STATE OF VERMONT
CONTRACT AMENDMENT

It is hereby agreed by and between the State of Vermont, Department of Vermont Health Access (the "State") and Brattleboro Retreat, with a principal place of business in Brattleboro, Vermont (the "Contractor") that the contract between them originally dated as of March 1, 2021, Contract #41429, (the "Contract") is hereby amended as follows:

I. **Maximum Amount.** The Maximum Amount, wherever such references appear, shall be changed from $28,633,834.00 to $67,266,334.00, representing an increase of $38,632,500.00.

II. **Contract Term.** The Contract Term, wherever such references appear, shall be changed from December 31, 2021, to December 31, 2022. This Contract may be renewed upon mutual agreement by both Parties for up to two (2) additional one-year terms.

III. **Attachment A, Scope of Work.** The Scope of Work is amended as follows:

A. Numbers 1, 2, and 3 are hereby deleted and replaced as follows:

1. Inpatient Days

Contractor agrees to provide Inpatient Days, defined as an admission of at least one night, for:

- Medicaid child, adolescent, and adult stays where Medicaid is the primary payer.
- Level 1 stays not covered by commercial insurance or other non-Medicaid payor sources.

2. Contractor Obligations

Contractor shall maintain compliance with all state and federal laws and regulations for licensed and certified psychiatric hospitals and for designated hospitals and shall comply with the following requirements set by the State.

a. Bed Capacity Requirements:

- Contractor agrees to maintain capacity for the agreed upon number of Inpatient Days for Medicaid Members as outlined in Attachment B.
- Specific to Level 1 beds:
    - Contractor shall maintain 26 Level 1 emergency examination or court-ordered observation psychiatric inpatient beds.
        - For the purposes of this Contract, emergency examination beds means Level 1 beds that are available to patients who are admitted for an emergency examination pursuant to 18 V.S.A. § 7508(a) and meet the Level 1 definition outlined in Attachment G.
        - Court-ordered observation psychiatric inpatient beds means Level 1 beds that are available to patients who are admitted for examination of competency and/or sanity pursuant to 13 V.S.A. § 4815(g) and meet the Level 1 definition outlined in Attachment G.
        - Contractor's Level 1 beds shall be no-refusal beds as defined in Act 79.

- State may request the Contractor to provide additional Level 1 bed capacity beyond the no-refusal bed capacity. The decision to extend the capacity will be made on a case-by-case basis and mutually agreed upon by both parties.
- Should Contractor refuse any clinically appropriate referred admission to a Level 1 unit, the Contractor's chief medical officer or designee shall, at the request of the DMH Care Management Director, detail in writing, the clinical justification for the refusal. This written documentation shall be sent to the DMH Care Management Director within one business day of the refusal.
- "Refusal" for a Level 1 bed shall be defined as any referral that DMH care management has referred to Contractor and Contractor has deferred a decision on, or declined to treat the current episode in any bed at the Contractor's place of business.
- Contractor must accept or decline a referral within 24 hours.
- Contractor must place the patient within 24 hours of acceptance of a referral.

- Inpatient Movement for Level 1 Beds:
  - During each Level 1 inpatient admission, Contractor agrees to determine on a weekly basis whether patients continue to meet the Level 1 definition outlined in Attachment G or if they would be appropriate for transfer to a non-Level 1 unit. Such determination will be made in conjunction with the DMH Utilization Review process and clinical review with the inpatient treatment team during regularly scheduled meetings.
    - Potential disruption to patient treatment plan or relationship with the treatment team will be considered but will not be the sole clinical determinant for remaining on a Level 1 Unit or being identified as a Level 1 patient.
    - Once DMH and Contractor agree that a patient does not meet Level 1 criteria and is clinically appropriate for transfer to a non-Level 1 unit, Contractor and DMH shall expedite the transfer process.
    - If there is not agreement as to whether a patient is ready to transfer to a non-Level 1 unit, Contractor's Medical Director commits to discussing with the DMH Medical Director/designee within the next business day following the established lack of agreement or as soon as practicable.
  - When a patient on another unit demonstrates clinical need for Level 1 services, Contractor will communicate with the DMH Mental Health Services Director, or designee, to discuss the needs of the system as it relates to the use of a Level 1 bed. In the case of emergent clinical needs that require an immediate change in placement between the Level 1 and non-Level 1 units, the Contractor will communicate with the Mental Health Services Director or designee as soon as practicable thereafter to discuss the change. For APM Year 2, any decision related to the placement of a patient will be made in collaboration with DMH, including the determination of whether a patient meets Level 1 criteria.

