l. **Parties.** This is a contract for personal services between the State of Vermont, Department of Vermont Health Access (hereafter called "State"), and MVP Health Care with a principal place of business in Schenectady, NY (hereafter called "Contractor"). The Contractor's form of business organization is a non-profit corporation providing health insurance. The Contractor's local address is 625 State Street, Schenectady, NY 12305. It is the Contractor's responsibility to contact the Vermont Department of Taxes to determine if, by law, the Contractor is required to have a Vermont Department of Taxes Business Account Number.

2. **Subject Matter.** The subject matter of this contract is health insurer participation in the implementation and statewide expansion of the Vermont Blueprint for Health integrated health services program.

3. **Maximum Amount.** This is a no-cost Agreement. The State will provide no financial reimbursement for the services to be performed by the Contractor.

4. **Contract Term.** The period of the Contractor's performance shall begin on July 1, 2013 and end on June 30, 2015.

5. **Prior Approvals.** If approval by the Attorney General's Office or the Secretary of Administration is required, (under current law, bulletins, and interpretations), neither this contract nor any amendment to it is binding until it has been approved by either or both such persons.

Approval by the Attorney General's Office **is** required.

Approval by the Secretary of Administration **is** required.

6. **Amendment.** No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and The Contractor.

7. **Cancellation.** This contract may be cancelled by either party by giving written notice at least 30 days in advance.

8. **Attachments.** This contract consists of 25 pages including the following attachments, which are incorporated herein:
Attachment A - Specifications of Work to be Performed
Attachment B - Payment Provisions
Attachment C - Customary State Contract provisions
Attachment F - Customary Contract Provisions of the Agency of Human Services

The order of precedence of documents shall be as follows:

1). This document
2). Attachment C
3). Attachment A
4). Attachment B
5) Attachment F

WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

BY THE STATE OF VERMONT:

E-SIGNED by Mark Larson
on 2013-07-14 13:23:01 GMT

MARK LARSON, COMMISSIONER DATE
DEPARTMENT OF VERMONT HEALTH ACCESS

BY THE CONTRACTOR:

E-SIGNED by William Little
on 2013-07-12 18:13:22 GMT

William Little, Vice President DATE
MVP Healthcare

ATTACHMENT A
SPECIFICATIONS OF WORK TO BE PERFORMED

The roles and responsibilities of the Contractor and the State during the contract period are as follows:

1. **Providing financial support for Blueprint Community Health Teams (CHTs).** All participating payers, including the Contractor, will share in the cost of the CHTs. Blue Cross Blue Shield of Vermont (BCBSVT) and the Department of Vermont Health Access (DVHA) will each pay 24.22% of total CHT costs for current patients. Medicare will pay 22.22% of total CHT costs for current patients. Cigna HealthCare (Cigna) will pay 18.22% of total CHT costs for current patients. MVP Health Care (MVP) will pay 11.12% of total CHT costs for current patients. For patients in practices scheduled for scoring but not yet scored that meet the criteria in Section 2. below, BCBSVT and DVHA will each pay 31.2% of the advance CHT costs, Cigna will pay 23.4% of the advance CHT costs, and MVP will pay 14.2% of the advance CHT costs.

   The State will ensure that there is at least one CHT in each of the Blueprint Health Service Areas (HSAs) in Vermont to provide support services for the population of patients receiving their care in Blueprint Advanced Primary Care Practices. As the Blueprint continues to expand to all willing primary care practices and the number of patients changes, the size of and financial support for the CHT(s) in each HSA will be scaled up or down based on the number of patients in the Blueprint-participating practices that the CHT(s) supports in the HSA.

   For purposes of this Agreement, "number of patients" means the number of total unique Vermont patients in Blueprint-participating practices with one or more Evaluation and Management coded visits to the practices during the previous 24 months, regardless of the patients' insurance coverage. The number of patients also will include the number of unique Vermont patients in primary care practices that are scheduled to be scored under National Committee for Quality Assurance ("NCQA PCMH") standards (as described in Section 2. below) during the following two quarters, and that wish to receive CHT services in advance of their scoring date. Appendix 1 contains the algorithm in use by the practices to calculate total unique Vermont patients as of the effective date of this contract.

