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 $134,356,834.00 to $210,000,000.00, representing an increase of $75,643,166.00.

II. **Contract Term.** The Contract Term, wherever such references appear, shall be changed from December 31, 2023, to December 31, 2024.

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

A. Section 1, as previously amended, is 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;
- Medicaid child, adolescent, and adult stays for patients who have exhausted their Medicare benefits and become covered by Medicaid; and
- Level 1 stays not covered by commercial insurance or other non-Medicaid payer sources.

B. Section 2.a, as previously amended, is hereby deleted and replaced as follows for APM Years 3 and 4:

2.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. In addition to maintaining the agreed upon number of Inpatient Days for Medicaid Members, Contractor shall increase total bed capacity, regardless of payer, to 80 beds by December 31, 2022, and to 100 beds by June 30, 2023. Total bed capacity may temporarily decrease due to emergent issues, including COVID outbreaks, but capacity shall only be decreased for the minimum necessary period and Contractor shall ensure Inpatient Days for Medicaid Members, State-referred patients, children, and adolescents are prioritized, provided they meet level of care, during decreased capacity so that Contractor maintains capacity for Inpatient Days.
- Specific to Level 1 beds:
  - Contractor shall maintain 20 Level 1 emergency examination or court-ordered observation psychiatric inpatient beds to support patients who require additional staffing resources for treatment and are referred by DMH Care Management.
    - 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 or are deemed Level 1 for admission by the State due to placement needs.
    - "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 or are deemed Level 1 for admission by the State due to placement needs.
    - Contractor's Level 1 beds shall be no-refusal beds as defined in Act 79.

- State may request 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.

- 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-designated bed. 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 in a Level 1-designated bed 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 to utilize a non-Level 1-designated bed, 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-designated bed, Contractor's Chief Medical Officer, or designee, shall discuss 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 in a non-Level 1-designated bed 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, Contractor shall 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.

- Referral Process for all State-referred admissions (including Level 1 referrals):
  - Should Contractor refuse any clinically appropriate Level 1-referred admission, 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. The written justification shall include specific detail regarding the barriers for providing active treatment and/or treating the patient safely in the milieu of the facility. This written documentation shall be sent to the DMH Care Management Director within one business day of the refusal.
  - "Refusal" for a State-referred admission 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 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.
  - Accepted Referrals that are not placed within 24 hours due to transportation problems beyond Contractor's control shall not be counted as refusals.
  - Accepted referrals that are not placed within 24 hours because the prospective patient voluntarily chose to receive care elsewhere after being accepted by Contractor shall not be counted as refusals.

C. By amending Sections 3.b (DMH/DVHA Specific Measures) and Section 3.c (DVHA Reporting) to be applicable to both APM Years 3 and 4.

IV. **Attachment B, Payment Provisions**. The Payment Provisions are hereby deleted and replaced entirely as shown in Exhibit 1 of this Amendment 4.

Sole Source Contract for Services. 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.

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.

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

This document consists of 13 pages. Except as modified by this Amendment No. 4, 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: Dawn O'Toole 12/27/2023
8AFAEBF6A026493...

TODD DALOZ (OR DESIGNEE) DATE
AHS Deputy Secretary
280 State Drive, Building E
Waterbury, VT 05671-1010
Phone: 802-585-5964
Email: Todd.Daloz@vermont.gov

BY THE CONTRACTOR:

DocuSigned by: Linda Rossi 12/27/2023
587B6F3664154A1...

LINDA ROSSI DATE
CEO
Brattleboro Retreat
Anna Marsh Lane
Brattleboro, VT 05301
Email: lrossi@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, except that Inpatient Days for which Medicaid is the payer because the patient's Medicare benefits have been exhausted are not 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, 2021 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, 2022 through December 31, 2022, is defined as APM Year 2. For the APM Year 2, the APM Payment for January 1, 2022 through June 30, 2022 is computed using a weighted average per diem amount of $2,550.00. The APM Payment for July 1, 2022 through December 31, 2022 is computed using a weighted average per diem amount of $3,100.00.