b. Admission and Discharge Capacity

Contractor shall provide 24 hour a day/7 day a week admission and discharge capacity for all patients covered under this agreement.

c. Service Authorization Submission Requirements.

Contractor shall fully participate with the State's care management system to ensure that every patient is receiving medically necessary services in the appropriate setting and that patients are discharged to appropriate services and settings in a clinically appropriate, timely manner. This participation shall include utilization review.

- Contractor shall submit admission notification forms within 24 hours of admission.
- Contractor shall submit written documentation of any refusal of an Inpatient Stay to DMH Care Management within 24 hours of refusal.
- Contractor shall continue to submit authorization requests and clinical documentation to support admission and continued stay under the existing practices established by DMH and the Department of Vermont Health Access (DVHA).

d. Case Consultation Requirements:

- Contractor shall continue weekly case consultation meetings specific to children and adolescents with DVHA's Quality and Clinical Improvement Unit, DMH, and the Department for Children and Families to assist disposition issues.
- Contractor shall request a case consultation with DMH or DVHA for adult inpatient admissions if any concerns are identified.

e. Case Notes and Discharge Planning Requirements:

- Contractor shall submit case notes demonstrating medical necessity, the discharge plan, final physician's note, and the current medication list within three (3) business days of discharge.
- Upon the State's request, within a reasonable time Contractor shall provide additional clinical information in the medical record.

f. Reporting Inpatient Bed Availability Requirements

Contractor shall report to the State the number of inpatient beds, via the electronic bed board reporting system made available to Contractor by the State, in accordance with the DMH Electronic Bed Board: Facility Admin User Guide.

g. Minimize Use of Restraints and Seclusion

Contractor shall minimize the use of restraints, both physical and chemical, and seclusion in compliance with Center for Medicare and Medicaid Services (CMS) standards. The Contractor shall continue participation in the Substance Abuse and Mental Health Services Administration (SAMHSA) Six Core Strategies for the Reduction of Seclusion and Restraint. Contractor shall comply with the Rule Establishing Standards for Emergency Involuntary Procedures. Occurrences of restraint, seclusion, and emergency involuntary medication shall be documented using a Certificate of Need (CON) form with core data elements and clinical content identified by DMH. The CON forms shall be submitted to DMH following the

discontinuation of the emergency involuntary procedure or no later than twice per month on the 1st and 15th of each month.

For APM Year 2, Contractor shall report how many staff were trained in the Six Core Strategies each quarter. The report shall be delivered to DMH quarterly for the preceding quarter (i.e. Q4 data on April 3; Q1 data on July 3, Q2 data on October 3 and Q3 data on December 31.)

h. Patient Escorts and Transports

Contractor shall be responsible for all escorts of patients within the facility and transports to any other treating facility for medically necessary care. The Department of Mental Health shall not be responsible for transports to and from providers, and other hospitals. All escorts/transports within the responsibility of Contractor shall be conducted in a manner that prevents physical and psychological trauma; respects the privacy of the individual; and represents the least restrictive means necessary for the safety of the patient given the medical condition and risk of danger or elopement of the patient at the time of the transport. All other transports shall be arranged by the State.