   Total CHT payments from all payers will occur at a rate of $17,500.00 per year ($4375.00 per quarter and $1458.34 per month) per 1,000 patients attributed to Blueprint-participating practices in each HSA. Total advance CHT payments for all payers except Medicare for patients in practices scheduled to be scored during the following two quarters will occur at the rate of $13,611.50 per year ($3402.88 per quarter and $1134.29 per month) for every additional increment of 1,000 attributed patients resulting from those practices. Appendix 2 contains tables showing CHT payment levels for participating practice and advance CHT payment levels for practices scheduled to be scored during the following two quarters. The Blueprint will work with CHT administrative entities to ensure that the advance CHT payments are used to provide core CHT services (in accordance with a CHT plan approved by the Blueprint) to patients in those practices that are scheduled to be scored during the following two quarters.

   The Contractor will make CHT payments monthly or quarterly, as determined by the Contractor in conjunction with the Blueprint Director, upon receipt of an invoice sent by the CHT administrative entity to the Contractor (if an invoice is required by the Contractor) by the 15th calendar day of the month or the 15th calendar day of each quarter. Invoices will reflect the administrative entities' CHT payments as determined by the Blueprint based on the total unique Vermont patients in Blueprint-participating practices, and advance CHT payments as determined by the Blueprint based on the total unique Vermont patients in practices scheduled to be scored during the following two quarters. Changes

in the amount of financial support due to scaling up or down of CHT capacity will be made by the Blueprint quarterly, and will be reflected in invoices from the CHT administrative entity (if applicable) and payments from the Contractor.

The Blueprint will provide reports to the Contractor and to CHT administrative entities reflecting changes in total unique Vermont patients and CHT financial support for each HSA by the first calendar day of each quarter, but no later than the fifth calendar day of each quarter. The information in these reports will be based on total unique Vermont patient data provided by CHT administrative entities to the Blueprint. The Blueprint will also provide the Contractor with a monthly NCQA scoring schedule, and regular reports reflecting the number of CHT staff hired and the type of CHT services provided in each HSA.

Monthly payments related to the initiation of a new CHT will begin on the first day of the month after (or on which) the Contractor receives information from the Blueprint indicating that practices affiliated with the new CHT have received their scores from the Vermont Child Health Improvement Program (VCHIP) and/or achieved NCQA PCMH recognition and the CHT begins clinical operations. As is the case for already-existing CHTs, the amount of financial support for new CHTs will be based on the number of total unique Vermont patients in Blueprint-participating practices, as well as the total unique Vermont patients in practices scheduled to be scored within the next two quarters that wish to receive CHT services in advance of their scoring dates. If the Contractor makes quarterly CHT payments, payment amounts will be pro-rated if a CHT begins clinical operations after the start of the quarter. Changes in payments related to scaling up or down of CHT capacity will begin on the first day of the quarter after (or on which) there are changes in the number of patients in Blueprint-participating practices and/or practices scheduled to be scored within the following two quarters that wish to receive CHT services in advance of their scoring dates.

CHTs under the same administrative entity within an HSA that are geographically dispersed throughout the HSA or otherwise segmented will be treated as a single CHT for payment purposes, regardless of the CHT's capacity and the number of patients in Blueprint-participating practices. If there is more than one administrative entity in the HSA, the CHTs for each administrative entity will be treated as individual CHTs for payment purposes. In the event that there is more than one administrative entity, each practice in the HSA will be assigned to one CHT and one administrative entity; a practice will not be split among administrative entities and CHTs.

2. **Providing financial support for enhanced provider payment to the participating practices.** The per person per month (PPPM) payment is designed to support the operations of a patient centered medical home and is based on each Blueprint-participating practice's NCQA PCMH score, as shown in Appendix 3 in Table 2 (for practices scored according to 2008 NCQA Standards) and Table 3 (for practices scored according to 2011 NCQA Standards). The Contractor will provide the enhanced PPPM payment for all of its attributed patients in the practice. Appendix 4 contains the algorithm in use by the Contractor and other commercial insurers to identify attributed patients as of the effective date of this contract. Upon request of the practices or their parent organizations, the Contractor will provide the list of attributed patients for review and reconciliation if necessary. To calculate the total amount of the PPPM payment for each practice, the Contractor will multiply the number of attributed patients in the practice by the PPPM amount associated with the practice's most recent applicable NCQA PCMH score as shown in Appendix 3. The actual payments to specific practices will be based on their most recent NCQA PCMH scores.