The time period January 1, 2023 through December 31, 2023, is defined as APM Year 3. For the APM Year 3, the APM Payment is computed using a weighted average per diem amount of $3,100.00.

The time period January 1, 2024 through December 31, 2024 is defined as APM Year 4. For the APM Year 4 the APM Payment is computed using a weighted average per diem amount of $3,100.00.

3. Methodology for Payment

3.1. APM Year 1

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

i. Historical Contractor inpatient utilization incurred by the Department of Mental Health (DMH) and DVHA;
ii. Projected Contractor inpatient utilization in APM Year 1;
iii. Recent cost-per-day values incurred by Contractor for direct care, fixed and administrative costs; and
iv. 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**

3.2. APM Year 2

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

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

The APM Payment for APM Year 2 January through June months of services is derived by multiplying the per diem amount of $2,550 by the number of expected Inpatient Days. The APM Payment for July through December months of service is derived by multiplying the per diem amount of $3,100 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	1,581	51	$4,901,100
August 2022	1,581	51	$4,901,100
September 2022	1,530	51	$4,743,000
October 2022	1,581	51	$4,901,100
November 2022	1,530	51	$4,743,000
December 2022	1,581	51	$4,901,100
Totals	**16,806**	**-**	**$48,016,500**

3.3. APM Year 3

The per diem amount in the APM Payment for APM Year 3 was derived using the following factors:

i. Historical Contractor inpatient utilization incurred by DMH and DVHA;
ii. Projected Contractor inpatient utilization in APM Year 3;
iii. Recent cost-per-day values incurred by Contractor for direct care, fixed and administrative costs; and
iv. A negotiated allowance for annual changes for direct care, fixed and administrative costs.

The APM Payment for APM Year 3 is derived by multiplying the per diem amount of $3,100 by the number of expected Inpatient Days. The State shall make a monthly APM Payment to Contractor as shown in Table 3.

Table 3. APM Year 3

Month	Expected Inpatient Days	Expected Beds per Day	Monthly Payment Amount
January 2023	1,581	51	$4,901,100
February 2023	1,428	51	$4,426,800
March 2023	1,581	51	$4,901,100
April 2023	1,530	51	$4,743,000
May 2023	1,581	51	$4,901,100
June 2023	1,530	51	$4,743,000
July 2023	1,581	51	$4,901,100
August 2023	1,581	51	$4,901,100
September 2023	1,530	51	$4,743,000
October 2023	1,581	51	$4,901,100
November 2023	1,530	51	$4,743,000
December 2023	1,581	51	$4,901,100
Totals	**18,615**	**-**	**$57,706,500**

3.4. APM Year 4

The per diem amount in the APM Payment for APM Year 4 was derived using the following factors:

v. Historical Contractor inpatient utilization incurred by DMH and DVHA;
vi. Projected Contractor inpatient utilization in APM Year 4;
vii. Recent cost-per-day values incurred by Contractor for direct care, fixed and administrative costs; and
viii. A negotiated allowance for annual changes for direct care, fixed and administrative costs.

The APM Payment for APM Year 4 is derived by multiplying the per diem amount of $3,100 by the number of expected Inpatient Days. The State shall make a monthly APM Payment to Contractor as shown in Table 4.

Table 4. APM Year 4

Month	Expected Inpatient Days	Expected Beds per Day	Monthly Payment Amount
January 2024	1,581	51	$4,901,100
February 2024	1,429	51	$4,429,900
March 2024	1,581	51	$4,901,100
April 2024	1,530	51	$4,743,000
May 2024	1,581	51	$4,901,100
June 2024	1,530	51	$4,743,000
July 2024	1,581	51	$4,901,100
August 2024	1,581	51	$4,901,100
September 2024	1,530	51	$4,743,000
October 2024	1,581	51	$4,901,100
November 2024	1,530	51	$4,743,000
December 2024	1,581	51	$4,901,100
Totals	**18,616**	**-**	**$57,709,600**

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 APM Years 1-2 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 with service dates on or after January 1, 2023, are considered part of APM Year 3. Claims with service dates on or after January 1, 2024 are considered part of APM Year 4. 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 APM Years 1 and 2:

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 units, 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 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.