i. Patient Representatives and Mental Health Care Ombudsman

Contractor shall ensure that a patient representative is available to all patients consistent with 18 V.S.A. § 7253(1)(J) and Act 140 (2020) and ensure that the patient representative be a regular presenter at Contractor's employee orientation programming. Contractor shall ensure that the Mental Health Ombudsman has access to all patients upon request.

j. Emergency Preparedness Plan

Contractor shall maintain an emergency preparedness plan for inpatient evacuation, transfer, and continuity of care of patients in accordance with requirements set forth by State of Vermont, Department of Health, Board of hospital licensing standards. The Contractor shall provide that plan to the State annually, or within thirty (30) days of the start of each Contract year.

3. Performance Indicators

At a minimum for this contract period, performance indicators will include:

a. Annual: Hospital-Based Inpatient Psychiatric Services Core Measure Set (HBIPS)

- HBIPS -1: Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed
- HBIPS-2: Hours of Physical Restraint Use
- HBIPS-3: Hours of Seclusion Use
- HBIPS-4: Patients Discharged on Multiple Antipsychotic Medications
- HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- HBIPS-6: Post Discharge Continuing Care Plan Created
- HBIPS-7: Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge

b. DMH/DVHA Specific Measures

APM Year 1

The following performance indicators will be reported to DMH and DVHA on a monthly basis, on or before the 30th day of the following month, will include:

i. Access to Care
   1. Percentage of bed days purchased with Medicaid funding filled during the month.
   2. Demonstrated progress in the re-opening of closed beds
   3. Comparison of time of referral to time of acceptance or denial.
   4. Number of involuntary admissions.

ii. Process of Care
   1. Percentage of admissions notification forms received within 24 hours.
   2. Percentage of case notes and discharge paperwork received within three (3) days of discharge.

iii. Clinical Outcomes
   1. Results of inpatient consumer survey.
   2. Number of members re-admitted within 15 and 30 days.
   3. Percentage of follow-up after hospitalization with a mental health provider at seven (7), and 30 days post-discharge.

For APM Year 1, Parties will together work to determine additional quality metrics by June 30, 2021.

APM Year 2

Contractor shall submit the following reports to DVHA:

i. By the 5th business day of the month, DVHA will send the Contractor a coverage report template with all admissions thought to have Medicare or other insurance coverage. Contractor will fill out the coverage report and return it within 2 business days of receipt.

ii. By the 10th business day of the month, using the format proscribed by DVHA, Contractor will report the number of all Medicaid and non-Medicaid bed days for which a claim has been submitted & processed, for the previous months.

iii. By the 5th business day of the month or as otherwise required below, Contractor shall provide to DVHA reports on the following performance indicators in the following timeframes:
   a. Access to Care
      1. Contractor will submit demonstrated progress in the re-opening of closed beds not later than five business days after the first of the following month.
      2. Contractor will submit comparison of time of referral to time of acceptance or denial not later than five business days of the first of the following month.
      3. Contractor will submit number of involuntary admissions not later than five business days of the first of the following month.
   b. Process of Care
      1. Contractor will send admission notification forms to DVHA within 24 hours.

2. Contractor will send case notes and discharge paperwork within three (3) days of discharge.

c. Clinical Outcomes
   1. Contractor will submit inpatient consumer survey results written report on a quarterly basis at the DMH Act 140 meeting. A written report template may be submitted to DMH for review and approval before submission.
   2. Contractor will submit the number of members re-admitted to the Brattleboro Retreat within 15 and 30 days on a monthly basis, no later than five (5) business days of the first of the following month.
   3. Contractor will schedule a mental health follow-up appointment with a mental health or primary care provider within seven (7) days of discharge. Contractor will include the follow-up appointment information on the discharge plan.

iv. Claims: Contractor shall submit claims to VT Medicaid in a timely manner in accordance with the Vermont Medicaid Provider Manual's Timely Filing Guidelines.

For APM Year 2, Parties will work together to determine additional quality metrics by March 31, 2022.

