AMENDMENT AND RESTATEMENT

l. Parties. This is a contract for services between the State of Vermont, Department of Vermont Health Access (hereafter called "State" or "DVHA"), and OneCare Vermont Accountable Care Organization, LLC., with a principal place of business and local address at 356 Mountain View Drive, Colchester, Vermont 05446 (hereafter called "Contractor" or "OneCare"), (together, "Parties"). The Contractor's form of business organization is a Limited Liability Corporation. 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 Contractor's services administering the accountable care organization for a portion of Vermont's Medicaid program. Detailed services to be provided by Contractor are described in Attachment A.

3. Maximum Amount. The maximum total contract value is $1,498,277,903.13. In consideration of the services to be performed by Contractor under this Amendment 3 for Calendar Year 2025, DVHA agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed $408,611,193.75.

4. Contract Term; Prospective Effect. The term of this Amendment 3 commences on January 1, 2025 and ends on December 31, 2025. DVHA may elect to renew the Contract for one (1) additional one-year period, subject to Contractor consent. DVHA shall notify Contractor of its intention to renew at least 120 days prior to the end of the then-current term. DVHA and Contractor agree that unless expressly provided otherwise, this Amendment 3 is intended to be only prospective in effect, and that the terms of the Base Contract govern all matters relating to Performance Years prior to the term of this Amendment 3.

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

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 DVHA and Contractor.

7. Contacts and Notices:

To the extent notices are made under this Contract, such notices shall only be effective if committed to writing and sent to the following persons as representatives of Parties:

CONTRACTOR:
Sara Barry, Chief Operating Officer
OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive
Colchester, VT 05446
Sara.Barry@OneCareVT.org

DVHA:
DVHA Commissioner's Office
Department of Vermont Health Access (DVHA)
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
AHS.DVHALegal@vermont.gov

Written notices may be sent by electronic mail except for the following notices, which must be sent by United States Postal Service certified mail: termination of contract, contract actions, damage claims, breach notifications, alteration of this paragraph.

The contacts for this award are as follows:

	DVHA Fiscal Manager	**DVHA Program Manager**	**For Contractor**
Name:	Alicia Cooper	Amy Coonradt	Sara Barry
Phone #:	802-585-4860	802-585-9063	802-363-6227
E-mail:	Alicia.Cooper@Vermont.gov	Amy.Coonradt@Vermont.gov	Sara.Barry@OneCareVT.org

8. **Cancellation.** This Contract may only be terminated for four reasons:

(A) Either party can terminate the Contract for cause or as set forth in Attachment C upon written notice as described in Section 7 above.

(B) Either party may terminate the Contract without cause. A no-cause termination may be made by either party by providing 180-day advance written notice to the other party in accordance with the provisions in section seven (7) above.

(C) DVHA may cancel this Contract upon immediate notice in the event of the failure of appropriations.

(D) OneCare may cancel this Contract on written notice as described in Section 7 above in the event that agreement cannot be reached on the Base Period and benchmark in Attachment B, Exhibit 1 after execution of this Agreement but before January 31, 2025.

(E) In the event of termination under Subsection A, for the month the termination is effective, prospective payments issued for that month will be recouped and all zero-paid claims with those dates of service will be reprocessed as fee-for-service claims. In the event of termination under, Subsection B, or Subsection C above the Parties agree to conduct a settlement process that measures the full year of performance as set forth in Attachment B, and to pro rate that analysis for the number of complete months during which the Contract was in effect and not terminated. In the event of a termination under Subsection D, there will be no such settlement process and any prospective payments issued during that period will be recouped and all zero-paid claims with those dates of service will be reprocessed as fee-for-service claims. The Parties will work together to minimize the burden and cash flow impact on Participating Providers.

(F) After notice of intent to terminate or actual termination for any reason, the Parties will meet after notice is provided and create a plan to turn over records related to this Contract to DVHA, including financial records and records necessary for audit of the VMNG program.

9. **Attachment C, Standard State Provisions for Contracts and Grants**. Attachment C is hereby deleted in its entirety and replaced as follows:

"Attachment C: Standard State Provisions for Contracts and Grants" (revision version dated December 7, 2023) constitutes part of this Contract and is hereby incorporated by reference as if fully set forth herein and shall apply to the Contractor and to the purchase of all goods and/or services by the State under this Contract. A copy of this document is available online at: https://bgs.vermont.gov/purchasing-contracting/forms.

10. Attachment F Agency of Human Services' Customary Contract/Grant Provisions is hereby deleted in its entirety and replaced by Attachment F dated June 19, 2024.

11. Attachments. This Contract consists of 108 pages including the following attachments, which are incorporated herein:

Attachment A - Specifications of Work to be Performed
Exhibit 1 – Included Service Codes {provided separately}
Exhibit 2 - Attribution Technical Specifications
Exhibit 3 – OneCare Compliance Plan Checklist
Exhibit 4 – Global Payment Program
Attachment B - Payment Provisions
Exhibit 1 - Expected Total Cost of Care and Value-Based Payments
Exhibit 2 – Global Payment Program Payment Provisions
Attachment C - Standard State Provisions for Contracts and Grants
Attachment D – Other Provisions
Attachment E - Business Associate Agreement
Attachment F - Agency of Human Services' Customary Contract Provisions
Attachment G – State of Vermont - Federal Terms Supplement
Appendix I – Subcontractor Compliance Form

The order of precedence of documents shall be as follows:
1). All terms appearing before the signature block to this Contract.
2). Attachment D
3). Attachment C
4). Attachment G
5). Attachment A (with exhibits)
6). Attachment B (with exhibits)
7). Attachment E
8). Attachment F
9). Other Attachments

12. Discretion. Parties each acknowledge their duty of good faith and fair dealing in the exercise of any discretion with respect to this Contract.

Taxes Due to the State. Contractor certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, the Contractor 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.

Child Support (Applicable to natural persons only; not applicable to corporations, partnerships or LLCs). Contractor is under no obligation to pay child support or is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date of this amendment.

Certification Regarding Suspension or Debarment. Contractor certifies under the pains and penalties of perjury that, as of the date this contract amendment is signed, neither Contractor nor Contractor'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.

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

State of Vermont Cybersecurity Standard Update. Contractor confirms that all products and services provided to or for the use of the State under the Contract shall be in compliance with State of Vermont Cybersecurity Standard Update in effect at the time of this Amendment to the Contract. The State of Vermont Cybersecurity Standard Update prohibits the use of certain branded products in State information systems or any vendor system, and a copy is available at: https://digitalservices.vermont.gov/cybersecurity/cybersecurity-standards-and-directives

State and Federal Terms for Products and Services. Contractor agrees that "STATE OF VERMONT-FEDERAL TERMS SUPPLEMENT (Non-Construction) Revision date: May 24, 2024)" which is attached as Attachment G to this amendment, applies to any products or services provided to the State, at any time, when using federal funds.

Byrd Anti-Lobbying Certification**.** Applicable to contracts over $100,000.00 - this clause must be included in all subcontracts over $100,000.00.

Contractor has provided the certification required by the Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352 (as amended, and will follow the requirements for certification of each lower tier (subcontract) to disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures will be forwarded from tier to tier up to the Contractor who in turn will forward the certification(s) to the federal awarding agency. ***THIS LANGUAGE MUST BE INCLUDED IN ANY AMENDMENT TO A PRE-EXISTING CONTRACT WHEN FEDERAL MONIES ARE INVOLVED AND WHEN THE DOLLAR THRESHOLD HAS CROSSED CAUSING THE AMENDMENT TO EXCEED $100,000.00. THIS LANGUAGE CAN BE DELETED HERE IF THIS REQUIREMENT IS NOT APPLICABLE.***

Except as modified by this Amendment No. 3, all provisions of the Contract remain in full force and effect.

THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT.

BY THE STATE OF VERMONT BY CONTRACTOR

DATE: Signed by: DaShawn Groves 12/27/2024
AAF9E799253647B...

DASHAWN GROVES, COMMISSIONER
AHS/DVHA
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
Phone: 802-798-4982
Email: DaShawn.Groves@vermont.gov

DATE: Signed by: 12/27/2024
D5D37E55A40B401...

TOM BORYS, INTERIM CHIEF EXECUTIVE OFFICER; CHIEF FINANCIAL OFFICER
OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive
Colchester, VT 05446
Phone: (802) 318-5475
Email: Thomas.Borys@onecarevt.org

ATTACHMENT A
SPECIFICATIONS OF WORK TO BE PERFORMED

Definitions

Parties agree that the following definitions apply to Attachment A and B of this Contract.

Actual Total Cost of Care (ATCOC): The cumulative total of the Fixed Prospective Payments and Fee-For-Service Payments issued for Covered Services for members in the Traditional Attribution Cohort and the Expanded Attribution Cohort delivered in the Performance Year, less the cost of Covered Services, determined by the fee for service and amounts that would have been paid to providers on Zero-Paid Claims, in excess of $500,000 for any individual member.

Aged, Blind, or Disabled (ABD): A subgroup of attributed Medicaid eligible Members that are Aged, Blind or Disabled under 42 U.S.C. §1396a (a) (10) (A)(i)(I) and (II) & (10)(A)(ii).

Attribution: The process under which members are attributed to Contractor as part of either of the Traditional Attribution and Expanded Attribution Cohorts.

Attribution-eligible: Members who are eligible for attribution to Contractor in any of the Attribution Cohorts discussed in Section 1.2 below, unless otherwise specified.

Attributed Member: A Member who has been attributed to either the Traditional Attribution or Expanded Attribution Cohorts identified in Sections 1.2 and 1.3 below.

Attribution Years (AYs): Historic years of data used to conduct the prospective attribution. For each Performance Year there will be two and three quarters historic years of data used.

Authorized Representative: Authorized representatives of the State are employees of the Agency of Human Services and agents acting on behalf of the Agency of Human Services in furtherance of this Contract.

Base Period: The period (no fewer than 12 months) that is used to calculate the Expected Total Cost of Care for Attributed Members.

Care Coordination Partners: Entities contracted with OneCare to support care coordination work to include Participating Providers, Designated Agencies, Home Health Agencies, Area Agencies on Aging and Support and Services at Home.

Care Model: A comprehensive approach developed and implemented by Contractor and Participating Providers to support Attributed Members with integrated care and coordinated services. The Care Model emphasizes screening and risk stratification of all Attributed Members; prevention, improvement, self-management, and coordinated treatment of disease; tailored interventions based on the level of risk; and effective team-based care.

CMS: Centers for Medicare and Medicaid Services

Cohorts: The Traditional Attribution Cohort and Expanded Attribution Cohort together.

Complex Care Ecosystem: A local network of organizations, sectors, fields, and/or professions working collectively to address the root causes of poor health among individuals with complex health and social needs. Complex Care Ecosystems may include: consumers and families, health systems and practitioners, diverse community-based organizations, public health thinkers and doers, social service and behavioral health organizations, payers, educators, first responders, faith-based organizations, and more.

Consolidated Children: A subgroup of attributed Medicaid eligible Members that are children (under 19) eligible under 42 U.S.C. §1396a(a)(10)(A)(i)(III)-(IX) & (10)(A)(ii).

Corrective Action Plan (CAP): A plan to remediate an identified program deficiency in response to an action or sanction by DVHA.

Covered Services: The health care services included in Total Cost of Care as set forth in detail in Section 3 of Attachment A. These services are those to which a Member is entitled to benefits and for which Parties have agreed is part of Total Cost of Care.

Eligible Member: Member who has been attributed to the VMNG Program and is eligible on a month-to-month basis as defined by the eligibility criteria set forth in Sections 1.2 and 1.3 below.

Expanded Attribution Cohort: A group of Attributed Members with a full Medicaid benefits package who do not have past primary care utilization with health care providers who are not Participating Providers as further described in Section 1.3.

Expected Total Cost of Care (ETCOC): The sum of money expected to be spent to provide Covered Services for Attributed Members. The ETCOC is the amount to which the Risk Corridor percentages apply. Exhibit 1 to Attachment B indicates the components and per member per month (PMPM) amounts of the ETCOC by MEG.

Fee-For-Service Payments: Payments made by DVHA directly to Participating Providers not receiving Fixed Prospective Payments for Covered Services provided to Eligible Members in the Traditional Attribution Cohort and Expanded Attribution Cohort according to DVHA's current fee-for-service fee schedules at the time of payment.

Fiscal Agent: The fiscal agent contracted by DVHA to perform the information system functions that are the responsibility of DVHA related to this Contract.

Fixed Prospective Payment: This payment is made in lieu of fee-for-service reimbursement for services included in the Expected Total Cost of Care.

Health Service Area (HSA): A health service area is defined as a geographic region that is relatively self-contained with respect to the provision of routine health care.

Legacy Practices: A Participating Practice that billed for services provided to Members in an Attribution Year or for any of the Base Period years but that will not bill for services during the Performance Year.

Legacy Providers: A Provider who billed for services provided to Members in an Attribution Year or for any of the Base Years, but who will not bill for services during the Performance Year.
Medicaid Eligibility Group (MEG): Attributed Members will be in one of five MEGs: (1) ABD; (2) New Adult; (3) Non-ABD Adult; (4) SCHIP Child and (5) Consolidated Child. The MEGs are further subdivided for the Expanded Attribution Cohort as described in Attachment B, Exhibit 1.

Members: Beneficiaries who are members of DVHA's Medicaid program.

New Adult: A subgroup of attributed Medicaid eligible Members that are adults eligible under 42 U.S.C. § 1396a (a)(10) (A)(i)(III)-(IX) & (10)(A)(ii).

Non-ABD Adult: A subgroup of attributed Medicaid eligible Members that are adults eligible under 42 U.S.C. § 1396a (a)(10) (A)(i)(III)-(IX) & (10)(A)(ii).

Participating Practice: A practice of one or more Participating Providers identified by its billing (group) National Provider Identifier (NPI) and Attending (individual) NPI combinations.

Participating Provider: A physician or a non-physician practitioner (NPP) who is a member of a Participating Practice that has entered into an agreement with Contractor. In the case of physician practices, Participating Providers are identified by a combination of billing (group) NPI and Attending (individual) NPI.

Performance Period (PP): The time during which the parties are performing their obligations under this Agreement which includes the Performance Year, inclusive of financial settlement.

Performance Year (PY): The period between January 1 and December 31 for each year of this Contract.

Preferred Provider: An individual or an entity that: (1) is identified by a Tax Identification Number; (2) does not qualify to attribute lives in ACO Programs; and (3) has entered into an agreement with Contractor.

Primary Care Practitioner: A physician or NPP whose principal specialty is included in Attachment A, Exhibit 2, Table 2 and designated as Primary Care Practitioner by Contractor in its annual submission of the Participating Provider roster during the Attribution Years.

Provider Reform Support Payment: Payments used to support Participating Provider and Preferred Provider healthcare reform efforts through primary care investment, population health management, quality, and coordination of care programs for the benefit of Members.

Qualified Evaluation and Management (QEM) services: Identified by the combination of Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes and physician specialty. The HCPCS and CPT codes used are listed in Attachment A, Exhibit 2, Table 1. A

QEM service must be provided by a physician specialty listed in Attachment A, Exhibit 2, Table 2. For purposes of identifying QEM services, Attachment A, Exhibit 2, Table 2 shall be deemed to include physician assistants under any of the listed specialties.

Risk Corridor: A percentage of the ETCOC Parties agree to assume payment risk for as provided in Section IV of Attachment B.

State Children's Health Insurance Program (SCHIP) Child: A subgroup of attributed Medicaid eligible Members that are children eligible under 42 USC § 1396a(e)(13).

Subcontract: A contractual agreement between Contractor and a Subcontractor for performance of work under this Agreement.

Subcontractor. A party to a Subcontract, but not including Contractor. The following entities are not Subcontractors and are excluded from the requirements and oversight of Subcontractors as identified in Section 2.8: Participating Providers, Preferred Providers and Participating Practices, and their respective employees; software vendors (except software as a service); entities related to office space, maintenance, equipment and supplies; attorneys, auditors, accountants, actuaries, insurers and brokers, bankers, and lenders; and Medicaid enrolled providers when providing services to Medicaid Enrolled Members in connection with this program.

Traditional Attribution Cohort: A group of Attributed Members whose past primary care utilization is predominantly with Participating Providers as further described in Section 1.2.

Value-Based Care Payment: The sum of the Fixed Prospective Payment and a Provider Reform Support Payment.

Value-Based Incentive Fund: A fund included in the Value-Based Incentive Program used to reward Participating Providers and Preferred Providers for high-quality care delivery.

Value-Based Incentive Program: A program used to reward Participating Providers and Preferred Providers for high-quality care delivery, as provided in Section VI of Attachment B, comprised of the Value-Based Incentive Fund and the Year End Quality Adjustment.

VMNG Program: The Vermont Medicaid Next Generation Accountable Care Organization program administered for DVHA by Contractor and its Participating Providers.

Year-End Quality Adjustment: A calculation whereby the annual quality score determined in accordance with the Year-End Reconciliation will be used to determine what amount Contractor shall pay to DVHA.

Year-End Reconciliation: The process that occurs after the end of the Performance Year where there is a comparison of the ETCOC and the ATCOC for the Traditional and Expanded Attribution Cohorts. This process will determine the amount of any cash exchange as defined by the requirements of the Risk Corridor.

Zero-Paid Claim: A claim submitted to DVHA by a Participating Provider, which is paid zero dollars with an explanation of benefits code indicating that the Member and services are covered by the VMNG Program under its Fixed Prospective Payment from the ACO.

1. Attribution Methodology

1.1 Attribution Overview

1.1.1 Introduction

Attribution will be prospectively conducted for the VMNG Program by DVHA for Members who are enrolled in Medicaid as of November 1st of the year preceding the Performance Year. These Members will be attributed to either the Traditional Attribution Cohort or Expanded Attribution Cohort as follows:

a. Attribute Members based on past primary care utilization with Participating Providers to the Traditional Attribution Cohort, as described in Section 1.2.

b. Attribute Members not in the Traditional Attribution Cohort who do not have past primary care utilization with health care providers who are not Participating Providers to the Expanded Attribution Cohort described in Section 1.3.

1.1.2 Monthly eligibility checks of Members during the Performance Year

On a monthly basis, Fiscal Agent will determine which, if any, Members in the Traditional Attribution Cohort and Expanded Attribution Cohort became ineligible for VMNG Program participation in the previous month due to one of the criteria stated in Section 1.2 or 1.3 as applicable, or as a result of the death of the Member or loss of Medicaid eligibility. An Attributed Member who was previously determined to be ineligible in any given month may regain eligibility in a future month if eligibility criteria are met.

1.1.3 Newborns

For the Traditional Attribution Cohort, children born to an Attributed Member mother after September 30 prior to the Performance Year, will not be attributed to Contractor in the Performance Year. For the Expanded Attribution Cohort, children born to an Attributed Member mother after October 30 prior to the Performance Year will not be attributed to Contractor in the Performance Year.

1.2 Traditional Attribution Cohort

To be attributed to the Traditional Attribution Cohort, Members must have at least one month of Medicaid enrollment during the Attribution Years. Members are attributed to the Traditional Attribution Cohort if they received on a weighted basis, more QEM services during the Attribution Years from Participating Providers than from non-Participating Providers. Member

is not eligible for attribution to the Traditional Attribution Cohort in the Performance Year if the Member falls into any of the following categories during the corresponding Attribution Years:

a. No QEM service claims were paid for the Member;
b. The Member is dually eligible for Medicare;
c. The Member had evidence of third-party liability coverage;
d. The Member has obtained coverage through commercial insurers; or
e. The Member is enrolled in Vermont Medicaid but receives a limited benefit package.

1.2.1 Attribution By Claims Data

Attribution of a Member to the Traditional Attribution Cohort is determined by comparing:

a. The weighted paid claims plus Zero-Paid Claims for all QEM services that the Member received from each of VMNG Program's Participating Providers; with
b. The weighted paid claims for all QEM services that the Member received from non-Participating Providers.

Only QEM services delivered by providers identified in Contactor's annual Participating Provider roster during the Attribution Years will be used in the attribution calculations.

The aggregate weighted paid claims plus Zero-Paid Claims for all Participating Providers compared with aggregate weighted paid claims of all non-participating providers determines whether the Member is attributed to the Traditional Attribution Cohort. If the former is greater than the latter, the Member will be attributed to the Traditional Attribution Cohort.

1.2.2 Use of weighted paid claims and Zero-Paid Claims in attribution

The payment amount on paid claims and Zero-Paid Claims for QEM services during the Attribution Years will be weighted as follows:

a. The payment amount on paid claims and/or Zero-Paid Claims for QEM services provided during the 1st half of the Attribution Years (16 months) will be weighted by a factor of one.
b. The payment amount on paid claims and/or Zero-Paid Claims for QEM services provided during the 2nd half of the Attribution Years (17 months) will be weighted by a factor of two.

The table below is intended as an example of the methodology described in Sections 1.2.1 and 1.2.2. The Member whose claims are represented in the table would be attributed to the Traditional Attribution Cohort.

	Claims: First Half of AY ($)	Claims: Second Half of AY ($)	Weighting Factor	Weighted Amount ($)		Claims: First Half of AY ($)	Claims: Second Half of AY ($)	Weighting Factor	Weighted Amount ($)
Participating Provider A	$100		1	$100	Non-Participating Provider E	$190		1	$190
Participating Provider B		$100	2	$200	Non-Participating Provider F		$240	2	$480
Participating Provider C	$120		1	$120					
Participating Provider D		$250	2	$500					
Total Weighted Amount				$920					$670

The payments that will be used in attribution will be obtained from claims for QEM services that are:

a) Incurred in the Attribution Years as determined by the date of service on the claim line-item; and,
b) Paid within three months following the end of the Attribution Years as determined by the paid date of the claim.

1.2.3 Tie-breaker rule

In the case of a tie in the dollar amount of the weighted paid claims plus Zero-Paid Claims for QEM services, the Member will be attributed according to the Primary Care Practitioner from whom the Member most recently obtained a QEM service.

1.2.4 Legacy Practice and Legacy Provider

Legacy Practices and Legacy Providers may be used to conduct attribution for the purpose of year over year continuity only if:

a. Merger, acquisition, or corporate reorganization has resulted in the consolidation or replacement of an NPI that appears on claims for QEMs provided during an Attribution Year; and
b. The NPI was in good standing with Contractor during Attribution Period and will not be used to bill for QEM services provided during the Performance Year.

1.3 Expanded Attribution Cohort

A Member is eligible for Attribution to the Expanded Attribution Cohort in the Performance Year if the Member: i) is not attributed to the Traditional Attribution Cohort through the methodology provided in Section 1.2 above, and ii) has no QEM services claims history in the AYs with non-Participating Providers, or iii) fell into one of the exclusion categories below during the AYs.

Members otherwise eligible for attribution to the Expanded Attribution Cohort in the Performance Year will not be attributed if they fall into any of the following exclusion categories:

1. Member is dually eligible for Medicare;
2. Member had evidence of third-party liability coverage;
3. Member has obtained coverage through commercial insurers; or
4. Member is enrolled in Vermont Medicaid but receives a limited benefits package.

2. Administrative Requirements

2.1 State Registration

Contractor shall maintain its registration as a business in good standing with the Vermont Secretary of State.

2.2 Certification

Contractor agrees to secure and maintain its status as a Vermont certified accountable care organization during the Performance Year in accordance with 18 V.S.A. § 9382 and implementing rules.

2.3 Administrative and Organizational Structure

Contractor shall have in place sufficient administrative and clinical staff and organizational components to comply with all Contract requirements and standards. Contractor shall manage the following major operational areas:

a. Administrative and fiscal management
b. Member services (but not Medicaid eligibility)
c. Provider services (but not DVHA provider enrollment)
d. Provider contracting (limited to contractual relationships between Contractor and its provider network)
e. Network development and management
f. Quality management and improvement
g. Care management
h. Information systems
i. Provider payments
j. Performance data reporting
k. Member and provider grievances, with the exception of fair hearings which are DVHA's responsibility as set forth in Section 4

2.4 Staffing

Contractor shall have in place sufficient administrative, clinical and organizational staffing to comply with all program requirements and standards. Contractor shall maintain a high level of contract performance and data reporting capabilities regardless of staff vacancies or turnover. Contractor shall have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment.

Contractor shall have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (e.g., high school, college degree or graduate degree), professional credentials (e.g., licensure or certifications), work experience, membership in professional or community associations, etc.

2.4.1 Key Staff

Contractor shall have an office in the State of Vermont. Contractor shall be responsible for all costs relating to securing and maintaining this facility.