The PPPM payment schedules shown in Appendix 3 and the attribution methodology found in Appendix 4 are the current models generated in collaboration with the Payment Implementation Work Group, and

approved by consensus by the Blueprint Executive Committee. The attribution methodology can be revised after seeking input from the Blueprint's Payment Implementation Work Group, Expansion Design and Evaluation Committee, and Executive Committee. The PPPM amounts can be revised if the applicable NCQA standards change; in addition, PPPM amounts can be changed by the Blueprint Director after seeking input from the Blueprint's Payment Implementation Work Group, Expansion Design and Evaluation Committee, and Executive Committee.

Payment for newly-scored practices will be effective on the first of the month after the date that the Blueprint transmits NCQA PCMH scores from VCHIP to the Contractor and the other payers, and will initially be based on VCHIP scores. Changes in payment resulting from subsequent receipt of NCQA scores, as well as changes for practices that are experiencing an add-on survey, an upgrade, or a re-score, will be implemented by the Contractor on the first of the month after the NCQA scores are received by the Contractor from the Blueprint. Practices must be re-scored every three years and may request an interim add-on survey or upgrade, pending availability of VCHIP reviewers, but not more frequently than once every six months. Payments to practices for add-on surveys, upgrades, or re-scores will not change based on VCHIP's review. Payment will remain at the previous level until the NCQA review is received, at which time it will be adjusted according to the NCQA score.

3. **Procedure for reducing PPPM and CHT payments if current NCQA recognition lapses or reducing CHT payments for frontloaded practices if initial NCQA recognition is not attained.** Appendix 5 contains examples of timelines for two hypothetical practices: one currently scored practice that isn't recognized during a rescore such that its NCQA recognition lapses, and one practice that has received advance CHT payments but that isn't recognized during the initial scoring process.

a. Procedure for reducing PPPM and CHT payments if current NCQA recognition lapses: The procedure for reducing PPPM payments and CHT payments for practices that do not achieve recognition before their current NCQA recognition lapses is as follows:

If a practice that is scheduled to be rescored does not achieve NCQA recognition as scheduled (due to either a postponement of the scoring date such that NCQA recognition will lapse, or failure to achieve recognition), the practice and the Blueprint Associate Director will develop an action plan with a clear timeline for achieving subsequent recognition, if CHT payments are to continue.

The action plan must have the following 3 components:
1. Identification of the reason(s) for the practice not achieving NCQA PCMH recognition,
2. A clear plan for targeted improvement with identification of parties responsible for the steps to take, and
3. A clear timeline for targeted improvement.

The action plan will be developed within 30 days of receipt of the initial score from VCHIP or NCQA in the event of a failure to achieve recognition, or within 15 days of the decision to postpone the scoring date, such that NCQA recognition will lapse.

Regardless of whether an action plan is developed, insurers will terminate PPPM payments on the last day of the month following the date on which NCQA recognition lapses, if the practice does not achieve recognition during that time period.

If an action plan is not developed as stated above, the additional CHT payments related to that practice's patients will end on the last day of the quarter during which NCQA recognition lapses. If an action plan

is developed, the additional CHT payments related to that practice's patients will remain in place for the quarter following the date on which NCQA recognition lapses, and will then decline by 25% for each quarter thereafter, until recognition is achieved (at which time full CHT payments will be restored).

If a subsequent VCHIP evaluation indicates that the practice will achieve recognition, insurers will pay (or continue to pay) the practice at the previous PPPM rate based on the most recent successful NCQA score, starting on the date of the VCHIP evaluation, until the new NCQA rescore is available. If NCQA determines that the VCHIP evaluation was wrong and that the practice did not achieve recognition, insurers will have the option of recouping the practice's PPPM payments back to the date on which those payments would have ended (i.e. – the last day of the month following the date on which NCQA recognition lapsed).

b. Procedure for reducing CHT payments for frontloaded practices if initial NCQA recognition is not attained: Regarding advance CHT funding for practices scheduled to be scored during the following two quarters, if a practice that is scheduled to be scored does not achieve NCQA recognition as scheduled (due to either a postponement of the scoring date or failure to achieve recognition), the practice and the Blueprint Associate Director will develop an action plan as described above.