B. By adding number 6, Sustainability Requirements, to the end of Attachment A.

6. <u>Sustainability Requirements</u>

Contractor will keep the Agency of Human Services (AHS), DMH, and DVHA informed of any event or occurrence that materially impacts its financial stability, performance, or viability, including, but not limited to, provision of federal payments. Contractor shall provide AHS its standard monthly financial report. AHS Chief Financial Officer, or designee, will notify Contractor of any additional needed information within five business days. Contractor shall respond within five business days of receipt of the request.

Contractor agrees to develop a draft a sustainability plan by January 31, 2022, for submission to State. The sustainability plan shall address the Contractor's continued viability and financial stability and consider contingencies to ensure the continuity of care for patients. The sustainability plan shall be reviewed and updated at least quarterly in collaboration with AHS and department representatives. Contractor and State will meet monthly to review the sustainability plan, as well as performance and utilization targets set by this Contract, unless the parties agree to a different meeting frequency.

IV. **<u>Attachment B, Payment Provisions</u>**. The Payment Provisions are hereby deleted and replaced entirely as shown in Exhibit 1 of this Amendment 1.

<u>Sole Source Contract for Services</u>. This Contract results from a "sole source" procurement under State of Vermont Administrative Bulletin 3.5 process and Contractor hereby certifies that it is and will remain in compliance with the campaign contribution restrictions under 17 V.S.A. § 2950.

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:

This document consists of 15 pages. Except as modified by this Amendment No. 1, all provisions of the Contract remain in full force and effect.

The signatures of the undersigned indicate that each has read and agrees to be bound by this Amendment to the Contract.

BY THE STATE OF VERMONT:

DocuSigned by:
Sandi Hoffman 12/30/2021
B34E5A2F3ED5411...

SANDI HOFFMAN DATE
DVHA Deputy Commissioner
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
Phone: 802-241-0241
Email: Sandi.Hoffman@vermont.gov

BY THE CONTRACTOR:

DocuSigned by:
Louis Josephson 12/30/2021
F35517FCE1CF485...

LOUIS JOSEPHSON, PH.D. DATE
PRESIDENT & CEO
Brattleboro Retreat
Anna Marsh Lane
Brattleboro, VT 05301
Email: ljosephson@brattlebororetreat.org

Exhibit 1
ATTACHMENT B
PAYMENT PROVISIONS

1. **General Payment Provisions**

The State agrees to compensate Contractor for actual services performed in accordance with the methodology described below, provided such services are within the scope of the Agreement and are authorized as provided for under the terms and conditions of this Contract. The payment schedule for delivered products, or rates for services performed, and any additional reimbursements, are included in this Attachment.

2. **Payment for Inpatient Days**

Effective for Inpatient Days under the term of this Contract, as defined in Attachment A, State shall issue monthly prospective payments to Contractor as reimbursement for Inpatient Days. Inpatient Days (both voluntary and involuntary admissions) when Medicaid is not the primary payer are excluded. All other services, rendered by Contractor for Vermont Medicaid members will continue to be reimbursed using existing Medicaid reimbursement methodologies. The time period March 1 through December 31, 2021, is defined as Alternative Payment Model (APM) Year 1. For APM Year 1, the prospective monthly payment per Inpatient Day (APM Payment) is computed using a weighted average per diem amount of $1,838,33.

The time period January 1 through December 31, 2022, is defined as APM Year 2. For the APM Year 2, the APM Payment is computed using a weighted average per diem amount of $2,550.00.

3. **Methodology for Payment**

APM Year 1

The per diem amount in the APM Payment for APM Year 1 was derived using the following factors:

- Historical Contractor inpatient utilization incurred by the Department of Mental Health (DMH) and DVHA;
- Projected Contractor inpatient utilization in APM Year 1;
- Recent cost-per-day values incurred by Contractor for direct care, fixed and administrative costs; and
- A negotiated allowance for annual changes for direct care, fixed and administrative costs.