Upon DVHA's request, Contractor shall deliver a current staffing plan, including all key staffing positions.

Contractor shall identify and disclose any staff or operational functions permanently located outside the State of Vermont. If any staff or operational functions are permanently located outside the State of Vermont, Contractor shall ensure that these locations do not compromise the delivery of integrated services and the seamless experience for Members and providers.

Contractor shall employ the key staff members listed below. In the event of a vacancy of a key staff member for any reason, Contractor shall notify DVHA in writing within thirty (30) business days of the vacancy and provide Contractor's plan to fill the vacancy.

The key staff positions or equivalent include:

a. Chief Executive Officer
b. Chief Operating Officer
c. Chief Medical Officer
d. Chief Compliance and Privacy Officer
e. Chief Financial Officer
f. Director, Payment Reform
g. Director, Value Based Care

2.4.2 Training

On an ongoing basis, Contractor must ensure that each staff person, including subcontracted staff, has appropriate education and experience to fulfill the requirements

of their positions, as well as ongoing training specific to their role in the organization. Contractor must ensure that all staff are trained in the major components of the VMNG Program, including Program Integrity training required in Section 10.

Contractor shall update its training materials on a regular basis to reflect VMNG Program changes. Contractor shall maintain documentation to confirm its internal staff training, curricula, schedules and attendance, and shall provide this information to DVHA upon request and during regular on-site visits.

2.4.3 Excluded and Debarred Individuals

In accordance with 42 CFR § 438.610, Contractor must not knowingly have a relationship with the following:

a. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 (51 FR 6370) or under guidelines implementing Executive Order No. 12549, which relates to debarment and suspension; or
b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR § 2.1.01, of a person described above.

For purposes of this prohibition, "relationship" includes directors, officers or partners of Contractor, persons with beneficial ownership of five percent (5%) or more of Contractor's equity, or persons with an employment, consulting or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under the Contract.

If DVHA finds that Contractor is in violation of 42 CFR § 438.610, this shall be grounds for Contract termination.

Contractor shall have policies and procedures in place to routinely monitor staff, Subcontractors, and Participating Providers, for individuals debarred or excluded by Federal agencies. Contractor shall monitor external data, such as the U.S. Department of Health and Human Services, Office of Inspector General (OIG) exclusion list, on a monthly basis, for individuals debarred or excluded by Federal agencies. Contractor's discovery of an excluded individual must be immediately referred to DVHA.

Contractor shall be required to disclose to DVHA Special Investigations Unit information required by 42 CFR § 455.106 regarding Contractor's staff and persons with an ownership interest in Contractor that have been convicted of a criminal offense related to that person's involvement in the Medicare or Medicaid program.

2.5 DVHA Meeting Requirements

Contractor shall comply with all reasonable meeting requirements established by DVHA, and is expected to cooperate with DVHA and/or its contractors in preparing for and participating in these meetings. DVHA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

Representatives of DVHA will meet at least annually with Contractor's executive leadership to review Contractor's performance.

2.6 Financial Stability and Accounting

DVHA will monitor Contractor's financial performance to ensure that Contractor is financially capable of performing its obligations under this Agreement. Contractor shall provide DVHA with copies of any filings Contractor is required to make to the Green Mountain Care Board (GMCB) related to Contractor's financial stability, within one business day of making filings with GMCB. Notwithstanding, Contractor is not required to provide any information that would provide an unfair advantage to DVHA in negotiations pertaining to the VMNG Program.

Contractor shall maintain separate accounting records for its Medicaid ACO programs that incorporates performance and financial data of Subcontractors, as appropriate.

Contractor shall notify DVHA of any person or corporation with five percent (5%) or more of ownership or controlling interest (as defined in 42 CFR 455.101 and 455.102) in Contractor and shall submit financial statements for these individuals or corporations.

Authorized Representatives or agents of State shall have access to Contractor's accounting records, whether held by Contractor or another entity, upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction to ensure that Contractor is financially capable of performing its obligations under this Agreement.

Copies of any financial and accounting records meeting these criteria shall be made available by Contractor within ten (10) days of receiving a written request from DVHA for specified records.

Contractor shall maintain financial records pertaining to the Contract, including all claims records, for the period specified in Attachment C of this Contract. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions of which Contractor has been provided timely notice and for one (1) year following the termination of any litigation relating to the Contract.

DVHA will require Contractor to produce the information on Contractor's financial condition at the close of its fiscal year and upon request by the DVHA Commissioner. Any financial statement submitted to DVHA shall be signed under penalty of perjury by Contractor's Chief Financial Officer, Chief Operating Officer or Chief Executive Officer. Information in the financial statement submission shall include, but not be limited to:

- A statement of revenues and expenses; and
- A balance sheet.

Upon request, Contractor shall provide to DVHA confirmation of appropriate insurance coverage for general liability, property, and workers' compensation, in conformance with state and federal regulations and Attachment C to this Agreement.

DVHA may make an examination of the affairs of Contractor as often as it deems prudent. The focus of the examination will be to ensure that Contractor is not subject to adverse actions which in DVHA's determination have the potential to impact Contractor's ability to meet its responsibilities with respect to its use of the payments received from DVHA and Contractor's compliance with the terms and conditions of any financial risk transfer agreement. Responses to DVHA requests shall fully disclose all financial or other information requested. Information designated as confidential may not be disclosed by DVHA without the prior written consent of Contractor except as required by law including Vermont Public Records Act (1 V.S.A. §§ 315 - 320). If Contractor believes the requested information is confidential and not to be disclosed to third parties, Contractor shall provide a detailed legal analysis to DVHA setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

2.7 Reporting Transactions with parties of interest

2.7.1 Contractor shall disclose to DVHA information on certain types of transactions they have with a "party in interest" defined as:

a. Any director, officer, partner or employee responsible for management or administration of Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of Contractor; and, in the case of Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

b. Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of Contractor; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the Contractor;

c. Any person directly or indirectly controlling, controlled by or under common control of Contractor; and

d. Any spouse, child or parent of an individual described above.

2.7.2 Business transactions which shall be disclosed include:

a. Any sale, exchange or lease of any property between Contractor and a party in interest;

b. Any lending of money or other extension of credit between Contractor and a party in interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

2.7.3 The information which must be disclosed in the transactions between Contractor and a party in interest listed above includes:

a. The name of the party in interest for each transaction;

b. A description of each transaction and the quantity or units involved;

c. The accrued dollar value of each transaction during the fiscal year; and

d. Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, Contractor may be required to submit a consolidated financial statement for Contractor and the party in interest.

2.8 Subcontracts

Contractor is responsible for the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of Contractor to DVHA to ensure that all activities under the Contract are carried out. Contractor shall oversee Subcontractor activities and submit an annual report on its Subcontractors' compliance, corrective actions, and outcomes of Contractor's monitoring activities. Contractor shall be held accountable for any functions and responsibilities that it delegates.

Contractor shall require that all Subcontracts indemnify and hold harmless the State of Vermont, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of Contractor and/or the Subcontractors.

The Subcontracts shall further provide that the State of Vermont shall not provide such indemnification to the Subcontractor.

Contractor shall monitor the financial stability of Subcontractor(s) whose payments are equal to or greater than five percent (5%) of DVHA's annual Value-Based Care Payments to Contractor. For these Subcontractors, at least annually, Contractor must obtain the following information from the Subcontractor and use this information to monitor the Subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance. Contractor shall make these documents available to DVHA upon request and DVHA shall have the right to review these documents during Contractor site visits.

Contractor shall comply with 42 CFR § 438.230 and the following subcontracting requirements:

a. Contractor must fill out and submit the Subcontractor Compliance Form (Appendix I: Department of Vermont Health Access Subcontractor Compliance Form) in order to seek approval from the State prior to signing a Subcontract. Upon receipt of the

Subcontractor Compliance Form, the State shall review and respond within five business days. Under no circumstances shall the Contractor enter into a Subcontract without prior authorization from the State. Contractor shall submit the Subcontractor Compliance Form to: AHS.DVHAGrantsContracts@vermont.gov.

b. The Subcontract shall ensure the Subcontractor is in full compliance with Attachment C and Attachment F regarding worker classification, fair employment practices and the Americans with Disabilities Act, taxes due to the State of Vermont, child support orders (if applicable) and debarment.

c. Contractor shall evaluate prospective Subcontractors' abilities to perform activities or obligations under this Contract prior to contracting with the Subcontractor. Prior satisfactory performance by the Subcontractor can establish this element.

d. In addition to the conditions specified in Attachment C and Appendix I: Subcontractor Compliance Form, Contractor shall have a written agreement with each Subcontractor that specifies Subcontractor's activities or obligations, and reporting responsibilities, and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement shall be in compliance with the State of Vermont statutes and federal laws and will be subject to the provisions thereof.

e. All Subcontractors shall fulfill all state and federal requirements appropriate to the services or activities that are delegated under the Subcontract. In addition, all Subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that apply to the Subcontract.

f. Contractor shall submit a plan to DVHA on how the Subcontractor will be monitored for debarred employees.

g. Contractor shall fulfill the requirements of 42 CFR § 434.6, which addresses general requirements for all Medicaid contracts and Subcontracts.

h. Contractor shall provide in Subcontracts that:

i. AHS, the Single State Agency; and CMS, the HHS Inspector General, the Comptroller General or their designees shall have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any services or determination of amounts payable. For purposes of such an audit, evaluation, or inspection, Subcontractor shall make available its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Members.

ii. The right to audit will exist through 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

iii. If, an Authorized Representative of the State, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, an Authorized

Representative of the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

Contractor must have policies and procedures addressing auditing and monitoring Subcontractors' data, data submissions, and performance. Contractor must integrate Subcontractors' performance data (when applicable) into Contractor's information system to accurately and completely report Contractor performance and confirm contract compliance.

If Contractor uses Subcontractors to provide direct services to Members, the Subcontractors shall meet the same requirements as Contractor, and Contractor shall demonstrate that the Subcontractors are in compliance with these requirements. Contractor shall require Subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the Subcontractors.

To the extent either party has a question about whether a particular party is a Subcontractor or a particular arrangement is a Subcontract, OneCare shall submit a reasonable description of the arrangement to DVHA for its consideration prior to executing a contract with the party. Thereafter the Program Managers shall discuss and attempt to come to an agreement about whether to treat the party as a Subcontractor or arrangement as a Subcontract. Should they not be able to agree, the Dispute Resolution Process in Attachment B, Section 6 may be invoked.

2.9 Confidentiality of Member Medical Records and Other Information

Contractor shall ensure that Member medical records as well as any other health and enrollment information that contains individually identifiable health information is used, stored/maintained and disclosed in accordance with the privacy requirements set forth in Attachment E: Business Associate Agreement.

2.10 Response to DVHA Inquiries

DVHA may directly receive inquiries and complaints from external entities, including but not limited to providers, Members, legislators or other constituents which Contractor will be required to research, respond to, and resolve in a reasonable timeframe specified by DVHA.

2.11 Dissemination of Information

Upon the request of DVHA Contractor shall distribute information prepared by DVHA, its designee, or the federal government to its Members.

2.12 Maintenance of Records

Contractor shall maintain all financial, quality measurement, and other records that relate to the payments under this Contract for a period of ten (10) years in accordance with DVHA's 1115a waiver document, or for the duration of contested case proceedings, whichever is longer.

2.13 Maintenance of Written Policies and Procedures

Contractor shall develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, State of Vermont Statutes, DVHA Rules applicable to this Contract, and this Contract. Written guidelines shall be maintained for developing, reviewing and approving all policies and procedures. Contractor shall review all policies and procedures at least annually to ensure they reflect current practice and shall update them as necessary. Reviewed policies shall be approved by appropriate key staff, as listed in Section 2.4.1, and dated. All medical and quality management policies shall be reviewed and approved by Contractor's Chief Medical Officer. DVHA has the right to review all Contractor policies and procedures applicable to the VMNG Program and Contractor shall provide evidence of key staff approvals of Contractor policies and staff approval of procedures. Should DVHA determine that a policy requires revision and provides a reasonable basis for the revision, Contractor shall work with DVHA to revise within ninety days. If DVHA determines that Contractor lacks a policy or process required to fulfill the terms of the Contract and provides a reasonable basis for the revision, Contractor must adopt a policy or procedure within ninety days.

2.14 DVHA Ongoing Monitoring

DVHA shall conduct ongoing monitoring of Contractor to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of DVHA and may include, but is not limited to, both scheduled and unannounced site visits, review of policies and procedures, and performance reporting.

In support of ongoing monitoring, the following guidance document created by DVHA will be effective, and binding on Contractor, upon execution of the Contract:

a. The ACO Reporting Manual contains a catalog of the reports that will be required to be submitted by Contractor to DVHA and the periodicity schedule of each report submission. For every report, DVHA will provide both a report template and instructions for how to complete each report.

The ACO Reporting Manual is considered a "living" document and will be updated, as needed, through mutual agreement throughout the course of the contract. The parties will collaborate on the 2025 ACO Reporting Manual reflecting the terms of this Contract and an initial version will be provided to the Contractor by March 31, 2025. In the past an initial version of this ACO Reporting Manual was agreed to before the beginning of the Performance Year, and for PY 2025, Contractor grants this extension. In the event there is no mutual agreement on the terms of the initial version of the ACO Reporting Manual by March 31, 2024, either Party may invoke the Dispute Resolution Process in Attachment B, Section V.6. Until the initial 2025 version of the ACO Reporting Manual is decided upon, the latest agreed-upon version of the ACO Reporting Manual remains in effect. For clarity, any changes to the ACO Reporting Manual after the initial version must be agreed to by both Parties in writing, through the iterative process in place which renders the Reporting Manual a living document.

2.15 Material Change

A material change to operations is any change to Contractor's business operation policies that was disclosed to DVHA and relied upon by DVHA, such as an appeals policy, only if that change affects, or can reasonably be expected to materially affect, DVHA's compliance with the federal Medicaid program requirements.

Prior to implementing a material change in operation, Contractor shall submit a notification to DVHA for review and objection or request for modification at least sixty (60) days in advance of the effective date of the change. DVHA may deny such a request if the change materially impacts DVHA's compliance with the federal Medicaid program requirements. The request shall contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. Contractor may be required, at the direction of DVHA, to communicate material changes to Members or providers at least thirty (30) days prior to the effective date of the change.

No change will alter the payment provisions outlined in Attachment B.

2.16 Future Program Guidance

In addition to complying with the ACO Reporting Manual, Contractor shall operate in compliance with all future VMNG program manuals, VMNG guidance and VMNG policies and procedures, as well as any amendments thereto. Future modifications that have a significant impact on Contractor's responsibilities, as set forth in this Contract, will be made through the Contract amendment process.

2.17 Performance Deadlines

To the extent one party's performance of an obligation under this Agreement depends on the other party to provide data or information, a delay in providing the data or information will automatically extend the deadline for performance of the dependent task for a minimum of the time the initial task is complete. By way of example, if Contractor's reporting depends on receipt of claims data from DVHA and DVHA does not send data for 45 days, Contractor's deadline to report is automatically extended by 45 days.

3. Covered Services

As currently contemplated for the next Performance Period, the following are the included and excluded services for the ETCOC. Changes to Covered Services may also be considered for future Performance Periods.

3.1 Covered Services Included in the ETCOC
The ETCOC for the Traditional and Expanded Attribution Cohorts includes payment for the following categories of Covered Services:

a. Inpatient hospital services
b. Outpatient hospital services

c. Physician services, primary care and specialty
d. Nurse practitioner services
e. Ambulatory surgical center services
f. Federally Qualified Health Center and Rural Health Clinic services
g. Home health services
h. Hospice services
i. Physical, occupational and speech therapy services
j. Chiropractor services
k. Audiology services
l. Podiatrist services
m. Optometrist and optician services
n. Independent laboratory services
o. Mental health and substance use disorder services funded by DVHA and not funded by other State of Vermont Departments; *however, H0001 – H2037 are excluded when billed on professional claims*
p. Ambulance transport
q. Durable medical equipment, prosthetics and orthotics (except eyewear)
r. Medical supplies
s. Dialysis facility services
t. Preventive services
u. Physician administered drug services
v. Dental services billed on institutional claims

A detailed listing, by CPT/HCPCS, of Covered Services appears in Attachment A, Exhibit 1. Specific benefits/services and the limitations for these benefits/services are described in Vermont Medicaid Rules and apply to this program. The detailed listing in Attachment A, Exhibit 1 represents national coding conventions at the time of execution of this Contract. Coding conventions are periodically updated. DVHA will update Attachment A, Exhibit 1 on a quarterly basis, as necessary, to align with changes in national coding guidance (including the addition of new codes and the removal of invalid codes All new codes will align with the codes used to establish the ETCOC (for example replacement codes), provided however, that for any new codes not used in calculating ETCOC that are added to Attachment A, Exhibit 1, the Parties agree to meet to discuss, as part of the Year-End Reconciliation, whatever reasonable and appropriate adjustments may be necessary in light of the new codes.

3.2 Services Not Included in the ETCOC

3.2.1 The following services are not Covered Services included in the Contractor's ETCOC:

a. Pharmacy
b. Nursing facility care
c. Psychiatric treatment in a state psychiatric hospital
d. Level 1 inpatient psychiatric stays (as defined in the Department of Mental Health's Designated Hospitals Manual and Standards) in any hospital when paid for by DVHA
e. Services provided by the Brattleboro Retreat
f. Dental services billed on professional claims
g. Non-emergency transportation (ambulance transportation is not part of this category)
h. Smoking cessation services
i. Services provided by Designated Agencies (DAs) and Specialized Service Agencies (SSAs)
j. Graduate Medical Education (GME) payments
k. Electronic Health Record (EHR) incentive payments
l. Disproportionate Share Hospital (DSH) payments
m. COVID-19 vaccinations and testing

3.2.2 Additionally, the following services for Members are paid for by State of Vermont departments other than DVHA and are not Covered Services included in the Contractor's ETCOC:

a. Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by State of Vermont agencies or departments other than DVHA;
b. Services administered and paid for by the Vermont Department of Mental Health;
c. Services administered and paid for by the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, through a preferred provider network;
d. Services administered and paid for by the Vermont Department of Disabilities, Aging and Independent Living;
e. Services administered and paid for by the Vermont Agency of Education; and
f. Services administered and paid for by the Vermont Department of Health, including smoking cessation services.

This list may not include all services for Members that are paid for by State of Vermont departments other than DVHA and that are not Covered Services included in the Contractor's ETCOC. As indicated in Section 6, the expectation is that Contractor shall ensure coordination with these services even though they are not Covered Services.

3.3 Continuity of Care

Contractor shall implement mechanisms to ensure Participating Providers maintain the continuity of care and coordination of medically necessary health care services for its Attributed Members.

If an Attributed Member in the Traditional Attribution Cohort or Expanded Attribution Cohort becomes ineligible pursuant to section 1.1.2 during an inpatient stay, Contractor will remain financially responsible for the hospital payment until the Member is discharged from the hospital or the Member's eligibility in Medicaid terminates.

3.4 Enhanced Services

Contractor is encouraged to provide programs that enhance the general health and well-being of Members, including programs that address preventive health, risk factors, or personal responsibility.

Enhanced services shall comply with the Member incentives guidelines set forth in Section 7 of this Attachment A and other relevant state and federal regulations regarding inducements.

For purposes of this section, enhanced services under this subsection are any service not included in Sections 3.1 and 3.2.

4. Member Services

4.1 Marketing and Outreach

In accordance with 42 CFR § 438.104, and the requirements outlined in Section 4.5, Contractor may market itself to Members. However, if Contractor chooses to conduct marketing activities, Contractor shall obtain DVHA approval for all marketing and outreach materials at least thirty (30) days prior to distribution.

Contractor may market by mail, mass media advertising (e.g., radio and television) and community-oriented marketing directed at potential members. Contractor shall not design their marketing efforts in such a way that the marketing materials target groups with favorable demographics or healthcare needs.

Any outreach and marketing activities (written and oral) shall be presented and conducted in an easily understood manner and format and at a sixth-grade reading level. Contractor shall not engage in marketing activities that mislead, confuse or defraud Members or DVHA. Statements considered inaccurate, false, or misleading include, but are not limited to, any assertion or written or oral statement that:

a. Member or potential member must join the VMNG Program or receive services from a Participating Provider to obtain benefits or to avoid losing benefits;

b. Contractor is endorsed by CMS, the federal or state government or a similar entity; or

c. Contractor's ACO is the only opportunity to obtain benefits under the State of Vermont's Medicaid program.

4.2 Member Non-Discrimination

Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to attribute to the VMNG Program. Additionally, Contractor shall not discriminate against individuals eligible to attribute on the basis of race, color, national

origin, disability, age, sex, gender identity or sexual orientation and will not use any policy or practice that has the effect of discriminating in such manner.

4.3 Member-Contractor Communications

4.3.1 Member Services Helpline

DVHA shall continue to maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the Vermont Medicaid program as well as basic information about the Contractor's programs. DVHA's member services helpline is intended to be equipped to handle a variety of basic, first-tier Member inquiries, including the ability to address Member questions, concerns, complaints and requests for PCP changes.
Contractor shall be responsible for its own member services helpline to handle second-tier questions from Members (including issues that require specific expertise and authority by Contractor to resolve). Staff assigned to this function will be available to all Member incoming inquiries via "live voice" between 8 a.m. and 4:30 p.m. Eastern Standard Time, Monday through Friday. Contractor shall provide an after-hours voice message system that informs callers of Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day. During hours of operation, Contractor must be able to receive transfers from DVHA's member services helpline, Agency of Human Services (AHS) staff and Members who wish to directly call Contractor.
Contractor's helpline may be closed on all holidays observed by the State of Vermont. Call center closures, limited staffing or early closures shall not burden a Member's access to care.

Contractor's helpline shall offer language interpretation services for Members whose primary language is not English and shall provide teletypewriter (TTY) services for hard of hearing Members free of charge.

Contractor's Helpline staff shall be trained to ensure that Member questions and concerns are resolved as expeditiously as possible. Contractor shall maintain a system for tracking and reporting the number and type of Members' calls and inquiries it receives during business hours and non-business hours. Contractor shall monitor its member services helpline service and report its telephone service level performance to DVHA in the timeframes and specifications described in the ACO Reporting Manual.

Upon a Member's attribution to the VMNG Program, Contractor shall inform the Member about DVHA's member services helpline as well as Contractor's helpline.

Contractor must meet the following performance standards related to the responsiveness of staffed telephone lines:

a. During open hours, seventy-five percent of all incoming calls that opt to talk to a live operator are answered by a live operator within 25 seconds of leaving Contractor's Interactive Voice Response (IVR) system;
b. Lost call abandonment rate after the call exits the IVR shall not exceed five percent; and
c. 98% of calls are answered by a live agent within four minutes.

4.3.2 Electronic Communications

Contractor shall provide an opportunity for Members to submit questions or concerns electronically, via e-mail and through the Contractor's website without requiring Member login.

Contractor shall respond to questions and concerns submitted by Members electronically within one (1) business day. If Contractor is unable to answer or resolve the Member's question or concern within one business day, Contractor shall notify the Member that additional time will be required and identify when a response will be provided. A final response shall be provided within three (3) business days.

Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. Contractor shall be prepared to provide this information to DVHA upon request.

4.4 Member Information, Outreach and Education

Contractor shall inform Members that information is available upon request in alternative formats and how to obtain them. DVHA defines alternative formats as Braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. To the extent possible, written materials shall not exceed a sixth grade reading level.

Contractor shall inform the Members that, upon the Member's request, Contractor will provide information on the structure and operation of Contractor and, in accordance with 42 CFR § 438.6(h), will provide information on Contractor's provider incentive plans.

Contractor shall be responsible for developing and maintaining Member education programs designed to provide the Members with clear, concise and accurate information about Contractor's program and Contractor's network.

DVHA encourages Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and Member education programs. DVHA encourages Contractor to develop community partnerships with these types of organizations, in particular with community mental health centers, local health offices and prenatal clinics in order to promote health and wellness within its Membership.

Contractor shall have in place policies and procedures to ensure that materials distributed to Members are accurate in content, accurate in translation relevant to language or alternate formats

and do not defraud, mislead or confuse the Member. Contractor shall provide information requested by DVHA for use in Member education, upon request.

4.4.1 New Member Materials

Contractor has the option to provide to its Members a welcome packet to introduce them to the VMNG Program. If Contractor chooses this option, the welcome packet is subject to review by DVHA to ensure consistency with other member materials sent out by DVHA. The welcome packet may include, but not be limited to, a new member letter, explanation of where to find information about Contractor's provider network, information about completing a health needs screening, and any unique features of the VMNG Program.

