue a notice within 30 days to the Participant and CMS for a hearing scheduled no fewer than 30 days after the date of the notice. This notice will specify the date, time and location of the hearing, and the issues in dispute.
- iv. Within 30 days of the hearing, the CMS hearing officer shall issue a written notice to the Participant containing its final determination on the issue, and announcing the effective date of the determination, if applicable.
- v. CMS's final determination shall be final and binding.
- vi. The parties shall proceed diligently with the performance of this agreement during the course of any dispute arising under the agreement.

23. **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.

24. **Agency Notifications and Submission of Reports.** Unless otherwise stated in writing after the Effective Date, all notifications and reports under this Agreement shall be submitted to the parties at the addresses set forth below:

Steve Cha
Director, State Innovations Group
Center for Medicare and Medicaid Innovation
Steve.Cha@cms.hhs.gov
(410) 786-1876

Al Gobeille
Chair, Green Mountain Care Board
Al.Gobeille@vermont.gov
<insert number>

25. **Entire Agreement.** 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 State 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 State with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date.

26. **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.

[SIGNATURE PAGE FOLLOWS]

DRAFT

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

CENTER FOR MEDICARE & MEDICAID SERVICES

Date _____

By: _____
Dr. Patrick Conway, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF THE STATE OF VERMONT

Date _____

By: _____
Peter Shumlin, Governor

GREEN MOUNTAIN CARE BOARD

Date _____

By: _____
Al Gobeille, Chair, Green Mountain Care Board

VERMONT AGENCY OF HUMAN SERVICES

Date _____

By: _____
Hal Cohen, Secretary, Vermont Agency of Human Services

Appendix 1 – Population-level Health Outcomes Targets, Healthcare Delivery System Quality Targets, and Process Milestones

a. Population-level Health Outcomes Targets

- i. **Substance Use Disorder Target.** The State must reduce deaths of Vermont residents related to drug overdose by 10 percent in aggregate over the Performance Period of this Model, using 2015 as the baseline.
 - 1) **Calculation methodology.** Target performance, measured as an age-adjusted rate per 100,000 Vermont residents, will be calculated using the Center for Disease Control (CDC) National Vital Statistics System Mortality File’s methodology and data for calculating deaths related to drug overdose.
 - 2) CMS may determine that the State is not on track to meet this target if, cumulatively across PY1-PY2, the State experiences an increase in deaths related to substance use disorder. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2015 (baseline year) age-adjusted death rate and the target rate does not decrease by: at least 30 percent by the end of Performance Year 3; at least 65 percent by the end of Performance Year 4; or at least 100 percent by the end of Performance Year 5..
- ii. **Suicide Target.** The State must reduce the number of deaths due to suicide to 16 per 100,000 Vermont residents, or reduce the State’s ranking on suicide rate from the 7th to the 20th highest by state across the United States.
 - 1) **Calculation methodology.** Target performance will be calculated using the CDC National Vital Statistics System Mortality File’s methodology and data for calculating deaths due to suicide.
 - 2) CMS may determine that the State is not on track to meet this target if, cumulatively across PY1-PY2, the State experiences an increase in its suicide rate relative to its 2015 baseline. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2015 suicide rate and the target rate does not decrease by: at least 30 percent by the end of Performance Year 3; at least 65 percent by the end of Performance Year 4; or at least 100 percent by the end of Performance Year 5.
- iii. **Chronic Conditions Targets.** The State must not increase prevalence of COPD, diabetes, and hypertension for Vermont residents, each measured separately as a percent of state population, by more than 1 percentage point, using 2016 as a baseline.
 - 1) **Calculation methodology.** Chronic Conditions targets’ performance will be calculated separately for each of the three chronic conditions using the CDC Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, based on the responses to the following questions:
 - a. Diabetes prevalence: “Have you been told that you have diabetes?”

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

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

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

2) CMS may determine that the State is not on track to meet this target if, starting in PY3, the prevalence of diabetes, COPD, and/or hypertension among Vermont residents is more than 1 percentage point greater than the prevalence of said chronic conditions in 2016.

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

1) **Calculation methodology.** Target performance will be calculated, using the CDC BRFSS questionnaire, as the percent of Vermont resident respondents who answer “yes” to the following question: “Do you have one person you think of as your personal doctor or health care provider?”