The action plan will be developed within 30 calendar days of receipt of the initial score from VCHIP or NCQA in the event of a failure to achieve recognition, or within 15 days of the decision to postpone the scoring date. If it is not developed within the applicable time frame, CHT payments for that practice's patients will end on the last day of the quarter in which the applicable time frame ends. If an action plan is developed, the additional CHT payments related to that practice's patients will decline by 25% for each quarter after the quarter in which the applicable time frame ends, until recognition is achieved.

ATTACHMENT B
PAYMENT PROVISIONS

1. This agreement has no cost obligation on the part of the State and will be handled as a no-cost contract.
2. No benefits or insurance will be reimbursed by the State.
3. No invoicing will be required.
4. The total maximum amount payable under this contract shall not exceed $0.

ATTACHMENT C
CUSTOMARY PROVISIONS FOR CONTRACTS AND GRANTS

1. **Entire Agreement.** This Agreement, whether in the form of a Contract, State Funded Grant, or Federally Funded Grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

2. **Applicable Law.** This Agreement will be governed by the laws of the State of Vermont.

3. **Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement.

4. **Appropriations:** If appropriations are insufficient to support this Agreement, the State may cancel on a date agreed to by the parties or upon the expiration or reduction of existing appropriation authority. In the case that this Agreement is funded in whole or in part by federal or other non-State funds, and in the event those funds become unavailable or reduced, the State may suspend or cancel this Agreement immediately, and the State shall have no obligation to fund this Agreement from State revenues.

5. **No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the state withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. **Independence, Liability:** The Party will act in an independent capacity and not as officers or employees of the State.

   The Party shall defend the State and its officers and employees against all claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The Party shall notify its insurance company and the State within 10 days of receiving any claim for damages, notice of claims, pre-claims, or service of judgments or claims, for any act or omissions in the performance of this Agreement.

   After a final judgment or settlement the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party.

   The Party shall indemnify the State and its officers and employees in the event that the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party.

7. **Insurance**: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverage is in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the state through the term of the Agreement. No warranty is made that the coverage and limits listed herein are adequate to cover and protect the interests of the Party for the Party's operations. These are solely minimums that have been established to protect the interests of the State.

   Workers Compensation: With respect to all operations performed, the Party shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.

   General Liability and Property Damage: With respect to all operations performed under the Agreement, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

   Premises - Operations
   Products and Completed Operations
   Personal Injury Liability
   Contractual Liability

   The policy shall be on an occurrence form and limits shall not be less than:

   $1,000,000 Per Occurrence
   $1,000,000 General Aggregate
   $1,000,000 Products/Completed Operations Aggregate
   $ 50,000 Fire/ Legal/Liability

   Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

   Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than: $1,000,000 combined single limit.

   Party shall name the State of Vermont and its officers and employees as additional insureds for liability arising out of this Agreement.

   Professional Liability*:** Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of ***$____N/A_____ per occurrence, and ***$____N/A_____*** aggregate.

8. **Reliance by the State on Representations:** All payments by the State under this Agreement will be made in reliance upon the accuracy of all prior representations by the Party, including but not limited to bills, invoices, progress reports and other proofs of work.

9. **Requirement to Have a Single Audit:** In the case that this Agreement is a Grant that is funded in whole or in part by federal funds, the Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a single audit is required for the prior fiscal year. If a single audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required.

   A single audit is required if the subrecipient expends $500,000 or more in federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a single audit is required.

10. **Records Available for Audit:** The Party will maintain all books, documents, payroll papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the Agreement and for three years thereafter for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this Agreement.

11. **Fair Employment Practices and Americans with Disabilities Act**: Party agrees to comply with the requirement of Title 21V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement. Party further agrees to include this provision in all subcontracts.

12. **Set Off**: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

13. **Taxes Due to the State**:

    a. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

    b. Party certifies under the pains and penalties of perjury that, as of the date the Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

    c. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.

    d. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

14. **Child Support**: (Applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date the Agreement is signed, he/she:

a. is not under any obligation to pay child support; or
b. is under such an obligation and is in good standing with respect to that obligation; or
c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

15. Sub-Agreements: Party shall not assign, subcontract or subgrant the performance of his Agreement or any portion thereof to any other Party without the prior written approval of the State. Party also agrees to include in subcontract or subgrant agreements a tax certification in accordance with paragraph 13 above.

Notwithstanding the foregoing, the State agrees that the Party may assign this agreement, including all of the Party's rights and obligations hereunder, to any successor in interest to the Party arising out of the sale of or reorganization of the Party.