Contractor is required to give DVHA Members the option to opt out of data sharing, that is, for DVHA to send Contractor claims information about the Member. A notice must be sent to Attributed Members by Contractor outlining the procedures that the Member may follow should they wish to change their claims data sharing preferences (either to opt in or opt out of data sharing). A Member has thirty (30) days from receipt of notice to opt out prior to their data being shared, but they may also opt out at any time subsequent to that thirty-day period.

4.4.2 Member Website

Contractor shall provide and maintain a website for Members to access information pertaining to Contractor's services. The website shall be in a DVHA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. Contractor's website information relevant to the VMNG Program shall be subject to DVHA approval. The website shall be accurate and current, culturally appropriate, and written for understanding at no higher than a sixth-grade reading level. Contractor shall inform Members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention by the user to install plug-ins or additional software. Contractor shall allow users print access to the information. Such website information shall include, at minimum, the following:

a. A link to DVHA's website so that Members have access to a searchable online directory of participating Medicaid providers and general Medicaid information;

b. Contractor's contact information for Member inquiries, grievances and appeals;

c. Contractor's Member services phone number, TTY number, hours of operation and after-hours access numbers;

d. The Member's rights and responsibilities, as enumerated in 42 CFR § 438.100, which relates to enrollee rights;

e. Contractor-distributed literature regarding all health or wellness promotion programs that are offered by Contractor;

f. Contractor's website privacy statement;

g. The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and

h. Information related to Contractor's annual quality measurement performance

4.5 Member and Potential Member Communications Review and Approval

Member and potential Member communications developed by Contractor shall be subject to DVHA's approval. Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate DVHA's review and approval of member materials and document its receipt and approval of original and revised documents.

Contractor shall not refer to or use DVHA or other state agency names or logos in its Member and potential Member communications without prior written approval. Any approval given for the DVHA or other state agency name or logo is specific to the use requested and shall not be interpreted as blanket approval.

4.6 Member-Provider Communications

Contractor shall comply with 42 CFR § 438.102, which relates to member-provider communications.

4.7 Member Rights

Contractor shall ensure that its Participating Providers adhere to the following Member's rights, in cooperation with DVHA:

a. The right to receive information in accordance with 42 CFR § 438.10, which relates to informational materials;

b. The right to be treated with respect and with due consideration for his or her dignity and privacy;

c. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

d. The right to participate in decisions regarding his or her health care, including the right to refuse treatment;

e. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

f. The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and

g. The right to be furnished health care services in accordance with 42 CFR § 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

Members shall be free to exercise protected member rights, and Contractor shall ensure that its Participating Providers do not discriminate against a Member that chooses to exercise his or her rights.

4.8 Interpretation Services

In accordance with 42 CFR § 438.10(d)(4), Contractor shall arrange for interpretation services to its Members free of charge for services it provides, including, but not limited to the member services helpline described in Section 4.3.1. Contractor shall notify its Members of the availability of these services and how to obtain them. The requirement to provide interpretation applies to all non-English languages. Interpretation services shall include American Sign Language and other signed languages interpretation services for deaf individuals.

Additionally, Contractor shall ensure that its Participating Providers arranges for interpretation services to Members seeking healthcare-related services in a provider's service location. This includes ensuring that Participating Providers who have twenty-four (24) hour access to healthcare services in their service locations (e.g. hospital emergency departments) shall provide Members with twenty-four (24) hour oral interpreter services, either through in-person or telephonic interpreters. For example, Contractor shall ensure that Participating Providers provide TTY services for hard of hearing Members, oral interpreters, and American Sign Language and other signed languages interpreters.

For purposes of this section, the terms “Contractor shall arrange for” and “Contractor shall ensure” means that Contractor’s network of Participating Providers shall fulfill those requirements.

4.9 Cultural Competency

In accordance with 42 CFR § 438.206, Contractor shall participate in DVHA's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

4.10 Advance Directives

Contractor, through its network of Participating Providers, shall comply with the requirements of 42 CFR § 422.128, which relates to advance directives, for maintaining written policies and procedures for advance directives.

4.11 Member Grievances and Appeals

DVHA shall maintain its own internal grievance and appeals processes. Contractor, however, shall serve as the first line to intake grievances and appeals that are specific to actions taken by Contractor related to its Members. Contractor shall establish written policies and procedures, subject to review and approval by DVHA, governing the resolution of grievances and appeals. For any grievances not resolved by Contractor, Contractor shall offer the Member the opportunity to escalate the grievance to the DVHA grievances and appeals process.

Contractor shall be responsible for addressing the following situations whenever a Member is attributed to the VMNG Program:

a. A Member expresses dissatisfaction (a grievance) with the VMNG Program, a VMNG Program policy or a provider affiliated with the VMNG Program; or

b. A Member wishes to appeal a decision or action taken by the VMNG Program (in accordance with the definitions provided in 42 CFR § 438.400(b)).

4.11.1 State Fair Hearing Process

In accordance with 42 CFR § 438.408, the State of Vermont maintains a fair hearing process which allows Members the opportunity to appeal Contractor's decisions to the State of Vermont.

If there is a reduction or termination in covered services in amount, duration or scope, then Members must have access to grievances, appeals and a state fair hearing process. In situations where an Attributed Member has exhausted Contractor's grievance and appeals process and is still dissatisfied, the Member may request a DVHA fair hearing within ninety (90) days from the date of Contractor's decision. Although DVHA staff will coordinate the fair hearing process, Contractor shall be responsible for providing all requested information made by DVHA related to the Member appeal in the timeframe requested by the State of Vermont. Contractor shall assist DVHA, as needed and requested by DVHA, in support of the fair hearing process including, but not limited to, attending the fair hearing.

Contractor shall include the DVHA fair hearing process as part of the written internal process for resolution of appeals.

4.11.2 Member Notice of Grievance, Appeal and Fair Hearing Procedures

Contractor shall follow and communicate, when necessary, information listed in the DVHA General Provider Agreement related to member grievance, appeal and State of Vermont fair hearing procedures and timeframes to providers and Subcontractors at the time they enter a contract with Contractor.

4.11.3 Recordkeeping Requirements of Grievances and Appeals

For purposes of quality review, Contractor shall accurately maintain records for grievances and appeals that contain, at minimum, the following information:

a. A general description of the reason for the appeal or grievance;
b. The date the appeal or grievance was received;
c. The date the appeal or grievance was reviewed;
d. The resolution of the appeal or grievance;
e. The date of the resolution of the appeal or grievance;
f. The dates and details of all correspondence/communication between Contractor and the Member related to the grievance or appeal; and
g. The name and UID number of the Member for whom the appeal or grievance was filed.

Contractor shall provide such record(s) of grievances and appeals monthly.

5. Provider Network and Services

Parties agree that while Contractor has a network of Participating Providers to serve Attributed Members, Contractor does not limit Attributed Members to its network of Participating Providers nor to services provided by Participating Providers. Parties further agree that Attributed Members may have care provided by any Medicaid provider in DVHA's network.

5.1 Network Development

Contractor shall develop and maintain a provider network in compliance with the terms of this section and 42 CFR § 438.206.

Contractor shall ensure that all of its Participating Providers can respond to the cultural and linguistic needs of its Attributed Members. The network shall be able to meet the unique needs of its Members, particularly those with special health care needs. Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

Contractor shall ensure that all of its network providers are enrolled as Medicaid providers and follow all Vermont Medicaid provider enrollment criteria.

Contractor must monitor medical care standards to evaluate access to care and quality of services provided to Members, evaluate providers regarding their practice patterns, and have a mechanism in place to address quality of care concerns.

5.2 Network Composition Requirements

Contractor shall submit network composition reports on a quarterly basis or at any time there is a significant change to the provider network. DVHA shall have the right to expand or revise the network requirements as it deems appropriate.

In accordance with 42 CFR § 438.12, Contractor shall not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. If Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This does not require Contractor to contract with providers beyond the number necessary to serve all of its Members' needs. Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with Contractor's responsibilities.

Contractor shall ensure that its Participating Providers adhere to requirements in the DVHA General Provider Agreement to offer hours of operation to DVHA Members that are no less than the hours of operation offered to commercial members. Contractor shall also make urgent or emergent covered services available 24-hours-a-day, 7-days-a-week, when medically necessary. In meeting these requirements, Contractor shall coordinate with DVHA's Provider and Member Relations unit to monitor the compliance of network providers and take corrective action if there is a failure to comply.

5.3 Provider Contracting

Contractor is responsible for ensuring, that as a condition of participation with Contractor, its Participating Providers have entered into, and shall keep current, a Vermont Medicaid General Provider Agreement. DVHA will continue to enroll and revalidate providers using the Provider Screening and Enrollment requirements in 42 CFR § 455, Subp. E. DVHA's enrollment criteria can be found here: http://www.vtmedicaid.com/#/home

DVHA shall immediately disenroll any Participating Provider if the provider becomes ineligible to participate in the Medicaid program for any reason. DVHA shall notify Contractor at the time of disenrollment.

DVHA is responsible for determining provider payment suspensions in accordance with 45 CFR § 455.23 where there is a credible allegation of fraud against a provider. Upon a partial or full suspension of payment to a Participating Provider, DVHA shall notify Contractor and Contractor shall take all necessary actions to ensure payments are suspended as determined to be appropriate by DVHA.

Contractor shall immediately inform the DVHA Special Investigations (SI) Unit in writing should it disenroll, terminate or deny provider enrollment for "program integrity" reasons (i.e., the detection and investigation of fraud, waste, or abuse). If Contractor terminates a Participating Provider due to fraud, program integrity, or quality reasons, such terminations are considered "for cause" and must be immediately reported to DVHA SI Unit.

Contractor shall report any Participating Provider at the Tax Identification Number (TIN) level on a monthly basis and include the Billing NPI, Medicaid ID and payment type. Refer to Section 9 in this Attachment A for more details on this process.

5.4 Provider Agreements

Contractor must have a process in place to review and authorize all Participating Provider contracts. The Participating Provider contracts must not be in conflict with any aspect of the DVHA General Provider Agreement. DVHA reserves the right to review and approve Contractor network contracts on an annual basis to ensure compliance with this Contract prior to them being sent to Participating Providers.

Participating Provider contracts will contain requirements to maintain active Medicaid participation, to report any events that may impact that participation, and to immediately report any termination from Medicaid. Participating Provider agreements will also require both the Participating Providers and Contractor to comply with all applicable federal, state and local laws and regulations.

Contractor shall include in all its provider agreements provisions to ensure continuation of benefits as required by law. Contractor shall identify and incorporate the applicable terms of this Contract with DVHA into its provider agreements. Under the terms of the Participating Provider contract, the provider shall agree that the applicable terms and conditions set out in the Participating Provider contract, any incorporated documents, and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to Members. The Participating Provider contracts shall meet the following requirements:

a. Describe the provider claim dispute resolution process;

b. Require each provider to maintain a current Vermont Medicaid General Provider Agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board;

c. Require providers to adhere to DVHA timely filing requirements for claims submissions;

d. Include a termination clause stipulating that Contractor shall terminate its contractual relationship with the provider as soon as Contractor has knowledge that the provider's license or Vermont Medicaid General Provider Agreement has terminated;

e. Obligate the terminating provider to submit all claims or encounters for services rendered to Contractor's Members to Fiscal Agent while serving as Contractor's Participating Provider;

f. Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors; and

g. Provide a copy of a Member's medical record at no charge upon request by the Member and facilitate the transfer of the Member's medical record to another provider at the Member's request.

For purposes of this section, Contractor agrees that its network consists of Participating Providers as defined above, which specifies that Participating Providers have a signed agreement with the Contractor meeting the requirements of this Section 5.4.

5.5 Medical Records

Contractor's Participating Providers shall permit Contractor and representatives of DVHA to review Members' medical records for the purposes of capturing information for clinical studies, monitoring quality or any other reason. The failure of Contractor and/or its Participating Providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its Participating Providers repaying DVHA or Contractor for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not provided in a timely manner.

5.6 Provider Education and Outreach

Contractor shall provide ongoing education about the VMNG Program as well as Contractor-specific policies and procedures to its provider network. In addition to developing its own provider education and outreach materials, Contractor shall coordinate with DVHA-sponsored provider outreach activities upon request.

Contractor shall educate its contracted providers, including mental health providers, regarding provider requirements and responsibilities, Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud and abuse, pay-for-outcome programs and any other information relevant to improving the services provided to Contractor's members.

5.6.1 Provider Communications Review and Approval

Provider communication materials specific to this Contract, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, shall be subject to DVHA review and approval.

Contractor shall include DVHA's program logo(s) in its provider communication materials upon DVHA's request.

Contractor shall not refer to or use DVHA or other state agency names or logos in its provider communications without prior written approval by DVHA. Any approval given for DVHA or any other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

5.6.2 Provider Policies and Procedures

Contractor will maintain provider policies and procedures specific to Contractor operations and these shall not be in conflict with the information provided in the Vermont General Provider Manual, found at: http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf.

Contractor provider policies and procedures shall be available both electronically and in hard copy (upon request) to all Participating Providers, without cost, when they are initially enrolled, when there are any changes in policies and procedures, and upon a provider's request.

5.7 Contractor Outreach with Providers

Contractor shall have in place policies and procedures to maintain frequent communications and provide information to its Participating Provider network. Contractor shall give Participating Providers at least thirty (30) days advance notice of material changes that may affect the Participating Providers' procedures such as changes in Subcontractors or prior authorization policies. Contractor shall post a notice of the changes on its website to inform Participating Providers and make policies available upon request.

In accordance with 42 CFR § 438.102, Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member.

5.7.1 Provider Website

Contractor shall maintain a provider website that contains information about its Medicaid line of business. Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 4.4.2.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. Contractor shall allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

a. Contractor's contact information;

b. A link to the Vermont Medicaid Provider Manual and any VMNG Program Provider Policy and Procedure Manual and associated forms;

c. Contractor's clinical guidelines;

d. Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;

e. Contractor's provider payment dispute resolution procedures;

f. Contractor's appeal procedures;

g. Contractor's website privacy statement;

h. The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and

i. Links to DVHA's website for general Medicaid information.

5.7.2 Provider Services Helpline

In addition to the provider service helpline provided by Fiscal Agent, Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints that are specific to VMNG Program operations. Contractor shall staff the provider services helpline with personnel trained to accurately address provider issues from 8:00 am to 4:30 pm Eastern Standard Time (EST), Monday through Friday, at minimum. Contractor shall provide a voice message system that informs callers of Contractor's business hours and offers an opportunity to leave a message after business hours.

The Contractor's provider services helpline may be closed on all holidays observed by the State of Vermont government.

Contractor must monitor its provider services helpline and report its telephone service performance to DVHA each month as described in the ACO Reporting Manual, notwithstanding, Contractor may report Member and provider hotline call statistics together.

5.7.3 Fiscal Agent Workshops and Seminars

Fiscal Agent sponsors workshops and seminars for all Vermont Medicaid providers. Contractor shall participate in the workshops and attend the provider seminars. A Contractor representative shall be available to make formal presentations and respond to questions during the scheduled time(s) as requested by DVHA.

5.8 Member Payment Liability

Contractor and its Subcontractors shall ensure that Members are not held liable for any of the following:

a. Covered Services provided to the Member which Contractor is responsible for which Contractor does not pay the provider; or

b. Contractor's debts or Subcontractor's debts, in the event of the entity's insolvency.

Contractor shall ensure that its Participating Providers do not balance bill its Members, i.e., charge the member for Covered Services above the amount paid to the provider by Contractor. If Contractor is aware that any provider is balance billing a Member, Contractor shall instruct the provider to stop billing the Member. Contractor shall also contact the Member to help resolve issues related to the billing.

Vermont Medicaid providers are prohibited from charging a Member, or the family of the Member, for any amount not paid as billed for a covered Medicaid service.

6. Care Management and Care Coordination

6.1 Integrated Team-Based Care

DVHA's goals are to achieve integrated team-based care that is person-centered for all Members with complex needs who need services from multiple provider types and who would benefit from strong communication and collaboration between those providers, and to support high-functioning Complex Care Ecosystems within each HSA. Members often seek care from a wide spectrum of health and human services providers to support comprehensive treatment of mental health conditions, substance use disorders, other health conditions, social determinant of health needs, and conditions requiring long-term services and supports. Integrated team-based care helps to ensure optimal care management and care coordination for those members. High-functioning Complex Care Ecosystems support integrated team-based care and the Care Model.

Contractor shall continue to implement, support, monitor, and evaluate a Care Model that is Member-directed, strengths-based, and responsive to the needs of Attributed Members. Contractor shall participate in activities to further align and improve care integration across the Medicaid benefit, as directed by DVHA. If DVHA conducts assessments of the current state of integrated team-based care and Complex Care Ecosystems, refines approaches to integrated team-based care and Complex Care Ecosystems, or provides forums and trainings to enhance design and implementation of identified approaches, Contractor shall participate in such activities, including attending meetings, reviewing and providing written feedback on approaches and documents, and providing in-kind support (e.g., expertise, faculty) for training and education as requested by DVHA.

For attributed members who receive Medicaid-funded case management or care coordination, Contractor shall coordinate the provision of care management and care coordination to ensure services are supplementary and not duplicative. Contractor shall maintain procedures for transitioning Members to or from other care coordination entities or programs, and for graduating members from Contractor's care coordination program. To the extent that an Attributed Member has needs that can be addressed by ongoing care coordination, but no longer requires intensive care team support, Contractor will ensure that policies and procedures are in place to establish a long-term care coordination relationship and monitor evolving needs of the Member. These procedures shall ensure that care team participants work together to

facilitate a smooth transition of tasks and responsibilities between care coordination programs and staff.

Contractor's Care Model shall be inclusive of case managers, care coordinators, and other relevant staff from the AHS and community organizations delivering Medicaid funded health care, home- and community-based services, and long-term services and supports. Contractor shall develop and maintain collaborative relationships and participate in initiatives that support design and implementation of Care Model refinements with State of Vermont agencies, departments, and programs in support of its Care Model activities, including the AHS; Blueprint for Health; Vermont Chronic Care Initiative (VCCI); Department of Disabilities, Aging, and Independent Living; Department of Mental Health (DMH); Vermont Department of Health (VDH); VDH's Division of Substance Use Programs (DSU); Department of Corrections; and Department for Children and Families.

6.2 Elements of Care Model

At a minimum, the Care Model shall include:

1. The use of data and care team experience to identify Attributed Members who could benefit from integrated team-based care as part of the Care Model. Use of data includes applying predictive analytics such as risk stratification and analyzing patterns of potentially avoidable utilization (e.g., frequent ED visits or inpatient admissions).
2. Processes for recruiting Attributed Members to participate in the Care Model.
3. The use of tools to identify and document a Member's life history, goals and care team. Examples include tools to provide comprehensive screenings; identify a Member's care team and support system (e.g., "eco-maps"); and identify a Member's goals, strengths, barriers, and communication style.
4. Conducting a review of a Member's health history and available medical records to identify underlying root causes of complex needs; conducting an analysis of root causes to determine how they are best addressed.
5. The identification of a Member's lead care coordinator, selected by the Member, to facilitate communication and collaboration across the Member's care team.
6. The adoption of a comprehensive shared care plan that documents key information about the Member, the care team, and the Member's goals.
7. Care team conferences inclusive of the Member, when invited and able to attend, and their care team conducted during initial development of the shared care plan to document the Member's goals and develop action plans for care team implementation, and at regular intervals thereafter to assess progress against goals.

6.3 Care Model Policies and Procedures

6.3.1 Contractor shall develop policies and procedures regarding the development, implementation, support, monitoring, and evaluation of its Care Model. Further, Contractor shall monitor and evaluate the effectiveness of its policies and procedures and develop and implement mechanisms to improve the Care Model over time using a continuous quality improvement framework. Contractor shall provide policies and

procedures regarding care management, care coordination, and its Care Model to DVHA upon request.

6.3.2 Through the course of regular program operations VCCI may conduct outreach and/or engage in services with Attributed Members who could benefit from VCCI services. When an Attributed Member is actively enrolled in the Care Model and is actively engaged with VCCI, VCCI should be included in all care team communications and shared care planning activities. As Attributed Members transition off VCCI services, care team participants will work together to ensure a smooth transition and warm hand-off of tasks and responsibilities that were previously led by VCCI to other members of the care team as facilitated by the lead care coordinator.

6.4 Care Team Communication and Shared Care Planning Support

6.4.1 Contractor will provide care coordination tools and expertise to support care coordination activities and facilitate care team communication.

6.4.2 Contractor shall provide to its Care Coordination Partners a structured means of reporting care team communication elements including cross organizational collaboration, shared care planning, and presence of lead care coordinator. Contractor shall require its Care Coordination Partners to report care team communication elements in January 2025, April 2025, and August 2025. Contractor shall support, track and audit annually care team communication and shared care planning as an essential component of the Care Model. To support communication of information across the Complex Care Ecosystem, Contractor shall:

a. Disseminate aggregated information in April 2025, July 2025, and November 2025 on care team communication elements it collects to its Care Coordination Partners,
b. Share information with Care Coordination Partners in April 2025, July 2025, and November 2025 for each Member whom they have reported as being care managed. Such information shall include which Care Coordination Partners, as privacy regulations allow, are on the Member's care team; which organization is the lead care coordinator; and whether a shared care plan has been created, and
c. Make available a standardized care planning template to all care team participants which can be electronically shared, edited, and exported.

6.4.3 Upon DVHA's approval, Contractor may utilize an AHS electronic care team communication and shared care planning platform should it become available.

6.5 Population Health Management

6.5.1 Contractor's Care Model shall include strategies for supporting Members at various levels of risk; for example, those Members identified as low risk, medium or rising risk, high risk, and very high risk of experiencing complex health conditions. Within 90 days of the beginning of each Performance Year, Contractor shall use best practices and predictive modeling tools to conduct comprehensive screening and risk stratification to predict all Attributed Members' risk (if possible, including tools that address needs of specific sub-populations and risk related to social determinants of health). Contractor shall provide information about screening and risk stratification tools and results to DVHA upon request.

6.5.2 Contractor shall work with DVHA, AHS, the State's Agency of Digital Services (ADS), and other stakeholders to continue exploring the feasibility of implementing a universal screening tool for social determinants of health within its provider network, including assessment of data availability for such a tool. Contractor shall meet periodically with DVHA, AHS, ADS, and other stakeholders to share information, update on progress to date, and to further collaborate on this initiative.

6.5.3 Contractor shall develop strategies to support Complex Care Ecosystem in providing recommended care coordination interventions and care for Members based on level of risk. These strategies shall include:

a. Mechanisms for Participating Provider judgement, experience, or other triggering events to inform, and potentially impact, predictive risk stratification results. Contractor shall identify triggers which would immediately move Members to higher care coordination levels and shall communicate those triggers to Participating Providers.
b. Mechanisms to identify and outreach Members who are due for recommended preventive health evaluations, screenings, or chronic condition management.
c. Tools to conduct comprehensive standardized assessments, such as screenings and assessments for mental health conditions, social determinants of health, substance use disorder, suicide risk, activities of daily living, cognitive and memory function, and women of child-bearing age. DVHA reserves the right to require use of a specific screening tool(s) to ensure alignment with AHS programming.
d. Mechanisms to ensure that Care Coordination Partners, and mechanisms to support other participants in the Complex Care Ecosystem, to work with Members to identify Members' goals, strengths, needs and available resources to enable person-directed planning, including family and caregiver input as appropriate.
e. Regardless of level of risk, support for all Members participating in the Care Model with Member-directed goal setting; identification of strengths, barriers and challenges; selection of lead care coordinator and care team; development of a shared care plan; convening of the care team; and prioritization of goals, action steps, tasks, and milestones. Contractor shall develop processes and provide support for Care Coordination Partners, lead care coordinators, other participants in the Complex Care Ecosystem, and Members to engage in and implement this Member-directed process.
f. Chronic condition management and self-management supports, shared decision-making tools, lifestyle programming aimed at reducing or eliminating tobacco use and improving nutrition and physical activity, and other beneficial supports.
g. Processes to support each Member participating in the Care Model to identify a lead care coordinator to serve as the Member's primary point of contact and facilitate care team meetings and activities.
h. Processes and support for the lead care coordinator to work with Care Coordination Partners and other participants in the Complex Care Ecosystem to develop a shared care plan to address the Member's needs in areas such as mental health conditions, social determinants of health, substance use disorder, suicide

risk, other health conditions, activities of daily living, and cognitive and memory function.

i. Processes and support for the lead care coordinator to ensure and facilitate regular care team conferences with the Member.
j. Processes and support for low and rising risk Members who wish to participate in Contractor's Care Model.
k. Processes and support to ensure that Care Coordination Partners communicate with medium or rising risk Members participating in the Care Model at least two times per Performance Year. This bi-annual outreach and engagement will include a comprehensive assessment of the Member's conditions and needs, as outlined in Section 6.5.3.c.
l. Processes and support to ensure that Care Coordination Partners communicate with high-risk Members participating in the Care Model at least four times per Performance Year. This quarterly outreach and engagement will include a comprehensive assessment of the Member's conditions and needs, as outlined in Section 6.5.3.c.
m. Processes and support to ensure that Members at very high risk who are enrolled in the Care Model receive more frequent outreach and engagement as needed, but at least monthly, to more regularly assess and address their needs.
n. Processes and support to ensure that medium and high-risk pregnant women receive pregnancy care health education materials and other services specific to their pregnancy risk factors.
o. Availability of Contractor's chief medical officer to consult with Care Coordination Partners and other participants in the Complex Care Ecosystem as needed to inform development of shared care plans for high-risk Members, and to consult with the DVHA medical director as appropriate. Contractor shall ensure that its Participating Providers assess palliative or hospice care needs for the highest risk Attributed Members.
p. Reinforcement of Complex Care Ecosystems concepts within each HSA, including but not limited to support for assessing the current state, identifying the desired future state, developing refinements, and effective implementation of the integrated team-based care and Complex Care Ecosystem components of the Care Model.