The APM Payment for APM Year 1 was derived by multiplying the per diem amount of $1,838.33 by the number of expected Inpatient Days. The State shall make a monthly APM Payment to Contractor as shown in Table 1.

Table 1. APM Year 1

Month	Expected Inpatient Days	Monthly Payment Amount
March 2021	1,240	$2,781,058
April 2021	1,320	$2,781,058
May 2021	1,426	$2,781,058
June 2021	1,410	$2,781,058
July 2021	1,674	$2,918,267
August 2021	1,674	$2,918,267
September 2021	1,680	$2,918,267
October 2021	1,736	$2,918,267
November 2021	1,680	$2,918,267
December 2021	1,736	$2,918,267
Total	**15,576**	**$28,633,834**

APM Year 2
The per diem amount in the APM Payment for APM Year 2 was derived using the following factors:

The per diem amount in the APM PAYMENT for APM Year 2 was derived using the following factors:

- Historical Contractor inpatient utilization incurred by DMH and DVHA;
- Projected Contractor inpatient utilization in APM Year 2;
- Recent cost-per-day values incurred by Contractor for direct care, fixed and administrative costs; and
- A negotiated allowance for annual changes for direct care, fixed and administrative costs.

The APM Payment for APM Year 2 was derived by multiplying the per diem amount of $2,550 by the number of expected Inpatient Days. The State shall make a monthly APM Payment to Contractor as shown in Table 2.

Table 2. APM Year 2

Month	Expected Inpatient Days	Expected Beds per Day	Monthly Payment Amount
January 2022	1,240	40	$3,162,000
February 2022	1,120	40	$2,856,000
March 2022	1,240	40	$3,162,000
April 2022	1,260	42	$3,213,000
May 2022	1,302	42	$3,320,100
June 2022	1,260	42	$3,213,000
July 2022	1,302	42	$3,320,100
August 2022	1,302	42	$3,320,100
September 2022	1,260	42	$3,213,000
October 2022	1,302	42	$3,320,100
November 2022	1,260	42	$3,213,000
December 2022	1,302	42	$3,320,100
Totals	**15,150**	**-**	**$38,632,500**

4. Claims Submission Requirements

Contractor will submit claims for Inpatient Days consistent with existing Medicaid claims submission requirements, such as the Timely Filing requirement, and the Level 1 requirements outlined below. All claims for inpatient days covered by the APM Payment will process and pay at a rate of $0. Claims with services dates between March 2021 and December 2021 are considered part of APM Year 1. Claims with service dates on or after January 1, 2022, are considered part of APM Year 2. Claims for all other services rendered by Contractor for Vermont Medicaid members will continue to be reimbursed using existing methodologies.

a. Level 1 Claims Submission Requirements:

For Level 1 patients with third party or Medicare insurance, the third party or Medicare will be the primary payer. Differences in these payments received by Contractor and the Reasonable Actual Costs that the State is required to pay Contractor for providing the care under Act 79 will be settled in the Year-End Reconciliation process as set forth in Section 6 of Attachment B.

"Reasonable Actual Costs" for this Contract shall be defined as all direct costs supporting the Level 1 unit, including but not limited to staffing costs, physician costs, patient supplies, pharmaceuticals, direct administrative costs, office expenses, staff education, physician continuing education, and ancillary services. Ancillary services will be determined using the Schedule C Part 1 of the most recent Cost Report to define the cost to charge ratio that will be applied to the charges determined from the Provider, Statistical & Reimbursement System (PS&R). Overhead will also be allocated to the unit, using percentages that will be calculated using Schedule B Part 1 of the most recent Cost Report, excluding depreciation. Contractor shall maintain discrete auditable records which will be used to determine Reasonable Actual Costs. Cost per bed will be established using the Level 1 cost reporting.