For APM Years 3 and 4:

For Level 1 patients with third party or Medicare insurance, payment by third party or Medicare constitutes full payment for the days covered by the third party or Medicare benefit structure. The State shall pay the APM rate for the days not reimbursed by third party or Medicare. Claims for Individuals who are not enrolled in Medicaid must be billed and paid with an aid category of MH or MU.

Stays of Level 1 patients for whom Medicaid is the primary payer, and stays of Level 1 patients who have no insurance or who have exhausted their Medicare benefits, as stated in "Attachment A: Scope of Work," fall under the definition of Inpatient Days. Accordingly, the State shall pay Contractor in accordance with the procedures outlined in this Attachment for payment for Inpatient Days, including but not limited to any applicable claims submission requirements and utilization risk corridors for Inpatient Days.

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 15,264 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 for the

period of January 1, 2022 through June 30, 2022 of 7,422. For the period of July 1, 2022 through December 31, 2022, the utilization corridor is 98% to 102% of the total prospective days purchased of 9,384.

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. For the period of January 1, 2022 through June 30, 2022, if the actual number of Inpatient Days utilized by Vermont Medicaid members is between 7,570 and 7,274 then Contractor shall be liable for the costs to serve patients for these days. For the period of July 1, 2022 through December 31, 2022, if the actual number of Inpatient Days utilized by Vermont Medicaid members is between 9,572 and 9,196 then Contractor shall be liable for the costs to serve patients for these days.
   2. For the period of January 1, 2022 through June 30, 2022, if the actual number of Inpatient Days utilized by Vermont Medicaid members is greater than 7,570 then the State will reimburse Contractor at a rate of $2,550 for each day above 7,570. For the period of July 1, 2022 through December 31, 2022, if the actual number of Inpatient Days utilized by Vermont Medicaid members is greater than 9,572, then the State will reimburse Contractor at a rate of $3,100 for each day above 9,572.
   3. For the period of January 1, 2022 through June 30, 2022, if the actual number of Inpatient Days utilized by Vermont Medicaid members is below 7,274, then Contractor shall reimburse back to the State an amount equivalent to $2,550 per day for each day below 7,274. For the period of July 1, 2022 through December 31, 2022, if the actual number of Inpatient Days utilized by Vermont Medicaid members is below 9,196, then Contractor shall reimburse back to the State an amount equal to $3,100 per day for each day below 9,196.

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 days specified in Section 5.2.a above, 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.

5.3 APM Year 3

The APM PAYMENT in this contract is a risk sharing arrangement. In APM Year 3, 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 3, the utilization corridor is 98% to 102% of the total prospective days purchased of 18,615.

i. The Utilization Risk Corridor, therefore, shall be applied as follows for APM Year 3 and calculations shall be factored into the Year-End Reconciliation.
   1. If the actual number of utilized Inpatient Days is between 18,243 and 18,987 then Contractor shall be liable for the costs to serve patients for these days.
   2. If the actual number of utilized Inpatient Days is greater than 18,987 during APM Year 3 then the State will reimburse Contractor an additional amount outside of the APM Payment for each day above 18,987 at a rate of $3,100 per day.
   3. If the actual number of utilized Inpatient Days is less than 18,243 during APM Year 3, then Contractor shall reimburse back to the State an amount equivalent to $3,100 per day for each day below 18,243.

ii. If during the contract, the State or Contractor determines that the Inpatient Days used are 10% or more under the expected utilization as specified in Table 3 of Attachment B, then the Parties may meet to discuss utilization or costs. Evaluations will occur no less frequently than monthly unless the parties agree to evaluate utilization less frequently.