6.6 Learning Network

Contractor shall support implementation, expansion and sustainability of its Care Model by providing Members, Participating Providers, and other care team participants with education, training, and technical assistance to meet the needs of the Member and care team participants and to further reinforce development of the Complex Care Ecosystem in each HSA. The learning network shall provide at a minimum:

1. Educational opportunities and support, either in-person or through access to virtual learning platforms, to ensure that lead care coordinators, care team participants, and other complex care management staff participate in training to develop expertise and experience in

providing care management and care coordination services for individuals with complex health needs, including individuals with mental health needs.

2. Access to forums for peer learning opportunities and connections with other care team participants both within and across Health Service Areas (HSAs), including forums that support high functioning Complex Care Ecosystems.

3. Support for developing standardized processes and workflows for Care Model dissemination both within and across HSAs.

4. Access to training and education materials to support development of core competencies in care management, care coordination, team-based care, and Complex Care Ecosystems.

5. Access to targeted data and analytics tools that support continuous quality improvement in Care Model implementation.

6.7 Accessible Communication

Contractor shall develop policies and procedures regarding the use of accessible communication with attributed Members and care team participants. These shall include, at a minimum:

1. Access to an interpreter for any Members or care team participants.

2. Access to diverse means of communication and information sharing that support all levels of learning and/or disability.

3. Ensuring that accessible standards are upheld in all care delivery settings, whether face-to-face, telehealth, or accessing information in electronic or written formats.

6.8 Reporting on Care Model and Population Health Management Activities

6.8.1 Contractor shall report information to DVHA on Care Model activities and progress on a regular basis. Specific reporting requirements will vary based on Contractor's Care Model design, specific business processes, and tools. Reporting shall identify data sources and include at a minimum:

a. Information on training to participants in the Complex Care Ecosystem to support adoption of Contractor's Care Model.

b. Information on technical assistance to Care Coordination Partners to support adoption of Contractor's Care Model.

c. Information on status of Members enrolled in Contractor's Care Model, indicating whether Members are active in the Care Model, receiving the recommended level of outreach and engagement for high and very high-risk members, and receiving key Care Model interventions. Such information shall include, at a minimum, numbers and rates of all Members and care managed Members by risk level who are engaged in community programs, receiving recommended frequency of outreach, with care team created, with

lead care coordinator, receiving care conferences with care plan created, and care managed.

d. Information on lead care coordinator and care team participation by organization type by health service area for care managed Members; and information on numbers and rates of high and very high-risk Members who are care managed, have a lead care coordinator, have a shared care plan created.

e. Information on numbers and rates of care team creation, lead care coordinator, shared care plan creation, care conferences, and care managed status for subpopulations of Members.

f. Information including attribution, quality measure progress, inpatient, emergency department, primary care provider, and post-acute care spend and utilization. The Parties may agree to add reporting information as it becomes available. Summaries of Contractor audits to verify identification of lead care coordinators, convening of care teams and care conferences, and development of shared care plans for Members for each health service area.

g. Information describing activities under the learning network, including educational opportunities and other trainings.

h. Narrative information describing progress in implementing integrated team-based care components of Contractor's Care Model including successes, challenges, lessons learned, risks and mitigation strategies. Narrative will also include means of supporting Complex Care Ecosystem strategies that arise from integrated planning forums.

i. Information detailing any payments made to care team participants for completing Care Model activities. Such information shall include, at a minimum, organization name, tax identification number, amount of payment, date of payment, and purpose of payment.

j. Contractor shall provide other information about Care Model processes, tools, mechanisms, and results to DVHA upon request.

7. Quality Management

7.1. Quality Management Overview and Definitions

7.1.1 Contractor shall monitor, evaluate, and take effective action to identify and address any needed improvements in the quality of care delivered to its Attributed Members by all providers, including specialists, in all types of settings, in accordance with the provisions set forth in the Contract. Contractor shall submit quality improvement data in a time and manner as set forth by DVHA including, but not limited to, data that meets Healthcare Effectiveness Data and Information Set (HEDIS®) standards for reporting and measuring outcomes.

7.1.2 Additionally, Contractor must submit information requested by DVHA to complete DVHA's annual quality strategy plan. This will include the results of any performance improvement projects or quality improvement projects. For purposes of this Section, a quality improvement project is a planned strategy for program improvement and is

incorporated into Contractor's quality management and improvement program work plan, and a performance improvement project is a planned strategy for program improvement which adhere sot CMS protocols for performance improvement projects.

7.2 Quality Management and Improvement Program

7.2.1 Contractor's chief medical officer shall be responsible for the coordination and implementation of Contractor's quality management and improvement program. The program shall have objectives that are measurable and supported by Contractor's medical and quality improvement staff. Through the quality management and improvement program, Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services that are safe, effective, timely and member-centered. Contractor's chief medical officer shall meet biannually with the DVHA's Chief Medical Officer or designee to review quality management and improvement plan activity and progress.

7.2.2 Contractor shall meet the requirements of 42 CFR § 438 subpart E on quality assessment and performance improvement, including but not limited to the requirements listed below, in developing its quality management and improvement program and a quality management and improvement program work plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to Members with special health care needs, (ii) completion of performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects; and (iii) production of quality of care reports at least annually or as otherwise required by DVHA.

7.2.3 Contractor's quality management and improvement program shall:

a. Include developing and maintaining an annual quality management and improvement program work plan which sets goals, establishes specific objectives based upon priorities identified, identifies the strategies and activities to undertake, monitors results, and assesses progress toward the goals. Requirements for the quality management and improvement program work plan are described in Section 7.4, below.
b. Have in effect mechanisms to detect both underutilization and overutilization of services and the ability to report these findings to DVHA as required. Contractor will maintain policies and practices that support regular and ongoing monitoring of under- and over-utilization, identification of trends, and identification and implementation of changes in policies, processes, and practices. Contractor will meet with the DVHA medical director and/or designees at least biannually to review utilization trends among Attributed Members and non-Attributed Members. The activities Contractor takes to address under-utilization and over-utilization must be documented and outcomes must be reported to DVHA.

c. Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines, and individuals responsible for implementation.
d. Incorporate an internal system for monitoring services and quality of care, including data collection and management for clinical studies, internal quality improvement activities, assessment of certain target populations and other quality improvement activities requested by DVHA.
e. Use Healthcare Effectiveness Data and Information Set (HEDIS®) performance data, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey data, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to Members.
f. Collect performance data related to areas of clinical priority. Contractor will obtain and incorporate input from DVHA when identifying areas of clinical priority and performance indicators.
g. Report data for any national performance measures developed by CMS in the future at the request of DVHA. Have procedures for collecting and assuring accuracy, validity and reliability of performance data that are consistent with protocols developed in the public or private sector.
h. Report the incentives offered and the results of any physician incentive program, if such a program has been put in place.
i. Report the incentives offered and the results of any Member incentive program, if such a program has been put in place.
j. Describe how Contractor shall participate in other quality improvement activities, including, but not limited to, external quality reviews (EQRs), to be determined by DVHA. For purposes of this section, the Contractor and DVHA agree that the term "participate" means DVHA may request consideration of quality improvement activities and provision of information in support of DVHA's EQR organization audits.

7.3 Quality Improvement Work Group(s)

7.3.1 Contractor shall establish one or more work groups that include Participating Providers to develop, approve, monitor, and evaluate the quality management and improvement program and work plan. Contractor's chief medical officer shall be an active participant in the work group(s). Work group(s) shall also include representatives of Contractor's management staff and analytics, clinical, finance, and quality departments. The DVHA medical director or designee shall be invited to participate in the work group focused on quality improvement. The work group(s) shall represent the geographic diversity of Contractor's network of Participating Providers, include representatives of Contractor's board of managers (BOM), primary and specialty care providers, continuum of care providers, as well as relevant subject matter experts.

7.3.2 Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the work group(s)

that develop, approve, monitor, and evaluate Contractor's quality management and improvement program work plan. All functional units in Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with Contractor's internal quality management and improvement committee to support Contractor's quality management and improvement goals and objectives.

7.3.3 Contractor shall have appropriate personnel attend and participate in regularly scheduled DVHA quality committee meetings.

7.4 Quality Management and Improvement Program Work Plan

7.4.1 Contractor's work group(s), in collaboration with Contractor's chief medical officer, shall develop an annual quality management and improvement program work plan. The plan shall identify Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals.

7.4.2 Contractor shall submit its quality management and improvement program work plan to DVHA by the end of Q1 of the initial Performance Period of this contract. Contractor shall provide progress reports to DVHA on no less than a quarterly basis. Contractor must be prepared to periodically, as determined by DVHA, report on its quality management activities to DVHA's quality committee.

7.4.3 Contractor shall prepare the annual quality management and improvement program work plan using a standardized format; Contractor shall have discretion in proposing a template for this reporting.

7.4.4 Annually, Contractor will also conduct a comprehensive evaluation of quality, experience of care, ATCOC, and utilization results to identify accomplishments and opportunities for improvement and to develop interventions to address identified opportunities. Relevant Contractor work group(s) will review the annual evaluation. The BOM will ultimately approve the evaluation and the results will be made available to DVHA. Contractor will also submit reports to, and work collaboratively with, DVHA when requested to satisfy legislative reporting requirements.

7.5 HEDIS® and CAHPS®

7.5.1 Contractor is not required to contract with a certified HEDIS® vendor or a certified CAHPS® survey vendor in this Performance Year to tabulate the results of performance measures pertaining to the DVHA Members attributed to the VMNG Program. Instead, Contractor will work in close collaboration with DVHA and its contracted HEDIS® vendor and CAHPS® survey vendor in sampling and measurement of results for DVHA Members both attributed and not attributed to the VMNG Program.

7.5.2 DVHA and Contractor shall implement a plan for quarterly monitoring of VMNG Program performance on claims-based HEDIS® measures that require data that is not shared with Contractor, including claims for diagnoses or procedures related to substance use disorder. To the extent that increased frequency of quality reporting incurs additional

costs to DVHA through its HEDIS® vendor, Contractor will be financially responsible for these costs.

In support of key contractor quality improvement initiatives as outlined in Section VI. Value-Based Incentive Program, DVHA will provide to contractor on a quarterly basis the DVHA Value-Based Incentive Program Mental Health and Substance Use Quality Improvement Support File that details, at the OneCare practice and Health Service Area (HSA) levels (as defined in collaboration with OneCare), numerator and denominator values for the most recent 12-month period of available data. No later than May 31, 2025, DVHA will make its best efforts to provide a report reflecting entirety of Performance Year timeframe. Measures to include: Initiation of Substance Use Disorder (HEDIS IET), Engagement of Substance Use Disorder (HEDIS IET), 30-day Follow-up after Emergency Department Visit for substance use (FUA), 30-day Follow-up after Emergency Department Visit for Mental Illness (FUM), and Follow-up after Hospitalization for Mental Illness – 7 Day Rate (FUH).

7.5.3 For the tabulation of HEDIS® measures requiring clinical data, Contractor will be responsible at the request of DVHA to conduct chart reviews for a random sample of Attributed Members receiving care from Participating Providers, and to report measure numerator and denominator information to DVHA. DVHA's contracted HEDIS® vendor will generate and provide the random samples for each applicable measure.

7.6 External Quality Review (EQR)

Pursuant to federal regulation, DVHA is subject to EQR. Contractor shall provide all information required for this review in the timeframe and format requested by the EQR organization. Contractor shall cooperate with and participate in all EQR activities, as requested. Contractor's quality management and improvement program should incorporate and address findings from these EQRs.

7.7 Incentive Programs

7.7.1 Value-Based Incentive Program

Contractor shall participate in a Value-Based Incentive Program that focuses on rewarding Contractor's, Participating Providers', Participating Practices' and Preferred Providers' efforts to improve quality and outcomes for their Attributed Members. The Value-Based Incentive Program is described in Attachment B.

7.7.2 Provider Incentive Programs

7.7.2.1 In addition to the Value-Based Incentive Program in Section 7.7.1, Contractor may establish incentives for its Participating Providers, Preferred Providers, and Participating Practices. Contractor will determine its own methodology for incentivizing Participating Providers, Participating Practices and Preferred Providers, subject to DVHA approval. Prior to implementation of any incentive programs, Contractor will provide

DVHA with policies related to provider incentives, updates to policies related to the VMNG Program are also subject to DVHA approval. Contractor shall comply with federal regulations regarding physician incentive plans includes those in 42 CFR § 438.3(h).

7.7.2.2 Contractor will make no specific payment directly or indirectly to a provider or provider organization as an inducement to reduce or limit medically necessary services furnished to an individual Member.

7.7.3 Member Incentive Programs

Contractor may establish Member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non-financial. Contractor will determine its own methodology for providing incentives to Members. Contractor must obtain DVHA approval prior to implementing its member incentive program and before making any changes thereto.

7.8 Prior Authorization Requirements

DVHA has waived prior authorization requirements for certain services that are (1) included in the ETCOC (see Section 3.1) for Attributed Members, (2) provided to Attributed Members, and (3) delivered by a provider enrolled with DVHA as a Medicaid provider. A detailed listing by CPT/HCPCS code of services still requiring prior authorization by DVHA appears in Attachment A, Exhibit 1; these services will require prior authorization review from DVHA notwithstanding DVHA's waiver. As described in Section 3.1 above, Exhibit 1 represents national coding conventions at the time of execution of this Contract and are updated periodically. DVHA will update Attachment A, Exhibit 1 no more frequently than quarterly, as necessary. DVHA reserves the right to modify the prior authorization waiver at any point during the Performance Year. DVHA will provide Contractor with written notice at least thirty (30) days prior to the effective date of any modifications.

7.9 Practice Guidelines

7.9.1 Contractor shall utilize practice guidelines that have been established by DVHA. The full list of guidelines is available at http://dvha.vermont.gov/providers/clinical-practice-guidelines . Contractor may adopt additional guidelines subject to review and approval by DVHA.

7.9.2 Pursuant to 42 CFR § 438.210(b), relating to authorization of services, Contractor shall consult with contracting health care professionals in developing practice guidelines. Contractor shall, at a minimum, review and update the guidelines biannually, distribute the guidelines to Participating Providers and make the guidelines available to Members upon request.

8. Performance Reporting

8.1 ACO Reporting Manual

Contractor shall submit performance data specific to the VMNG Program unless otherwise specified by DVHA. DVHA reserves the right to publish the evaluation of the VMNG Program's performance.

Contractor shall comply with all reporting requirements set forth in the 2025 ACO Reporting Manual as referenced in Section 2.14 of this Attachment A, the ACO Reporting Manual will contain a catalog of the reports that will be required to be submitted by Contractor to DVHA and the periodicity schedule of each report submission. For the majority of reports, DVHA will provide both a report template and instructions for how to complete each report. Contractor will have discretion to propose the format for reports for which DVHA does not supply templates.

Contractor shall submit the requested data completely and accurately within the requested or required timeframes and in the formats identified by DVHA. DVHA reserves the right to require Contractor to work with and submit data to third-party data warehouses or analytic vendors.

Contractor shall have policies, procedures and mechanisms in place to ensure that all performance data submitted to DVHA is materially accurate and materially complete. Contractor shall submit its performance data and reports with verification of the approval of any key staff identified in Section 2.4.1, certifying Contractor's data is materially accurate and materially complete.

DVHA reserves the right to audit Contractor's self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

8.2 CMS Reporting

Contractor shall provide DVHA with data requested by the Centers for Medicare and Medicaid Services (CMS) to meet the reporting obligations described in the CMS Special Terms and Conditions (STCs) for the DVHA's Global Commitment waiver reporting. Contractor shall submit this data in the timeframe specified by DVHA.

8.3 Other Reporting

DVHA shall have the right to require additional reports determined by DVHA to be necessary for VMNG Program monitoring.

9. Information Systems

Unless otherwise specified, the provisions of this section apply to Members in the Cohorts.

9.1 Summary of Contractor Information System Responsibilities

Contractor shall have an information system (IS) sufficient to support the VMNG Program requirements, and Contractor shall be prepared to submit all required data and reports accurately and completely in the format specified by DVHA. Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Contract.

In the event the State of Vermont's technical requirements require amendment during the term of the Contract, DVHA will work with Contractor in establishing the new technical requirements. Contractor shall be capable of adapting to any new technical requirements established by the State of Vermont, and the DVHA may require Contractor to agree in writing to the new requirements. Contractor-initiated changes to the requirements shall require DVHA approval. Contractor is required to pay for new technical requirements for its own systems.

Contractor shall develop processes for developing, testing, and promoting system changes and maintenance. Contractor shall notify DVHA prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements that may impact mission critical business processes, such as file exchanges with the Fiscal Agent, service authorization management, provider payment data management, care management files, and any other processing affecting Contractor's capability to interface with DVHA or DVHA's contractors.

Contractor shall have written policies and procedures sufficient to manage the VMNG Program. These policies and procedures will ensure accurate and valid provider payment detail data and will reflect that services delivered to Members and payments made to providers are made in compliance with state and federal regulations and in accordance with this Contract. These policies shall address the submission of provider payment data from any Participating Providers or Subcontractors. DVHA shall monitor Contractor's performance utilizing a random sample audit of all program documentation and payments. DVHA will review Contractor's compliance with its internal policies and procedures to ensure the accuracy and timeliness of the payments to providers and services provided to Members. Contractor is required to comply with the requirements of the review and audit and to provide all requested documentation. DVHA shall require Contractor to submit a corrective action plan and will require non-compliance remedies for Contractor's failure to comply with payment accuracy reporting standards.

Contractor will provide DVHA with a project plan for all system changes or system upgrades associated with this Contract. A project plan will include but is not limited to: project timeline, costs, milestones, deliverables, testing processes and protocols, criteria for a go-no go decision, contingency plan and mitigation strategies. Contractor will provide project plans to DVHA allowing for a thirty (30) day review. Contractor will proceed with the plan only after DVHA's written acceptance and approval of the plan.

Contractor shall have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), which address security and privacy of individually identifiable health information.

Contractor shall attend in person any meetings hosted by DVHA or its Fiscal Agent in relation to the development of and the ongoing remediation of any issues that arise from the data exchange process. Notwithstanding any scheduled meetings where these issues may be addressed, Contractor shall report any problems with data submissions to the designated DVHA Program Manager.

9.2 Security and Privacy Practices

Contractor's IS shall meet the requirements as specified by DVHA. Contractor's electronic mail encryption software for HIPAA security purposes must be compatible with DVHA's and with Fiscal Agent email software.

Contractor's IS plans for privacy and security shall include, but not be limited to:

a. Administrative procedures and safeguards (45 CFR 164.308);
b. Physical safeguards (45 CFR 164.310); and
c. Technical safeguards (45 CFR 164.312).

Contractor shall make all data available to DVHA and, upon request, to CMS. In accordance with 42 CFR § 438, subpart H, which relates to certifications and program integrity, Contractor shall submit all data, under the signatures of either its VP of Finance or Chief Executive Officer certifying the accuracy, truthfulness and completeness of Contractor's data. Software and services provided to or purchased by DVHA shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d). Any deviation from these architecture requirements shall be approved in writing by DVHA in advance. Contractor shall comply with all DVHA Application Security Policies. Any deviation from DVHA policies shall be approved in writing.

9.3 Disaster Recovery Plan

Information system contingency planning shall be developed in accordance with the requirements of this Section and with 45 CFR § 164.308, which relates to administrative safeguards. Contingency plans shall include: data backup plans, disaster recovery plans and emergency mode of operation plans. Application and Data Criticality analysis and Testing and Revisions procedures shall also be addressed within Contractor's contingency plan documents. Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. Contractor shall protect against hardware, software and human error. Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. Contractor shall maintain full and complete back-up copies of data and software, and shall back up and store its data in an off-site location.

For purposes of this Attachment A, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. DVHA and Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include, but is not limited to, natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

Contractor shall notify DVHA, at minimum, within four (4) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as those affecting Contractor's capability to interface with DVHA or DVHA's contractors. Depending on the anticipated length of disruption, DVHA, in its discretion, may require Contractor to provide DVHA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster, Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) days. In the event of other disasters or system unavailability caused by the failure of systems and technologies within Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) days.

DVHA may review Contractor's Disaster Recovery Plan for sufficiency at any time upon request.

9.4 Data File Exchanges

This Contractor will be responsible for the receipt and delivery of file exchanges with Fiscal Agent. Contractor must accept and submit data files in electronic format, currently via secure file transfer protocol ("SFTP") or as directed by DVHA. DVHA shall have the right to amend the data transfer process during the Contract term.

Contractor's information systems must utilize DVHA's unique identification number (UID) to properly identify each Member.

The list of data file exchanges is summarized below; however, this list may change in number and/or periodicity at any time during the course of the contract based on the needs of DVHA.

File Name	Inbound to DVHA (or Fiscal Agent)/ Outbound from DVHA (or Fiscal Agent)	Periodicity
Contractor Affiliated Provider File	Inbound	Monthly
DVHA Attributed Member Demographics File	Outbound	Monthly
DVHA Covered Services Claims File	Outbound	Weekly

DVHA Claims Summary Report	Outbound	Weekly
DVHA FFS Payments File	Outbound	Weekly
DVHA Covered Confidential and Opt Out Claims File	Outbound	Weekly
DVHA FFS Confidential and Opt Out Claims File	Outbound	Weekly
Contractor Non-Claims Payments File	Inbound	Monthly
DVHA Remittance Advice File	Outbound	Monthly
DVHA Attribution PMPM File	Outbound	Monthly
DVHA Pharmacy Claims File	Outbound	Weekly
DVHA Interim Financial Settlement File	Outbound	Quarterly
DVHA Historical Services Claims Files	Outbound	Annual (initial file) and Weekly
DVHA Historical Covered Confidential Claims and Opt Out Claims Files	Outbound	Annual (initial file) and Weekly
DVHA Historical FFS Confidential Claims and Opt Out Claims File	Outbound	Annual (initial file) and Weekly
DVHA Historical Pharmacy Claims Files	Outbound	Annual (initial) and Weekly
DVHA Historical Eligibility Files	Outbound	Annual
DVHA Attributed Non-ACO Claims File	Outbound	Weekly
DVHA VBIF Mental Health and Substance Use Quality Improvement Support File	Outbound	Quarterly

The organizations involved in file exchange below are noted in parentheses. Specifications for each file type and structure are documented in the "ACO File Format Specifications" document, an updated version of which will be available in first quarter of the Performance Year, and which may be updated as needed throughout the Performance Year and shall be adhered to unless otherwise mutually agreed upon in writing. Errors or omissions will be corrected by the responsible party within five business days unless otherwise mutually agreed upon timeframes are established and documented in writing.

Parties will mutually agree on the MHSUD measure run out period and timing of submission by January 31, 2025.

9.4.1 Contractor Affiliated Provider File

(Contractor to Fiscal Agent) This file contains the current list of TIN level Vermont Medicaid enrolled providers (Billing NPIs) who are affiliated with the Contractor. Contractor shall submit provider roster updates to Fiscal Agent in an agreed upon format

and process. Contractor shall keep provider enrollment and disenrollment information up-to-date.