Procedures for establishing a Level 1 billing approval are in the Psychiatric Inpatient Billing Procedures Manual.

b. Applicable to APM Year 1 Only:
For inpatient stays where the Medicaid patient had service days prior to and after the start of APM Year 1, State will pay any Inpatient Days incurred through February 28, 2021, on a fee-for-service basis. For these patients where the Inpatient Days are for service dates on or after March 1, 2021, no payment will be made through fee-for-service. These days are included in the APM Payment. This payment methodology will require claim processing system modifications to allow for zero-dollar payment on future Inpatient Days claims. These modifications will require additional time to implement after the effective date of this agreement. On an ongoing basis, as needed until the claim processing system is modified, the State will instruct the claims processor to recoup payments made on any days incurred on or after March 1, 2021, for which a fee-for-service payment was made. Parties agree that any fee-for-service payments on claims covered by the APM Payment are an overpayment, and the State is entitled to recoup these payments. This activity will not require Contractor to resubmit claims. To prevent Contractor from having to reimburse the State for duplicate claims payments, State will initiate weekly recoupments. Should the State take longer than sixty (60) days to recoup any such overpayments on properly submitted claims, such delay will not result in those overpayments being treated as false claims.

5. Risk Corridor

5.1. APM Year 1
The APM Payment in this contract is a risk sharing arrangement. In the pilot APM Year 1, Contractor shall be subject to the following risk corridor.

a. Utilization Risk Corridor
The Utilization Risk Corridor is defined as the number of Inpatient Days that wrap around the days that State has committed to purchase on a prospective basis in the APM Year. This corridor will be determined using a percentage threshold above and below the value of prospective purchase days. In APM Year 1, the utilization corridor is 98% to 102% of the total prospective days purchased of 15,576.

i. The Utilization Risk Corridor, therefore, shall be applied as follows for APM Year 1 and calculations shall be factored into the Year-End Reconciliation.

1. If the actual number of Inpatient Days utilized by Vermont Medicaid members is between 15,576 and 15,888, then Contractor shall be liable for the costs to serve patients for these days. If the actual number of Inpatient Days utilized by Vermont Medicaid members is greater than 15,888 during APM Year 1, then the State will reimburse Contractor an additional amount outside of the APM Payment for each day above 15,888 at a rate of $1,838.33 per day.

2. Conversely, if the actual number of Inpatient Days utilized by Vermont Medicaid members is between 15,264 and 15,576, Contractor will be entitled to retain 100% of the APM prospective payments. If the actual number of Inpatient Days utilized by Vermont Medicaid members is less than 15,576 during APM Year 1, then

Contractor shall reimburse back to the State an amount equivalent to $1,838.33 per day for each day below 15,264.

ii. If during the contract, the State or Contractor determines that utilization is 10% or more under the expected utilization as specified in Table 1 of Attachment B, then the parties shall meet and confer utilization or costs. Evaluations will occur no less frequently than monthly unless the Parties agree to evaluate utilization less frequently.

iii. Parties agree to monitor changes in demand/delivery during the APM Year 1 with specific regard to impacts that may be resulting from the current COVID-19 public health emergency. If during the duration of the COVID-19 public health emergency related shifts are noted that were not captured in part or in full during the process to set the APM Payment, Parties shall meet to discuss these shifts and potential adjustments to the Utilization Risk Corridor.

iv. Notwithstanding the provisions above, at the State's sole discretion, Contractor may qualify for an adjustment to the lower boundary of the utilization risk corridor. This adjustment is tied to ensuring that Level 1 admissions continue to be prioritized among all inpatient admissions. Contractor will be entitled to an offset of any monies owed back to the State if the anticipated Vermont Medicaid days do not meet the required 98% of total target of 15,576, or 15,264 days, under the following conditions:

1. If Contractor had a refusal rate of 7% instead of 8%, then the lower bound overall utilization is -2.25%, not -2.00% from target.
2. If Contractor had a refusal rate of 6% instead of 8%, then the lower bound overall utilization is -2.50%, not -2.00% from target.
3. If Contractor had a refusal rate of 5% instead of 8%, then the lower bound overall utilization is -2.75%, not -2.00% from target.
4. If Contractor had a refusal rate of 4% instead of 8%, then the lower bound overall utilization is -3.00%, not -2.00% from target.
5. If Contractor had a refusal rate of 3% instead of 8%, then the lower bound overall utilization is -3.25%, not -2.00% from target.
6. If Contractor had a refusal rate of 2% instead of 8%, then the lower bound overall utilization is -3.50%, not -2.00% from target.
7. If Contractor had a refusal rate of 1% instead of 8%, then the lower bound overall utilization is -3.75%, not -2.00% from target.
8. If Contractor had a refusal rate of 0% instead of 8%, then the lower bound overall utilization is -4.00%, not -2.00% from target.

5.2 APM Year 2

The APM PAYMENT in this contract is a risk sharing arrangement. In APM Year 2, Contractor shall be subject to the following risk corridor.

a. Utilization Risk Corridor

The Utilization Risk Corridor is defined as the number of Inpatient Days that wrap around the days that State has committed to purchase on a prospective basis in the APM Year. This corridor will be determined using a percentage threshold above and below the value of prospective purchase days. In APM Year 2, the utilization corridor is 98% to 102% of the total prospective days purchased of 15,150.

i. The Utilization Risk Corridor, therefore, shall be applied as follows for APM Year 2 and calculations shall be factored into the Year-End Reconciliation.
   1. If the actual number of Inpatient Days utilized by Vermont Medicaid members is between 14,847 and 15,453 then Contractor shall be liable for the costs to serve patients for these days.
   2. If the actual number of Inpatient Days utilized by Vermont Medicaid members is greater than 15,453 during APM Year 2 then the State will reimburse Contractor an additional amount outside of the APM Payment for each day above 15,453 at a rate of $2,550 per day.
   3. If the actual number of Inpatient Days utilized by Vermont Medicaid members is less than 14,847 during APM Year 2, then Contractor shall reimburse back to the State an amount equivalent to $2,550 per day for each day below 14,847.

ii. If during the contract, the State or Contractor determines that the Inpatient Days utilization are 10% or more under the expected utilization as specified in Table 2 of Attachment B, then the Parties shall meet to discuss utilization or costs. Evaluations will occur no less frequently than monthly unless the parties agree to evaluate utilization less frequently.

iii. Parties agree to monitor changes in demand/delivery during the APM Year 2 with specific regard to impacts that may be resulting from the current COVID-19 public health emergency. If during the duration of the federal or state COVID-19 public health emergency related shifts are noted that were not captured in part or in full during the process to set the APM Payment, Parties shall meet to discuss these shifts and potential adjustments to the Utilization Risk Corridor.

iv. Notwithstanding the provisions above, at the State's sole discretion, Contractor may qualify for an adjustment to the lower boundary of the utilization risk corridor. This adjustment is tied to ensuring that Level 1 admissions continue to be prioritized among all inpatient admissions. Contractor will be entitled to an offset of any monies owed back to the State if the anticipated Vermont Medicaid days do not meet the required 98% of total target of 15,150 or 14,487 days, under the following conditions:
   1. If Contractor had a refusal rate of 7% instead of 8%, then the lower bound overall utilization is -2.25%, not -2.00% from target.
   2. If Contractor had a refusal rate of 6% instead of 8%, then the lower bound overall utilization is -2.50%, not -2.00% from target.
   3. If Contractor had a refusal rate of 5% instead of 8%, then the lower bound overall utilization is -2.75%, not -2.00% from target.
   4. If Contractor had a refusal rate of 4% instead of 8%, then the lower bound overall utilization is -3.00%, not -2.00% from target.
   5. If Contractor had a refusal rate of 3% instead of 8%, then the lower bound overall utilization is -3.25%, not -2.00% from target.
   6. If Contractor had a refusal rate of 2% instead of 8%, then the lower bound overall utilization is -3.50%, not -2.00% from target.
   7. If Contractor had a refusal rate of 1% instead of 8%, then the lower bound overall utilization is -3.75%, not -2.00% from target.