2) CMS may determine that the State is not on track to meet this target if, cumulatively across PY1-PY2, the State decreases the percent of adults who have a personal doctor or health care provider. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2016 (baseline year) percentage of adults that report that they have a usual primary care physician and the target percentage does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

b. Healthcare Delivery System Quality Targets

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

1) **Calculation methodology.** Target performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment” (endorsed by NQF as Measure #4). Performance on initiation and engagement will be assessed separately. The State’s performance will be measured against healthcare plans nationally using performance data for NQF Measure #4 reported in NCQA’s Quality Compass data for Performance Year 1. Vermont’s performance and the national 75th percentile comparison data for each payer type will each be averaged together across payers weighted by the relative proportion of payer types for Vermont residents

included in the State's performance calculation.

- 2) CMS may determine that the State is not on track to meet these initiation and engagement targets if, cumulatively across PY1-PY2, the State decreases initiation and engagement rates. During PY3-PY5, CMS may determine that the State is not on track to meet these two targets if the differences between Vermont's 2016 (baseline year) rates of initiation and engagement of alcohol and other drug dependence treatment and the target rates do not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

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

- 1) **Calculation methodology.** Target performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence" (endorsed by NQF as Measure #2605). Vermont's performance for each payer type will be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State's performance calculation.
- 2) CMS may determine that the State is not on track to meet this target if, cumulatively across PY1-PY2, the State decreases this rate. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the differences between Vermont's 2016 (baseline year) rate of follow-up after discharge from the emergency department and the target rate do not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

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

- 1) **Calculation methodology.** Target performance for any given Performance Year will be measured according to NCQA HEDIS measure specifications for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence" (endorsed by NQF as Measure #2605). Vermont's performance for each payer type will be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State's performance calculation.
- 2) CMS may determine that the State is not on track to meet this target if, cumulatively

across PY1-PY2, the State decreases this rate. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the differences between Vermont's 2016 (baseline year) rate of follow-up after discharge from the emergency department and the target rate do not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

- iv. **Suicide and Substance Use Disorder Target – Mental Health and Substance Abuse-related Emergency Department Visits.** The State must reduce the rate of growth of emergency department (ED) visits with a primary diagnosis of mental health or substance abuse condition across payers in Vermont hospitals, using 2016 as a baseline. Vermont and CMS shall establish a target by June 30, 2017.
- 1) **Calculation methodology.** This target's performance for any given Performance Year will be measured using Vermont Department of Health's hospital discharge data and counting the number of ED visits at Vermont hospitals with a primary diagnosis of mental health or substance abuse condition.
 - 2) CMS may determine that the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State increases the rate of growth of ED visits due to mental health and substance abuse across payers. During PY3-PY5, CMS shall determine that the State is not on track to meet this target if the difference between the growth rate in ED visits with a primary diagnosis of mental health or substance abuse condition growth rate and the target growth rate does not decrease by: at least 30% by the end of Performance Year 3 (using the difference in 2016 as a baseline); at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.
- v. **Chronic Conditions Target – Composite of Diabetes, Hypertension, and Multiple Chronic Conditions.** The State must achieve the 75th percentile, as compared to national Medicare performance, for a composite measure comprising of diabetes, hypertension, and multiple chronic condition morbidity of VMA ACO or Modified Next Generation ACO-aligned Vermont Medicare Beneficiaries.
- 1) **Calculation methodology.** This target's performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measures ACO 27 ("Diabetes: Hemoglobin A1c Poor Control"), ACO 28 ("Controlling High Blood Pressure"), and ACO 38 ("All-cause Unplanned Admissions for Patients with Multiple Chronic Conditions"). The State's performance on ACO 28, ACO 38, and ACO 27 will each be assessed against the national Medicare performance percentile information used for the Medicare Shared Savings Program quality measure benchmarks for PY1, and each of the measures will be assigned a percentile based on the comparison to the national Medicare performance percentile information. The State's percentiles for ACO 28, ACO 38, and ACO 27 will be averaged together. This averaged percentile will then be compared to the target of 75th percentile of national

Medicare performance used for the Medicare Shared Savings Program quality measure benchmarks for PY1.

- 2) CMS may determine that the State is not on track to meet this target if, cumulatively across PY1-PY2, the State decreases its average percentile. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont's 2016 (baseline year) Medicare average percentile and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

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

- 1) **Calculation methodology.** This target's performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measure, specifications, and data for ACO-1 ("Getting Timely Care, Appointments, and Information"). The national Medicare 75th percentile will be equal to the national Medicare 75th percentile used for the Medicare Shared Savings Program quality measure benchmarks for PY1.
- 2) CMS may determine that the State is not on track to meet this target if, starting in PY2, the cumulative average percentile across performance years (from PY1 through the current performance year) is less than the target.

c. **Process Milestones.**

i. **Substance Use Disorder Milestone – Prescription Drug Monitoring Initiative**

Utilization. The State must increase the utilization of Vermont's prescription drug monitoring program, using 2017 as a baseline. Vermont and CMS shall establish a target by June 30, 2017.