9.4.2 DVHA Remittance Advice File

(DVHA or Fiscal Agent to Contractor) This file contains for both Traditional and Expanded Cohorts the total of PMPM payments made by DVHA to the Contractor.

Contractor, being enrolled as a Medicaid provider, receives a remittance advice in the standard available formats for the monthly PMPM payment(s) made to the Contractor. The PMPM lump sum payment is reported as a single line item in the "Financial Items" section of the remittance advice. DVHA Attribution PMPM File will be provided separately and will contain the details of the Members included in the payment.

Contractor shall be responsible for reconciling Value-Based Care Payments against the DVHA Attribution PMPM File and identifying any errors or omissions to the Fiscal Agent within fifteen (15) business days of receipt of the DVHA Attribution PMPM File

9.4.3 DVHA Covered Services Claims File

(DVHA or Fiscal Agent to Contractor) This file contains information related to claims submitted by Participating Providers for VMNG Program -covered services for all Attributed Members to the VMNG Program. The DVHA Covered Claims File contains DVHA's disposition of the claim status which may be Zero-Paid Claims or denied with the denial reason.

Fiscal Agent will continue to receive all claims from Vermont Medicaid providers. All claims will continue to be processed through DVHA's edits and audits.

Claims identified as the responsibility of the Contractor will be provided to the Contractor on an agreed upon schedule. The Contractor will then be responsible for any additional review of the claims and payment to Participating Providers for services rendered.

9.4.4 DVHA Pharmacy Claims File

(DVHA or Fiscal Agent to Contractor). This file contains paid pharmacy claims data for all Attributed Members to the Contractor paid by DVHA on a fee-for-service basis.

9.4.5 Contractor Non-Claims Payments File

(Contractor to DVHA or Fiscal Agent) This file contains fixed prospective payments and Comprehensive Payment Reform (CPR) pilot program Payments the Contractor has made to their Participating Providers which were not paid at a claim level.

9.4.6 DVHA FFS Payments File

(DVHA or Fiscal Agent to Contractor) This file contains paid claims data or denied claims with the denial reason, for all Attributed Members to the Contractor paid on a fee-for-service basis for covered services: a) for services provided to Attributed Members not included in the Value-Based Care Payments; or b) for VMNG Program-covered services provided to Attributed Members by non-participating providers.

9.4.7 DVHA Claims Summary Report

DVHA will provide monthly report summarizing data feeds for Covered Services Claims File and FFS Payment File. Totals in summary files should be raw and unadjusted.

9.4.8 Contractor Attributed Member Demographics File

(DVHA or Fiscal Agent to Contractor) This file contains summary demographic information on all Attributed Members.

9.4.9 DVHA Covered Confidential and Opt Out Claims File

(DVHA or Fiscal Agent to Contractor) This file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to the VMNG Program Attributed Members. For both Traditional and Expanded Cohorts, the file also contains payment totals, by provider, for Attributed Members who have opted out of data sharing. The file will contain Medicaid ID and Provider ID, a count of claims, a unique member count, a total confidential payment, the amount that would have been paid FFS, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Members' attributed health service area, Attributed Members' MEG, claim type, Opt Out/Confidential Indicator, and Cohort.

9.4.10 DVHA FFS Confidential and Opt Out Claims File

(DVHA or Fiscal Agent to Contractor) This file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to VMNG Program Attributed Members which Fiscal Agent paid fee for service. The file also contains for both Traditional and Expanded Cohorts payment totals, by provider, for Attributed Members who have opted out of data sharing. The file will contain Medicaid ID and Provider ID, a count of claims, a unique member count, a total confidential payment, the amount that was paid FFS, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Member's attributed health service area, Attributed Members' MEG, claim type, Opt Out/Confidential Indicator, and Cohort.

9.4.11 DVHA Attribution PMPM File

(DVHA or Fiscal Agent to Contractor) In addition to the DVHA Remittance File, a summary file will be generated containing PMPM payment information for each Attributed Member in the Traditional and Expanded Attribution Cohorts. The file will contain all of the Attributed Members for whom a PMPM payment was made along with the PMPM amount, the MEG and Member ID, and all of the Attributed Members for whom a payment was not made including the reason the payment was not made.

9.4.12 DVHA Interim Financial Settlement File

(DVHA or Fiscal Agent to Contractor) This file contains claim level detail information for all claims incurred by Attributed Members (both Zero-Paid Claims and fee for service claims) in each calendar quarter and payment totals by provider for confidential services and services incurred by Attributed Members who have opted out of dating sharing. A quarterly schedule outlining the dates of service and claims paid through dates for each quarterly report will be mutually agreed upon by both Parties prior to submission of the first Interim Financial Settlement File.

9.4.13 DVHA Historical Services Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Services Claims File contains claim level detail information for all claims incurred by Attributed Members for dates of service in the three years prior to the Performance Year. The weekly Historical Services Claims file contains claim level detail information for all claims incurred by Attributed Members for dates of service in the three years prior to the Performance Year through the current week's paid date.

9.4.14 DVHA Historical Covered Confidential and Opt Out Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Confidential and Opt Out Claims file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance abuse treatment services for which the Contractor will not receive claim-level detail) provided to the VMNG Program Attributed Members in the three years prior to the Performance Year. The weekly Historical Confidential and Opt Out Claims File contains payment totals, by provider, for confidential services provided to Attributed Members for dates of service in the three years prior to the Performance Year through the current week's paid date. For both Traditional and Expanded Cohorts, the files also contain payment totals, by provider, for Attributed Members who have opted out of data sharing. The files will contain Medicaid ID and Provider ID, a count of claims, a unique member count, the amount that was zero-paid, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Members' attributed health service area, Attributed Members' MEG, claim type, Opt Out/Confidential Indicator, and Cohort. This file should be a full refresh for all members attributed during the Performance Year.

9.4.15 DVHA Historical FFS Confidential and Opt Out Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Confidential and Opt Out Claims file contains for both Traditional and Expanded Cohorts payment totals, by provider, for confidential services (e.g. substance use disorder treatment services for which the Contractor will not receive claim-level detail) provided to the VMNG Program Attributed Members in the three years prior to the Performance Year. The weekly Historical Confidential and Opt Out Claims File contains payment totals, by provider, for confidential services provided to Attributed Members for dates of service in the three years prior to the Performance Year through the current week's paid date. For both Traditional and Expanded Cohorts, the files also contain payment totals, by provider, for Attributed Members who have opted out of data sharing. The files will contain Medicaid ID and Provider ID, a count of claims, a unique member count, the amount that was paid FFS, the years and months of services, the Performance Year, the Contractor excluded services flag, Attributed Members' attributed health service area, Attributed Members' MEG, claim type, Opt Out/Confidential Indicator, and Cohort. This file should be a full refresh for all members attributed during the Performance Year.

9.4.16 DVHA Historical Pharmacy Claims Files

(DVHA or Fiscal Agent to Contractor) The initial, annual Historical Pharmacy Claims File contains paid pharmacy claims data for all Attributed Members for dates of service in the three years prior to the Performance Year. The weekly Historical Pharmacy Claims File contains paid pharmacy claims data for all Attributed Members for dates of service in the three years prior to the Performance Year through the current week's paid date.

9.4.17 DVHA Historical Eligibility File

(DVHA or Fiscal Agent to Contractor) The annual Historical Eligibility File contains eligibility information by month for all Attributed Members for the three years prior to the Performance Year.

9.4.18 DVHA Attributed Non-ACO Claims File

(DVHA or Fiscal Agent to Contractor) This file contains paid claims data or denied claims with the denial reason, for all Attributed Members to the Contractor paid on a fee-for-service basis for non-covered services provided to Attributed Members by participating or non-participating providers for services outside of the ACO's Total Cost of Care risk.

9.4.19 Historical Data Retention Files

In addition to receiving and maintaining the historical files noted above, and in recognition of the importance of historical data to the effective performance of an ACO year over year, Contractor may maintain data provided to it by DVHA pursuant to the VMNG and Vermont Medicaid Shared Saving Program agreements in prior years. Any such data shall be governed by the most recent BAA in effect between DVHA and Contractor.

9.4.20 DVHA Value-Based Incentive Program Mental Health and Substance Use Quality Improvement Support File

See detailed description in Section 7.5.2 above.

9.5 Year-End Reconciliation Process

DVHA will complete a Year-End Reconciliation process no later than September 20th of the calendar year following the Performance Year. DVHA will submit the Year-End Reconciliation to Contractor upon completion. The complete Year-End Reconciliation shall be validated by both Parties as described in Attachment B, Section V, and the Year-End Reconciliation shall be considered final at the time both Parties agree in writing that the results are final. Subject to appropriations, settlement payments will be tendered within sixty (60) days from the date the settlement is deemed final. The Parties will take all reasonable proactive measures to prepare for a potential settlement payment in spirit of meeting the sixty (60) day payment timeframe. If the Party with payment due is, or expects to be, unable to meet the sixty (60) day payment timeframe, the reason for the delay and an estimated payment date will be communicated to the other Party promptly. This process will be used to reconcile any payments owed from or to Contractor arising out of the PY (refer to the appropriate Attachment B for the PY under reconciliation for application of the Risk Corridor for each party). The files described in Section 9.4 will serve as the primary basis for this reconciliation. However, on an as needed basis, DVHA may request from Contractor additional files to exchange with Fiscal Agent to support this year end reconciliation. Contractor shall provide these files as requested.

DVHA reserves the right for a period of six years following the end of the term or termination of a PY, to reopen a final settlement in order to recalculate amounts owed and make or demand payment of any additional amounts owed to or by the Contractor, if, as a result of later information, it is later determined that the amounts due between the Parties was calculated in error due to material errors as referenced in Section I. of Attachment B.

9.6 Health Information Technology and Data Sharing

Contractor shall cooperate and participate in the development and implementation of current and future DVHA- or State of Vermont-sponsored health information technology (HIT) initiatives to the degree they relate directly to VMNG Program.

9.7 Special Data Sharing Provisions

Contractor is a business associate of covered entities providing care under Medicaid and is authorized to request and receive protected health information (PHI) and to act as custodian of such PHI on its covered entities' behalf.

As permitted by law, Contractor may request and receive Medicaid data from DVHA on behalf of another covered entity for treatment, payment, or health care operations purposes. Contractor will comply with the safeguarding requirements for Medicaid data found in 33 V.S.A. § 1902a and the privacy and security requirements for PHI under HIPAA with respect to all data received

from DVHA on behalf of another covered entity and all data received or created on behalf of DVHA pursuant to this Contract.

Contractor will act as a Business Associate of DVHA and will comply with the terms of Attachment E: Business Associate Agreement in all instances in which PHI is provided by DVHA to Contractor in its capacity as a Business Associate, including the "Special Data Sharing" instance detailed in Sections 9.7.1.

Contractor will not use or disclose the PHI received or created pursuant to the terms of 9.7.1 for any purpose other than the purpose stated in that section or as provided in Attachment E.

9.7.1 Data sharing for activities relating to actuarial analyses and financial modeling

Contractor agrees to assist DVHA in the review of the actuarial analysis and financial modeling related to the VMNG Program by other DVHA contractors. This review may require access to PHI that is outside the scope of data available to Contractor as a Business Associate of Covered Entities currently participating in the VMNG Program.

To achieve this purpose, Contractor shall be provided the claims data set underlying any actuarial analysis or financial model for which DVHA requests review, including claims data relating to providers who are not currently participating in Contractor's network. Contractor, acting as a Business Associate of DVHA, and its actuarial subcontractor shall use this data set for the sole purpose of evaluating and validating DVHA's actuarial findings and reporting its conclusions and recommendations to DVHA. Claim-level detail in the dataset provided to Contractor will not include any confidential claims (data that falls under 42 CFR Part 2). Refer to Sections 9.4.9-9.4.10 and 9.4.14-9.4.15 for further description of confidential data exchange.

Contractor will return or destroy all PHI received under this Section 9.7.1 in accordance with the Business Associate Agreement.

10. Program Integrity

Contractor shall comply with Program Integrity requirements in accordance with 42 CFR § 438.608 and other federal and state law that are applicable to ACOs, as more fully set out below.

10.1 Compliance Program

Contractor will establish a compliance program that will fulfill all program integrity responsibilities set forth in this section and as required by 42 CFR § 438.608. The compliance program shall include a regulatory compliance committee comprised primarily of Contractor's senior management and chaired by Contractor's compliance officer who is responsible to the Contractor's board of directors and senior management. The compliance committee will be responsible for overseeing Contractor's compliance program and compliance with this Contract. The compliance committee shall provide reports on Contractor's compliance activities to its board of directors.

Contractor's compliance officer and compliance committee shall ensure that compliance policies, procedures, and standards of conduct, including the compliance plan as detailed below in Section 10.3, are up to date. The compliance officer and compliance committee shall also ensure that appropriate annual training and education occurs, that provisions are in place to detect fraud, waste and abuse, and for the development of corrective action initiatives. All of the aforementioned activities shall comply with the applicable requirements outlined in 42 C.F.R. § 438.608(a)(1)(i) – (vii).

Contractor will provide training to Contractor's staff, including those who are responsible for staffing the toll-free Member services and provider relations phone line, Contractor's senior management, and the Contractor's compliance officer for the detection of fraud, waste, and abuse and how to report such instances or suspicions to the appropriate personnel. Contractor shall provide DVHA training schedules, content, and participation lists within 10 days of completion of each training conducted under this Contract. In addition to the above, trainings shall, at a minimum, be conducted annually and include:

a. Federal and State standards and requirements under this Contract;
b. Identifying, reporting, and appropriately handling provider terminations for "program integrity" reasons and the appropriate procedures for reporting those terminations to DVHA Special Investigations (SI) Unit; and
c. Information about the rights of employees to be protected against retaliation for reporting compliance concerns.

Contractor's compliance program shall include procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems to reduce the potential for recurrence, and ongoing compliance with requirements under this Contract.

Contractor's compliance program shall provide for cooperation with the DVHA SI Unit's fraud, waste and abuse efforts, including DVHA SI Unit initiated audits of Participating Providers. Contractor shall refer program integrity matters to DVHA SI Unit for investigation.

10.2 Code of Conduct

Contractor will establish a code of conduct for all employees and board of directors that requires compliance with all applicable state and federal laws, regulations, and standards. The code of conduct will include information about the standards of conduct, policies, and procedures as well as a prohibition against retaliation for reporting compliance concerns. The code of conduct will describe lines of communication between Contractor representatives and the compliance officer and encourage the reporting of concerns. The code of conduct will also include disciplinary guidelines for enforcement of these standards within the first quarter of the Performance Year.

A copy of Contractor's code of conduct shall be submitted to DVHA by January 31st of each Performance Year. If the code of conduct is updated during the Performance Year, it shall be submitted to DVHA within 10 days of the revision becoming final.

10.3 Compliance Plan

Contractor's compliance program must include a written compliance plan that describes in detail the manner in which Contractor, through its compliance committee, will detect fraud, waste, and abuse in accordance with federal and state law and regulation, including 42 CFR § 438.608. Contractor shall submit the compliance plan which reflects the requirements of this Contract to DVHA's Program Manager and DVHA SI Unit no later than 30 days after the effective date of this Contract and no later than ten business days after any relevant revisions are made. The table provided in Exhibit 3 shall be completed and attached as a cover sheet to the Compliance Plan upon submission. Upon receipt, if DVHA SI Unit determines it necessary, a meeting will be scheduled to discuss the compliance plan and any necessary changes.

The compliance plan shall include specific and detailed internal procedures for Contractor to efficiently detect, report, and, where appropriate, investigate, fraud, waste, and abuse, including:

a. The designation of a compliance officer and a compliance committee.

b. A detailed list of the type and frequency of training and education that will be provided.

c. An organizational chart of Contractor's organization and communication plan highlighting lines of communication between the compliance officer and the organization's employees as well as DVHA SI Unit.

d. Detailed descriptions of the processes for internal monitoring and auditing.

e. Description of the specific controls in place for prevention, detection, and reporting of potential or suspected fraud, waste, and abuse, including, but not limited to:

    i. Process for the confidential reporting of compliance plan violations to the compliance officer or designated person.

    ii. Adherence to ACO related regulations and applicable waivers granted under the Affordable Care Act, Stark Law, Anti-kickback statute, civil money penalty law (CMP), Gainsharing CMP, and incentives.

    iii. Ensuring that the identities of individuals reporting violations of Contractor are protected and that there is no retaliation against such persons.

f. Provisions enabling the efficient identification, investigation, and resolution of fraud, waste and abuse issues of vendors, subcontractors and Contractor itself based on the information available to Contractor.

g. Provisions for the prompt referral of any identified, suspected, or alleged instances of fraud, waste, or abuse to DVHA SI Unit.

h. Provisions for development of, and adherence to, corrective action plans and initiatives.

i. Prompt notification to DVHA in the event Contractor receives information about changes in a Member's circumstances including a change in the enrollee's residence or the death of an enrollee.

10.4 Risk Assessments

Contractor shall conduct risk assessments of its compliance program, including its program for detecting and preventing fraud, waste and abuse, and requirements of its contracts with subcontractors and Participating Providers on a semi-annual basis, with the first due to DVHA SI Unit by March 31st of the Performance Year and the second due to DVHA SI Unit by September 30th of the Performance Year. The risk assessment shall also be updated after program integrity related actions are taken. The risk assessments will identify and prioritize the top three areas of risk that indicate a vulnerability that deviates from the VMNG Program; and is not an intended shift in utilization. The risk assessments will provide an action plan to mitigate those risks. Specifically, Contractor's risk assessment report to DVHA shall provide the following information for each area of risk: 1) area of risk identified, 2) controls currently in place to minimize risk, 3) vulnerability, 4) risk identified, and 5) proposed corrective action plan for each area of risk.

Upon receipt, if DVHA SI Unit determines it necessary, a meeting will be scheduled to discuss the risk assessment, and, as reasonably determined by DVHA, any clarifications or required additional information.

Discovery of any other program integrity related actions will be communicated to DVHA SI unit within 30 days and notice of such actions shall outline action plans to mitigate such risk.

10.5 Ongoing Monitoring of Contractor's Provider Network

Contractor shall promptly refer incidents of any suspected or confirmed fraud, waste and abuse to the DVHA SI Unit.

Contractor will work cooperatively, and maintain communication, with the DVHA SI Unit to develop and implement any necessary corrective action plans identified in Contractor's risk assessment or required in the event of Contractor's fraud, waste or abuse. Contractor shall further require their Participating Providers or subcontractors to comply with corrective action plans as a result of fraud, waste, and abuse activities identified by either Contractor or the DVHA SI Unit.

Contractor shall cooperate with all appropriate state and federal agencies, including the Medicaid Fraud and Residential Abuse Unit (MFRAU) and the DVHA SI Unit, in their investigations of fraud, waste, and abuse.

Contractor's compliance officer shall attend and participate in DVHA-provided trainings to Participating Providers on detecting fraud, waste, and abuse.

Contractor shall submit a detailed report to DVHA outlining Contractor's compliance and program integrity related activities, description of activities directed toward detecting potential fraud, waste, or abuse in programmatic performance, as well as identifying Contractor's progress in meeting program integrity related goals and objectives. The report shall be made in accordance with the ACO Reporting Manual. Contractor's report shall include detailed updates concerning its monitoring of the VMNG Program for potential instances of fraud, waste, and

abuse; the review, audit (if any), and investigative activities related to actual and potential program integrity issues under this Agreement; and the outcomes, including any findings and/or non-findings of audits and investigative activities.

Contractor agrees that the DVHA SI Unit is responsible for overseeing the integrity of all Medicaid payment, including the underutilization of services or the over reporting of services such as split billing, unbundling of services or other billing methods that would cause the VMNG Program's ETCOC to increase artificially in future years.

Contractor agrees that the DVHA SI Unit may conduct oversight reviews of Contractor's compliance program or other program integrity-related activities to determine the Contractor's compliance with this Contract. Such audit activities will be conducted, to the extent feasible, with minimal disruption to Contractor's activities, and may include conducting interviews of relevant staff, reviewing all documentation, and any performance metrics. The DVHA SI Unit may issue a corrective action plan or performance improvement plan and outline timelines for improvement measures and Contractor shall cooperate in promptly implementing such plan.

11. Payment Reform Initiatives

DVHA may engage the Contractor in new payment reform initiatives during the term of this Contract. These initiatives will be detailed within an Exhibit to both Attachment A for scope and Attachment B for payment provisions describing the initiative and adopting the relevant provisions of those Attachments. The Contractor may propose initiatives for the State's consideration.

EXHIBIT 1

TO

ATTACHMENT A

Included and Excluded Service Codes

{PROVIDED SEPARATELY}

EXHIBIT 2

TO

ATTACHMENT A

Attribution Technical Specifications

Table 1. Qualifying Evaluation & Management (QEM) Services

Code	Description
Office or Other Outpatient Services	
99201	New Patient, brief
99202	New Patient, limited
99203	New Patient, moderate
99204	New Patient, comprehensive
99205	New Patient, extensive
99211	Established Patient, brief
99212	Established Patient, limited
99213	Established Patient, moderate
99214	Established Patient, comprehensive
99215	Established Patient, extensive
99241	Consultation: Office and Outpatient, 15 minutes
99242	Consultation: Office and Outpatient, 30 minutes
99243	Consultation: Office and Outpatient, 40 minutes
99244	Consultation: Office and Outpatient, 60 minutes
99245	Consultation: Office and Outpatient, 80 minutes
Nursing Facility Care	
99304	Initial Nursing Facility Care, brief
99305	Initial Nursing Facility Care, moderate
99306	Initial Nursing Facility Care, comprehensive
99307	Subsequent Nursing Facility Care, brief
99308	Subsequent Nursing Facility Care, limited
99309	Subsequent Nursing Facility Care, comprehensive
99310	Subsequent Nursing Facility Care, extensive
99315	Nursing Facility Discharge Services, brief
99316	Nursing Facility Discharge Services, comprehensive
99318	Other Nursing Facility Services
Domiciliary, Rest Home, or Custodial Care Services	
99324	New Patient, brief

99325	New Patient, limited
99326	New Patient, moderate
99327	New Patient, comprehensive
99328	New Patient, extensive
99334	Established Patient, brief
99335	Established Patient, moderate
99336	Established Patient, comprehensive
99337	Established Patient, extensive
Domiciliary, Rest Home, or Home Care Plan Oversight Services	
99339	Brief
99340	Comprehensive
Home Services	
99341	New Patient, brief
99342	New Patient, limited
99343	New Patient, moderate
99344	New Patient, comprehensive
99345	New Patient, extensive
99347	Established Patient, brief
99348	Established Patient, moderate
99349	Established Patient, comprehensive
99350	Established Patient, extensive
Preventative Care/Wellness Visits	
G0438	Annual wellness visit
G0439	Annual wellness visit
99381	Preventive Medicine Visits - Initial, age younger than 1 year
99382	Preventive Medicine Visits – Initial, age 1 through 4 years
99383	Preventive Medicine Visits – Initial, age 5 through 11 years
99384	Preventive Medicine Visits – Initial, age 12 through 17 years
99385	Preventive Medicine Visits – Initial, age 18 through 39 years
99386	Preventive Medicine Visits – Initial, age 40 through 64 years
99387	Preventive Medicine Visits – Initial, age 65 years and older
99391	Preventive Medicine Visits – Periodic, age younger than 1 year
99392	Preventive Medicine Visits – Periodic, age 1 through 4 years
99393	Preventive Medicine Visits – Periodic, age 5 through 11 years
99394	Preventive Medicine Visits – Periodic, age 12 through 17 years
99395	Preventive Medicine Visits – Periodic, age 18 through 39 years
99396	Preventive Medicine Visits – Periodic, age 40 through 64 years
99397	Preventive Medicine Visits – Periodic, age 65 years and older
99401	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 15

99402	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 30
99403	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 45
99404	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 60
99406	Counseling Services: Smoking and Tobacco Cessation, 3 to 10 minutes
99407	Counseling Services: Smoking and Tobacco Cessation, greater than 10
99408	Counseling Services: Alcohol and/or substance abuse, 3 to 10 minutes
99409	Counseling Services: Alcohol and/or substance abuse, greater than 10
99411	Counseling Services: Preventive medicine in group setting, 30 minutes
99412	Counseling Services: Preventive medicine in group setting, 60 minutes
99420	Health Risk Assessment – Admin and interpretation of health risk
99429	Health Risk Assessment – Unlisted preventive medicine service
Child and Maternal Health	
99460	Evaluation and Management Svcs. for Age 28 Days or less, initial hosp.
99461	Evaluation and Management Svcs. for Age 28 Days or less, initial care
99462	Evaluation and Management Svcs. for Age 28 Days or less, subsequent
99463	Evaluation and Management Svcs. for Age 28 Days or less, admitted and
99464	Attendance at Delivery
99465	Newborn Resuscitation
FQHC/RHC Encounter	
T1015	Clinic visit/ encounter, all-inclusive (includes revenue codes 521, 522,
Other	
99354	Prolonged Services Direct Contact, first hour
99355	Prolonged Services Direct Contact, each additional 30 minutes
99358	Prolonged Services Indirect Contact, first hour
99359	Prolonged Services Indirect Contact, each additional 30 minutes
99490	Comprehensive Care Plan
99495	Communication (14 Days of Discharge)
99496	Communication (7 Days of Discharge)

Table 2. Specialty and Category of Service codes used for attribution based on primary care practitioners

Specialty Code	Specialty
1	General Practice
8	Family Medicine
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner

S15	Certified Family Practitioner
S16	Certified Pediatric Practitioner
S17	Other Certified Nurse Practitioner as PCP
S36	Naturopathic Physician with Childbirth Endorsement
S37	Naturopathic Physician w/o Childbirth Endorsement
1201	Rural Health Clinic (RHC)
1401	Federally Qualified Health Center (FQHC)

Table 3. Funding sources excluded from expenditure calculations

Funding Source	**Description**
B	DAIL – DS Services
C	GENERAL ASSISTANCE - STATE FUND (DCF)
E	HIV DRUG – DOH
G	DMH
H	DOE
I	DCF
J	VDH
K	DSU
L	DAIL
R	VHAP - DSU SERVICES (VDH)
S	DMH - CRT CASE RATE
Z	YOU FIRST (VDH)
2	DAIL (CHOICES FOR CARE)

EXHIBIT 3 TO ATTACHMENT A

OneCare Compliance Plan Checklist

Contractor's Compliance Plan, as detailed in Attachment A, Section 10 of this Contract, shall provide the specific manner in which Contractor will detect fraud, waste, and abuse, including cooperation with and referral to DVHA's SI Unit.