8. If Contractor had a refusal rate of 0% instead of 8%, then the lower bound overall utilization is -4.00%, not -2.00% from target.

6. Year-End Reconciliation

The State will complete a Year-End Reconciliation process within 150 days after the close of each APM Year. In order to meet this deadline, Contractor agrees to provide all information necessary, as reasonably identified by the State, to complete the Year-End Reconciliation within 90 days after the end of each APM Year. This includes, adjudicated and approved claims submissions for patients who discharged prior to the end of each APM Year, census information for days for patients who did not discharge by the end of each APM Year, and financial information pertaining to the Level 1 Cost Settlement through the end of each APM Year. If the State reasonably determines that additional information is necessary, Contractor will provide such information.

a. Level 1 Cost Settlement

The State shall reimburse Contractor's Reasonable Actual Costs, net of all other revenues, for providing care capacity for 26 Level 1 Beds, in accordance with the requirements of Act 79 (2012). The State and Contractor agree to settle on an annual basis the difference between all revenues (including interim daily payments made by DMH or the State and APM Payments) and Reasonable Actual Costs. A mid-year review may be conducted at the request of either party to assess whether the interim rate needs to be adjusted. A final review consistent with Act 79 legislation will be for the fiscal period ending December 31st of each year for which this contract is in force.

If, after completion of that review, there is a difference in Reasonable Actual Costs as defined in this contract and actual costs incurred, and the State disallows expenditures, Contractor may request that the State review the disallowed expenditures in accordance with Attachment B, Section 7: Dispute Resolution. If there is a disagreement in Reasonable Actual Costs, as defined in this contract, and actual costs incurred by Contractor, Contractor and the State will work together to determine a revised reasonable actual cost definition.

Upon the completion of the Year-End Reconciliation process, if there is a Medicare claim or cost report adjustment resulting in the recovery of a previous reimbursement, Contractor may reopen the reconciliation process to identify additional costs.

b. Utilization Risk Corridor Reconciliation

The calculation of the Utilization Risk Corridor will be conducted utilizing the following information:

- All approved and paid claims submitted by Contractor by March 31st following each APM Year; and
- Information as requested by the State provided by Contractor to inform census for Medicaid eligible and Level 1 eligible members in an active Inpatient Day stay at Contractor for which a final claim has not yet been submitted to the State as of March 31st after each APM Year, and
- Any monies owed to or by Contractor as a result of the Utilization Risk Corridor reconciliation will be reflected by claims and final census data received by March 31st after

each APM Year. Claims or additional census data for eligible Inpatient Days during each APM Year received after the annual March 31st deadline will not be considered in the Utilization Risk Corridor calculation and Contractor will not receive payment for these services under this contract.

c. Combined Settlement
The amounts derived from the application of the Utilization Risk Corridor and the Level 1 cost settlement shall be combined to determine the overall amount owed either to Contractor by the State or to the State by Contractor.

7. Dispute Resolution
Contractor may appeal the State's decision to deny, in whole or in part, Reasonable Actual Costs, as defined in this Attachment B, Section 6.a, to the Secretary of the Agency of Human Services. Appeals to the Secretary must be made within 30 days of Contractor receiving a denial of the disallowed expenditures by the State. The AHS Secretary's decision is subject to review pursuant to V.R.C.P. 75. The State shall pay Contractor based on the definition of Reasonable Actual Costs in this contract until there is a final determination of a disallowed expenditure, including a court determination pursuant to V.R.C.P. 75. Upon the final decision, based on the outcome, there will be a settlement payment to Contractor or payback to the State which shall be made within 30 days of the final decision.