- 1) **Calculation methodology.** This milestone's performance will be measured as the number of times prescribers (or their delegates) query the prescription drug monitoring program system divided by the number of patients for whom a prescriber writes prescriptions for controlled substances.
- 2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State decreases its prescription drug monitoring program utilization. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont's 2017 (baseline year) rate of utilization and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

- ii. **Substance Use Disorder Milestone – Medication-assisted Treatment Utilization.** The State must increase the number of Vermont residents receiving medication-assisted treatment (MAT) for substance use disorder to 150 per 10,000 Vermont residents of ages 18-64 (or up to the rate of demand).
- 1) **Calculation methodology.** This milestone’s performance will be calculated, using Vermont Department of Health data, as the unique number of Vermont residents of ages 18-64 receiving MAT. CMS shall consider Vermont to have achieved this target if MAT utilization is less than 150 per 10,000 residents of ages 18-64 but no residents remain on the MAT waitlist (proxy for demand being satisfied).
 - 2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State does not increase the number of Vermont residents (per 10,000, ages 18-64) receiving MAT. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2016 (baseline year) rate of MAT utilization and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.
- iii. **Suicide Milestone – Screening for Clinical Depression.** The State must achieve the 75th percentile, as compared to national Medicare performance, for the percent of Vermont ACO-aligned beneficiaries who received a screening for clinical depression, and if depression was detected, a follow-up plan.
- 1) **Calculation methodology.** This milestone’s performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measure and specifications for ACO-18 (“Screening for Clinical Depression and Follow-up Plan”). The milestone’s performance will include Vermont Medicare Beneficiaries and beneficiaries enrolled in Vermont Medicaid, in a Vermont Commercial Plan, or in a Vermont Self-insured Plan who are also aligned to a Vermont ACO. The national Medicare performance percentile will be equal to the national Medicare 75th percentile used for the Medicare Shared Savings Program quality measure benchmarks for PY1. The following steps will be done to determine Vermont’s performance on this milestone:
 - Assign percentile to each of the payers for this measure as compared to the PY1 national Medicare performance.
 - Average the percentiles for each of the payers weighted by the relative proportion of attributed population.
 - Determine whether the percentile is greater than or equal to 75%.CMS and Vermont will regularly assess whether multi-payer national benchmarks are/become available against which to compare Vermont’s performance, instead of using national Medicare performance.
 - 2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State decreases its depression screening rate. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference

between Vermont’s 2016 (baseline year) rate of screening for clinical depression and follow-up plan and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

iv. **Chronic Conditions Milestone - Tobacco Use Assessment and Cessation Intervention.**

The State must achieve the 75th percentile, as compared to national Medicare performance, for the percent of Vermont ACO-aligned beneficiaries who were screened for tobacco use and who received cessation counseling intervention if identified as a tobacco user.

1) **Calculation methodology.** This milestone’s performance for any given Performance Year will be measured using the Medicare Shared Savings Program quality measure and specifications for ACO-17 (“Tobacco Use: Screening and Cessation Intervention”). The milestone’s performance will include Vermont Medicare Beneficiaries and beneficiaries enrolled in Vermont Medicaid, in a Vermont Commercial Plan, or a Vermont Self-insured Plan who are also aligned to a Vermont ACO. The national Medicare performance percentile will be equal to the national Medicare 75th percentile used for the Medicare Shared Savings Program quality measure benchmarks for PY1. The following steps will be done to determine Vermont’s performance on this milestone:

- Assign percentile to each of the payers for the measure as compared to Medicare National Benchmark.
- Average the percentiles for each of the payers weighted by the relative proportion of attributed population.
- Determine whether the percentile is greater than or equal to 75%.

CMS and Vermont will regularly assess whether multi-payer national benchmarks are/become available against which to compare Vermont’s performance, instead of using national Medicare performance.

2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State decreases its tobacco use assessment and cessation intervention rate. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2016 (baseline year) rate of tobacco use assessment and cessation intervention and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

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

1) **Calculation methodology.** This milestone’s performance for any given Performance Year will be measured according to measure specifications for NCQA HEDIS measure “Medication Management for People with Asthma.” The State’s performance will be measured against healthcare plans nationally using performance

data for HEDIS measure “Medication Management for People with Asthma” recorded in the NCQA’s Quality Compass data for PY1. Vermont’s performance and the national comparison data for each payer type will each be averaged together across payers weighted by the relative proportion of payer types for Vermont residents included in the State’s performance calculation.