Contractor is required, in accordance with Attachment A, Section 10.3, to submit its Compliance Plan to DVHA no later than 30 days after the effective date of the Contract and no later than ten days after any revisions to the Compliance Plan are made. The below table must be completed and attached as a cover sheet with the submission of Contractor's Compliance Plan.

Program Integrity Responsibility Requirement		Location in Compliance Plan (section and page number)
Designation of a Compliance Officer and a Compliance Committee		
A detailed list of type and frequency of training and education that will be provided to Contractor's staff to detect fraud, waste, and abuse		
An organizational chart of Contractor's organization		
A communication plan highlighting lines of communication between:	1. Compliance Officer and the organizations employees	
	2. Contractor and the DVHA SI Unit	
Detailed descriptions of processes for internal monitoring and auditing		
Description of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse		
Provisions enable efficient identification, investigation, and resolution of fraud, waste, and abuse issues of vendors, subcontractors, and Contractor		
Provisions for prompt referral of any identified, suspected, or alleged instances of fraud, waste, or abuse to the DVHA SI Unit		
Provisions for development of, and adherence to, corrective action plans and initiatives		
Provisions for the prompt notification to DVHA in the event Contractor receives information about changes in a Member's circumstances including a change in the enrollee's residence or the death of an enrollee.		

EXHIBIT 4

TO

ATTACHMENT A

Calendar Year 2025 Global Payment Program

DVHA has requested Contractor's collaboration in implementing an alternative payment model to health care providers in furtherance of efficiency in payment for healthcare services. This Exhibit 4 to Attachment A describes the specific requirements of Contractor and DVHA relating to a new program that will issue prospective payments for Covered Services provided to GPP Members, as set forth in Section 3.1 of Attachment A to this Contract, but are occurring at certain Participating Entities for services not currently covered by the Value-Based Care Payments in the VMNG program.

Notwithstanding anything to the contrary in this Agreement, including but not limited to the hierarchy of interpretation, the following provisions do not apply to this Global Payment Pilot Program:

Attachment A – Section 1; Section 2.6; Sections 3.3, 3.4; Section 4; Section 5; Section 6; Section 7; Section 9.5; Section 10.

The GPP will be effective for the members of each group that elect to participate as follows: (1) Primary Care Practices in the Comprehensive Payment Reform program beginning January 1, 2025; (2) hospitals beginning April 1, 2025. These start dates are dependent on the approval of funding from the State of Vermont. DVHA shall endeavor to secure this funding at least two weeks prior to the aforementioned start dates. In the event that funding is not approved within this timeframe, DVHA shall have three (3) business days to notify Contractor of such. Upon receipt of funding approval, DVHA shall promptly inform Contractor, and the Parties shall have an additional three (3) business days to meet and determine the earliest practical start date for the GPP.

Definitions

Parties agree that the following definitions apply to Exhibit 4 to Attachment A of this Contract. All other defined terms in Attachment A of this Contract shall apply to this Exhibit.

Global Payment Participating Entity ("Participating Entity(ies)"): A hospital or primary care practice that has elected to receive prospective payments from DVHA through the Global Payment Program as identified in writing by Contractor.

Global Payment Program ("Program"): A program whereby Contractor is issued a Global Payment Program Monthly Payment for Covered Services, as defined in Section 3.1 of Attachment A to this Contract, as reimbursement for Covered Services delivered at Participating Entities to Non-Attributed Members or ACO-Attributed Members who do not qualify for Value-Based Care Payments in a given month under the VMNG program. Accordingly, specific references within this contract to the VMNG program are not intended to apply automatically to the GPP, but instead to only apply where they involve GPP programmatic elements.

Global Payment Program Member ("GPP Member"): Non-Attributed Members and ACO-Attributed Members who do not qualify for Value-Based Care Payments in a given month under the VMNG program.

Global Payment Program Monthly Payment ("Monthly Payment"): A single lump sum dollar amount paid to Contractor on a monthly basis on behalf of the Global Payment Participating Entities, in lieu of fee-for-service reimbursement for Covered Services included in Exhibit 1 to Attachment A (Covered Services).

Global Payment Program (GPP) Zero-Paid Claim(s): A claim submitted to DVHA by a Global Payment Participating Entity, which is paid zero dollars with an explanation of benefits code indicating that the Member and services are covered by the Global Payment Program under its Monthly Payment from the ACO and includes a Would Have Paid Provider (WHPP) fee-for-service equivalent amount.

1. Program Scope

DVHA's actuary shall develop, with validation by Contractor or its designee, Monthly Payments. Monthly Payments will be calculated by identifying the total Base Period claims for Covered Services provided to GPP Members using four months of runout for each Participating Entity, a completion factor, and trending the Base Period claims forward to the Performance Year by applying a trend factor, agreed to by the Parties, that combines the impact of utilization changes, rate changes, and population changes.

DVHA will issue a Monthly Payment to Contractor for all Participating Entities in the Program, as outlined in Exhibit 2 to Attachment B. Contractor will allocate the Monthly Payment amongst the Participating Entities and will distribute each Participating Entity's Monthly Payment. Payments to Participating Entities will be made pursuant to Board approved Contractor policy and are not based directly or indirectly on the volume or value of referrals between Participating Entities.

All Program funds received by Contractor shall be distributed to Participating Entities in their entirety or refunded to DVHA through the Year-End Reconciliation process described below. Participating Entities will continue to submit claims to DVHA for Covered Services provided to all Medicaid Members and DVHA will zero pay those claims. Contractor will supply DVHA with monthly reports displaying the distribution of Monthly Payments for the prior month.

2. Year-End Reconciliation Process

The aggregate difference between the Monthly Payments to Contractor and the GPP Zero-Paid Claims associated with those Monthly Payments will be determined by subtracting the GPP Zero-Paid Claims WHPP amounts, with four months of claims runout from the Monthly Payments. If the value of the Monthly Payments exceeds the value of the GPP Zero-Paid Claim WHPP amounts for Participating Providers, Contractor is liable for the difference and must return the excess to DVHA. If the value of the Monthly Payments is less than the value of the GPP Zero-Paid Claim WHPP amounts for Participating Providers, DVHA is liable for the difference and must pay that difference to the Contractor.

DVHA will complete a Year-End Reconciliation process no later than September 20th of the calendar year following the Performance Year. DVHA will submit the Year-End Reconciliation to Contractor upon

completion. The complete Year-End Reconciliation shall be validated by both Parties, and the Year-End Reconciliation shall be considered final at the time both Parties agree in writing that the results are final. Settlement payments will be tendered within sixty (60) days from the date the settlement is deemed final. The Parties will take all reasonable proactive measures to prepare for a potential settlement payment in spirit of meeting the sixty (60) day payment timeframe. If the Party with payment due is, or expects to be, unable to meet the sixty (60) day payment timeframe, the reason for the delay and an estimated payment date will be communicated to the other Party promptly. The files described in Section 3 of this Exhibit below will serve as the primary basis for this reconciliation.

Due to the reconciled nature of the Monthly Payment, DVHA and Contractor will meet and compare the initial Year-End Reconciliation result to an updated calculation using fifteen (15) months of claims runout. Any material variation between the two calculations will be reconciled via payment from Contractor to DVHA or from DVHA to Contractor.

3. Data Sharing

In a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164) and in accordance with Attachment E to this Contract, DVHA shall share with Contractor the zero paid claims data associated with Monthly Payments for all Members with a treatment relationship with Participating Entities in the Performance Year consistent with the data and format for the DVHA Covered Services Claims File and DVHA Covered Confidential and Opt Out Claims File detailed in Section 9 of Attachment A. These Program files shall be provided separately from the VMNG attributed lives files and reports. Contractor will provide Participating Entities with reports to assist in the implementation of the Program. Consistent with HIPAA and regulatory requirements, and in order to assist Contractor in determining payment amounts to Participating Entities, DVHA will supply Contractor with a monthly Medicaid membership file, which will contain summary counts of member months by MEG and HSA. Parties will work during the Performance Year to explore possibilities for sharing additional member-level data related to the GPP in future amendments to this contract.

4. Monitoring

DHVA and Contractor will monitor the GPP Zero-Paid Claims under the scope of this Exhibit throughout the course of the Program, and will mutually agree in writing to adjust the amount of the Monthly Payment if payments deviate materially from the GPP Zero-Paid Claim WHPP amounts for Participating Entities for the purpose of minimizing the magnitude of the expected Year-End Reconciliation.

Contractor and DVHA shall monitor utilization for Medicaid Members receiving services from Participating Entities using a mutually agreed upon set of claims-based measurements and reporting schedule. Further detail regarding measures and the monitoring framework shall be included in the ACO Reporting Manual described in Section 8.1 of Attachment A, and will be mutually agreed upon by both parties prior to the commencement of reporting. Parties will agree to reporting requirements for the GPP no later than March 31, 2025.

ATTACHMENT B
PAYMENT PROVISIONS

I. General Payment Provisions

The maximum dollar amount payable under this Contract is not intended as any form of a guaranteed amount. Contractor will be paid in accordance with the provisions as specified in Attachments A and B up to the maximum allowable amount specified in this Contract.

The expenditures incurred by an Attributed Member, for purposes of financial calculations for any Performance Year or Base Period, is the sum of all Medicaid payments on claims for Covered Services, subject to the inclusions and exclusions for the ETCOC set forth in Sections 3.1 and 3.2. Refer to Exhibit 1 to Attachment A (Included Service Codes) for a detailed listing of the codes that represent the services included in the financial calculations.

The expenditures used in financial calculations represent the total amount paid to providers for Covered Services, as listed in Attachment A, Section 3.1, that are incurred during the Base Period or Performance Year and paid within four months of the close of the Base Period or Performance Year. The financial calculations shall include an estimated completion factor. As such, claims for dates of service within the Performance Year that are submitted for payment more than four months after the end of the Performance Year will not be used in financial calculations, but will be processed in the same manner as any claims submitted for payment during or within four months of the close of the Performance Year.

This is a risk sharing arrangement wherein DVHA holds Contractor accountable to an ETCOC measured against the actual expenditures by DVHA to providers for delivering that care. Within the Risk Corridor as defined in Section 4 below, if the ATCOC is greater than the ETCOC, Contractor shall pay DVHA the difference between the ATCOC and ETCOC and if the ATCOC is less than the ETCOC, DVHA shall pay Contractor the difference between the ATCOC and ETCOC.

The Parties acknowledge that this financial agreement is based on calculations that rely on underlying data from DVHA, which is assumed to be valid and accurate. To the extent that it is discovered that there is a material error(s) in the underlying data or calculation thereon, DVHA and Contractor will work together to remedy the material error(s) and re-negotiate these payment terms with corrected data.

The Parties shall meet to discuss the specific payment provision calculations for the next Performance Year at least 90 days before the start of a Performance Year. If the payment provisions are not acceptable to Contractor or DVHA, either may terminate this Contract for the upcoming Performance Year at any time before December 31st of the year before the Performance Year begins.

As part of this Contract, DVHA will pay to Contractor for Eligible Members in the Traditional Attribution Cohort and the Expanded Attribution Cohort a Value-Based Care Payment. The Value-Based Care Payment is paid monthly and includes the following components:

a. A Fixed Prospective Payment to be used for reimbursement of services to meet the healthcare needs of Attributed Members; and
b. Provider Reform Support Payment of $4.75 per Eligible Member per month. Contractor must distribute the totality of funds received to Participating Practices and Preferred Providers.

Contractor will supply DVHA with quarterly reports displaying the distribution of Provider Reform Support Payments. Any funds undistributed to Participating Providers or Preferred Providers will be returned to DVHA.

II. Methodology for ETCOC

DVHA's actuary shall develop, with validation by Contractor or its designee, rates set in this Contract.

1. The following methodology will be utilized to calculate the ETCOC:

   A. Summarize Base Period incurred claims for past performance period Attributed Members by MEG. An adjustment for outstanding incurred but not paid (IBNP) claims will be applied using commonly accepted actuarial methods.

   B. Calculate the baseline expenditure on a PMPM basis for each of the MEGs.

   C. For each MEG, trend the Base Period claims forward to the Performance Year by applying a trend factor, agreed to by the Parties, that combines the impact of utilization changes, rate changes, truncation adjustment (in alignment with the methodology used to determine the ATCOC), population changes, population mix between the Traditional Attribution Cohort and the Expanded Attribution Cohort, and resumption of the redetermination process to determine the pre-adjusted ETCOC PMPM for each MEG. The factor incorporated to account for the resumption of redetermination will be adjusted retrospectively upon expiration of the COVID-19 federal public health emergency consistent with the initial ETCOC development methodology. The trend factor for each MEG will be adjusted for mutually agreed upon, material external changes in underlying reimbursements or policies that are not expected to continue into the Performance Year. The trend factor shall be developed independent of any assumptions about Contractor activity or efficiency during the Performance Year.

   D. Apply a VMNG Program efficiency factor equaling a 0.2% reduction applied to the pre-adjusted ETCOC PMPM for each MEG.

III. Payment for ETCOC Services

1. DVHA agrees to pay Contractor prospectively on a monthly basis a Value-Based Care Payment. Parties agree that DVHA will provide Contractor thirty (30) days or until January 31, 2025, whichever is sooner, to conduct an actuarial review of the benchmarks in Exhibit 1 to Attachment B. Upon Contractor's completion of the actuarial review, Parties will meet to finalize the benchmark and derivative payments and calculations, which may include adjustment to Exhibit 1 to Attachment B for material changes of 1% or more for any PMPM rate. If, after good faith negotiations, Parties are not able to reach agreement on the adjustments, Contractor may terminate this Contract.

The monthly Value-Based Care Payment is calculated by multiplying the PMPM amount in Exhibit 1 to Attachment B by the number of Eligible Members in the corresponding MEG. The sum of these MEG-specific calculations will total the Value-Based Care Payment.

If it is determined that a Value-Based Care Payment was paid with respect to any Eligible Member(s) who were or should have been ineligible in any given month, the Value-Based Care Payment(s) will be recouped in the Year-End Reconciliation for the Performance Year. In the event of the death of an Eligible Member, Contractor shall receive 100% of the usual Value-Based Care Payment for the month in which the Eligible Member died.

2. DVHA shall directly reimburse providers not participating in the Fixed Prospective Payment model for covered services provided to Eligible Members according to DVHA's current, approved fee-for-service fee schedules. The Fee-For-Service Payments and the underlying methodology will not be affected by the Contract.

3. In exchange for the payment described in Section III(1) above, Contractor agrees to pay for healthcare services in a manner that aligns with the goals stated in this Contract and in general alignment with the Medicaid covered services described in Section 3 of Attachment A of this Contract subject to the limitations noted in this Contract.

IV. Risk Corridor

1. The Parties agree that the ETCOC serves as the benchmark upon which the Risk Corridor is based.

2. Additionally, the Parties agree to a Risk Corridor arrangement as follows:

   A. The Risk Corridor for the Traditional Attribution Cohort and Expanded Attribution Cohort will be 3% in aggregate.
   B. The aggregate Risk Corridor for the Traditional Attribution Cohort and Expanded Attribution Cohort shall be applied as follows:
      i. If, at the time of Year-End Reconciliation, the ATCOC is between 100% and 103% of the ETCOC amount for the two cohorts in aggregate, Contractor agrees it is liable for the costs between 100% and 103%. To the extent those costs are borne by DVHA during the year, Contractor shall be liable to DVHA. If the ATCOC is greater than 103% of the ETCOC amount for the two cohorts in aggregate, Contractor is liable for costs between 100% and 103%, and DVHA is liable for any costs exceeding 103%.
      ii. Conversely, if the ATCOC is between 97% and 100% of the ETCOC amount for the two cohorts in aggregate, Contractor will be entitled to receive from DVHA payment of the full amount of the ETCOC. If the ATCOC is lower than 97% of the ETCOC amount for the two cohorts in aggregate, Contractor will be entitled to receive payment of the full value of the ETCOC less the difference between the ATCOC and 97% of the ETCOC.

3. If during the Contract, DVHA or Contractor determines that the Fee-for-Service Payments are

10% or more above the expected allocation of Fee-for-Service Payments multiplied by the number of member months or if the ATCOC is projecting to exceed the upper bound of the risk corridor, then the parties shall meet to discuss utilization or costs and potential remedies. Evaluations will occur no less frequently than quarterly within 60 days of the end of the quarter.

V. Year-End Reconciliation Process

1. The Parties agree that year-end reconciliation, as defined in Attachment A, will be conducted in accordance with Section 9.5 of Attachment A of this Contract using all reports in Section 9.4 through and including 9.4.16 of Attachment A.

2. Before calculating any differences between the ETCOC and ATCOC, DVHA will retrospectively review attribution and Member eligibility for the Performance Year. DVHA will communicate proposed changes to Contractor and Contractor will have the opportunity to review and validate the proposed changes to the extent possible. In the event there are valid changes, DVHA will calculate any corresponding financial reconciliation of the ETCOC and Fixed Prospective Payment and present this reconciliation to Contractor. Contractor will have the opportunity to review the reconciliation for accuracy. After validation, the dollar amount of the reconciliation will be factored into the calculation to determine the final program settlement amount.

3. Prior to calculating any differences between the ETCOC and ATCOC, DVHA will remove from the calculation of the ATCOC the cost of Covered Services, determined by combining the fee-for-service payments and amounts that would have been paid to providers on Zero-Paid Claims, in excess of $500,000 for any individual Members after all other exclusion rules have been applied.

4. The aggregate difference between the ETCOC and ATCOC will be determined by subtracting the ATCOC from the ETCOC. By way of example, the calculations will be applied in the following order.

Table 1. Year-End Reconciliation Calculations

DVHA Fixed Prospective Payment to Contractor = Total Expected Zero-paid Claims	(A)	
Total Actual Zero-paid Claims	(B)	
Zero-paid Claims Over (Under) Spend	(C)	*(B) – (A)*

Total Expected FFS Claims	(D)	
Actual FFS Claims - In Network	(E)	
Actual FFS Claims - Out of Network	(F)	
Total Actual FFS Claims	(G)	*(E) + (F)*
FFS Claims Over (Under) Spend	(H)	*(G) – (D)*

ETCOC	(I)	*(A) + (D)*
ATCOC	(J)	*(A) + (G)*

Adjustments to ATCOC (e.g. for truncation)	(K)	
Total Cost of Care Over (Under) Spend	(L)	*(J) + (K) – (I)*

Year-End Quality Adjustment	(M)	

Contractor Financial Liability before Risk Corridor	(N)	*(L) + (M)*

Contractor Financial Liability after Risk Corridor*	(O)	
Year-End Reconciliation of Value-Based Care Payment (if necessary)	(P)	
Final Cash Settlement	**(Q)**	***(O) + (P)***

* Limits the amount in row (N) to the risk corridor terms contained in Attachment B section IV

5. Hold Harmless

Fee-for-service rate increases or reductions for any Covered Services in this Contract will result in two impacts on this Contract. First, the Fixed Prospective Payment totals will be adjusted accordingly as part of the annual financial reconciliation. Second, the ETCOC will need to be increased or decreased. Under those circumstances DVHA will hold Contractor harmless for any material fee-for-service reimbursement changes implemented during the Performance Year as follows:

- The ETCOC will be increased to fully mitigate the impact to Contractor of any fee-for-service reimbursement increases implemented by DVHA.
- The ETCOC will be decreased to fully mitigate the impact to Contractor of any fee-for-service reimbursement decreases implemented by DVHA.

6. Dispute Resolution Process

1. The Parties agree that to resolve disputes regarding Attachment B using the following dispute resolution process prior to pursuing a remedy from a third party:

    a. The issue in dispute will be referred to the DVHA Program Manager, and the individual referred to in Section 7 on page 2 of this Contract for Contractor, or their respective designees. Each representative shall consult with the managerial or directorial staff who are routinely tasked with oversight of work concerning the subject matter of the issue in dispute. The Parties shall gather the information they need to evaluate the issue in dispute and will have fourteen (14) business days from the date the issue is referred to resolve the dispute.

    b. If the individuals referred to in the preceding paragraph have not resolved the issue in dispute within fourteen (14) business days, the issue will be referred to the Commissioner of DVHA, or his or her designee, and to the Chief Executive Officer of Contractor, or his or her designee. The Parties shall gather the information they

need to evaluate the issue in dispute and will have thirty (30) business days from the date the issue is referred to resolve the dispute.

c. If the issue is not resolved by the management in subsection (b) within thirty (30) business days from referral, DVHA or Contractor may bring an action for relief in the Washington Civil Division of the Vermont Superior Court.

VI. Value-Based Incentive Program

1. Contractor is required to maintain a Value-Based Incentive Program, which shall be used to incentivize Participating Providers and Preferred Providers for high-quality care delivery and support investments in quality improvement activities for Members. The program consists of:
   a. A DVHA-funded Value Based Incentive Fund of up to $2.12 million, from which Contractor shall issue monthly value-based payments to Participating Providers and Preferred Providers based on Contractor's Board of Managers (BOM)-approved quality initiatives throughout the Performance Year. The Parties intend for these payments to be made monthly and Contractor shall take all reasonable actions to make those payments on a monthly basis. Contractor shall provide DVHA with reporting on quality performance and payment distribution quarterly throughout the Performance Year. Contractor will return any unspent Value Based Incentive Funds to DVHA through the Performance Year reconciliation process. Of the $2.12 million Value Based Incentive Fund, $500,000 in value-based payments shall be issued by Contractor to Vermont designated mental health agencies based on Contractor's BOM-approved targets and methodology. Specific to the $500,000 in value-based payments, designated mental health agencies will be evaluated on HSA performance on three measures related to follow-up care: 1) 30-day Follow-up after Emergency Department Visit for Substance Use (FUA), 2) 30-day Follow-up after Emergency Department Visit for Mental Illness (FUM), and 3) Follow-up after Hospitalization for Mental Illness – 7 Day Rate (FUH).
   b. A calculation performed at the end of the Performance Year as part of the Year-End Reconciliation process described in Section VI(5)(j) below, whereby the annual ACO quality score is used to determine the Year-End Quality Adjustment.