16. No Gifts or Gratuities: Party shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

17. Copies: All written reports prepared under this Agreement will be printed using both sides of the paper.

18. Certification Regarding Debarment: Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs, or programs supported in whole or in part by federal funds.

Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: http://bgs.vermont.gov/purchasing/debarment

19. Certification Regarding Use of State Funds: In the case that Party is an employer and this Agreement is a State Funded Grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

ATTACHMENT F
AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT PROVISIONS

1. **Agency of Human Services – Field Services Directors** will share oversight with the department (or field office) that is a party to the contract for provider performance using outcomes, processes, terms and conditions agreed to under this contract.

2. **2-1-1 Data Base:** The Contractor providing a health or human services within Vermont, or near the border that is readily accessible to residents of Vermont, will provide relevant descriptive information regarding its agency, programs and/or contact and will adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211. If included, the Contractor will provide accurate and up to date information to their data base as needed. The "Inclusion/Exclusion" policy can be found at www.vermont211.org

3. **Medicaid Program Contractors**:

Inspection of Records: Any contracts accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid program must fulfill state and federal legal requirements to enable the Agency of Human Services (AHS), the United States Department of Health and Human Services (DHHS) and the Government Accounting Office (GAO) to:

Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and Inspect and audit any financial records of such Contractor or subcontractor.

Subcontracting for Medicaid Services: Having a subcontract does not terminate the Contractor, receiving funds under Vermont's Medicaid program, from its responsibility to ensure that all activities under this agreement are carried out. Subcontracts must specify the activities and reporting responsibilities of the Contractor or subcontractor and provide for revoking delegation or imposing other sanctions if the Contractor or subcontractor's performance is inadequate. The Contractor agrees to make available upon request to the Agency of Human Services; the Department of Vermont Health Access; the Department of Disabilities, Aging and Independent Living; and the Center for Medicare and Medicaid Services (CMS) all contracts and subcontracts between the Contractor and service providers.

Medicaid Notification of Termination Requirements: Any Contractor accessing payments for services under the Global Commitment to Health Waiver and Medicaid programs who terminates their practice will follow the Department of Vermont Health Access, Managed Care Organization enrollee notification requirements.

Encounter Data: Any Contractor accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid programs must provide encounter data to the Agency of Human Services and/or its departments and ensure that it can be linked to enrollee eligibility files maintained by the State.

Federal Medicaid System Security Requirements Compliance: All contractors and subcontractors must provide a security plan, risk assessment, and security controls review document within three months of the start date of this agreement (and update it annually thereafter) to support audit compliance with 45CFR95.621 subpart F, *ADP* (Automated Data Processing) *System Security Requirements and Review Process*.

4. **Non-discrimination Based on National Origin as evidenced by Limited English Proficiency**. The Contractor agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that contractors and subcontractors receiving federal funds must assure that persons with limited English proficiency can meaningfully access services. To the extent the Contractor provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.

5. **Voter Registration**. When designated by the Secretary of State, the Contractor agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

6. **Drug Free Workplace Act.** The Contractor will assure a drug-free workplace in accordance with 45 CFR Part 76.

7. **Privacy and Security Standards.**

   Protected Health Information: The Contractor shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this contract. The Contractor shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

   Substance Abuse Treatment Information: The confidentiality of any alcohol and drug abuse treatment information acquired by or provided to the Contractor or subcontractor shall be maintained in compliance with any applicable state or federal laws or regulations and specifically set out in 42 CFR Part 2.

   Other Confidential Consumer Information: The Contractor agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to information. The Contractor agrees to comply with any applicable Vermont State Statute, including but not limited to 12 VSA §1612 and any applicable Board of Health confidentiality regulations. The Contractor shall ensure that all of its employees and subcontractors performing services under this agreement understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

   Social Security numbers: The Contractor agrees to comply with all applicable Vermont State Statutes to assure protection and security of personal information, including protection from identity theft as outlined in Title 9, Vermont Statutes Annotated, Ch. 62.