5.4 APM Year 4

The APM Payment in this contract is a risk sharing arrangement. In APM Year 4, 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 utilized days thresholds above and below the value of prospective purchase days.

i. The Utilization Risk Corridor, therefore, shall be applied as follows for APM Year 4 and calculations shall be factored into the Year-End Reconciliation.
   1. Contractor shall be liable for the costs to serve patients between 18,616 and 18,988 Inpatient Days.
   2. The State shall pay Contractor a rate of $3,100 per day for each Inpatient Day utilized between 18,989 and 20,788.
   3. Contractor shall be liable for the costs to serve patients between 20,789 and 21,347 Inpatient Days.

4. The State shall pay Contractor a rate of $3,100 per day for each Inpatient Day utilized above 21,347.
5. If the actual number of utilized Inpatient Days is less than 18,243 during APM Year 4, then Contractor shall reimburse back to the State an amount equivalent to $3,100 per day for each day below 18,243.

ii. If during the contract, the State or Contractor determines that the Inpatient Days used are 10% or more under the expected utilization as specified in Table 4 of Attachment B, then the Parties may meet to discuss utilization or costs. Evaluations will occur no less frequently than monthly unless the parties agree to evaluate utilization less frequently.

6. Year-End Reconciliation

The State will complete a Year-End Reconciliation after the close of each APM Year. 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, for APM Years 1 and 2 only, financial information pertaining to the Level 1 Cost Settlement through the end of APM Years 1 and 2. If the State reasonably determines that additional information is necessary, Contractor will provide such information. The State's ability to complete the Year-End Reconciliation is dependent on Contractor's timely submission of the necessary information. Any delay in completing the Year-End Reconciliation by the State that results from untimely submissions by Contractor shall not be considered a breach of this Contract by the State.

a. Preliminary Reconciliation Permitted

In APM Years 3 and 4, the State and Contractor may mutually agree to preliminary reconciliation estimates at any point. Any preliminary payments resulting from a preliminary reconciliation shall be included in the final APM Year 4 reconciliation.

b. Level 1 Cost Settlement for APM Years 1 and 2 only

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 and Reasonable Actual Costs as demonstrated by Contractor through audited financial information. If audited financial information is not available for the Level 1 Cost Settlement within 90 days after the end of each APM Year due to timing of the audit and cost report submission, preliminary unaudited financial information may be submitted to State. State will use that information to initiate a Level 1 cost settlement review. Contractor shall submit audited financial information within 150 days for State to confirm or adjust the Level 1 cost settlement amount. 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.

For APM Years 3 and 4, the Parties agree that the APM Per Diem rate is a fair and reasonable prospective estimate of the reasonable actual cost of care. Therefore, Contractor will not seek additional compensation from the State for Level 1 Patient days except as authorized by Section 4.a of this Attachment B.

c. Utilization Risk Corridor Reconciliation

The State will complete the Utilization Risk Corridor Reconciliation within 150 days after the close of each APM Year. 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
- All information as requested by the State provided by Contractor concerning active Inpatient Day stays 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 between the annual March 31st deadline and the completion of the Year-End Reconciliation may be included at the State's discretion.

d. Combined Settlement for APM Years 1 and 2 only

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 for APM Years 1 and 2.

For APM Years 3 and 4, this provision is no longer in effect.

7. Dispute Resolution

Contractor may appeal the State's decision to deny, in whole or in part, any portion of the reimbursement authorized by this Contract, to the Secretary of the Agency of Human Services. Appeals to the Secretary must be made within 30 days of Contractor receiving a denial in writing of the disallowed amounts 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 this Attachment B in this Contract until there is a final determination of a disallowed amount, 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.