2. Value-Based Incentive Fund Distribution and Reporting

   Contractor shall maintain BOM-approved policies detailing the quality metrics and performance thresholds that will be used to evaluate the quality performance of Participating Providers and Preferred Providers during the Performance Year, and establishing Participating Providers' and Preferred Providers' eligibility for value-based payments from the Value-Based Incentive Fund. The Value-Based Incentive Fund shall be distributed by Contractor to Participating Providers and Preferred Providers based on quality performance evaluated by Contractor and reported to DVHA during the Performance Year. DVHA shall have the right to review Contractor policies related to the Value-Based Incentive Program in accordance with Attachment A, Section 2.13 of this Contract and these policies shall be submitted to DVHA by January 15, 2025. A VMNG-specific Value-Based Incentive Fund distribution plan including measures, targets, allocation methodology, provider types receiving allocations, and proposed timing of distributions shall be submitted to DVHA by January 15, 2025 and is subject to review and approval by DVHA. Distributions not approved by DVHA shall not be paid out of the Value-Based Incentive Fund.

Contractor agrees to submit Value Based Incentive Fund reports to State. Reports shall provide details of the amount OneCare is invoicing for payments to be distributed in that payment period by provider TIN. DVHA shall have two weeks to object to the report. If DVHA fails to object within two weeks, the Value-Based Incentive Fund Report shall be deemed approved and Contractor shall submit invoice for payment. Once State has received both a Value Based Incentive Fund report and its corresponding invoice no earlier than two weeks after report submission, State shall pay out that invoice within 30 days to Contractor. All invoices to State must be received no later than May 15, 2025. Invoices shall be submitted quarterly, for an amount not to exceed $500,000 per quarter. Constraints relating to data availability may impact the timing of payments, which may require that Contractor exceed the $500,000 per quarter maximum in the later quarters. If this occurs, Contractor shall communicate with State in a timely manner.

Contractor may be required to pay up to $50,000.00 should the DVHA Commissioner find that Contractor is in violation of a Corrective Action Plan, subject to Contractor's appeal rights under this Contract and the Vermont Administrative Procedures Act.

3. Quality Measures, Incentive Payment Structure, and Year-End Quality Adjustment

DVHA has established a framework that includes quality measures, allocation of funds and points, and a scoring methodology, found in Tables 2-4 below. The framework shall be applied to the Year-End Quality Adjustment that factors into Year-End Reconciliation.

Quality measures, allocation of funds and points, and scoring methodology may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement. These components of the framework shall be established annually by DVHA and reflected in an amendment to the Contract.

Contractor performance on payment measures, as defined in Table 2 below, will be the basis for the calculation of the Year-End Quality Adjustment amount. Payment measure results will be scored according to Table 4 and the methodology outlined in subsections A. through F., below. Reporting measures are those that Contractor is required to report; however, Contractor performance on reporting measures will not impact the distribution of the Value-Based Incentive Fund or the calculation of the Year-End Quality Adjustment amount. Reporting measures will not be scored. All quality measures for the Expanded Attribution Cohort will be reporting measures, as set forth below.

Contractor quality measure results shall be calculated based on care delivered during the Performance Year. Contractor shall submit information to DVHA, in the format and detail specified by DVHA, with respect to each quality measure set forth below. Contractor will be responsible for collecting and submitting information for those measures for which performance results are based on clinical data. Contractor shall provide documentation of the quality measurement data upon request to allow DVHA staff to review Contractor's clinical measure results. DVHA will supply random samples of eligible Members for medical record review to determine performance on clinical data measures. DVHA will provide performance results for measures that rely on claims and survey data. Any payment measure results received from Contractor after the required submission date will not be included in the scoring calculation.

Table 2: Quality Measures

Measure	Measure Use – Traditional Attribution Cohort	Measure Use – Expanded Attribution Cohort	Data Source	National or Multi-State Medicaid Benchmarks Available for Performance Year
30 Day Follow-Up after ED Visit for Substance Use (FUA)	Payment	Reporting	Claims	Yes
30 Day Follow-Up after ED Visit for Mental Illness (FUM)	Payment	Reporting	Claims	Yes
Child and Adolescent Well Care Visits (WCV, 3-21 years)	Payment	Reporting	Claims	Yes
Risk Standardized Hospital Admission Rate for Patients with Multiple Chronic Conditions (18 and over)	Payment	Reporting	Claims	No
Developmental Screening in the First 3 Years of Life (CMS Child Core CDEV)	Payment	Reporting	Claims	Yes
Glycemic Status Assessment for Patients with Diabetes (GSD)	Payment	N/A	Clinical	Yes
Hypertension: Controlling High Blood Pressure (CBP)	Payment	N/A	Clinical	Yes
Initiation of Substance Use Disorder Treatment (IET)	Payment	Reporting	Claims	Yes
Engagement of Substance Use Disorder Treatment (IET)	Payment	Reporting	Claims	Yes
Screening for Clinical Depression and Follow-Up Plan	Payment	N/A	Clinical	No
Follow-Up after Hospitalization for Mental Illness 7 Day Rate (FUH)	Payment	Reporting	Claims	Yes
Tobacco Use Assessment and Tobacco Cessation Intervention	Reporting	N/A	Clinical	No
Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey Composite Measures collected by DVHA§	Reporting	N/A	Survey	No

§ DVHA's certified CAHPS® vendor will calculate VMNG Program specific performance on behalf of Contractor.

A. Each payment measure will carry equal weight in the scoring methodology; reporting measures will not be scored.
B. Contractor's quality performance in each Performance Year will be compared to national

Medicaid percentile benchmarks (or multi-state benchmarks, if no national benchmarks are available) that are the most currently available to DVHA, and each measure will be scored individually. DVHA will inform Contractor of the versions of benchmarks to be utilized within a reasonable timeframe to permit Contractor to effectively measure.

C. Contractor may earn up to 2 points per measure for attainment relative to national benchmarks (or multi-state benchmarks if no national benchmarks are available). Contractor may earn points for statistically significant improvement between the current Performance Year and the prior Performance Year. Statistical significance will be defined by a p-value of 0.05 using a one-way ANOVA. Points are determined by Contractor's net improvement in measures and are calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. One bonus point will be awarded for each significantly improved quality measure and one bonus point subtracted for each measure with a statistically significant decline in performance. However, any quality measure with a statistically significant decline that remains within the highest benchmark quartile will be exempted from the calculation of Contractor's net bonus quality improvement score. The total number of bonus points cannot exceed eight and will not be less than zero.

D. If national or multi-state benchmarks are unavailable, current year performance will be compared to prior year VMNG Program-specific performance. Statistical significance will be defined by a p-value of 0.05 using a one-way ANOVA. 2 points will be awarded for significant improvement, 1 point will be awarded for no change and 0 points will be awarded for significant decline. In the event the current performance compared to prior year performance is statistically no different than zero, the measure will only be eligible for a maximum of 1 point as the improvement from the prior year that would be needed to attain 2 points will not be possible. This may impact the total possible points available. The total possible points will be calculated as the number of payment measures multiplied by a maximum of 2 points per payment measure; Contractor may not earn more than the total possible points for attainment and improvement combined.

E. If a measure no longer meets best clinical practice due to change in clinical evidence or guidelines, or identification of potential harm to patients, the measure will revert to pay for reporting for the current Performance Year, be awarded two points, and be modified or removed from future performance years as mutually determined by DVHA and Contractor.

F. In the event that the COVID-19 public health emergency hinders accurate quality measurement or alters Contractor's ability to effectively administer quality measure operations, DVHA will engage in negotiations with contractor to determine a mutually agreeable amendment to this agreement.

G. DVHA will make its best efforts to distribute a report identifying Contractor's performance during the calendar year following the performance year and the amount of incentive payments, if any, earned for each measure by August 1 of the year following the performance year.

Table 3: Allocation of Funds and Points	
Maximum of Year-End Quality Adjustment as % of ETCOC for the Traditional Attribution Cohort	1.0%
Total Possible Points	Up to 22

Points Awarded for Reporting	0
Improvement Points Available	0-9

Table 4: Scoring Methodology	
National (or Multi-State) Benchmark	**Points Awarded**
90th+ percentile*	2
75th+ percentile	1.75
50th+ percentile	1
25th+ percentile	0.25
<25th percentile	0

*In the event 90th percentile benchmarks are not available for any measure, two points shall be awarded for achieving the 75th percentile on such measures.

H. The Year-End Quality Adjustment shall be determined by the overall quality score per the formula below.

Year-End Quality Adjustment to be incorporated into the Year-End Reconciliation = ETCOC – (ETCOC*(1-(.01/[total possible points])*([total possible points] – [points earned])))

EXHIBIT 1

TO

ATTACHMENT B

Expected Total Cost of Care (ETCOC) and Value Based Care Payment

Table 1. Traditional & Expanded Attribution Cohorts

	A=B+C	B	C	D	E = C + D
MEG	**ETCOC**	**Allocation for FFS**	**Allocation for FPP**	**Provider Reform Support Payment**	**Monthly Value-Based Care Payment to Contractor**
ABD	$713.65	$335.33	$378.32	$4.75	$383.07
New Adult	$330.63	$132.22	$198.41	$4.75	$203.16
Non-ABD Adult	$436.08	$148.39	$287.69	$4.75	$292.44
Consolidated Child	$141.77	$80.08	$61.69	$4.75	$66.44
SCHIP Child	$121.27	$70.78	$50.49	$4.75	$55.24

EXHIBIT 2

TO

ATTACHMENT B

Global Payment Program Payments

Global Payment Participating Entity Type	Monthly Payment Amount*
Comprehensive Payment Reform Primary Care Practices	$164,982
Hospitals	$4,883,909

The GPP will be effective for the members of each group that elect to participate as follows: (1) Primary Care Practices in the Comprehensive Payment Reform program beginning January 1, 2025; (2) hospitals beginning April 1, 2025. These start dates are dependent on the approval of funding from the State of Vermont. DVHA shall endeavor to secure this funding at least two weeks prior to the aforementioned start dates. In the event that funding is not approved within this timeframe, DVHA shall have three (3) business days to notify Contractor of such. Upon receipt of funding approval, DVHA shall promptly inform Contractor, and the Parties shall have an additional three (3) business days to meet and determine the earliest practical start date for the GPP.

The Parties agree that this Exhibit 2 to Attachment B may be updated to reflect the mid-year start date and Monthly Payment amounts for certain GPP participants, per Exhibit 4 to Attachment A. The Parties additionally agree that adjustments to Monthly Payment amounts outlined in the table above can be made periodically if payments deviate materially from the GPP Zero-Paid WHPP amounts for Participating Entities, per Exhibit 4 to Attachment A. The Parties must mutually agree in writing to any such changes.

*This amount will change based on the actual start date for the Participating Entities starting the GPP after 1/1/2025, and will be mutually agreed upon in writing by both parties.

Attachment C, Standard State Provisions for Contracts and Grants.

"Attachment C: Standard State Provisions for Contracts and Grants" (revision version dated December 7, 2023) constitutes part of this Contract and is hereby incorporated by reference as if fully set forth herein and shall apply to the Contractor and to the purchase of all goods and/or services by the State under this Contract. A copy of this document is available online at: https://bgs.vermont.gov/purchasing-contracting/forms.

ATTACHMENT D

OTHER PROVISIONS

1. The insurance requirements contained in Attachment C, Section 8 are amended to add:

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 $2,000,000 per occurrence, and $6,000,000 aggregate.

Automotive Liability: To the extent the Party does not own, rent, or use motor vehicles in connection with this Agreement, the requirement for automotive liability insurance is void. If Party's employee uses a personal vehicle in connection with this Agreement, Party shall ensure limits of coverage shall not be less than $100,000 for bodily injury, with a combined single limit of $300,000.

2. TECHNOLOGY PROFESSIONAL LIABILITY AND CYBER LIABILITY INSURANCE COVERAGE

In addition to the insurance required in Attachment C to this Contract, before commencing work on this Contract and throughout the term of this Contract, Contractor, to the extent Contractor has access to, processes, handles, collects, transmits, stores or otherwise deals with State Data, Contractor shall maintain first party Breach Notification Coverage of not less than $2,000,000.

Before commencing work on this Contract the Contractor must provide certificates of insurance to show that the foregoing minimum coverages are in effect.

3. Attachment E is amended as follows:

i. The definition for "Targeted Unsuccessful Security Incident" is deleted and replaced with:
"*Targeted Unsuccessful Security Incident*" means an *Unsuccessful Security Incident* that an IT professional reasonably determines appears to be an attempt to obtain unauthorized Access, Use, Disclosure, modification or destruction of the Covered Entity's *Electronic PHI*.

ii. Section 5.2 (Reporting *Unsuccessful Security Incidents*) is deleted in its entirety.

iii. Section 9 (Agreements with Subcontractors) is deleted and replaced with:

Agreements with Subcontractors. *Business Associate* shall enter into a Business Associate Agreement with any *Subcontractor* to whom it provides *PHI* to require compliance with HIPAA and to ensure *Business Associate* and *Subcontractor* comply with the terms and conditions of this Agreement. *Business Associate* must enter into such written agreement

before any Use by or Disclosure of *PHI* to such *Subcontractor*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to pursue claims for the return of PHI directly against Subcontractor. *Business Associate* shall provide a copy of the written agreement it enters into with a *Subcontractor* to Covered Entity upon request. *Business Associate* may not make any Disclosure of *PHI* to any *Subcontractor* without prior written consent of Covered Entity.

4. Additional Modifications

Contractor shall comply with the provisions of the Notices of Waiver of Certain Fraud and Abuse Laws in Connection with the Vermont Medicare ACO Initiative and the Vermont All Payer Model dated December 20, 2018 (the "Federal Waiver"). The State intends to permit conduct and arrangements that are permissible under the Federal Waiver.
Nothing in this Contract shall limit the State of Vermont's right to establish Vermont specific conditions related to fraud and abuse for participation in the VMNG Program that differ from, or are in addition to, the conditions set forth by CMS in the Federal Waiver. Vermont shall provide Contractor with written notice of any Vermont specific conditions related to the fraud and abuse waivers in writing 90 days prior to their effect.

5. Additional Term

Cybersecurity Standard Update 2023-01: Contractor confirms that all products and services provided to or for the use of the State under this Agreement shall be in compliance with *State of Vermont Cybersecurity Standard Update 2023-01*, which prohibits the use of certain branded products in State information systems or any vendor system that is supporting State information systems, and is available on-line at: https://digitalservices.vermont.gov/cybersecurity/cybersecurity-standards-and-directives .

BUSINESS ASSOCIATE AGREEMENT

SOV CONTRACTOR: OneCare Vermont Accountable Care Organization, LLC.,

SOV CONTRACT No. 42438 **CONTRACT Effective DATE:** January 1, 2022

THIS BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT") IS ENTERED INTO BY AND BETWEEN THE STATE OF VERMONT AGENCY OF HUMAN SERVICES, OPERATING BY AND THROUGH ITS DEPARTMENT OF VERMONT HEALTH ACCESS ("COVERED ENTITY") AND PARTY IDENTIFIED IN THIS AGREEMENT AS CONTRACTOR OR GRANTEE ABOVE ("**BUSINESS ASSOCIATE"). THIS AGREEMENT SUPPLEMENTS AND IS MADE A PART OF THE CONTRACT OR GRANT ("CONTRACT OR GRANT") TO WHICH IT IS ATTACHED.**
Covered Entity and Business Associate enter into this Agreement to comply with the standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. **Definitions**. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations. Terms defined in this Agreement are italicized. Unless otherwise specified, when used in this Agreement, defined terms used in the singular shall be understood if appropriate in their context to include the plural when applicable.

"*Agent*" means an *Individual* acting within the scope of the agency of the *Business Associate*, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c) and includes Workforce members and *Subcontractors*.

"*Breach*" means the acquisition, Access, Use or Disclosure of *Protected Health Information* (*PHI*) which compromises the Security or privacy of the *PHI*, except as excluded in the definition of *Breach* in 45 CFR § 164.402.

"*Business Associate*" shall have the meaning given for "Business Associate" in 45 CFR § 160.103 and means Contractor or Grantee and includes its Workforce, *Agents* and *Subcontractors*.

"*Electronic PHI*" shall mean *PHI* created, received, maintained or transmitted electronically in accordance with 45 CFR § 160.103.

"*Individual*" includes a Person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"*Protected Health Information*" ("*PHI*") shall have the meaning given in 45 CFR § 160.103, limited to the *PHI* created or received by *Business Associate* from or on behalf of Covered Entity.

"*Required by Law*" means a mandate contained in law that compels an entity to make a use or disclosure of *PHI* and that is enforceable in a court of law and shall have the meaning given in 45 CFR § 164.103.

"*Report*" means submissions required by this Agreement as provided in section 2.3.

"*Security Incident*" means the attempted or successful unauthorized Access, Use, Disclosure, modification, or destruction of Information or interference with system operations in an Information System relating to *PHI* in accordance with 45 CFR § 164.304.

"*Services*" includes all work performed by the *Business Associate* for or on behalf of Covered Entity that requires the Use and/or Disclosure of *PHI* to perform a *Business Associate* function described in 45 CFR § 160.103.

"*Subcontractor*" means a Person to whom *Business Associate* delegates a function, activity, or service, other than in the capacity of a member of the workforce of such *Business Associate*.

"*Successful Security Incident*" shall mean a *Security Incident* that results in the unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

"*Unsuccessful Security Incident*" shall mean a *Security Incident* such as routine occurrences that do not result in unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System, such as: (i) unsuccessful attempts to penetrate computer networks or services maintained by *Business Associate*; and (ii) immaterial incidents such as pings and other broadcast attacks on *Business Associate's* firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above with respect to *Business Associate's* Information System.

"*Targeted Unsuccessful Security Incident*" means an *Unsuccessful Security Incident* that appears to be an attempt to obtain unauthorized Access, Use, Disclosure, modification or destruction of the Covered Entity's *Electronic PHI*.

2. Contact Information for Privacy and Security Officers and Reports.

2.1 *Business Associate* shall provide, within ten (10) days of the execution of this Agreement, written notice to the Contract or Grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer of the *Business Associate.* This information must be updated by *Business Associate* any time these contacts change.

2.2 Covered Entity's HIPAA Privacy Officer and HIPAA Security Officer contact information is posted at: https://humanservices.vermont.gov/rules-policies/health-insurance-portability-and-accountability-act-hipaa

2.3 *Business Associate* shall submit all *Reports* required by this Agreement to the following email address: AHS.PrivacyAndSecurity@vermont.gov

3. Permitted and Required Uses/Disclosures of PHI.

3.1 Subject to the terms in this Agreement, *Business Associate* may Use or Disclose *PHI* to perform *Services*, as specified in the Contract or Grant. Such Uses and Disclosures are limited to the minimum necessary to provide the *Services*. *Business Associate* shall not Use or Disclose *PHI* in any manner that would constitute a violation of the Privacy Rule if Used or Disclosed by Covered Entity in that manner. *Business Associate* may not Use or Disclose *PHI* other than as permitted or required by this Agreement or as *Required by Law* and only in compliance with applicable laws and regulations.

3.2 *Business Associate* may make *PHI* available to its Workforce, *Agent* and *Subcontractor* who need Access to perform *Services* as permitted by this Agreement, provided that *Business Associate* makes them aware of the Use and Disclosure restrictions in this Agreement and binds them to comply with such restrictions.

3.3 *Business Associate* shall be directly liable under HIPAA for impermissible Uses and Disclosures of *PHI*.

4. Business Activities. *Business Associate* may Use *PHI* if necessary for *Business Associate's* proper management and administration or to carry out its legal responsibilities. *Business Associate* may Disclose *PHI* for *Business Associate's* proper management and administration or to carry out its legal responsibilities if a Disclosure is *Required by Law* or if *Business Associate* obtains reasonable written assurances via a written agreement from the Person to whom the information is to be Disclosed that such *PHI* shall remain confidential and be Used or further Disclosed only as *Required by Law* or for the purpose for which it was Disclosed to the Person, and the Agreement requires the Person to notify *Business Associate*, within five (5) business days, in writing of any *Breach* of Unsecured *PHI* of which it is aware. Such Uses and Disclosures of *PHI* must be of the minimum amount necessary to accomplish such purposes.

5. Electronic PHI Security Rule Obligations.

5.1 With respect to *Electronic PHI*, *Business Associate* shall:

a) Implement and use Administrative, Physical, and Technical Safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312;

b) Identify in writing upon request from Covered Entity all the safeguards that it uses to protect such *Electronic PHI*;

c) Prior to any Use or Disclosure of *Electronic PHI* by an *Agent* or *Subcontractor*, ensure that any *Agent* or *Subcontractor* to whom it provides *Electronic PHI* agrees in writing to implement and use Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of *Electronic PHI*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce

any breach of the agreement concerning the Use or Disclosure of *Electronic PHI*, and be provided to Covered Entity upon request;

d) Report in writing to Covered Entity any *Successful Security Incident* or *Targeted Unsuccessful Security Incident* as soon as it becomes aware of such incident and in no event later than five (5) business days after such awareness. Such *Report* shall be timely made notwithstanding the fact that little information may be known at the time of the *Report* and need only include such information then available;

e) Following such *Report*, provide Covered Entity with the information necessary for Covered Entity to investigate any such incident; and

f) Continue to provide to Covered Entity information concerning the incident as it becomes available to it.

5.2 Reporting *Unsuccessful Security Incidents*. *Business Associate* shall provide Covered Entity upon written request a *Report* that: (a) identifies the categories of *Unsuccessful Security Incidents*; (b) indicates whether *Business Associate* believes its current defensive security measures are adequate to address all *Unsuccessful Security Incidents*, given the scope and nature of such attempts; and (c) if the security measures are not adequate, the measures *Business Associate* will implement to address the security inadequacies.

5.3 *Business Associate* shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

6. <u>Reporting and Documenting Breaches</u>.

6.1 *Business Associate* shall *Report* to Covered Entity any *Breach* of Unsecured *PHI* as soon as it, or any Person to whom *PHI* is disclosed under this Agreement, becomes aware of any such *Breach*, and in no event later than five (5) business days after such awareness, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Such *Report* shall be timely made notwithstanding the fact that little information may be known at the time of the *Report* and need only include such information then available.

6.2 Following the *Report* described in 6.1, *Business Associate* shall conduct a risk assessment and provide it to Covered Entity with a summary of the event. *Business Associate* shall provide Covered Entity with the names of any *Individual* whose Unsecured *PHI* has been, or is reasonably believed to have been, the subject of the *Breach* and any other available information that is required to be given to the affected *Individual*, as set forth in 45 CFR § 164.404(c). Upon request by Covered Entity, *Business Associate* shall provide information necessary for Covered Entity to investigate the impermissible Use or Disclosure. *Business Associate* shall continue to provide to Covered Entity information concerning the *Breach* as it becomes available.

6.3 When *Business Associate* determines that an impermissible acquisition, Access, Use or Disclosure of *PHI* for which it is responsible is not a *Breach*, and therefore does not necessitate notice to the impacted *Individual*, it shall document its assessment of risk, conducted as set forth

in 45 CFR § 402(2). *Business Associate* shall make its risk assessment available to Covered Entity upon request. It shall include 1) the name of the person making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the *PHI* had been compromised.

7. Mitigation and Corrective Action. *Business Associate* shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible Use or Disclosure of *PHI*, even if the impermissible Use or Disclosure does not constitute a *Breach*. *Business Associate* shall draft and carry out a plan of corrective action to address any incident of impermissible Use or Disclosure of *PHI*. *Business Associate* shall make its mitigation and corrective action plans available to Covered Entity upon request.

8. Providing Notice of Breaches.

8.1 If Covered Entity determines that a *Breach* of *PHI* for which *Business Associate* was responsible, and if requested by Covered Entity, *Business Associate* shall provide notice to the *Individual* whose *PHI* has been the subject of the *Breach*. When so requested, *Business Associate* shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. *Business Associate* shall be responsible for the cost of notice and related remedies.

8.2 The notice to affected *Individuals* shall be provided as soon as reasonably possible and in no case later than sixty (60) calendar days after *Business Associate* reported the *Breach* to Covered Entity.