8. **Abuse Registry.** The Contractor agrees not to employ any individual, use any volunteer, or otherwise provide reimbursement to any individual in the performance of services connected with this agreement, who provides care, custody, treatment, transportation, or supervision to children or vulnerable adults if there is a substantiation of abuse or neglect or exploitation against that individual. The Contractor will check the Adult Abuse Registry in the Department of Disabilities, Aging and Independent Living. Unless the Contractor holds a valid child care license or registration from the Division of Child Development, Department for Children and

Families, the Contractor shall also check the Central Child Protection Registry. (See 33 V.S.A. §4919(a)(3) & 33 V.S.A. §6911(c)(3)).

9. **Reporting of Abuse, Neglect, or Exploitation.** Consistent with provisions of 33 V.S.A. §4913(a) and §6903, any agent or employee of a Contractor who, in the performance of services connected with this agreement, has contact with clients or is a caregiver and who has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall make a report involving children to the Commissioner of the Department for Children and Families within 24 hours or a report involving vulnerable adults to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. This requirement applies except in those instances where particular roles and functions are exempt from reporting under state and federal law. Reports involving children shall contain the information required by 33 V.S.A. §4914. Reports involving vulnerable adults shall contain the information required by 33 V.S.A. §6904. The Contractor will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

10. **Intellectual Property/Work Product Ownership.** All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement - including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio), pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement - or are a result of the services required under this grant - shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion - unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30 days notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Contractor or subcontractor, shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

    The Contractor shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State.

    If the Contractor is operating a system or application on behalf of the State of Vermont, then the Contractor shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Contractor's materials.

11. **Security and Data Transfers.** The State shall work with the Contractor to ensure compliance with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy

and security. The State will advise the Contractor of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Contractor to implement any required.

The Contractor will ensure the physical and data security associated with computer equipment - including desktops, notebooks, and other portable devices - used in connection with this agreement. The Contractor will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. The Contractor will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, the Contractor shall securely delete data (including archival backups) from the Contractor's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

12. **Computing and Communication:** The Contractor shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Contractor as part of this agreement. Options include, but are not limited to:

    1. Contractor's provision of certified computing equipment, peripherals and mobile devices, on a separate Contractor's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.
    2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

    The State will not supply e-mail accounts to the Contractor.

13. **Lobbying.** No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

14. **Non–discrimination.** The Contractor will prohibit discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. No person shall on the grounds of sex (including, in the case of a woman, on the grounds that the woman is pregnant) or on the grounds of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by state and/or federal funds.

The Contractor will also not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity under Title 9 V.S.A. Chapter 139.

15. **Environmental Tobacco Smoke.** Public Law 103-227, also known as the Pro-children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, child care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds.

    The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

    Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

    Contractors are prohibited from promoting the use of tobacco products for all clients. Facilities supported by state and federal funds are prohibited from making tobacco products available to minors.

Attachment F - Revised AHS -12/10/10

APPENDIX 1

VERMONT BLUEPRINT COMMUNITY HEALTH TEAM
TOTAL UNIQUE VERMONT PATIENTS ALGORITHM

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all patients who are Vermont residents.

3. Identify the number of Vermont patients who had at least one visit to a primary care provider in the practice with one or more of the following qualifying CPT Codes during the look back period (most recent 24 months).

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive:

CPT-4 Code Description Summary
• 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner
Medicare-Covered Wellness Visits: Codes G0404, G0438, and G0439