- 2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State decreases the percent of Vermont residents receiving appropriate asthma medication management. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2016 (baseline year) rate of medication management for people with asthma and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; at least 100% by the end of Performance Year 5.
- vi. **Access to Care Milestone – Medicaid Adolescents with Well-Care Visits.** The State must achieve the 50th percentile, as compared to Medicaid plans nationally, for the percentage of Vermont adolescents enrolled in Vermont Medicaid who have a well-care visit.
- 1) **Calculation methodology.** This milestone’s performance for any given Performance Year will be measured for Vermont Medicaid adolescents according to measure specifications for NCQA HEDIS measure “Adolescents with Well-Care Visits.” The State’s performance will be measured against Medicaid plans nationally using Medicaid performance data for HEDIS measure “Adolescents with Well-Care Visits” recorded in the NCQA’s Quality Compass data for PY1.
 - 2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State decreases the percentage of Medicaid adolescents with well-care visits. During PY3-PY5, CMS may determine that the State is not on track to meet this target if the difference between Vermont’s 2016 (baseline year) percentage of Medicaid adolescents with well-care visits and the target rate does not decrease by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; at least 100% by the end of Performance Year 5.
- vii. **Access to Care Milestone – Medicaid Beneficiaries Aligned to a Vermont ACO.** The State must ensure that the percent of Vermont Medicaid beneficiaries aligned to a Vermont ACO not be less than that of Vermont Medicare Beneficiaries by more than 15 percentage points.
- 1) **Calculation methodology.** This milestone’s performance will be comparing in any given Performance Year the percentage of Vermont residents enrolled in Vermont Medicaid who are aligned to a Scale Target ACO Initiative to the percentage of Vermont Medicare Beneficiaries who are aligned to a Scale Target ACO Initiative.
 - 2) CMS may determine the State is not on track to meet this milestone if, cumulatively across PY1-PY2, the State decreases the percentage of Vermont Medicaid beneficiaries aligned to a Vermont ACO. During PY3-PY5, CMS may determine that

the State is not on track to meet this target if the difference between the percentage of Medicaid beneficiaries attributed to a Vermont ACO and 10 percentage points less than that of Medicare beneficiaries decreases by: at least 30% by the end of Performance Year 3; at least 65% by the end of Performance Year 4; or at least 100% by the end of Performance Year 5.

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Appendix 2 – One-time Funding Terms

Permissible Uses for One-time Funding. Vermont shall use the One-time Funding to support Medicare FFS beneficiaries through one or more of the following activities:

- a. Connect patients with community-based resources. Examples include the below.
 - Develop and maintain up-to-date local information about formal and informal resources beyond those covered by Medicare, including peer and community-based programs.
 - Assist and support access to community resources based on individual patient needs and goals. Community resources include transportation services for patients with restricted mobility, nutritional counseling and support, housing subsidies, and food assistance.
 - Provide information and supporting participation in vocational and employment services to promote economic self-sufficiency.
- b. Coordinate transitions across care settings with appropriate involvement of the patient’s primary care provider. Examples include the below.
 - Develop and maintain collaborative relationships between providers such as hospital emergency departments, hospital discharge departments, and primary care providers.
 - Reconcile medication.
 - Plan follow-up with primary care provider and other necessary providers.
 - Review post-discharge care management plan with patient.
- c. Coordinate care across providers. Examples include the below.
 - Schedule appointments and perform outreach to support attendance at scheduled treatment and human services appointments.
 - Monitor treatment progress, implementation of the care management plan, and medication adherence.
 - Coordinate with other providers to monitor individuals’ health status and participation in treatment.
- d. Support health promotion and self-management by patients. Examples include the below.
 - Provide health education specific to a patient’s chronic conditions
 - Identify health and life goals and develop of self-management plans with the patient.
 - Provide health promoting lifestyle interventions including but not limited to nutritional counseling, obesity reduction, and increasing physical activity.
 - Teach patients to use their DME equipment.
 - Review medications.
 - Ensure patients are following self-management plans.
- e. Support practice improvement and transformation. Examples include the below.
 - Meet nationally recognized patient medical home standards.
 - Respond to data to reduce variation and improve care.
 - Collaborate with community-based care coordinators to identify and link community-based services for high risk patients.

Restrictions on One-time Funding. Vermont shall not use the One-time Funding for the following activities:

- a. Pay for any community services (e.g., housing, food, violence intervention programs, and transportation).

- b. Provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.
- c. Match any federal funds.
- d. Provide services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

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