8.3 The notice to affected *Individuals* shall be written in plain language and shall include, to the extent possible: 1) a brief description of what happened; 2) a description of the types of Unsecured *PHI* that were involved in the *Breach*; 3) any steps *Individuals* can take to protect themselves from potential harm resulting from the *Breach*; 4) a brief description of what the *Business Associate* is doing to investigate the *Breach* to mitigate harm to *Individuals* and to protect against further *Breaches*; and 5) contact procedures for *Individuals* to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.4 *Business Associate* shall notify *Individuals* of *Breaches* as specified in 45 CFR § 164.404(d) (methods of *Individual* notice). In addition, when a *Breach* involves more than 500 residents of Vermont, *Business Associate* shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. Agreements with Subcontractors. *Business Associate* shall enter into a Business Associate Agreement with any *Subcontractor* to whom it provides *PHI* to require compliance with HIPAA and to ensure *Business Associate* and *Subcontractor* comply with the terms and conditions of this Agreement. *Business Associate* must enter into such written agreement before any Use by or Disclosure of *PHI* to such *Subcontractor*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the Use or Disclosure of *PHI*. *Business Associate* shall provide a copy of the written agreement it enters into with a *Subcontractor* to Covered Entity upon request. *Business Associate* may not make any Disclosure of *PHI* to any *Subcontractor* without prior written consent of Covered Entity.

10. **Access to PHI**. *Business Associate* shall provide access to *PHI* in a Designated Record Set to Covered Entity or as directed by Covered Entity to an *Individual* to meet the requirements under 45 CFR § 164.524. *Business Associate* shall provide such access in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for Access to *PHI* that *Business Associate* directly receives from an *Individual*.

11. **Amendment of PHI**. *Business Associate* shall make any amendments to *PHI* in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an *Individual*. *Business Associate* shall make such amendments in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for amendment to *PHI* that *Business Associate* directly receives from an *Individual*.

12. **Accounting of Disclosures**. *Business Associate* shall document Disclosures of *PHI* and all information related to such Disclosures as would be required for Covered Entity to respond to a request by an *Individual* for an accounting of disclosures of *PHI* in accordance with 45 CFR § 164.528. *Business Associate* shall provide such information to Covered Entity or as directed by Covered Entity to an *Individual*, to permit Covered Entity to respond to an accounting request. *Business Associate* shall provide such information in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any accounting request that *Business Associate* directly receives from an *Individual*.

13. **Books and Records**. Subject to the attorney-client and other applicable legal privileges, *Business Associate* shall make its internal practices, books, and records (including policies and procedures and *PHI*) relating to the Use and Disclosure of *PHI* available to the Secretary of Health and Human Services (HHS) in the time and manner designated by the Secretary. *Business Associate* shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether *Business Associate* is in compliance with this Agreement.

14. **Termination.**

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all the *PHI* is destroyed or returned to Covered Entity subject to Section 18.8.

14.2 If *Business Associate* fails to comply with any material term of this Agreement, Covered Entity may provide an opportunity for *Business Associate* to cure. If *Business Associate* does not cure within the time specified by Covered Entity or if Covered Entity believes that cure is not reasonably possible, Covered Entity may immediately terminate the Contract or Grant without incurring liability or penalty for such termination. If neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary of HHS. Covered Entity has the right to seek to cure such failure by *Business Associate*. Regardless of whether Covered Entity cures, it retains any right or remedy available at law, in equity, or under the Contract or Grant and *Business Associate* retains its responsibility for such failure.

15. **Return/Destruction of PHI**.

15.1 *Business Associate* in connection with the expiration or termination of the Contract or Grant shall return or destroy, at the discretion of the Covered Entity, *PHI* that *Business Associate* still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. *Business Associate* shall not retain any copies of *PHI*. *Business Associate* shall certify in writing and report to Covered Entity (1) when all *PHI* has been returned or destroyed and (2) that *Business Associate* does not continue to maintain any *PHI*. *Business Associate* is to provide this certification during this thirty (30) day period.

15.2 *Business Associate* shall report to Covered Entity any conditions that *Business Associate* believes make the return or destruction of *PHI* infeasible. *Business Associate* shall extend the protections of this Agreement to such *PHI* and limit further Uses and Disclosures to those purposes that make the return or destruction infeasible for so long as *Business Associate* maintains such *PHI*.

16. Penalties. *Business Associate* understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of *PHI* and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations.

17. Training. *Business Associate* understands its obligation to comply with the law and shall provide appropriate training and education to ensure compliance with this Agreement. If requested by Covered Entity, *Business Associate* shall participate in Covered Entity's training regarding the Use, Confidentiality, and Security of *PHI*; however, participation in such training shall not supplant nor relieve *Business Associate* of its obligations under this Agreement to independently assure compliance with the law and this Agreement.

18. Miscellaneous.

18.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the Contract or Grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the Contract or Grant continue in effect.

18.2 Each party shall cooperate with the other party to amend this Agreement from time to time as is necessary for such party to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA. This Agreement may not be amended, except by a writing signed by all parties hereto.

18.3 Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule, Security Rule, and HITECH) in construing the meaning and effect of this Agreement.

18.5 *Business Associate* shall not have or claim any ownership of *PHI*.

18.6 *Business Associate* shall abide by the terms and conditions of this Agreement with respect to all *PHI* even if some of that information relates to specific services for which *Business Associate* may not be a "*Business Associate*" of Covered Entity under the Privacy Rule.

18.7 *Business Associate* is prohibited from directly or indirectly receiving any remuneration in exchange for an *Individual's PHI*. *Business Associate* will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. *Reports* or data containing *PHI* may not be sold without Covered Entity's or the affected Individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for *Business Associate* to return or destroy *PHI* as provided in Section 14.2 and (b) the obligation of *Business Associate* to provide an accounting of disclosures as set forth in Section 12 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

Attachment F
AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT/GRANT PROVISIONS

1. **Definitions:** For purposes of this Attachment F, the term "Agreement" shall mean the form of the contract or grant, with all of its parts, into which this Attachment F is incorporated. The meaning of the term "Party" when used in this Attachment F shall mean any named party to this Agreement *other than* the State of Vermont, the Agency of Human Services (AHS) and any of the departments, boards, offices and business units named in this Agreement. As such, the term "Party" shall mean, when used in this Attachment F, the Contractor or Grantee with whom the State of Vermont is executing this Agreement. If Party, when permitted to do so under this Agreement, seeks by way of any subcontract, sub-grant or other form of provider agreement to employ any other person or entity to perform any of the obligations of Party under this Agreement, Party shall be obligated to ensure that all terms of this Attachment F are followed. As such, the term "Party" as used herein shall also be construed as applicable to, and describing the obligations of, any subcontractor, sub-recipient or sub-grantee of this Agreement. Any such use or construction of the term "Party" shall not, however, give any subcontractor, sub-recipient or sub-grantee any substantive right in this Agreement without an express written agreement to that effect by the State of Vermont.

2. **Agency of Human Services**: The Agency of Human Services is responsible for overseeing all contracts and grants entered by any of its departments, boards, offices and business units, however denominated. The Agency of Human Services, through the business office of the Office of the Secretary, and through its Field Services Directors, will share with any named AHS-associated party to this Agreement oversight, monitoring and enforcement responsibilities. Party agrees to cooperate with both the named AHS-associated party to this contract and with the Agency of Human Services itself with respect to the resolution of any issues relating to the performance and interpretation of this Agreement, payment matters and legal compliance.

3. **Medicaid Program Parties** (*applicable to any Party providing services and supports paid for under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver*):

   Inspection and Retention of Records: In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u).

   Subcontracting for Medicaid Services: Notwithstanding any permitted subcontracting of services to be performed under this Agreement, Party shall remain responsible for ensuring that this Agreement is fully performed according to its terms, that subcontractor remains in compliance with the terms hereof, and that subcontractor complies with all state and federal laws and regulations relating to the Medicaid program in Vermont. Subcontracts, and any service provider agreements entered into by Party in connection with the performance of this Agreement, must clearly specify in writing the responsibilities of the subcontractor or other service provider and Party must retain the authority to revoke its subcontract or service provider agreement or to impose other sanctions if the performance of the subcontractor or service provider is inadequate or if its performance deviates from any requirement of this Agreement. Party shall make available on request all contracts, subcontracts and service provider agreements between the Party, subcontractors and other service providers to the Agency of Human Services and any of its departments as well as to the Center for Medicare and Medicaid Services.

Medicaid Notification of Termination Requirements: Party shall follow the Department of Vermont Health Access Managed-Care-Organization enrollee-notification requirements, to include the requirement that Party provide timely notice of any termination of its practice.

Encounter Data: Party shall provide encounter data to the Agency of Human Services and/or its departments and ensure further that the data and services provided can be linked to and supported by enrollee eligibility files maintained by the State.

Federal Medicaid System Security Requirements Compliance: Party shall 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) in order to support audit compliance with 45 CFR 95.621 subpart F, *ADP System Security Requirements and Review Process*.

4. **Workplace Violence Prevention and Crisis Response** (*applicable to any Party and any subcontractors and sub-grantees whose employees or other service providers deliver social or mental health services directly to individual recipients of such services*):

Party shall establish a written workplace violence prevention and crisis response policy meeting the requirements of Act 109 (2016), 33 VSA §8201(b), for the benefit of employees delivering direct social or mental health services. Party shall, in preparing its policy, consult with the guidelines promulgated by the U.S. Occupational Safety and Health Administration for *Preventing Workplace Violence for Healthcare and Social Services Workers*, as those guidelines may from time to time be amended.

Party, through its violence protection and crisis response committee, shall evaluate the efficacy of its policy, and update the policy as appropriate, at least annually. The policy and any written evaluations thereof shall be provided to employees delivering direct social or mental health services.

Party will ensure that any subcontractor and sub-grantee who hires employees (or contracts with service providers) who deliver social or mental health services directly to individual recipients of such services, complies with all requirements of this Section.

5. **Non-Discrimination**:

Party shall not discriminate, and will prohibit its employees, agents, subcontractors, sub-grantees and other service providers from 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, and on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. Party shall 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 as provided by Title 9 V.S.A. Chapter 139.

No person shall on the grounds of religion or on the grounds of sex (including, on the grounds that a woman is pregnant), 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 of Vermont and/or federal funds.

Party further shall 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, requiring that contractors and subcontractors receiving federal funds assure that persons with limited English proficiency can meaningfully access services. To the extent Party provides assistance to individuals

with limited English proficiency through the use of oral or written translation or interpretive services, such individuals cannot be required to pay for such services.

6. **Employees and Independent Contractors**:

Party agrees that it shall comply with the laws of the State of Vermont with respect to the appropriate classification of its workers and service providers as "employees" and "independent contractors" for all purposes, to include for purposes related to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party agrees to ensure that all of its subcontractors or sub-grantees also remain in legal compliance as to the appropriate classification of "workers" and "independent contractors" relating to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party will on request provide to the Agency of Human Services information pertaining to the classification of its employees to include the basis for the classification. Failure to comply with these obligations may result in termination of this Agreement.

7. **Data Protection and Privacy:**

Protected Health Information: Party 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 Agreement. Party 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: Substance abuse treatment information shall be maintained in compliance with 42 C.F.R. Part 2 if the Party or subcontractor(s) are Part 2 covered programs, or if substance abuse treatment information is received from a Part 2 covered program by the Party or subcontractor(s).

Protection of Personal Information: Party agrees to comply with all applicable state and federal statutes to assure protection and security of personal information, or of any personally identifiable information (PII), including the Security Breach Notice Act, 9 V.S.A. § 2435, the Social Security Number Protection Act, 9 V.S.A. § 2440, the Document Safe Destruction Act, 9 V.S.A. § 2445 and 45 CFR 155.260. As used here, PII shall include any information, in any medium, including electronic, which can be used to distinguish or trace an individual's identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with any other personal or identifiable information that is linked or linkable to a specific person, such as date and place or birth, mother's maiden name, etc.

Other Confidential Consumer Information: Party agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to and uses of personal information relating to any beneficiary or recipient of goods, services or other forms of support. Party further agrees to comply with any applicable Vermont State Statute and other regulations respecting the right to individual privacy. Party shall ensure that all of its employees, subcontractors and other service providers performing services under this agreement understand and preserve the sensitive, confidential and non-public nature of information to which they may have access.

Data Breaches: The notice required under the Use and Protection of State Information terms of Attachment C shall be provided to the Agency of Digital Services Chief Information Security Officer. https://digitalservices.vermont.gov/about-us/contacts. Party shall in addition comply with any other data breach notification requirements required under federal or state law or Attachment E.

8. **Abuse and Neglect of Children and Vulnerable Adults:**

Abuse Registry. Party agrees not to employ any individual, to use any volunteer or other service provider, or to otherwise provide reimbursement to any individual who in the performance of services connected with this agreement provides care, custody, treatment, transportation, or supervision to children or to vulnerable adults

if there has been a substantiation of abuse or neglect or exploitation involving that individual. Party is responsible for confirming as to each individual having such contact with children or vulnerable adults the non-existence of a substantiated allegation of abuse, neglect or exploitation by verifying that fact though (a) as to vulnerable adults, the Adult Abuse Registry maintained by the Department of Disabilities, Aging and Independent Living and (b) as to children, the Central Child Protection Registry (unless the Party holds a valid child care license or registration from the Division of Child Development, Department for Children and Families). See 33 V.S.A. §4919(a)(3) and 33 V.S.A. §6911(c)(3).

Reporting of Abuse, Neglect, or Exploitation. Consistent with provisions of 33 V.S.A. §4913(a) and §6903, Party and any of its agents or employees who, in the performance of services connected with this agreement, (a) is a caregiver or has any other contact with clients and (b) 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: as to children, make a report containing the information required by 33 V.S.A. §4914 to the Commissioner of the Department for Children and Families within 24 hours; or, as to a vulnerable adult, make a report containing the information required by 33 V.S.A. §6904 to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. Party 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.

9. **Information Technology Systems**:

Computing and Communication: Party 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 Party as part of this agreement. Options include, but are not limited to:

1. Party's provision of certified computing equipment, peripherals and mobile devices, on a separate Party'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.

***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 Party (or subcontractor or sub-grantee), shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

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

If Party is operating a system or application on behalf of the State of Vermont, Party 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 Party's materials.

Party acknowledges and agrees that should this agreement be in support of the State's implementation of the Patient Protection and Affordable Care Act of 2010, Party is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Such agreement will be subject to, and incorporates here by reference, 45 CFR 74.36, 45 CFR 92.34 and 45 CFR 95.617 governing rights to intangible property.

Security and Data Transfers: Party shall comply with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Party of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Party to implement any required.

Party will ensure the physical and data security associated with computer equipment, including desktops, notebooks, and other portable devices, used in connection with this Agreement. Party 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. Party 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, Party shall securely delete data (including archival backups) from Party's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

Party, in the event of a data breach, shall comply with the terms of Section 7 above.

10. **Other Provisions**:

Environmental Tobacco Smoke. Public Law 103-227 (also known as the Pro-Children Act of 1994) and Vermont's Act 135 (2014) (An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands) restrict the use of tobacco products in certain settings. Party shall ensure that no person is permitted: (i) to use tobacco products or tobacco substitutes as defined in 7 V.S.A. § 1001 on the premises, both indoor and outdoor, of any licensed child care center or afterschool program at any time; (ii) to use tobacco products or tobacco substitutes on the premises, both indoor and in any outdoor area designated for child care, health or day care services, kindergarten, pre-kindergarten, elementary, or secondary education or library services; and (iii) to use tobacco products or tobacco substitutes on the premises of a licensed or registered family child care home while children are present and in care. Party will refrain from promoting the use of tobacco products for all clients and from making tobacco products available to minors.

Failure to comply with the provisions of the federal 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. The federal Pro-Children Act of 1994, however, does not apply to 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.

2-1-1 Database: If Party provides health or human services within Vermont, or if Party provides such services near the Vermont border readily accessible to residents of Vermont, Party shall adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211 (Vermont 211), and will provide to Vermont 211 relevant descriptive information regarding its agency, programs and/or contact information as well as accurate and up to date information to its database as requested. The "Inclusion/Exclusion" policy can be found at www.vermont211.org.

Voter Registration: When designated by the Secretary of State, Party 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.

Drug Free Workplace Act: Party will assure a drug-free workplace in accordance with 45 CFR Part 76.

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.

ATTACHMENT G

STATE OF VERMONT- FEDERAL TERMS SUPPLEMENT (Non-Construction)

(Revision date: *May 24, 2024*)

PROCUREMENT OF RECOVERED MATERIALS

In the performance of this contract, the Contractor shall make maximum use of products containing recovered materials that are EPA-designated Items unless the products cannot be acquired-

1. Competitively within a time frame providing for compliance with the contract performance schedule;
2. Meeting contract performance requirements; or
3. At a reasonable price

Information about this requirement, along with the list of EPA-designated items, is available at the EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive-procurement-guideline-cpg-program.

The Contractor also agrees to comply with all other applicable requirements of section 6002 of the Solid Waste Disposal Act.

CLEAN AIR ACT

1. The contractor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.

2. The contractor agrees to report each violation to the State of Vermont and understands and agrees that the State of Vermont will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency, and the appropriate Environmental Protection Agency Regional Office.

3. The contractor agrees to include these requirements in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance provided by FEMA.

FEDERAL WATER POLLUTION CONTROL ACT

1. The contractor agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq.

2. The contractor agrees to report each violation to the State of Vermont and understands and agrees that the State of Vermont will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency, and the appropriate Environmental Protection Agency Regional Office.

3. The contractor agrees to include these requirements in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance provided by FEMA. **a.** Standard. Non-Federal entities and contractors are subject to the debarment and suspension regulations implementing Executive Order 12549, *Debarment and Suspension* (1986) and Executive Order 12689, *Debarment and Suspension* (1989) at 2 C.F.R. Part 180 and the Department of Homeland Security's regulations at 2 C.F.R. Part 3000 (Nonprocurement Debarment and Suspension).

CONTRACTOR BREACH, ERRORS AND OMISSIONS

1. Any breach of the terms of this contract, or material errors and omissions in the work product of the contractor must be corrected by the contractor at no cost to the State, and a contractor may be liable for the State's costs and other damages resulting from errors or deficiencies in its performance.

2. Neither the States' review, approval or acceptance of nor payment for, the services required under this contract shall be construed to operate as a waiver of any rights under this contract or of any cause of action arising out of the performance of this contract.

3. The rights and remedies of the State provided for under this contract are in addition to any other rights and remedies provided by law or elsewhere in the contract.

TERMINATION FOR CONVENIENCE

1. General

   a. Any termination for convenience shall be effected by delivery to the Contractor an Order of Termination specifying the termination is for the convenience of the Agency, the extent to which performance of work under the Contract is terminated, and the effective date of the termination.

   b. In the event such termination occurs, without fault and for reasons beyond the control of the Contractor, all completed or partially completed items of work as of the date of termination will be paid for in accordance with the contract payment terms.

   c. No compensation will be allowed for items eliminated from the Contract.

   d. Termination of the Contract, or portion thereof, shall not relieve the Contractor of its contractual responsibilities for work completed and shall not relieve the Contractor's Surety of its obligation for and concerning any just claim arising out of the work performed.

2. Contractor Obligations

   After receipt of the Notice of Termination and except as otherwise directed by the State, the Contractor shall immediately proceed to:

   a. To the extent specified in the Notice of Termination, stop work under the Contract on the date specified.

   b. Place no further orders or subcontracts for materials, services, and/or facilities except as may be necessary for completion of such portion(s) of the work under the Contract as is (are) not terminated.

   c. Terminate and cancel any orders or subcontracts for related to the services, except as may be necessary for completion of such portion(s) of the work under the Contract as is (are) not terminated.

   d. Transfer to the State all completed or partially completed plans, drawings, information, and other property which, if the Contract had been completed, would be required to be furnished to the State.

   e. Take other action as may be necessary or as directed by the State for the protection and preservation of the property related to the contract which is in the possession of the contractor and in which the State has or may acquire any interest.

   f. Make available to the State all cost and other records relevant to a determination of an equitable settlement.

3. Claim by Contractor

   After receipt of the Notice of Termination from the state, the Contractor shall submit any claim for additional costs not covered herein or elsewhere in the Contract within 60 days of the effective termination date, and not thereafter. Should the Contractor fail to submit a claim within the 60-day period, the State may, at its sole discretion, based on information available to it, determine what, if any, compensation is due the Contractor and pay the Contractor the determined amount.

4. Negotiation

   Negotiation to settle a timely claim shall be for the sole purpose of reaching a settlement equitable to both the Contractor and the State. To the extent settlement is properly based on Contractor costs, settlement shall be based on actual costs incurred by the Contractor, as reflected by the contract rates. Consequential damages, loss of overhead, loss of overhead contribution of any kind, and/or loss of anticipated profits on work not performed shall not be included in the Contractor's claim and will not be considered, allowed, or included as part of any settlement.

PROHIBITION ON CERTAIN TELECOMMUNICATIONS AND VIDEO SURVELLIENCE SERVICES OR EQUIPMENT- this clause must be included in all subcontracts.

In connection with this contract, Contractors and Subcontractors are prohibited from:

(a) Utilizing, procuring or obtaining equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(i) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

(ii) Telecommunications or video surveillance services provided by such entities or using such equipment.

(iii) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

(b) In implementing the prohibition under Public Law 115-232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

(c) See Public Law 115-232, section 889 for additional information.

(d) See also § 200.471.

SUSPENSION AND DEBARMENT - This clause must be included in all subcontracts

This contract is a covered transaction for purposes of 2 C.F.R. Part 180 and 2 C.F.R. Part 3000. As such, the contractor is required to verify that none of the contractor's principals (defined at 2 C.F.R. § 180.995) or its affiliates (defined at 2 C.F.R. § 180.905) are excluded (defined at 2 C.F.R. § 180.940) or disqualified (defined at 2 C.F.R. § 180.935). The contractor must comply with 2 C.F.R. Part 180, subpart C and 2C.F.R. Part 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction it enters into. This certification is a material representation of fact relied upon by (insert name of the recipient/subrecipient/applicant). If it is later determined that the contractor did not comply with 2 C.F.R. Part 180, subpart C and 2 C.F.R. Part 3000, subpart C, in addition to remedies available to (insert name of recipient/subrecipient/applicant), the federal government may pursue available remedies, including but not limited to suspension and/or debarment. The bidder or proposer agrees to comply with the requirements of 2 C.F.R. Part 180, subpart C and 2 C.F.R. Part 3000, subpart C while this offer is valid and throughout the period of any contract that may arise from this offer. The bidder or proposer further agrees to include a provision requiring such compliance in its lower tier covered transactions

BYRD ANTI-LOBBYING CERTIFICATION - Applicable to contracts over $100,000.00- this clause must be included in all subcontracts over $100,000.00.

Contractor has provided the certification required by the Byrd Anti-Lobbying Amendment, 31 U.S.C. § 1352 (as amended, and will follow the requirements for certification of each lower tier (subcontract) to disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award. Such disclosures will be forwarded from tier to tier up to the Contractor who in turn will forward the certification(s) to the federal awarding agency.

DOMESTIC PREFERENCE FOR PROCUREMENTS

As appropriate, and to the extent consistent with law, the contractor should, to the greatest extent practicable, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States. This includes, but is not limited to iron, aluminum, steel, cement, and other manufactured products. For purposes of this clause: Produced in the United States means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States. Manufactured products mean items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber."

CONTRACTING WITH SMALL AND MINORITY BUSINESSES, WOMEN'S BUSINESS ENTERPRISES, AND LABOR SURPLUS FIRMS.

(a) Contractor entity must take all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

(b) Affirmative steps must include:

(1) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;

(2) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;

(3) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;

(4) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;

(5) Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and

(6) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (b)(1) through (5) of this section

The following clauses are applicable when a contract utilizes State and Local Fiscal Recovery Funds (SLRF) funds, and must be passed down to subcontractors and grantees:

WHISTLEBLOWER PROTECTIONS

Contractor shall comply with 41. U.S.C. § 4712 and inform their employees of their rights and remedies in the predominant native language of the workforce.

FAIR EMPLOYMENT PRACTICES

Contractor must comply with 42 U.S.C. §2000d *et seq*., and as enacted by 31 C.F.R. Part 22

FEDERAL AND STATE LAW, REGULATION, AND AGENCY GUIDANCE

Contractor must comply with comply the requirements of the Social Security Act, 42 U.S.C. §§ 602 and regulations adopted by Treasury pursuant to section 602(f) of the Social Security Act, and guidance issued by Treasury regarding the forgoing, and comply with all other federal statues, regulations, and executive orders, including generally applicable environmental laws and regulations

UNIFORM GUIDANCE

Contractor must comply with 2 C.F.R. Part 200 as modified by the Treasury's guidance.

INCREASING SEATBELT USE

Contractor must comply with Executive Order 13043, 62 FR 1927 (April 18, 1997)

REDUCING TEXTING WHILE DRIVING

Contractor must comply with Executive Order 13513, 74 FR 51225 (Oct. 6, 2009).