APPENDIX 2

ANNUAL CHT PAYMENT LEVELS FOR CURRENT AND FRONTLOADED PRACTICES

Table 1: ANNUAL CHT PAYMENT LEVELS FOR 1,000 PATIENT INCREMENTS -- CURRENT PRACTICES					
Number of Patients	Annual CHT Payment -- Total for All Insurers	Annual BCBSVT and Medicaid Share (24.22%)	Annual Medicare Share (22.22%)	Annual Cigna Share (18.22%)	Annual MVP Share (11.12%)
1,000	$17,500.00	$4,238.50	$3,888.50	$3,188.50	$1,946.00
2,000	$35,000.00	$8,477.00	$7,777.00	$6,377.00	$3,892.00
3,000	$52,500.00	$12,715.50	$11,665.50	$9,565.50	$5,838.00
4,000	$70,000.00	$16,954.00	$15,554.00	$12,754.00	$7,784.00
5,000	$87,500.00	$21,192.50	$19,442.50	$15,942.50	$9,730.00
6,000	$105,000.00	$25,431.00	$23,331.00	$19,131.00	$11,676.00
7,000	$122,500.00	$29,669.50	$27,219.50	$22,319.50	$13,622.00
8,000	$140,000.00	$33,908.00	$31,108.00	$25,508.00	$15,568.00
9,000	$157,500.00	$38,146.50	$34,996.50	$28,696.50	$17,514.00
10,000	$175,000.00	$42,385.00	$38,885.00	$31,885.00	$19,460.00
11,000	$192,500.00	$46,623.50	$42,773.50	$35,073.50	$21,406.00
12,000	$210,000.00	$50,862.00	$46,662.00	$38,262.00	$23,352.00
13,000	$227,500.00	$55,100.50	$50,550.50	$41,450.50	$25,298.00
14,000	$245,000.00	$59,339.00	$54,439.00	$44,639.00	$27,244.00
15,000	$262,500.00	$63,577.50	$58,327.50	$47,827.50	$29,190.00
16,000	$280,000.00	$67,816.00	$62,216.00	$51,016.00	$31,136.00
17,000	$297,500.00	$72,054.50	$66,104.50	$54,204.50	$33,082.00
18,000	$315,000.00	$76,293.00	$69,993.00	$57,393.00	$35,028.00
19,000	$332,500.00	$80,531.50	$73,881.50	$60,581.50	$36,974.00
20,000	$350,000.00	$84,770.00	$77,770.00	$63,770.00	$38,920.00

Table 2: ANNUAL CHT PAYMENT LEVELS FOR 1,000 PATIENT INCREMENTS -- FRONTLOADED PRACTICES				
Number of Patients	Annual CHT Payment -- Total for All Insurers	Annual BCBSVT and Medicaid Share (31.2%)	Annual Cigna Share (23.4%)	Annual MVP Share (14.2%)
1,000	$13,611.50	$4,246.79	$3,185.09	$1,932.83
2,000	$27,223.00	$8,493.58	$6,370.18	$3,865.67
3,000	$40,834.50	$12,740.36	$9,555.27	$5,798.50
4,000	$54,446.00	$16,987.15	$12,740.36	$7,731.33
5,000	$68,057.50	$21,233.94	$15,925.46	$9,664.17
6,000	$81,669.00	$25,480.73	$19,110.55	$11,597.00
7,000	$95,280.50	$29,727.52	$22,295.64	$13,529.83
8,000	$108,892.00	$33,974.30	$25,480.73	$15,462.66
9,000	$122,503.50	$38,221.09	$28,665.82	$17,395.50
10,000	$136,115.00	$42,467.88	$31,850.91	$19,328.33
11,000	$149,726.50	$46,714.67	$35,036.00	$21,261.16
12,000	$163,338.00	$50,961.46	$38,221.09	$23,194.00
13,000	$176,949.50	$55,208.24	$41,406.18	$25,126.83
14,000	$190,561.00	$59,455.03	$44,591.27	$27,059.66
15,000	$204,172.50	$63,701.82	$47,776.37	$28,992.50
16,000	$217,784.00	$67,948.61	$50,961.46	$30,925.33
17,000	$231,395.50	$72,195.40	$54,146.55	$32,858.16
18,000	$245,007.00	$76,442.18	$57,331.64	$34,790.99
19,000	$258,618.50	$80,688.97	$60,516.73	$36,723.83
20,000	$272,230.00	$84,935.76	$63,701.82	$38,656.66

APPENDIX 3

Table 2: Enhanced Provider Payment based on 2008 NCQA Standards ($ PPPM for each provider)

NCQA PPC-PCMH Score, in Points	Average PPPM Payment (in $)
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	1.20
30	1.28
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Requires 5 of 10 must pass elements.

Level 1 (25-49pts)

Requires 10 of 10 must pass elements.

Level 2 (50-74 pts)

Level 3 (75-100 pts)

Table 3: Enhanced Provider Payment based on 2011 NCQA Standards ($ PPPM for each provider)

NCQA PPC-PCMH Score, in Points	Average PPPM Payment (in $)
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	0.00
30	0.00
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Requires 6 of 6 must pass elements.

Level 1 (35-59pts)

Level 2 (60-84 pts)

Level 3 (85-100 pts)

APPENDIX 4

VERMONT BLUEPRINT PPPM COMMON ATTRIBUTION ALGORITHM COMMERCIAL INSURERS AND MEDICAID

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members/beneficiaries who meet the following criteria as of the last day in the look back period:
   - Reside in Vermont for Medicaid (and Medicare);
   - Employer sitused in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members/beneficiaries to select a primary care provider, attribute those members/beneficiaries to that provider if the provider is in a Blueprint-recognized practice.

4. For other members/beneficiaries, select all claims for beneficiaries identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 24 months) for primary care providers included on Blueprint payment rosters, where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine, nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397

CPT-4 Code Description Summary
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member/beneficiary to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member/beneficiary has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5. and 6. above when conducting their attribution. However, at a minimum use the greatest number of claims (5. above), followed by the most recent claim if there is a tie (6. above).

8. Insurers will run their attributions at least quarterly. Medicaid plans to continue to run their attribution monthly, and CIGNA plans to move from semi-annual to quarterly attribution in April of 2013.

9. Insurers will make PPPM payments at least quarterly, by the 15th of the second month of the quarter. CIGNA plans to move from semi-annual to quarterly payment in April of 2013. Base PPPM payments on the most current PPPM rate that insurers have received from the Blueprint prior to check production.

10. For insurers paying quarterly: if a new practice goes live in the third month of a quarter, add that practice to the attribution and payment schedule for the subsequent quarter. Payment would be made for the first month of participation, but it would be based on the attribution for the subsequent quarter and would be included in the subsequent quarter's payment. For example, if a practice becomes recognized on 3/1/2013, payment for 3/1/2013 through 6/30/2013 would occur by 5/15/13.

APPENDIX 5

EXAMPLES OF PAYMENT IMPACTS ON:

1. CURRENT PRACTICE FOR WHICH NCQA RECOGNITION LAPSES

2. FRONTLOADED PRACTICE THAT DOES NOT ACHIEVE RECOGNITION

The following table outlines relevant time frames for a hypothetical current practice with a rescore date of September 1, 2013 and an NCQA recognition lapse date of September 28, 2013:

Event	Date
Practice notified by VCHIP of non-recognition, or date on which practice decides to postpone scoring date	August 31, 2013
VCHIP rescore date	September 1, 2013
NCQA recognition lapse date	September 28, 2013
Action Plan due date, indicating revised rescore date by December 31, 2013 if CHT payments are to continue in full (15 days after decision to postpone scoring date*, or 30 days after notification from VCHIP+)	September 15* or September 30+, 2013
CHT payment termination date if no action plan developed (last day of quarter during which NCQA recognition lapses)	September 30, 2013
PPPM payment termination date if recognition not achieved (last day of the month following the date on which NCQA recognition lapses)	October 31, 2013
Quarter in which practice-related CHT payment is reduced by 25% if recognition not achieved and action plan is developed (first quarter following the quarter after NCQA recognition lapses)	January-March 2014
Quarter in which practice-related CHT payment is reduced by 50% if recognition not achieved (second quarter following the quarter after NCQA recognition lapses)	April-June 2014
Quarter in which practice-related CHT payment is reduced by 75% if recognition not achieved (third quarter following the quarter after NCQA recognition lapses)	July-September 2014
Quarter in which practice-related CHT payment is reduced by 100% if recognition not achieved (fourth quarter following the quarter after NCQA recognition lapses)	October-December 2014

The following table outlines relevant time frames for a hypothetical frontloaded practice with an original score date of December 1, 2013 (assume that practice postpones scoring):

Event	Date
Frontloading begins	April 1, 2013
Original score date; practice decides on November 30, 2013 to postpone scoring	December 1, 2013
Action Plan due date if advance CHT payments are to continue (15 days after decision to postpone scoring date)	December 15, 2013
Practice-related advance CHT payment termination date if no action plan developed (last day of quarter during which action plan is due)	December 31, 2013
Quarter in which practice-related advance CHT payment is reduced by 25% if recognition not achieved and action plan is developed (first quarter after action plan is due)	January-March 2014
Quarter in which practice-related advance CHT payment is reduced by 50% if recognition not achieved and action plan is developed (second quarter after action plan is due)	April-June 2014
Quarter in which practice-related advance CHT payment is reduced by 75% if recognition not achieved and action plan is developed (third quarter after action plan is due)	July-September 2014
Quarter in which practice-related advance CHT payment is reduced by 100% if recognition not achieved and action plan is developed (fourth quarter after action plan is due)	October-December 2014